



House of Commons
Health Committee

Impact of the Spending Review on health and social care

First Report of Session 2016–17



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*Report, together with formal minutes
relating to the report*

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Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Summary

We welcome the Five Year Forward View, which sets out the funding challenge facing the NHS over the next five years and, for the first time, a vision for the service to equip it to meet patients' needs. Last year's Spending Review aimed to provide the funds to make the Forward View a reality.

The scale of the funding challenge is colossal, especially given the timescale for achieving it. While the NHS has been treated favourably in comparison with other departments, the funding allocated for the NHS in the Spending Review is less than would appear to be the case from official pronouncements. We call on the Government to be clearer in the presentation of its funding commitments. We are concerned that the shift in resources, especially from public health, health education, transformation and capital budgets, will make it far more difficult to achieve the ambitions set out in the Forward View. In our view, the funding announced in the Spending Review does not meet the Government's commitment to fund the Five Year Forward View.

There are also new challenges, most notably the rising deficits in NHS providers. The proposed strategies for reducing their costs—cutting the tariffs paid to hospitals, strict pay restraint, imposing agency price caps and reducing capital spending—are not sustainable ways of securing efficiencies in the long term.

The funding designed to pump prime the transformation of services to create better and more efficient services in the future, the Sustainability and Transformation Fund, is being used almost entirely to plug provider deficits, rather than to transform the health and social care system at scale and pace. The transfers from capital to revenue budgets are storing up future costs as well as reducing the funding available for essential transformation of services. We call for the Transformation element of the Fund to be protected to allow the ambitions of the Five Year Forward View to be realised.

The ongoing work to integrate health and social care services, in ways that better meet the needs of patients, shows great promise. But integration and devolution to local areas do not offer quick solutions to the financial problems facing the NHS and social care services. The Transformation fund is essential to get these promising plans off the ground, and we shall be monitoring how it is spent.

Historical cuts to social care funding have now exhausted the capacity for significant further efficiencies in this area. Increasing numbers of people with genuine social care needs are no longer receiving the care they need because of a lack of resource. This not only causes considerable distress to these individuals and their families but results in additional costs to the NHS. We will be monitoring the extent to which the Better Care Fund and Social Care Precept are successful in raising revenue and how this is distributed to reflect need and health inequality. We also note with concern that this funding will not arrive until later in the Spending Review period.

Workforce supply must be improved if we are to meet the future health and social care needs of the population. Most immediately, the Government should review the likely impact of the proposed abolition of NHS bursaries on the supply of nursing staff and other allied health professionals.

We are concerned about the cuts to Health Education England at a time when the workforce shortfall is already placing a strain on services and driving higher agency costs.

The Government has made it clear that it wishes to see more NHS services available at the weekends. Whilst there is now a clearer account of their intentions for seven-day services in hospitals and GP surgeries, we will continue to monitor their implementation. Given the constraints on NHS resources we will be reviewing whether the focus on seven-day services is delivering value for patients given the concern that it may displace measures which would be more cost effective.

The cuts to public health budgets set out in the Spending Review threaten to undermine the necessary upgrade to prevention and public health set out in the Five Year Forward View. We believe that cutting public health is a false economy, creating avoidable additional costs in the future.

We shall be looking for clear, verifiable evidence that the additional funding promised for mental health is being delivered to the front line, as well as evidence of sustainable progress towards the culture change across the NHS, from commissioners to providers, necessary to deliver genuine parity of esteem.

While the Forward View sets out the vision, we call on the Department of Health and NHS England to set out a detailed plan for realising the efficiencies and demand reductions needed to realise the Forward View. This needs to be accompanied by strategic thinking from Ministers about what priorities will best support achievement of the vision in the long term when resources are constrained.

We believe it is time for the Government and NHS England to set out how they will manage the shortfall in NHS and social care finances if the measures proposed by the Forward View fail to bridge the funding gap. If the funding is not increased, there needs to be an honest explanation of what that will mean for patient care and how that will be managed.

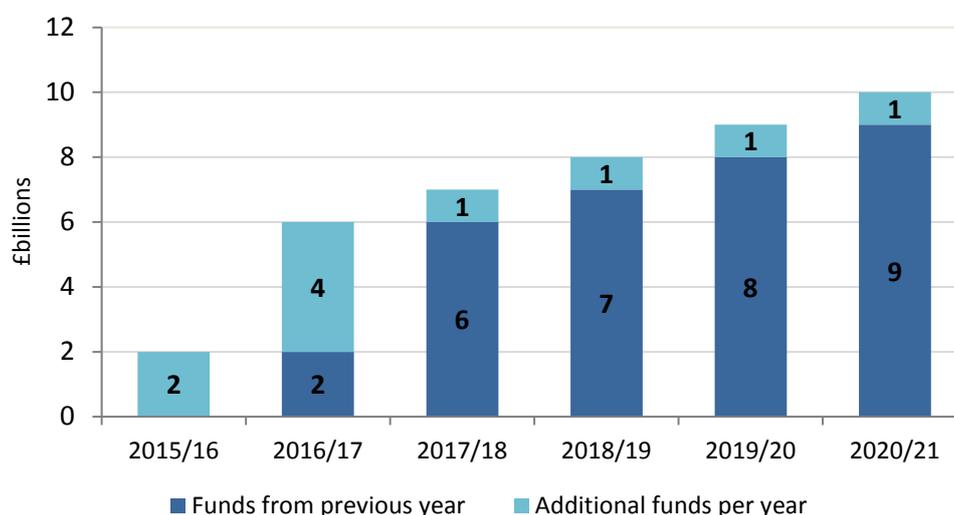
1 Introduction

The Spending Review settlement for health and social care

The settlement for health

1. The Government’s Spending Review and Autumn Statement 2015 announced that NHS England would receive an additional £8.4 billion above inflation by 2020–21. With the extra funding received in 2015–16, this meant that “the NHS will receive £10 billion more a year in real terms by 2020–21 than in 2014–15”.¹ The additional funding above inflation would be “front-loaded”, i.e. larger increases would come at the start of the spending review period. An additional £3.8bn would be provided in 2016–17, with further increases then spread over the rest of the period.

Figure 1: Cumulative delivery of Spending Review commitment to the NHS



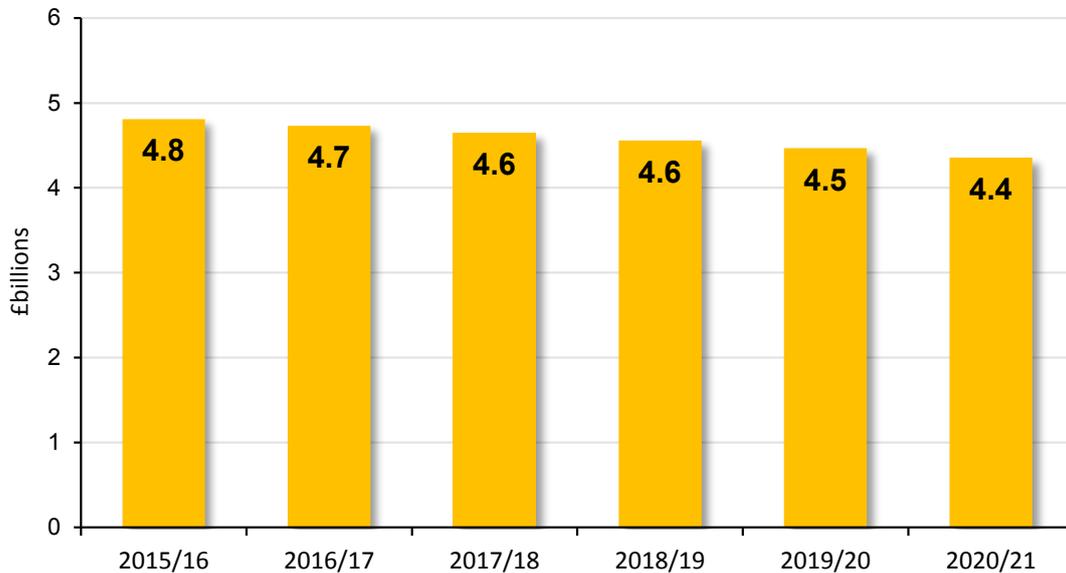
Source: HM Treasury, [Spending Review and Autumn Statement 2015](#) (Cm 9162), November 2015, Table 2.9

2. Capital spending will, however, remain flat in cash terms over the spending review period, at £4.8bn each year.² That represents a real-terms reduction of 9% from 2015–16 to 2020–21.

¹ HM Treasury, [Spending Review and Autumn Statement 2015](#) (Cm 9162), November 2015, para 1.97

² CSR 042, para 5.

Figure 2: Capital spending 2015/16–2020/21, in real terms at 2015–16 prices



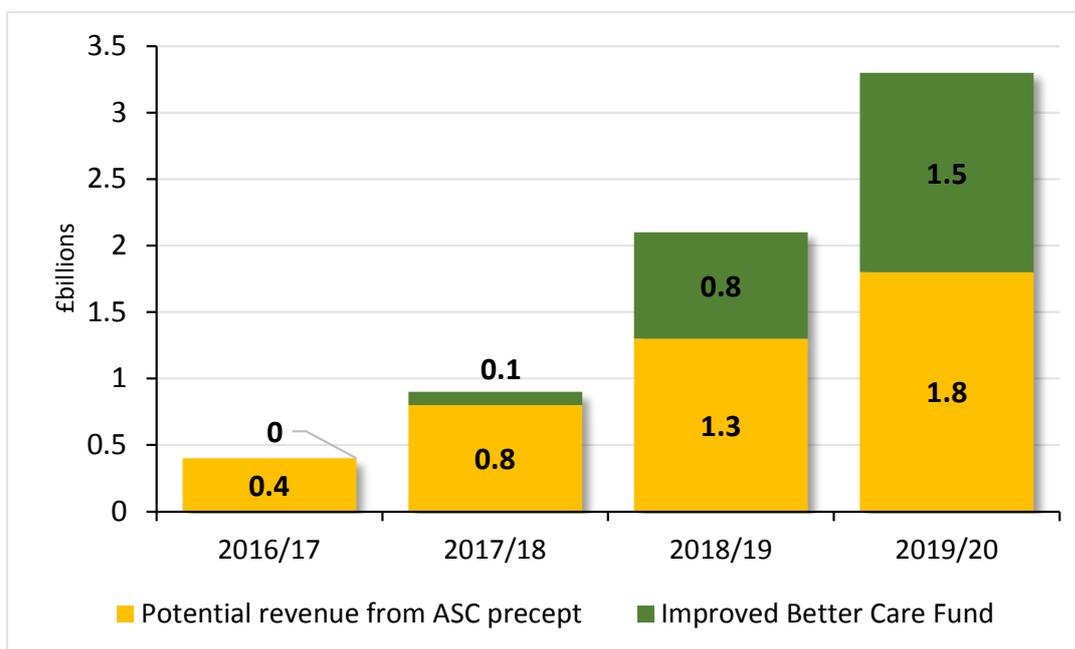
Source: House of Commons Scrutiny Unit, using figures from written evidence from the Department of Health

The settlement for social care

3. In social care, the Spending Review announced an additional “£3.5 billion of support for adult social care by 2019-20”. As the graph below demonstrates, this funding will be “back-loaded”, i.e. larger increases will come towards the end of the Spending Review period. The Review announced two new sources of funding:

- Councils will be able to introduce a new Social Care Precept, allowing them to increase council tax by an additional 2%. It was estimated at the spending review that if all local authorities used this to its maximum effect it could help raise nearly £2 billion a year by 2019-20, assuming full take-up.
- From April 2017, the spending review makes available social care funds for local government, rising to £1.5 billion by 2019-20, to be included in the Better Care Fund.

The distribution of these new funds over the spending review period is set out in the graphic below.

Figure 3: New funding for social care announced in the Spending Review

Source: Written evidence from the Department of Health

4. As the Department of Health's written evidence notes, adult social care funding is part of wider local government finance.³ Local authorities are responsible for deciding how much of their income they spend on social care. Alongside the increases in social care funding, the Government announced a reduction in its grant funding to local authorities of £6.1 billion by 2019–20, matched, the Spending Review noted, by projected increases in other sources of income such as council tax and business rates of £6.3 billion by 2019–20.⁴ In the meantime, the Government will consult on changes to the local government finance system to pave the way for the retention by local authorities of all the business rate income they raise, 50% of which is currently passed directly back to the Treasury and redistributed through Government's grant funding to local authorities. The consultation will take into account all the main resources currently available to councils, including council tax and business rates.⁵

Extent of our inquiry

5. Health and social care are devolved functions for the UK, and so policy and spending decisions outside England will depend on decisions made by the devolved administrations of Northern Ireland, Scotland and Wales. The UK government uses the Barnett formula to allocate public funding to the devolved administrations and in devolved areas such as health, the devolved administrations receive a proportional share of any changes in funding. As such, funding decisions in England may influence the overall level of funding in the devolved administrations. In the case of health expenditure, we note that these

³ CSR0042, para 29.

⁴ [Spending Review and Autumn Statement 2015](#), paras 2.123 and 2.127.

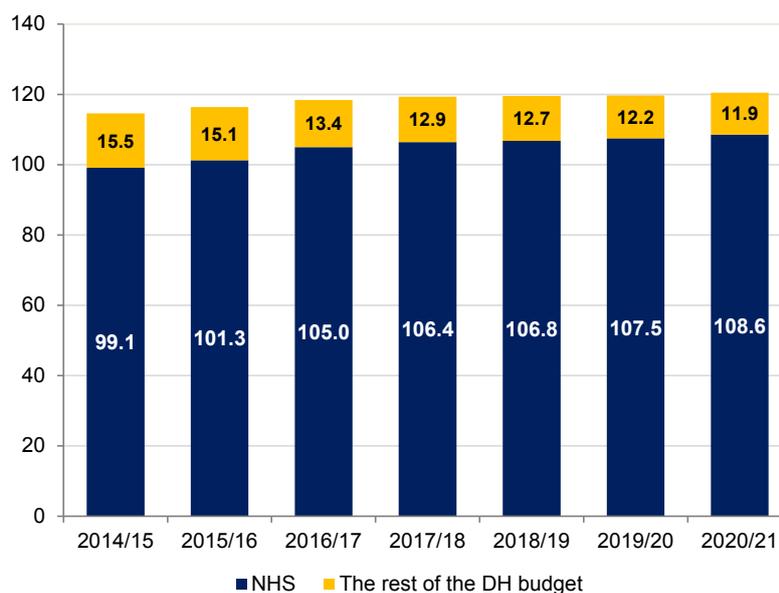
⁵ [Spending Review and Autumn Statement 2015](#), para 2.126.

so-called “Barnett consequentials” are calculated on the basis of total health expenditure, not allocations to NHS England. In accordance with our remit, which extends to the administration, expenditure and policy of the Department of Health and its associated public bodies, which as a consequence of devolution have only very limited responsibilities outside England, this inquiry focused exclusively on the spending review decisions for health and social care in England.

The Spending Review claim of an additional £10 billion for the NHS

6. Our starting-point has been to consider the Spending Review claim that the NHS will receive an additional £10 billion above inflation by 2020–21. There are two reasons why this figure does not, in our view, accurately reflect the impact of the Spending Review on health expenditure. The first is that the £10 billion figure is expressed in 2020–21 prices, rather than the current (2015–16, the time of the Spending Review) prices which would normally be expected to have been used in the calculation of such figures. At 2015–16 prices, NHS England’s budget will rise by £9.5 billion between 2014–15 and 2020–21. The second reason is that the £10 billion figure refers to the additional sum allocated to NHS England, not to total health spending. Part of the increase in funding to NHS England is being funded by reductions in areas of health spending which fall outside NHS England’s budget, such as the public health grant to local authorities, and education and training funded through Health Education England. Those reductions amount to £3.5 billion in real terms, at 2015–16 prices, between 2014–15 and 2020–21. The overall impact is that total health spending—the Department of Health’s budget—will increase in real terms, at 2015–16 prices, by £6 billion between 2014–15 and 2020–21. If the spending review period is considered—2015–16 to 2020–21—that increase is £4.5 billion. We cover this point in greater detail later in this report.⁶

⁶ See para 53ff. The figures quoted here have been calculated with reference to the Summer Budget 2015 deflator, consistent with the way the £10 billion (increase between 2014–15 and 2020–21) has been reported at Table 2.8 of the [Spending Review and Autumn Statement 2015](#) (Cm 9162). Later in this report, we revert to the Spending Review 2015 deflator, to stay consistent with the figure of £8.4 billion (increase between 2015–16 and 2020–21) quoted in the Department of Health’s written evidence to this inquiry ([CSR0042](#), Table 2).

Figure 4: Total health spending, 2014/15–2020/21, in real terms at 2015/16 prices

Source: House of Commons Scrutiny Unit. Note: totals may not match those in para 6 above due to rounding

Our report

7. The body of this report is in three sections. In Chapter 2, we assess the current state of health and social care finances. Chapter 3 considers the effect of the Spending Review announcements, and the scope and plans for further efficiency savings in health and social care over the spending review period. Chapter 4 looks in more detail at a number of major initiatives and key policy changes which will have a significant impact on the financial position of the NHS and social care, both in the next few years and in the longer term. Finally, in a concluding chapter, we draw together our assessment of the impact of the Spending Review on health and social care, and set out our intention to examine the subject of the impact of the Government's spending decisions upon health and social care on a regular basis and hold Ministers, NHS England and NHS Improvement regularly to account over the course of the Spending Review period.

8. Our inquiry took place, and the evidence was gathered, before the vote on 23 June 2016 on the UK's membership of the European Union. The implications of the decision resulting from that vote have yet to become clear, but will clearly affect health and social care, as we have heard in the evidence we have taken separately on the implications for health of the UK's membership of the EU.⁷ Our future consideration of the impact of the Spending Review on health and social care will be informed by developments resulting from the UK's expected exit from the EU, and we will be scrutinising those developments very closely in light of the concerns about the impact on the social care system, the National Health Service and research.

7 Available on the Committee's website: [Inquiries > Impact of membership of the EU on health policy in the UK](#)

2 The current state of health and social care finances

9. Over the last parliament the Department of Health budget grew by an average of 1.1% a year, from £109.3 billion in 2009–10 to £116.6 billion in 2015–16.⁸ Unlike many other departments, the Department of Health’s budget has been protected from spending cuts in recent years, while other Government expenditure set at Spending Reviews has declined (from £421.6 billion in 2009–10 to £356.7 billion in 2015–16). As a result, the Department of Health’s share of that expenditure⁹ grew from 25.8% in 2009–10 to 32.7% in 2015–16.¹⁰ Nevertheless the rate at which the budget has increased has been at historically low levels.

Figure 5: Total Health expenditure in England from 2009-10 to 2015-16

| | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 |
|---|---------|---------|---------|---------|---------|---------|---------|
| Health expenditure, cash terms (£m) | 98,419 | 100,418 | 102,844 | 105,222 | 109,777 | 113,300 | 116,574 |
| Annual change, cash terms (%) | | 2.0 | 2.4 | 2.3 | 4.3 | 3.2 | 2.9 |
| Health expenditure, 2015/16 prices (£m) | 109,341 | 108,558 | 109,226 | 109,976 | 112,419 | 114,433 | 116,574 |
| Annual change, real terms (%) | | -0.7 | 0.6 | 0.7 | 2.2 | 1.8 | 1.9 |

Note: Health expenditure is measured as total department expenditure limit, excluding depreciation

Source: HM Treasury. Public Expenditure Statistical Analyses 2015.

10. Figure 6 shows that public spending on health in the UK as a proportion of GDP has fallen in recent years. We were told that overall (public and private) healthcare spending is also low relative to that of comparable countries.¹¹ The figures for 2013 show that the UK spent 8.5% of GDP on public and private health.¹² This is lower than the average for OECD countries (9.1%) and for the EU-15 (10.1%).¹³ Of the EU-15 countries only Luxembourg and Ireland dedicated less of their GDP to health. Austria, Belgium, Denmark, France, Germany, the Netherlands, and Sweden all chose to spend over 10% of their GDP on

8 The Department of Health budget is measured as the Total Department Expenditure limit (DEL) in 2015-16 prices, excluding depreciation.

9 This excludes about half of total government spending, which is harder to control, volatile and/or demand-led, and therefore not subject to the firm multi-year limits that are set at Spending Reviews. The main such area of spending is benefits and tax credits.

10 Source: House of Commons Scrutiny Unit

11 CSR 0091, para 1.4; Q4; Qq 49–50.

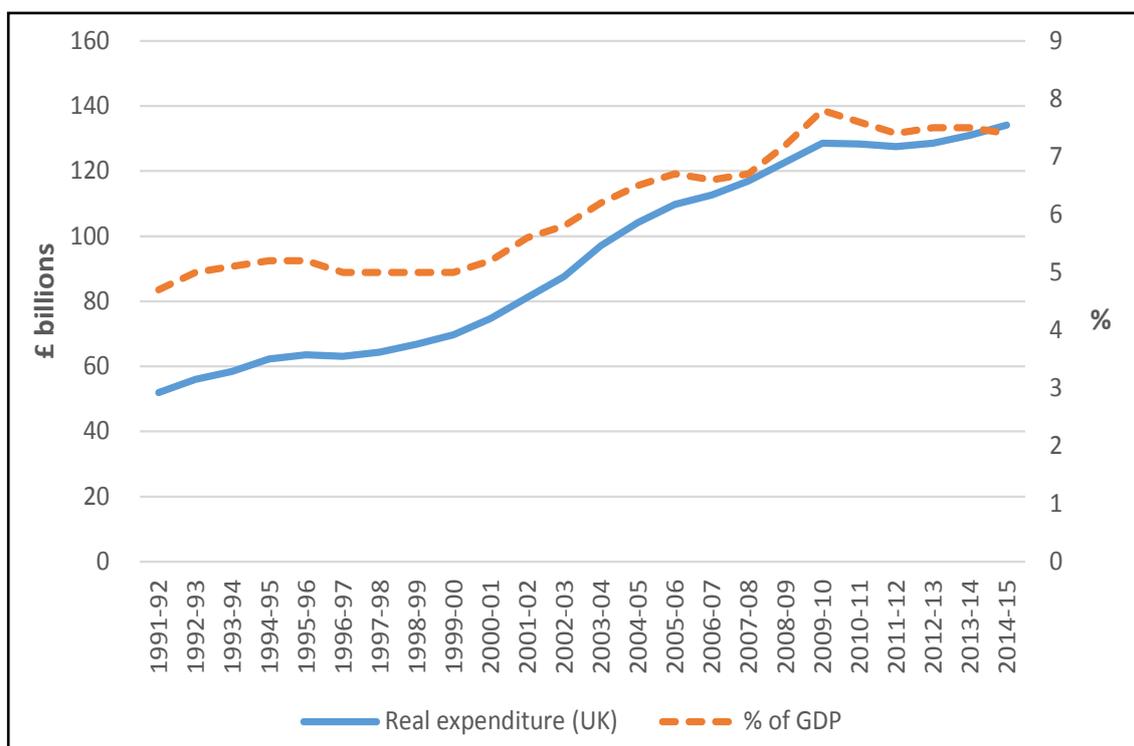
12 [OECD health data](#).

13 The EU 15 are the member countries in the European Union prior to the accession of ten candidate countries on 1 May 2005. They are comprised of the following 15 countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Luxembourg, Netherlands, Portugal, Spain, Sweden, and the United Kingdom.

health care in that year.¹⁴ However, a 2014 report by the Commonwealth Fund suggests the UK is a leader in maximising the value from its resources, ranking first out of eleven healthcare systems on measures of efficiency.¹⁵

11. John Appleby of the King's Fund told us that its projections for 2016 suggest NHS spending as a proportion of GDP will fall in 2016, because the UK economy is growing at a faster rate than increases in health spending.¹⁶ Likewise, it follows that were a country's GDP to fall, the measure of health spending as a proportion of its GDP may increase, even if health spending were to remain the same.

Figure 6: Public spending on health in UK as a percentage of national income 1991-92 to 2014-15 (in 2014-15 prices)



12. However, international comparisons of health spending are difficult because the proportion which is spent by individuals, families and charities and the proportion spent by governments and other public bodies varies considerably from country to country. What counts as “health spending” is also the subject of discussion. Five years ago the OECD changed its methodology for defining health spending, removing some things such as capital spending and adding others such as health-related social care and long-term care. Since we finished taking evidence for this inquiry, the Office for National Statistics has published figures for UK health spending for the years 2013 and 2014 using

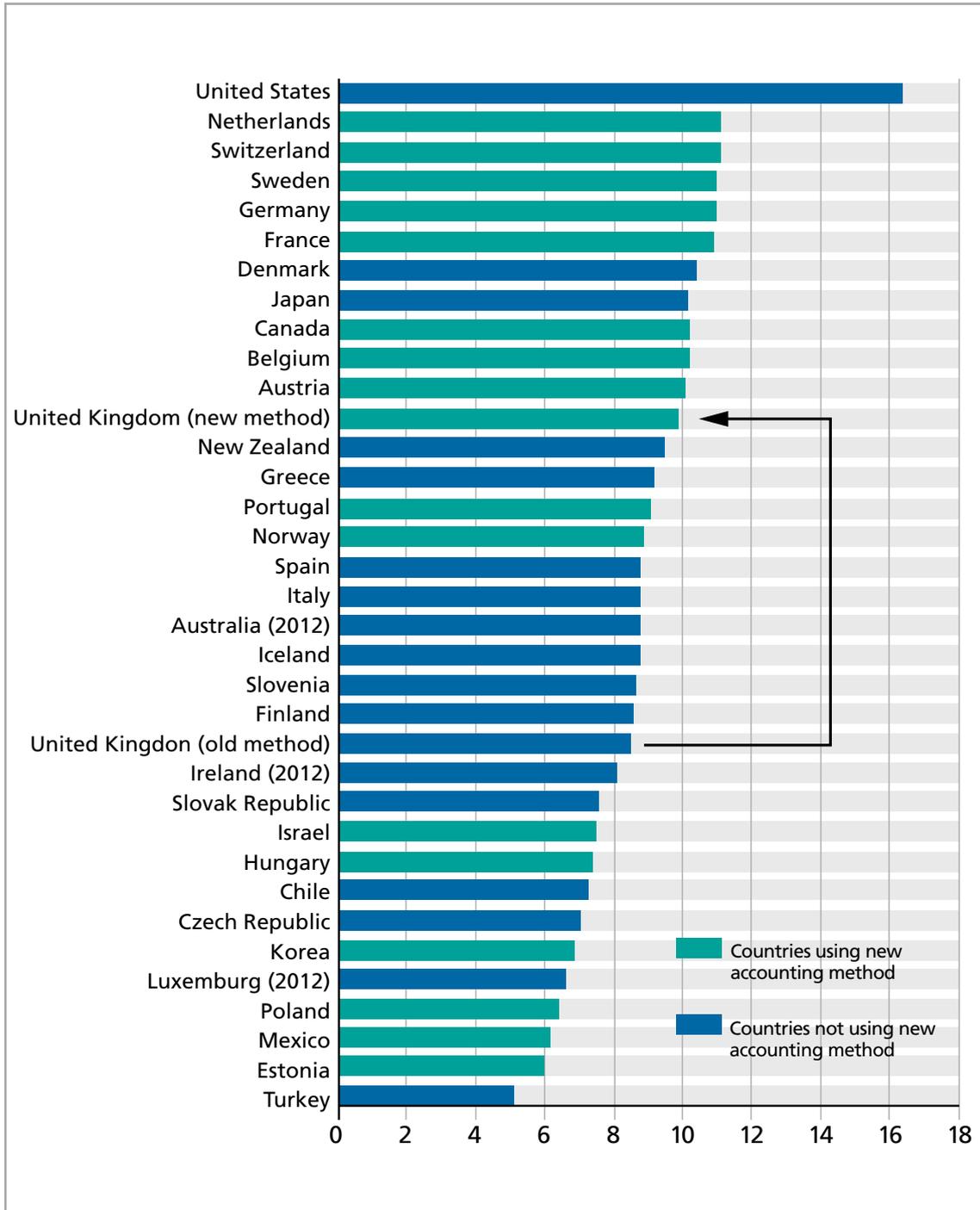
¹⁴ [OECD. Health expenditure and financing dataset. 2015](#)

¹⁵ The eleven healthcare systems examined by the Commonwealth Fund are: Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the UK and the USA.

¹⁶ Q 48

this changed OECD methodology.¹⁷ On this basis, the UK’s spending on health in 2013 was 9.9% of GDP—closer to that of other comparable countries, as shown by the following chart, which sets out public and private spending on health combined.

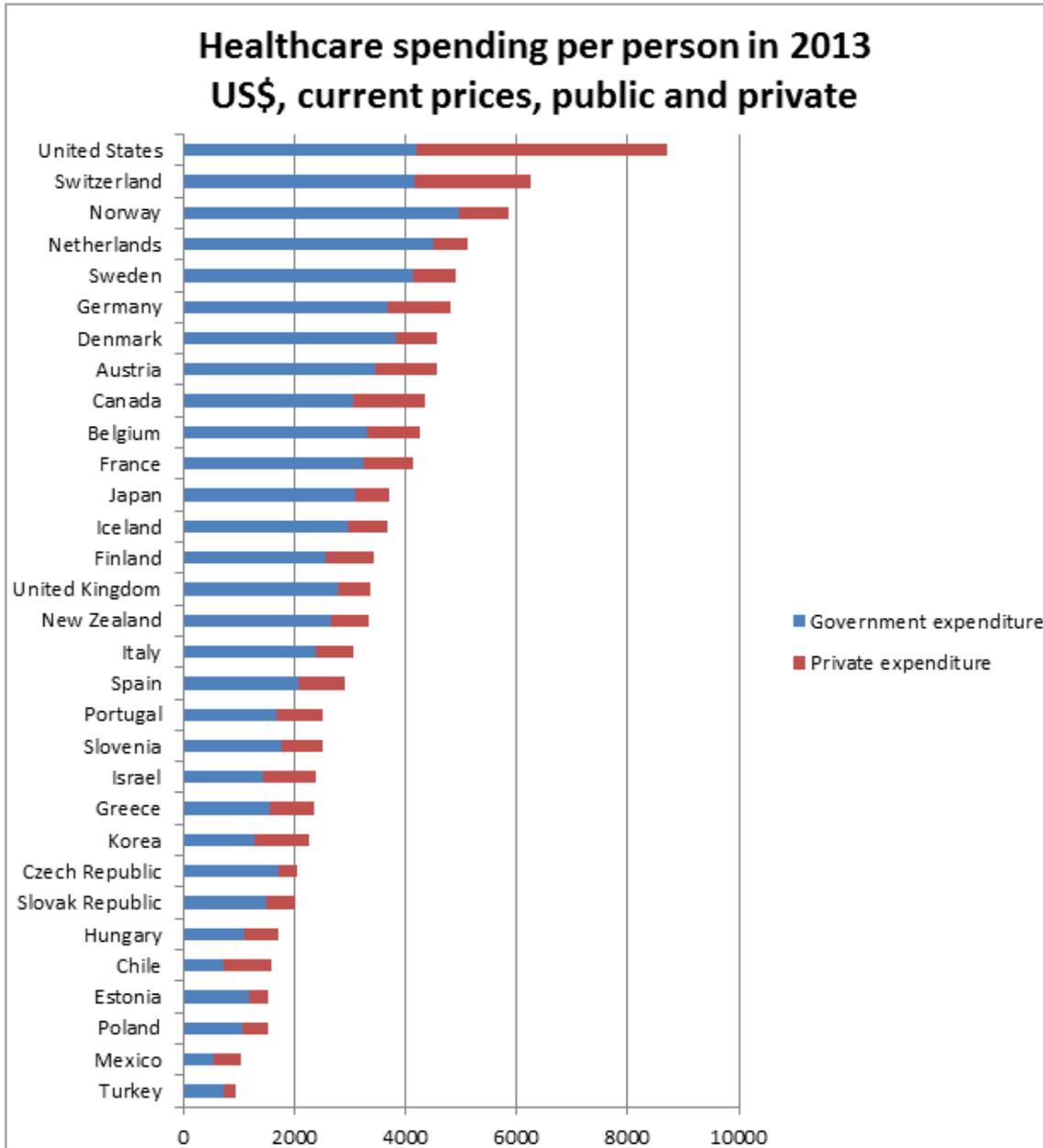
Figure 7: Total (public+private) current health spending in OECD countries, 2013



Source: John Appleby, “Is the UK spending more than we thought on healthcare (and much less on social care)?”, BMJ, 2016;353:i3094 (<http://www.bmj.com/content/353/bmj.i3094>)

13. The UK also fares better in international comparisons if public spending on health is separated from private spending. The chart below shows healthcare spending per person in US\$ in 2013.¹⁸

Figure 8: Government, private and total expenditure per person on healthcare in 2013, converted to 2013 US dollars at purchasing power parity



Source: Nuffield Trust, using figures from http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT (accessed 14 June 2016)

18 Using the old definition of healthcare spending: equivalent figures using the new definition are not yet available.

14. Public satisfaction with the NHS is the second highest it has ever been, and people are just as likely to think the NHS has improved as they are to think it has deteriorated over the past five years.¹⁹ On some measures quality has improved. For example, Health and Social Care Information Centre data shows significant improvements in survival following hospital treatment over the past decade for stroke, non-elective surgery, coronary artery bypass grafts, fractured proximal femur and myocardial infarction. On the downside, although waiting times are shorter than they were in 2004–05, they have been getting longer since 2007–08. Part of this may be explained by the increasing demand for services: compared with 2004–5, hospitals are treating 4 million (32%) more patients, the number of GP consultations has increased by an estimated 25% and community care activity has increased by 14%.²⁰

The current financial situation in health

15. Many submissions to the inquiry noted that deficits in NHS providers have been growing and are widespread. In 2014–15, NHS trusts and NHS foundation trusts reported a combined deficit of £843 million.²¹ This reflects a continued decline in performance from the trusts' £592 million surplus reported in 2012–13 and the £91 million deficit reported in 2013–14. In total, 115 trusts were in deficit and 125 trusts were in surplus in 2014–15.²²

16. NHS Improvement's provisional data for 2015–16 suggests that the financial situation in trusts continued to deteriorate in 2015–16.²³ It reports that NHS trusts and NHS foundation trusts had a combined deficit of £2.45 billion in 2015–16. Halfway through the year, the NHS had predicted an end of year loss of £2.8 billion. As John Appleby of the King's Fund told us in February, "You can see the downward trend [...] this is not just a few isolated mismanaged trusts. This is 95% of all acute trusts—essentially everybody—now looking at a deficit by the end of the year."²⁴ The point is reinforced by the news that even Salford Royal Foundation Trust, which we visited during our inquiry and which is generally recognised as an example of a well-run and well-managed trust which has made important progress in a number of areas towards the service transformation envisaged in the Five Year Forward View, ran a deficit in 2015–16.²⁵

17. We heard that the deficits can be attributed to three main factors:

- Increasing demand for services as a result of an ageing population living with multiple health problems, and delayed hospital discharges as a result of not having adequate social care packages in place.
- Reductions in the price that providers are paid through the tariff, where providers have not reduced their costs sufficiently to compensate for the annual 4% efficiency factor in the tariff; and

19 Appleby J, Robertson R, Taylor E. Public Attitudes towards the NHS in Austere Times; 2015:1-20.

20 Professor Andrew Street (CSR0094), para 5 and 8.

21 National Audit Office, Sustainability and financial performance of acute hospital trusts, 16 December 2015

22 *ibid.*

23 NHS Improvement, [Quarter four sector performance report, 20 May 2016](#). (accessed 12 July 2016)

24 Q47

25 [Salford Royal NHS Trust Annual Report and Accounts 1 April 2014 to 31 March 2015, p.209](#). (accessed 12 July 2016)

- Additional staffing costs following the Francis review of events at Mid Staffordshire NHS Trust, where a shortage of permanent staff to fill these extra posts has seen spending on agency staff costs increase.

Increasing demand

18. It has long been Government policy to try to curb the increasing demand for services and to encourage less expensive alternative forms of care provision, but as Professor Sutton of the University of Manchester explained, initiatives for keeping people out of hospital have so far failed:

We have had 4% growth in emergency admissions last year—but also in planned care and elective admissions. Elective admissions rose 5% and outpatients rose 5%. Although we talk about the important things being prevention, quality, keeping people out of hospitals and treating them closer to home, essentially none of the existing initiatives has been working and there is more activity going through hospitals. If you look, for example, at accident and emergency departments, the increase in attendances there is 2%, but then the people waiting over four hours has risen by 11%. It is clear that there is activity rising, but it is controlling or coping with that level of activity that has been the problem.²⁶

19. Nigel Edwards of the Nuffield Trust shared these views, adding that nowhere in the world has managed to “bend the curve on admissions”.²⁷ Julie Wood of NHS Clinical Commissioners told us that “commissioners are trying to deal with that rise in demand, in terms of contracting for it, and providers are seeking to deliver services with more patients going through, and that has also contributed in part to the deficit that we see.”²⁸

20. Anita Charlesworth of the Health Foundation added that providers report that delayed discharges of care are a “big part of their problems at the moment”.²⁹ Likewise, Professor Briggs, Consultant Orthopaedic Surgeon at the Royal National Orthopaedic Hospital Trust, told us that “at any one time, up to 30% of patients are ready to be discharged. They are blocking beds, which cost about £1,000 a day. We have to unblock those beds. By doing that, you make the whole system much more productive, more efficient and at the same time reduce variation.”³⁰

Payments to providers

21. In response to our questions about deficits, Mr Edwards explained:

If you do not give the trusts the money that they need to deliver what they need and you set them efficiency targets that have never been achieved anywhere in the NHS’s history, do not be surprised if the income separates from the expenditure over time, particularly against a background of growing demand.³¹

26 Q2

27 Q47

28 Q92

29 Q70

30 Q112

31 Q47

22. The national tariff is the price that hospitals receive for treating particular types of patients. The NHS has historically achieved annual productivity improvements of 0.8%, which have increased to 1.5%–2% in recent years, but the tariff prices have been reduced by an annual 4% efficiency factor since 2011–12.³² John Appleby of the King’s Fund explained to us that “over the last five or, I think, six years the tariff has been reduced in real terms each year to encourage hospitals to be more productive”. However, he added “cost-improvement programmes are yielding less and generating more savings over time has become tougher”. He explained that the result is that costs have become greater than income, and the deficits are the result.³³ The Secretary of State for Health acknowledged to us that the 4% efficiency factor used in recent years was “too high” and confirmed that it would be reduced to 2% for 2016–17.³⁴

23. NHS Clinical Commissioners told us that the tariff system “works against long-term priorities by concentrating money and resources on hospital activity”. It explained that the tariff was originally introduced to address hospital waiting list times, therefore rewarding expensive hospital activity, rather than keeping the population healthy and out of hospital.³⁵ Similarly, Professor Mays of the London School of Hygiene and Tropical Medicine told us that the integrated care pioneers have reported that it is difficult to remove the incentive in the tariff to pay for hospital activity. The payment mechanism had therefore acted as a barrier to providing more integrated and coordinated care.³⁶ Professor Sutton of the University of Manchester pointed out that financial strategies that focus on maximising activity in order to maximise revenue may push trusts into deficit if there is an insufficient consideration of costs.³⁷

24. The Chief Executive of NHS Improvement, Jim Mackey, told us in oral evidence in January 2016 that the tariff mechanism is “not fit for what we need to do in the future—or even now”. He said:

We need to look at our payment mechanisms and make sure there is standardisation, where necessary. We support local initiatives. We will create a framework that encourages and supports people to do the things I have just described. That moves away from the kind of widget-counting tariff mechanisms we had a few years ago and will require different instruments. Those instruments might change over time depending on what the issues are.³⁸

Whilst there is an important role for the “widget-counting” to which Mr Mackey referred insofar as it has provided a degree of transparency about hospital activity which had been difficult to achieve prior to the tariff mechanisms—transparency which it will be important to retain in any reformed system—nonetheless we agree with him that different instruments need to be found to achieve the right incentives within the system.

25. In response to our questions in April 2016 about progress to reform the tariff, Bob Alexander, Executive Director of Resource and Deputy Chief Executive of NHS Improvement, told us:

32 National Audit Office, Sustainability and financial performance of acute hospital trusts, 16 December 2015

33 Q47

34 Q317

35 NHS Clinical Commissioners ([CSR65](#)) para 4.11

36 Q11

37 Qq18-19

38 [Oral evidence: Establishment and work of NHS Improvement](#), HC 617, 19 January 2016, Q75

The tariff function within NHSI is working with colleagues in Simon's organisation [NHS England] to determine changes that need to be made to payment mechanisms to enable the sorts of changes that the Five Year Forward View articulated and supported. That piece of work needs to go as an enabler of change, not as a leader of change, I think. You need to balance that, and we have started it with some of the things that we did immediately for 2016–17, by calling a halt to tariff changes, the consequences of which were not clear to see. We want to move payment mechanisms; we want to improve them; we want to make them more fit for purpose across the range of service. But the most important thing is to be clear that we understand the consequence of those changes such that when they are implemented they have the desired effect rather than effects that maybe particular organisations or particular services recognise.³⁹

26. The financial situation in the NHS has become increasingly tight. Health spending rose at an historically low rate of 1.1% in real terms between 2009–10 and 2015–16. NHS provider deficits have become so widespread that there is a risk that running a deficit is no longer taken seriously as a sign of poor financial management. The need to manage deficits also risks skewing attention and draining resources from other NHS priorities.

27. We have heard compelling evidence that the current payment system does not drive greater efficiency or support the transformation that is required across the system. The payment system needs to be reformed, so that it does not continue the perverse incentives which can drive inappropriate hospital admissions. It must however ensure that hospitals are paid a fair price, and that the system encourages them to manage their costs appropriately, with care being carried out in the right settings. Whilst we recognise that reforms of this scale cannot be rushed, we note that we and our predecessor Health Committees have been hearing concerns about the payment system for many years. We therefore recommend that NHS England and NHS Improvement set out a clear timetable for reforms to the payment system, and clarify the underlying problems that the changes will address.

Staff costs

28. A key driver of higher costs across the NHS has been the rising dependency on agency staff. NHS spending on this has increased from £2.2 billion in 2009–10 to £3.3 billion in 2014–15.⁴⁰ The Secretary of State for Health told us that spending was expected to be as high as £3.7 billion in 2015–16, although it has a target to reduce that to around £2.5 billion in 2016–17.⁴¹

29. Anita Charlesworth of the Health Foundation explained how staff shortages have contributed to the problems with agency spending:

The NHS was planning on needing fewer workers; its plans were not to grow the number of workers. We reduced the number of nurses we brought in from other countries in the early years of this decade, we reduced the numbers

39 Q322

40 National Audit Office, *Managing the supply of NHS clinical staff in England*, February 2016.

41 Q313

in training and we have also seen many fewer numbers coming through on return to practice. That was predicated, in essence, on both ability to reduce demand—the number of admissions that would come into the system—and a belief that we could work those nurses harder through reducing ratios. That proved to be unsustainable. We saw the numbers of nurses employed falling; then from 2013 onwards, crudely, we re-employed them but we employed them more expensively.⁴²

30. Professor Cumming of Health Education England told us that “roughly speaking, at the moment, about 7.5% of all clinical posts across England are vacant, but that hides a number of issues. In parts of London, that figure is 15%, and in parts of the north-west that figure is 3.5%, so it is very variable. Our number one issue has been getting the balance right in terms of overall number but also geographical number.”⁴³ Evidence from Professor Cumming in November last year to an earlier inquiry reinforces the point about geographical variation: discussing GP training fill rates, he told us “we have filled all the training jobs in London and the south-east and drawn predominantly from the north and the east, with bits of the west midlands and the east midlands thrown in. In the north and the east numbers have gone down, in London the numbers have gone up.”⁴⁴

31. Anita Charlesworth told us that “critical to being able to hold down the pay problem and to hold down the agency costs problem is being able to recruit and retain”. She argues that a failure to have a “fit-for-purpose workforce strategy” is an underlying issue at the heart of the deficit.⁴⁵ She reflected that workforce planning needs to include an understanding of why so many nurses leave the profession and a programme of work to address those concerns. Some 24,000 nurses left the nursing register in 2012–13, for example, to retire from practice or change career. However, the number completing return to practice courses has reduced from around 18,500 between 1999 and 2004 to around 4,800 from 2010 to 2014⁴⁶. The Secretary of State acknowledged to us that the issue of workforce planning has been “a problem over decades”.⁴⁷

32. Christina McAnea of Unison told us “in terms of an individual’s choice to go and work for an agency, part of that is because of the pay rates that they get—so they get extra money—but a big part is also about flexibility and they feel they have more control over the hours they are having to work by choosing to work for an agency.” She added that people who leave the profession say they do so because of low pay and wanting more flexible working and the feeling of being valued and rewarded.⁴⁸

33. To help reduce the size of the provider deficits, the Department announced in June 2015 that it would introduce controls on agency staff spending by trusts. These include an annual ceiling on the level of nursing agency spend (implemented from 1 October 2015) and a shift-based or day/hourly rate-cap for agency staffing (implemented from 23 November 2015). The Secretary of State for Health told us that since introducing these controls, the NHS had saved £290 million compared with its trajectory of agency spending, which had been forecast to be £4 billion in 2015–16. He added that two thirds of trusts

42 Q47

43 Q165

44 [HC \(2015–16\) 408](#), Q78

45 Q47

46 National Audit Office, [Managing the supply of NHS clinical staff in England](#), February 2016.

47 Q354

48 Q186

say they are making savings as result of the controls and nurse agency costs are 10% lower than in October.⁴⁹ We welcome this progress, although note that the NHS has some way to go if it is to meet its target of reducing agency spending from £3.7 billion in 2015–16 to around £2.5 billion.

34. Contrasting with the growing cost of agency staff are the constraints which have been placed on pay for permanent NHS staff. The British Medical Association told us that “staff have borne a disproportionate burden of efficiency savings so far”. It highlighted that in 2011–12 and 2012–13, some £1.7 billion of savings were made from pay freezes.⁵⁰ Christina McAnea of Unison told us “between 2010 and until now, if I use a nurse as an example, if it had kept pace with RPI, a nurse would be earning £4,700 more today than they currently earn.”⁵¹ Similarly, the Shelford Group, which represents ten academic NHS organisations, expressed concern that what it called the “disparity between private and public sector will result in potentially significant difficulties in public sector recruitment and retention.” The Group recommends reviewing the public sector maximum pay awards, particularly in light of challenges around nurse shortages and the need to ensure safe staffing across health and social care services.⁵²

35. In March 2016, the Government announced that the NHS will hold pay at 1% a year over the spending review period—a move which may be unsustainable. The Office for Budget Responsibility has estimated that pay rates for the rest of the economy will increase by between 2.6% and 3.6% annually over the spending review period,⁵³ widening the NHS pay gap with comparable roles in other sectors. There is a risk that a rigid long-term squeeze on pay will impact on the ability to recruit and retain NHS staff, and increase the reliance on more expensive agency staff.

36. There is no doubt that spending on agency staff on the scale seen since 2009–10 has been a major contributor to provider deficits. The cap on agency costs and rates has helped to turn the corner, but this may be undermined by the widening gap between NHS pay and that for comparable jobs outside the NHS. Over the previous Parliament, much of the efficiency gain was achieved thanks to a pay freeze, but a long-term pay squeeze has unintended consequences for recruitment and retention, which may drive higher costs. The problems with agency spending are likely to remain until the underlying issues of workforce supply and staff shortages are addressed. We therefore call on the Government to set out its plan for how it will recruit and retain the NHS future workforce, including by making working as a permanent member of staff a more attractive option.

Managing the financial situation

37. The Department of Health came extremely close to exceeding its £111 billion revenue budget authorised by Parliament in 2014–15, underspending by just £1.2 million, or 0.001%.⁵⁴ In February 2015, the Department needed to increase its overall budget for

49 Q311

50 British Medical Association ([CSR0063](#)), para 2.2.

51 Q147

52 The Shelford Group ([CSR0093](#)), para 4.1.

53 Table 1.1: Overview of the economy forecast, <http://budgetresponsibility.org.uk/efo/economic-fiscal-outlook-march-2016/>

54 National Audit Office, Sustainability and financial performance of acute hospital trusts, December 2015.

2015–16 by £205 million to avoid breaching its limit.⁵⁵ In addition, the Department made a capital to resource budget transfer of £945 million to cover the deficits in the provider sector. The Director General of Finance at the Department of Health told us that it was too soon to know whether the Department has stayed within its control total for 2015–16: those figures will be published with the Department’s Annual Report and Accounts, expected in the summer.⁵⁶

38. This is the second year in a row that the Department has used money originally intended for capital projects to cover deficits in current spending. Anita Charlesworth of the Health Foundation told us that “the underlying finances are worse than the current financial picture looks because much of the current finances are predicated on capital to resource transfers. That is fine for the short term, but we are overtrading and we are using what should be investment funds to bail out day to day running costs.”⁵⁷ The Department’s written submission shows that current spending on capital will remain at £4.81bn over the spending review period. This means that, by 2020–21, capital spending will have decreased to £4.37bn in real terms (after adjusting for inflation).⁵⁸ This figure will be further eroded if there are ongoing capital to resource transfers.

39. Commentators are concerned about the squeeze on capital investment. NHS Providers said that “as we look to create a world class health service for the 21st century, the upgrade of NHS estate and diagnostic equipment is essential to patient safety and operational efficiency. Essential work needed between now and 2020 must be properly assessed and considered against the significant restrictions on capital expenditure resulting from the settlement, which members tell us are a cause of concern.”⁵⁹ This will reduce the capital-to-labour ratio, the likelihood being that this will reduce NHS productivity. In response to our questions about capital funding, Simon Stevens said it was not yet possible to judge whether there would be sufficient funding. He added that local sustainability and transformation plans will be produced by the summer of 2016 outlining “what it would take to lubricate change” in their area and “then we will have some tough prioritisation to make, but we will be able to exemplify what the case would be for good capital investment in some of those geographies.”⁶⁰ We took a clear message from his responses to our questioning that the level of capital investment in the NHS over the spending review period is a matter of some concern. For instance, asked whether he was confident that the NHS capital budget was going to be sufficient, Mr Stevens said that he would not be able to answer that question until he knew more about the backlog of maintenance and other capital requirements for the NHS.⁶¹

40. Concerns have also been raised that in 2015–16, NHS Improvement told trusts that “we need boards and executive teams to pursue all possible and legitimate savings that can be made from reviewing balance sheets (specifically reviewing areas such as accruals and bad debt provisions)”.⁶² The Director General of Finance at the Department told us that “it

55 HM Treasury, [Central Government Supply Estimates 2015–16: Supplementary Estimates](#) (HC 747), p.97ff and [memorandum to the Health Committee on the Supplementary Estimate](#), para 5.

56 Q301

57 Q70

58 Department of Health ([CSR42](#)) para 16. See also figure 2 above.

59 NHS Providers ([CSR36](#)) para 15

60 Q304

61 Qq 305-06

62 NHS Improvement, Quarterly report on the performance of the NHS provider sector: 9 months ended 31 December 2015.

is not just clever accounting, but, as you will know from the 2014–15 accounts, the overall out turn at group level is quite tightly managed and we want to make sure that we are making every effort this year as well to deliver within the sums voted out by Parliament.”⁶³

41. However, we remain concerned that the NHS may be using accounting devices to balance the books. Changes to accounting estimates do not change the underlying financial position, but may, for example, push expenditure into successive years. The overall impact of such measures is to give a false impression that the current financial situation is better than it is.

42. We are concerned that the Government has resorted to short-term measures to deal with the financial situation. Capital was transferred to revenue for the second year running in 2015–16 and trusts were encouraged to review their accounting estimates for savings. We are concerned that these measures are masking the true scale of the underlying financial problems facing the NHS. We are also concerned about the consequences of repeated raids on the capital budget to meet current spending, especially as that budget is already set to reduce in real terms over the spending review period.

43. Anita Charlesworth of the Health Foundation reflected that NHS and policy has been “too focused on short-term tactical solutions.” She explained that many of the savings in the NHS have been made by one-off changes such as abolishing primary care trusts and strategic health authorities. She added “we dealt with it as a short-term problem to get through and then thought everything would return to normal rather than tackling the underlying challenge of embedding improvement in the way we work.”⁶⁴

44. The conclusion we draw from the evidence we have heard is that the proposed strategies for reducing costs—cutting the tariff price (albeit at a lower rate), strict pay restraint, imposing agency price caps and reducing capital spending—are not sustainable ways of securing long-term efficiencies. The NHS will need a new approach if it is to adapt to increasing patient demand and funding constraints.

The current situation in social care

45. Alongside pressures on health spending there have been even tighter financial constraints in local authority social service departments. The National Audit Office (NAO) estimates that government funding to local authorities reduced in real-terms by 37% between 2010–11 and 2015–16.⁶⁵

46. Many of the submissions to the inquiry stressed the financial pressures currently faced by local government and generally in social care. ADASS told us that “local authorities have shouldered more of the spending cuts than the rest of government” with central government funding for local authorities having been cut by 40% in real terms over the last spending period.

63 Q302

64 Q47

65 National Audit Office, [Financial sustainability of local authorities 2014](#), p. 4, 19 November 2014

ADASS reported that adult social care budgets reduced by some £4.6 billion (31%) from 2010–11 to 2015–16.⁶⁶ Sarah Pickup of the Local Government Association (LGA) told us that pressures on social care funding have been compounded by demographic changes as a result of an increasing number of older people with greater need, as well as increases to national insurance and pension fund costs.⁶⁷

47. ADASS, the LGA and others reported that local authorities have responded to budget pressures by reducing the availability of social care. ADASS told us that in June 2015, some 400,000 fewer disabled and older people received social care than in 2009–10. It highlighted the results of its survey of councils which in 2015–16 found that some £228 million (28%) of reported “efficiencies” were in fact met by reducing volumes of care packages.⁶⁸ Ray James of ADASS explained that “in essence, what we have probably seen is people with lower-level needs not being supported as much by councils.”⁶⁹ In other words, this has resulted not only in reduced numbers of people who have been eligible for care but in a reduction of the packages of care received.

48. Local authorities have reduced the prices they pay for social care and we have heard that in some cases, the rates are no longer financially viable. Sarah Pickup of the LGA told us that there was already evidence that some providers were moving out of the local authority market.⁷⁰ Professor Green of Care England shared these concerns, adding that its work has identified that around 50% of services would no longer be viable in some areas. He told us:

It is already happening. We have seen people withdrawing from contracts. We have seen it in the domiciliary care sector. Certainly, some organisations are saying, “We are no longer going to develop services in particular areas” and it will not be long before they start saying, “It is not viable and we are going to close in certain areas”.⁷¹

49. Care England told us that, in the interest of financial viability, some care homes are no longer taking local authority clients, creating the risk of a “two-tier system” of care emerging between those who can and cannot fund their own care.⁷² Professor Green was concerned this may have an impact on the geographical distribution of services:

In some areas, particularly those where there are large numbers of self-funders, we are getting the development of some new services. But when we look across other parts where we are dependent upon public funding, we see lots of services that are in danger of closing. What I think we will see is the demand and supply equation changing as a result of this. It will not happen immediately but it will happen over a period of probably a year to 18 months but it will definitely have an impact, so there will not be the services available

66 Association of Directors of Adult Social Care (CSR86) paras 3, 55. According to the ADASS Budget Survey for 2015, the organisation had, since 2010, “tracked a total of £4.6 billion budget reductions for Adult Social Care. This is equivalent [to] 31% of the 2010/11 Net Adult Social Care budget, and the £4.6 billion cumulative savings over 5 years equates to cash reductions of £1.6 billion, demographic increases of £1.75 billion and price pressures of £1.25 billion.”

67 Q 195

68 ADASS (CSR86) para 7

69 Q196

70 Q206

71 Ibid.

72 Care England (CSR5) para 2.3

in some areas. One of the challenges is that it will be very geographical and there will be some areas where more services will go down because they are reliant on public funding.⁷³

The impact of pressures in social care funding on health

50. The reductions in social care funding have led to adverse consequences for the NHS. Dr José-Luis Fernández of the London School of Economics told us “there is now growing evidence that there is a clear interrelationship between health and social care. For example, by providing more social care you reduce demand, to some extent, on the healthcare system, or there is complementarity between the two systems so that by providing social care you make the activity on the healthcare side more effective.”⁷⁴

51. Supplementary evidence to our inquiry from NHS England (NHSE) referred to the adequacy of funding for social care as one of the “five tests” which NHSE used to assess the outcome of the Spending Review relative to the Five Year Forward View:

[...] the Forward View made the obvious point that the level of patient demand on the NHS is partly a function of the availability of social care, particularly for frail older people. The SR makes some welcome moves to hypothecate new funding streams for social care, but the overall funding quantum nationally and the distributional effects across England still imply a widening gap between growing need and available services. If unaddressed this would result in extra demand on GPs, community health services and hospitals over and above the FYFV NHS cost estimates. Our ‘fifth test’ should therefore be regarded as ‘unfinished business’.⁷⁵

52. The Secretary of State for Health told us his department is “very conscious” of how pressures in social care are impacting on health. For example, reduced social care support may mean that people go to A&E when their problems become critical; and difficulties putting adequate care packages in place contribute to delays in discharging patients from hospital.

53. We are concerned about the effect of reduced access to adult social care as a result of the cuts to funding and the impact of this on the NHS. Given the evidence of the linkages between health and social care, we were concerned that none of the senior officials giving evidence from the Department of Health, NHS England or NHS Improvement were able to quantify the financial cost of one of the most visible interfaces between health and social care, namely delayed transfers of care as a result of not having adequate social care packages in place. The supplementary evidence sent to us by the Department, NHS England and NHS Improvement following the session was able only to refer us to estimates from a recent National Audit Office report.⁷⁶

54. We recommend that the Government urgently assess and set out publicly the additional costs to the NHS as a result of delayed transfers of care, and the wider costs to the NHS associated with pressures on adult social care budgets more generally. That

73 Q198

74 Q31

75 Supplementary evidence from NHS England ([CSR107](#)), Chapter 4.

76 [CSR108](#), section 4.

assessment should be accompanied by a plan for adult social care which demonstrates that the Government is addressing the situation in social care and dealing with its effect on health services.

3 The impact of the Spending Review on health and social care finances

The Spending Review announcements on health

55. The following two tables show the 2015 Spending Review settlement for health, as taken from the Department of Health's written evidence to our inquiry. Table 1 sets out the Department of Health's budget for the 2015 spending review period and table 2 shows the funding for the NHS, allocated through NHS England. The baseline for the Spending Review period stated in these tables, 2015–16, includes the additional £2 billion provided to the NHS in 2015–16, prior to the period covered by the Spending Review, which is included in the figure of £10 billion for the NHS by 2020–21 discussed in para 6 above.

Figure 9: Department of Health budget for Spending Review period, in nominal terms

| £ billion | 2015-16 baseline | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|----------------------|---------------------|---------|---------|---------|---------|---------|
| RDEL (1),(3) | 111.56 | 115.61 | 118.72 | 121.31 | 124.09 | 128.24 |
| Real terms growth | | 1.9% | 0.8% | 0.2% | 0.2% | 1.1% |
| CDEL (2) | 4.81 | 4.81 | 4.81 | 4.81 | 4.81 | 4.81 |
| Real terms growth | | -1.6% | -1.8% | -1.9% | -2.0% | -2.2% |
| TDEL | 116.37 | 120.42 | 123.53 | 126.12 | 128.90 | 133.05 |
| Real terms growth | | 1.8% | 0.7% | 0.2% | 0.1% | 1.0% |

Source: Department of Health ([CSR0042](#)) table 1.

(1) The Resource Department Expenditure Limit (RDEL) is the budget authorised by Parliament to cover current spending on the cost of providing services and maintaining assets.

(2) The Capital Department Expenditure Limit (CDEL) is the budget authorised by Parliament to cover investment spending on creating, purchasing and disposing of assets.

(3) RDEL excludes depreciation.

(4) The real term growth figures are expressed in 2020-21 prices, rather than current prices (2015-16 at the time of the spending review).

Figure 10: NHS England’s budget for Spending Review period, in nominal terms

| Revenue and capital combined | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---------|---------|---------|---------|---------|---------|
| Total (£ billion) | 100.50 | 105.98 | 109.34 | 111.82 | 114.93 | 119.04 |
| Real terms increase on previous year (%) | | 3.7% | 1.3% | 0.3% | 0.7% | 1.3% |
| Real terms increase on 2015-16 baseline (£ billion) | | 3.8 | 5.3 | 5.8 | 6.7 | 8.4 |

Source: Department of Health ([CSR0042](#)) table 2

(1) These figures differ from the NHS TDEL figures announced at SR due to a number of technical adjustments, including transfers of functions. The main transfer of function is the move of 0-5 public health services from NHS England to local government. There are a small number of other transfers including the move of the Leadership Academy to Health Education England. To ensure comparability of numbers, in this table £500 million has been removed from the 2015-16 baseline, representing 6 months of funding for 0-5 public health services between 1 April and 30 September 2015 and these other planned transfers.

(2) The real term increases are expressed in 2020-21 prices, rather than current prices (2015-16 at the time of the spending review).

56. Notwithstanding the Government’s announcements at the time of the Spending Review, the Health Foundation, King’s Fund and Nuffield Trust think tanks assessed the actual increase to NHS England’s budget as £7.6 billion, rather than £8.4 billion. They note that the “additional” £8.4 billion is reported in terms of 2020–21 prices, which is a change from usual practice. If 2015–16 prices are used, as would normally be the case for these reports, NHS England’s budget increases by £7.6 billion between 2015–16 and 2020–21 and by £9.5 billion between 2014–15 and 2020–21.⁷⁷ Figure 11 below sets out the profile of Department of Health spending, as expressed in 2015–16 prices.

Figure 11: NHS England and Department of Health’s budget for the spending review

| Funding in £billion, 2015-16 prices | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | Change 2015-16 to 2020-21 |
|-------------------------------------|---------|---------|---------|---------|---------|---------|---------------------------|
| NHS England | 101.3 | 105 | 106.4 | 106.8 | 107.5 | 108.9 | 7.6 |
| Other Department of Health | 15.1 | 13.4 | 12.8 | 12.7 | 12.2 | 12 | -3.1 |
| Department of Health (TDEL)* | 116.4 | 118.4 | 119.3 | 119.5 | 119.7 | 120.9 | 4.5 |

Source: Nuffield Trust, Health Foundation and King’s Fund ([CSR0091](#))

57. The three health think tanks also pointed out that a substantial element of the additional funding is not extra money, but a transfer from the overall Department of Health budget to NHS England. They explained that previous governments have defined

⁷⁷ Nuffield Trust, Health Foundation and King’s Fund ([CSR0091](#)), section 1

health spending using the whole of the Department of Health’s budget, but the spending review defines ‘NHS spending’ as NHS England’s budget.⁷⁸ Whilst NHS England’s budget will rise by £7.6 billion in real terms over the period, other areas of health spending, including on public health, education and training, will fall by more than £3 billion. The three health think tanks told us that using the previous definition of health spending, and taking 2015–16 as the baseline, health spending in England will increase in real terms by £4.5 billion by 2020–21.

58. Chris Hopson of NHS Providers told us that there is uncertainty about how the additional funding will be spent:

If I am honest, we see the £8.4 billion real terms extra increase being spent several times over in a rather confusing way... we welcome the fact that extra money is on the way but we need pinpoint clarity on which priorities are going to be delivered when and, therefore, how much money is coming to the front line to deliver those priorities. At the moment, it is pretty unclear and woolly.⁷⁹

He added that providers need clarity on where the extra money is going to be spent, on what and with a clear profile across the rest of the spending review period.

59. The three think tanks, NHS Clinical Commissioners and NHS Providers all welcomed the “front-loaded” nature of the settlement. NHS Clinical Commissioners told us it would provide resource to “begin to tackle some of the key systemic issues”.⁸⁰ Chris Hopson of NHS Providers added that it “provides the beginnings of a good plan. We would describe it as reversing the car out of the financial ditch into which it has been driven.”⁸¹ The Chief Executive of NHS England, Simon Stevens, told us the front-loading would “enable people to re-baseline and focus on sorting themselves out this year”.⁸²

60. However, Professor Sutton of the University of Manchester, amongst others, was concerned that most of the front-loading would be “taken up by things like additional pension contributions and the deficits that are already there.”⁸³ Chris Hopson said he considered it unlikely that the front-loading will be sufficient to reverse the deficit position in 2016-17:

Our view would be that, if you look at the sums of money involved and at the likely size of the provider deficit, it will be a struggle to get back to surplus in 2016–17. It is more likely that you will get back to surplus in 2017–18. If you look at the degree to which the financial pressures are building on our members—there is £1 billion extra national insurance related pension cost—if you look at the increases in demand, there are a whole number of different issues that mean that, if you were to ask what would be our best guess for the provider sector’s overall position in 2016–17, we would probably say a £0.5 billion deficit is about as far as we can get. However, if we end the year, as we probably expect, at minus 2.8 billion, there is a lot of progress to have got from minus 2.8 billion to minus 500 million.⁸⁴

78 Nuffield Trust, Health Foundation and King’s Fund ([CSR91](#)) para 1.2

79 Q134

80 NHS Clinical Commissioners ([CSR65](#)) para 4.2

81 Q88

82 Q386

83 Q28

84 Q88

61. Health spending will not increase by as much as expected from official pronouncements. In previous years, spending reviews have defined health spending as the entirety of the Department of Health’s budget, but the 2015 spending review defines spending in terms of NHS England’s budget, which excludes, for example, spending on public health, education and training. Excluding these aspects of spending—which are being cut over the spending review period—is misleading, as these organisations play a vital role in providing front line services to patients, reducing demand through prevention and in training the future workforce. We call on the Government to set out the rationale for changing the definition of health spending. Until there is a clear case for the change, we will continue to use the previous definition of health spending, and we call on the Government to do likewise.

62. Using the original definitions, and taking 2015–16 as the base year, total health spending will increase by £4.5 billion in real terms by 2021. This is a welcome increase, particularly in the context of the financial constraints faced by other Government departments, but is clearly far less than the £8.4 billion implied by the Spending Review announcements and does not in our view meet the commitment to fund the Five Year Forward View.

The Spending Review settlement for social care

63. The Department of Health told us that “social care continues to be a key priority for this Government. It is critical in enabling people to retain their independence and dignity. This is why, against the context of tough public sector finances the Government has taken steps to protect social care services.”⁸⁵

Figure 12: Additional funding for adult social care announced in the Spending Review

| £ billions | 2016–17 | 2017–18 | 2018–19 | 2019–20 |
|------------------------------------|---------|---------|---------|---------|
| Potential revenue from ASC precept | 0.4 | 0.8 | 1.3 | 1.8 |
| Improved Better Care Fund | 0.0 | 0.1 | 0.8 | 1.5 |
| Total additional funding | 0.4 | 0.9 | 2.1 | 3.3 |

Source: Department of Health ([CSR0042](#)), table 4

64. The LGA and ADASS both told us that the overall funding settlement for social care was unclear. Specifically, the spending review assumes that all councils will raise council tax by the full 2% in each year of the spending review, but the LGA and ADASS both considered that unlikely.⁸⁶ The three think tanks agreed with this view, reflecting that only around half of councils chose to increase council tax in 2015–16.⁸⁷ Sarah Pickup of

⁸⁵ Department of Health ([CSR42](#)) para 13

⁸⁶ Local Government Association ([CSR15](#)) para 8.5; ADASS ([CSR86](#)) para 33

⁸⁷ Nuffield Trust, Health Foundation and King’s Fund ([CSR91](#)) para 42

the LGA told us that the funding settlement is likely to mean that social care spending will be roughly flat in cash terms and therefore with “real-term reductions in budgets over the four year spending review period”.⁸⁸ ADASS estimates the settlement will be broadly flat in real terms.⁸⁹

65. We heard concerns that any additional funding for social care will be swallowed up by demographic pressures and additional costs for providers of implementing the National Living Wage. Sarah Pickup of the LGA told us “the biggest pressures in adult social care are demographic pressures and they are, in part, due to the rising number of older people in the population and their rising levels of needs.”⁹⁰ But Ms Pickup also said that “what we must not forget is that the number and levels of many people with learning disabilities is as big a financial pressure on council budgets as older people.”⁹¹ ADASS estimates that additional cost pressures will leave a funding gap of at least £1.1 billion by 2019–20, with a gap of at least £1.4 billion in 2016–17 and £1.6 billion in 2017–18. This assumes full take up of the council tax precept. ADASS reports that in a scenario where only 50% of councils raise the precept for all four years, the gap would be nearly £2 billion.⁹²

66. Whilst the introduction of the council tax precept has been welcomed, we heard concerns that poorer areas with greater social care needs may be less able to raise revenue in this way. Dr Fernández of the London School of Economics explained:

The challenge of the precept is its impact on perhaps spatial or geographical equity and the fact that a 2% increase in council tax will not translate into the same increased revenue for local councils across the country. This is important because those councils that have the greatest opportunity to raise resources—the wealthier councils and, therefore, those with the highest tax base—are also those that are likely to be faced with the least demand for social care, because there is a very strong correlation between deprivation and demand for local authority supported care.⁹³

67. Ray James of ADASS gave a helpful illustration of the same point:

In the most affluent areas you will raise about two-thirds of your council spend through the council tax. In the most deprived areas you will raise less than 20% of your council spend through the council tax, so 2% on two-thirds versus 2% or less than 20% is quite a marked difference. It is also perhaps not surprising that there is a very strong correlation between increased social care demand and high levels of deprivation. One of the distribution challenges with the precept is that it raises least money in areas of greatest need.⁹⁴

68. The Secretary of State acknowledged that this was an area of concern and told us the Government would therefore introduce a redistribution mechanism in which additional funding from the Better Care Fund (BCF) will be distributed to those authorities which benefit least from the council tax precept.⁹⁵ The fact there will be a redistribution

88 Q197

89 ADASS ([CSR86](#))

90 Q195

91 Q195

92 ADAS ([CSR86](#)) para 29

93 Q34

94 Q197

95 Q333

mechanism has generally been welcomed, although more detail is needed about the plans for redistribution so that the impact can be better understood. We also note that proposals to use the Better Care Fund for redistribution will reduce the amount available for transformation and integration of care, the purpose for which the BCF was originally established.

69. The LGA, ADASS, Health Foundation, King’s Fund and Nuffield Trust all expressed concern that the additional money provided through the Better Care Fund will not begin to come through until 2017–18. Sarah Pickup of the LGA told us there is therefore “a big gap in funding in those first two years of the spending review”.⁹⁶ Similarly Ray James told us that “the money that is available in the first two years of the Parliament simply does not meet the increased cost of the living wage and the increased demand for services”.⁹⁷ Professor Green added that the impact of the National Living Wage and back-loaded settlement means there will be a “big challenge around cash flow”.⁹⁸

The impact of the Spending Review on future efficiencies

70. In the Five Year Forward View, NHS England estimated that, with no action, meeting rising demand and cost pressures would require an extra £30 billion above inflation for its budget by 2020–21. It forecast that if the NHS had £8 billion more funding, the gap between resource and patient needs would be £22 billion by 2020–21.⁹⁹ To close the gap, demand and efficiency savings will be required each year, with £22 billion required in 2020–21 alone. NHS Providers told us that it welcomed the Five Year Forward View, which it said provides a “compelling vision of the gaps the service needs to address and the alternative care models the NHS might adopt.”¹⁰⁰

71. The Chief Executive of NHS England, Simon Stevens, told us that he did not consider that the size of the funding gap had changed following the spending review.¹⁰¹ However, we heard evidence that the financial situation is more challenging than when estimates were made for the Five Year Forward View. Anita Charlesworth explained:

If you go back to 2014–15, the additional £8 billion was the minimum that NHS England identified as necessary and, as Simon Stevens has said, it was predicated on a number of things. The first was some of that money coming up front, which has happened, but there were two other things that are really important that it was predicated on. One was effective action and a strategy on public health and population health, and, as he has said, there are real questions about that now. The second was an effective, sustainable social care system. Again, although this spending review settlement is more generous for social care than the previous Parliament spending resettlement, the work that we three organisations have done suggests it leaves a very big gap, and while the health settlement is front-loaded the social care settlement is back-loaded.¹⁰²

96 Q197

97 Q200

98 Q197

99 [Five Year Forward View](#), pp. 35-36. See also supplementary evidence from NHS England ([CSR107](#)), Chapter 4.

100 NHS Providers ([CSR36](#)) para 4

101 Q299

102 Q70

72. Simon Stevens provided us with a high-level breakdown of where the £22 billion of efficiencies would come from:

£6.7 billion of it will be delivered nationally through a range of measures that the NHS nationally, the Department of Health and wider Government will be able to take, and that leaves us £14.9 billion to secure locally. Of that, £1 billion we already have in hand, so that leaves us just under £14 billion, of which £8.6 billion will come from the 2% provider tariff efficiencies and the rest from service change and the process that is now under way through the local planning processes—the sustainability and transformation plans that are being developed in 44 geographical footprints across the country.¹⁰³

73. However, other than this high-level breakdown, many organisations observed that as yet, there is no detailed plan for how the £22 billion—or even the £9 billion or £15 billion of which Simon Stevens spoke—of savings will be made. NHS Providers told us that the Five Year Forward View “now needs to be complemented by a clear plan of how this destination will be reached including how the service will fund transformation in the middle years of the settlement”.¹⁰⁴ Likewise, the British Medical Association told us “there is still no credible plan to enable this unprecedented scale of efficiency savings to be made. This is even more unrealistic when we consider the fact that this expectation is balanced against the NHS priority for improving performance”.¹⁰⁵ Similar views were expressed by a number of other witnesses, including the Health Foundation, Nuffield Trust, King’s Fund and NHS Clinical Commissioners.¹⁰⁶

74. We welcome the Five Year Forward View, which provides NHS England’s assessment of the challenge and proposes a way forward for the NHS to be able to meet the widening funding gap.

75. NHS England published further details of where the £22 billion of savings will come from on the day of our final oral evidence session, but we consider that it falls short on detail. It is still not sufficiently clear how or when the stated efficiencies will be achieved, or the contribution that individual organisations and sectors are expected to make.

76. The Department and NHS England now need to set out a detailed plan for realising the savings and demand reductions that are needed to realise the aspirations of the Five Year Forward View, so that bodies understand the contribution they need to make. The plan needs to be seen to be realistic, show the profile of savings and include metrics and milestones for monitoring progress against a trajectory. We will return to this subject on a regular basis through the spending review period to monitor progress against achieving the plan.

Opportunities for efficiencies in health

77. In its evidence, the Department pointed to work led by Lord Carter of Coles, which is helping to identify some of the efficiency savings. His report found that hospitals could save £5 billion per annum by 2020. The report concluded that variation in clinical costs,

103 Q299

104 NHS Providers ([CSR36](#)) para 4

105 BMA ([CSR63](#)) para 2.1

106 Health Foundation, Nuffield Trust, King’s Fund ([CSR91](#)) para 2.1; NHS Clinical Commissioners ([CSR65](#)) para 4.6

infection rates, readmission rates, litigation payments and device and procedure selection highlights “huge opportunity” for hospitals to tackle these variations. The Department is developing the “model hospital” which will set out what “good” looks like and provide indicators and benchmarks. Trusts will also be provided with analysis to identify their potential saving opportunities.¹⁰⁷

78. The Secretary of State for Health told us that the Carter programme of efficiencies for NHS providers is “motoring”. He added that “there is lots more work to do, but there are some very encouraging signs. For example, as of this year, for the first time, 92 trusts are sharing full data about the 100 products that they purchase the most, so they can see complete transparency on who is spending what”. He added that from the start of 2015–16, the NHS would start collecting monthly data to track trusts’ progress in meeting the efficiency targets. “We are putting together a programme that supports trusts that are struggling to meet their Carter efficiency programme so that they will get better help from the centre.”¹⁰⁸

79. We heard mixed views on the extent to which addressing unwarranted variation between providers—such as through the work of Lord Carter—might realise further efficiencies. Professor Sutton of the University of Manchester and the three think tanks were sceptical about the savings that could be made. For example, Nigel Edwards of the Nuffield Trust told us that variation in data is normal and can be explained by systemic differences between areas, such as difficulties attracting staff in rural areas. Nigel Edwards and Professor Sutton both commented that previous attempts at cutting costs by reducing variation had had little impact.¹⁰⁹

80. NHS Providers told us it welcomed the approach being used by Lord Carter, but suggested that even if £5 billion of efficiencies are released, it still leaves a significant gap. It acknowledged that further savings may be identified from tackling variation within community, mental health, ambulance, primary care and specialist acute services, but told us work has not yet started within these sectors.¹¹⁰

81. We also heard that there is good practice to build on. Professor Andrew Street of the Centre for Health Economics at the University of York—our specialist adviser for this inquiry—told us that since 2007–08, NHS productivity had outpaced that of the wider economy. He argued that notwithstanding this achievement, there remains scope for improvement. Specifically, he found that productivity has not improved at the same rate across all NHS settings, with the productivity of the hospital sector having fallen by 0.5% between 2012–13 and 2013–14. Research shows that hospital productivity varies substantially across hospitals. In 2012–13, hospital productivity ranged from +31% above to -50% below the national average. Professor Street explained that “for individual hospitals, relative productivity is fairly stable from one year to the next. This persistence over time suggests scope to improve the performance of hospitals with low productivity”.¹¹¹

82. Professor Timothy Briggs, author of a national review of adult elective orthopaedic services in England, told us his review showed there are opportunities to both make

¹⁰⁷ Review of Operational Productivity in NHS providers: An independent report for the Department of Health by Lord Carter of Coles. Interim Report June 2015, p. 3

¹⁰⁸ Qq 311–12

¹⁰⁹ Q9, Q62

¹¹⁰ NHS Providers ([CSR36](#)) para 4

¹¹¹ Professor Andrew Street ([CSR94](#)) para 16

efficiencies and improve the quality of care by tackling variation. Following his 2012 report, Professor Briggs initiated a national pilot to look at variation in practice across the country:

We got 12 different datasets together on every single trust. We got that together into a unique dataset—the first time it has ever really been done—sent that to every single trust and then went to visit them. In the past two years, I have been to 248 hospitals in England, Wales and Scotland to look at data, which tell a very compelling story about how we can reduce variation, improve quality, do things better and make some savings.¹¹²

Professor Briggs added that tackling variation works best where it is driven by clinicians who work “shoulder to shoulder with managers”.

83. Similarly, Julie Wood of NHS Clinical Commissioners said that there are opportunities for commissioners to identify where tackling variation across the whole system can lead to efficiencies. She said that data published by the NHS Atlas of variation shows there is variation in practice across the country and between clinical commissioning groups. She argued that the data helps initiate conversations about the cause of variation and the extent to which it might point to areas for efficiencies.¹¹³

84. We are encouraged by the progress that has been made to build on good practice in the NHS, including through the work of Lord Carter and Professor Briggs. We heard mixed views on whether addressing unwarranted variation can realise sufficient efficiency savings but we are hopeful about what might be achieved with the engagement of providers and clinicians. The NHS must now set out how it will tackle variation within community, mental health, ambulance, primary care and specialist acute services. We recommend that the NHS publish details of the profile of saving targets within each sector so that we can assess progress when we next return to this subject.

Opportunities for efficiencies in social care

85. The Secretary of State for Health acknowledged to us that the funding for social care “is not going to be enough if we do not make the challenging efficiency savings that we all know we need to make”. He elaborated: “it will need to be combined with imaginative thinking and efficiency improvements at a local level that improve patient care rather than detract from it.”¹¹⁴ Sarah Pickup of the LGA was sceptical about the scope for efficiencies, explaining that “I would never say there is no more room for efficiencies because there always is, but I think in some cases they have pretty much gone as far as they can go”.¹¹⁵

86. Cuts to social care funding over a number of years have now exhausted the capacity for significant further efficiencies in this area. We have heard that the savings made by local councils in the last parliament have gone beyond efficiency savings and have already impacted on the provision of services. Based on the evidence we have heard we are concerned that people with genuine social care needs may no longer be receiving

112 Q90

113 Q106

114 Qq 333, 335

115 Q207

the care they need because of a lack of resource. This not only causes considerable distress to the individuals concerned but results in significant additional costs to the NHS.

4 The Spending Review and Government aspirations for the future of the NHS and social care

87. The previous chapter set out some of the difficulties facing the NHS in achieving the savings it needs to make during the Spending Review period. This chapter considers a number of major initiatives and key policy changes which will have a significant impact on the financial position of the NHS and social care, both in the next few years and in the longer term.

88. Some of these initiatives were set out in the Five Year Forward View, where NHS England said that “there is now quite broad consensus on what a better future should be” for the Service. In particular, the Five Year Forward View listed a number of specific ways in which demand for expensive hospital services could be reduced, while at the same time improving services to patients. Among the initiatives mentioned in the Five Year Forward View are these:

- A “radical upgrade” in prevention and public health
- Patients to be given greater control of their own care, including the option of shared budgets combining health and social care.
- “Decisive steps” to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, and between health and social care. In some areas this integration would be associated with full devolution of the management of health and social services.

89. The Five Year Forward View makes clear the importance of these initiatives for the future of the NHS. The document “makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care”, continuing “While the positive effects of these [measures] will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial.” However, the Five Year Forward View cautions that the “net impact” of these measures will “also partly depend on the availability of social care services over the next five years.”¹¹⁶

90. This chapter asks whether, in view of the financial situation, these and other aspirations for the NHS and social care in England appear to be realistic.

Funding for public health

91. The Five Year Forward View emphasised the importance of major improvements in prevention and public health, stating that “The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.”¹¹⁷

¹¹⁶ NHS England, [Five Year Forward View](#), p.35

¹¹⁷ Ibid. p. 9

92. The document also made clear that NHS England sees prevention as key to financial stability as well as better health: “Twelve years ago Derek Wanless’s health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded—and the NHS is on the hook for the consequences.”¹¹⁸

93. The Government told us that it “remains fully committed to improving the health of the people of England ... Local authorities will receive over £16 billion to spend on public health over the next five years. This is in addition to what the NHS will continue to spend on vaccinations, screening and other preventative interventions—including the world’s first national diabetes prevention programme.”¹¹⁹ However, despite the warnings of the Five Year Forward View, spending on the public health grant to local authorities in England fell in 2015–16 with an in-year cut of £200 million. It is due to be cut further over the next five years, with the cuts being “significantly front-loaded”, according to the Health Foundation. Real terms reductions in the first four years from 2015–16 (-3.8%, -4.2%, -4.4%, - 4.6%) are followed by a lower reduction in 2020–21 of -2.2%. The Health Foundation calculates that this amounts to a real terms reduction from £3.47bn in 2015–16 to just over £3bn in 2020–21.¹²⁰

94. Public Health England recalled that 2013 reforms to the public health system “recognised these wider drivers of good health and wellbeing” with the statutory duty to improve the health of the population being given to upper tier local authorities—the metropolitan and non-metropolitan authorities and the Greater London A ring-fenced grant is provided by the Secretary of State for Health to those authorities. Directors of Public Health and their teams transferred from primary care trusts to local government. The transition was completed in October 2015 with the transfer of responsibility for public health services for children aged under 5 to local authorities. The NHS continues to play a role in public health, including in commissioning and delivering immunisation and screening programmes.¹²¹

95. The three health think tanks have not identified any cuts to the 2016–17 budget for public health services within NHS England’s remit, such as immunisation and screening programmes. However, they say, “complex changes to what this budget covers—such as the transfer of child public health duties to local government—make it difficult to be exact about the net effect.”¹²²

96. In an interview in October 2015, Mr Stevens of NHS England set out five “tests” of whether the spending review settlement would meet the needs of the NHS; one was action in relation to public health.¹²³ That test echoed a comment made in oral evidence to us in July 2015. Referring to the in-year cut of £200m in the public health grant to local authorities which was effected in 2015–16, Mr Stevens suggested that further reductions in funding for public health “would not be a smart approach”.¹²⁴ Giving evidence to this

118 [Five Year Forward View](#), p.3. A report by Derek Wanless, [Securing our future health: taking a long-term view - the Wanless Review](#), was published in 2002.

119 Department of Health ([CSR42](#)) para 14

120 Health Foundation, supplementary evidence ([CSR97](#))

121 Public Health England ([CSR59](#)) para 1.3

122 Nuffield Trust, the Health Foundation and The King’s Fund ([CSR 91](#)) para 3.5

123 Health Service Journal, 22 October 2015

124 Oral evidence to this Committee on NHS Current Issues, 21 July 2015, [HC323](#), Q74

inquiry in May 2016, Mr Stevens was asked whether his view of reductions in public health spending had changed since July 2015. His understated reply—“Overall, it is not helpful”—speaks volumes.¹²⁵

97. Public Health England accepted that “No reduction in the public health grant is ever welcome” but, they say, the Spending Review “did not fundamentally derail the system.”¹²⁶ When asked in oral evidence whether the planned spending would be enough to fund the aims within the Five Year Forward View, Michael Brodie, Finance and Commercial Director of Public Health England, responded “There is enough within the system.”¹²⁷

98. Many of our witnesses took a less sanguine view of the financial situation in public health. The three health think tanks noted that the reduction in public health spending will affect a wide range of services including health visiting, sexual health and vaccinations, and argued that it “will have a significant knock-on effect on the NHS. This is a false economy, undermining the government’s commitments on prevention and the NHS Five Year Forward View”.¹²⁸ NHS Clinical Commissioners made similar points.¹²⁹

99. Sarah Pickup of the LGA called the situation with public health “local government’s worst fears realised ... A service is transferred and then it is reduced.”¹³⁰ The LGA told the Committee in written evidence that “Local authorities were eager to take on public health duties in 2013 but many now feel they have been handed all of the responsibility without the necessary resources to do the job.”¹³¹ Local authorities such as Cheshire West and Chester Council and Essex County Council expressed similar views, with the latter forced to impose “considerable cuts” in public health—£3.7m in 2015–16 and a further £2m in 2016–17.¹³²

100. Some clinical organisations criticised the level of and reductions in public health spending.¹³³ A range of charities also opposed the spending plans.¹³⁴ The National Voices group of charities were concerned that cuts to local public health services “often in effect means a cut to what the public would consider ‘front-line’ NHS services—HIV and Aids support in sexual health clinics, and smoking cessation services, for example. This puts people’s health at direct risk.”¹³⁵

101. Supplementary evidence sent to us by NHS England reinforces the point, quoting NHS England’s public Board assessment of the Spending Review settlement:

[...] the Forward View called for a radical upgrade in prevention, and support for wider public health measures. Given the funding pressures in the local authority financed public health services and the need for wider government

125 Q346

126 Public Health England ([CSR59](#)) para 3.8

127 Q172

128 Nuffield Trust, the Health Foundation and The King’s Fund ([CSR 91](#)) para 3.6

129 NHS Commissioners ([CSR65](#)) para 7.2

130 Q210

131 Local Government Association ([CSR15](#)) para 5.8

132 Cheshire West and Chester Council ([CSR73](#)) ; Essex County Council ([CSR89](#)) para 5.1

133 In particular in written evidence from the [Royal Society of Public Health](#), [Royal College of Physicians](#), [Royal College of Nursing](#), [Royal College of Surgeons/Faculty of Dental Surgery](#) and the [British Medical Association](#).

134 Several submissions on this issue were from organisations concerned with sexual health – the [FPA](#), [National Aids Trust](#), the [Advisory Group on Contraception](#) and the [Terrence Higgins Trust](#). Other charities making similar points included [Cancer Research UK](#) and the [British Heart Foundation](#).

135 National Voices ([CSR82](#)) para 20

action on obesity and related challenges, we cannot yet conclude that this test has been met. Much hinges on whether the Government’s proposed childhood obesity strategy [which has yet to be published] comprises an effective package of credible actions [...] Absent this, and other linked action, the NHS will be exposed to patient demand and consequent funding pressures over and above that modelled in the Five Year Forward View assumptions.¹³⁶

102. Cuts to public health budgets threaten to undermine key parts of the vision set out in the Five Year Forward View, which are predicated on, among other things, a “radical upgrade in prevention and public health”. Failing to promote prevention with sufficient vigour will mean increasing operational and financial pressure on the NHS. The overwhelming view amongst our witnesses is that the public health cuts will turn out to have been a false economy.

103. Given that even greater responsibility for public health has been transferred to local authorities, monitoring what is spent, how it is spent, and what it has achieved is of great importance. The Government needs to analyse and closely monitor the effects of the public health cuts on the aspirations set out in the Five Year Forward View. The Government should set out clearly, with measurable objectives and milestones, what it expects public health spending to achieve over the next five years, in terms of improved health and savings in NHS expenditure. We will return to this issue in future consideration of the financial situation in health and social care.

104. By the time this report is published, a new Prime Minister will have taken office. We are concerned about the future of the childhood obesity strategy. We call on the Government under Theresa May as Prime Minister to publish and implement the strategy at the earliest possible opportunity, and on the Chancellor of the Exchequer to implement the existing plans for a levy on the manufacturers of sugary soft drinks.

Transformation, integration and devolution

105. The Five Year Forward View and the Spending Review placed great emphasis on service integration, including “new models” combining primary and secondary care and health and social care. In some areas, there is not simply integration but also devolution of entire categories of public spending, including spending on health.

106. In Spending Round 2013 the Government announced the Better Care Fund (BCF), which in 2015–16 mandated local authorities and the NHS to establish pooled budgets in every area in England, totalling £3.8 billion nationally. The Department of Health told us that “Local leaders and clinical experts have put together plans setting out how these local pooled budgets will be used to commission more person-centred, co-ordinated services for local people, and these plans have been signed off by health and wellbeing boards.”¹³⁷

107. The Spending Review 2015 included an obligation on every part of the country to have a plan for longer term integration in place by 2017, to be implemented by 2020. The Spending Review said that “Areas will be able to graduate from the existing BCF programme management once they can demonstrate that they have moved beyond its

¹³⁶ Supplementary evidence from NHS England ([CSR107](#)), Chapter 4.

¹³⁷ Department of Health ([CSR42](#)) para 116

requirements, meeting the Government's key criteria for devolution".¹³⁸ We understand that further details of the policy are being worked out and will be announced in due course. There are 50 "vanguard" projects across England, taking the lead on the development of new care models.

108. As noted above, NHS England is also placing £2.1 billion in 2016–17 into a Sustainability and Transformation Fund, rising to £3.4 billion (in cash terms) in 2020–21. The transformation element of the fund is intended to support "the ongoing development of new models of care along with the investment identified to begin implementation of policy commitments in areas such as seven-day services, GP access, cancer, mental health and prevention."¹³⁹ However, these plans have been delayed because of the deficit position of the hospital sector. In 2016–17, £1.8 billion forms the sustainability element of the fund, the purpose of which is to support NHS Improvement to bring the provider trust sector back to financial balance in-year.

109. NHS England intends that over the five-year period the split between sustainability and transformation requirements for local health economies will change. The Department told us: "As the provider sector comes back into underlying balance under NHS Improvement's supervision, the share of the funding available for transformation and new policy commitments will increase in subsequent years."¹⁴⁰

110. The purpose of front loading the financial settlement over the spending review period had been to allow the funding of the transformation of service. This is fundamental to delivering the efficiency savings necessary to close the financial gap set out in the Five Year Forward View. So much has now been diverted to plugging provider deficits that we are deeply concerned about the funding available for service transformation.

111. There was a welcome from a number of witnesses for the policy of integration and transformation. The Turning Point social enterprise, for example, acknowledged that "Although cuts can be detrimental, they also (to a degree) provide an opportunity for providers to do things differently, to develop new partnerships, to integrate provision in different areas where needs overlap, and deliver digital solutions."¹⁴¹

112. The most ambitious and comprehensive plan for integration is that being implemented in Greater Manchester. This is the Greater Manchester Combined Authority, responsible for the programme which is popularly known as 'Devo Manc', under which the councils and NHS in Greater Manchester have taken control of the region's £6 billion health and social care budget, as well as other public spending. This is being delivered in ten 'localities'—parts of Greater Manchester which will have their own approach within an overall framework. We took evidence in Salford from two people closely concerned with the devolution of health and other public services in Greater Manchester.

113. Sir Howard Bernstein, Head of the Greater Manchester Combined Authority Paid Service, summarised the key framework for devolution that is embodied in that health and social care plan, which describes a "collective set of priorities", including driving "radical changes in improvements in population health ... not just around the public health programme, but a wider public sector reform, a behavioural change programme

138 HM Treasury, [Spending Review and Autumn Statement 2015](#) (Cm 9162) November 2015, para 1.112

139 Department of Health ([CSR42](#)) para 47

140 *Ibid.* para 48

141 Turning Point ([CSR74](#)) para 1.33

for Greater Manchester.” Another priority is transforming community-based care, “with a real focus on how we shift the demand away from acute hospitals into community settings.” Thirdly, there is the standardisation of acute care itself and “how we move increasingly to more collaborative service models around particular localities ... we are working towards an integrated hospital service.” There is also an aim of standardising clinical support and back office services.¹⁴²

114. Most other areas of England, except those with highly developed vanguard schemes, are not as far advanced towards integration as Greater Manchester, although good progress was being made. In Somerset, we heard, planning is going ahead for a programme called Somerset Together, a key component of which is to introduce outcome-based contracts from April 2017 across as many services as possible, including health. The intention is to pay for services on a per capita basis or per head of population rather than an activity-basis, making the service focused better on the user rather than the organisation.¹⁴³ Other parts of the country have less well-developed plans.

115. We heard evidence on one issue which appeared to have the potential to slow progress towards integration. The original intention in Somerset was to set up joint commissioning across health and social care. David Slack of Somerset CCG explained that this was not thought to be possible, because the CCG wished to be able to award contracts to bodies that qualified as Most Capable Providers, while Somerset County Council, responsible for social care, believed that it had to follow stricter procurement rules which precluded such considerations.¹⁴⁴ There have been a number of recent changes to these regulations. NHS Improvement told us that there was nothing in the regulations to prevent joint commissioning as “both CCGs and local authorities have freedom to design appropriate processes that meet their commissioning objectives as long as they meet the minimum standards for transparency and equal treatment required by the rules.”¹⁴⁵

116. We expect the Government to clarify the situation for CCGs wanting to adopt integrated commissioning with local authorities including through “most capable provider” approaches. During the passage of the Health and Social Care Act, the then Secretary of State assured our predecessor committee that integration would trump competition where that was in the best interests of patients. All those working towards the goal of providing an integrated service need clarity about the legal avenues open to them in order to do so.¹⁴⁶

117. The current financial problems of the NHS, in particular trust deficits, have provided a difficult backdrop for the efforts at transformation and integration. Many witnesses expressed concern at what they saw as the diversion of the Sustainability and Transformation Fund to correct deficits rather than to support transformation. Chris Hopson of NHS Providers suggested that there might not be a provider surplus in 2016–17, which would mean that “you will probably need to take another chunk out of the 2017–18 sustainability and transformation fund to get providers back into surplus. You then have the worrying-looking 2018–19 and 2019–20 settlement”. Mr Hopson believed

142 Q227

143 Q214, Q226

144 Q214, Q221–225

145 NHS Improvement ([CSR105](#)) para 12

146 Health Committee, [Report of the NHS Future Forum - Oral Evidence](#), HC 1248 – I, 5 July 2011 Q156, Andrew Lansley: “What we are doing, through amendments to the legislation, is to make it absolutely clear that integration around the needs of patients trumps other issues, including the application of competition rules.”

that in these circumstances “you could not afford to spend the money on sustainability and transformation in those years because you would need to keep the day-to-day ship upright”.¹⁴⁷

118. Several witnesses agreed that the problems caused by deficits hampered the early investment that was important if integration and other transformation projects were to be successful. UNISON said that it had often pointed to the need “to provide upfront investment when moving to new models of care to allow for items such as double-running costs or staff redeployment and retraining when establishing new systems.”¹⁴⁸ Similar points were made by the County Councils Network and also by NHS Clinical Commissioners, who told us: “The current CCG annual spending round [militates] against investment in services that will transform the NHS and make savings in the longer term ... In order to support transformation there needs to be a shift away from annual budget rounds towards a more mature funding cycle that will allow CCGs to plan with certainty and clarity.”¹⁴⁹ Similar points were made by Anita Charlesworth of the Health Foundation.¹⁵⁰

119. It was also clear to several of those close to the process of integration that, if savings were to be realised, they would take some time to emerge. It seemed unlikely that there would be substantial savings within the Spending Review period. When we asked David Slack from Somerset CCG about the prospects of savings from the integration projects in his county, he was cautious, saying that “I think the savings will take a significant period of time”.¹⁵¹ We had a similar answer from Sir Howard Bernstein of the Greater Manchester Combined Authority, who told us “The key is that over the next five years, we have to get pretty close to delivering financial sustainability.”¹⁵² Whether this meant that in fact devolution in Greater Manchester would contribute to the savings targets set out in the Spending Review is not clear.

120. There is evidence that there might be net costs rather than net savings from integration. Professor Nick Mays of the London School of Hygiene and Tropical Medicine said that “if anything ... the most consistent finding of better co-ordinated care is that it uncovers unmet need and raises costs.”¹⁵³ The Health Secretary said that he did believe there were savings to be produced by integration, although “We are not putting a cash amount to it except for the fact that, across all our plans, we recognise that we will only make the numbers add up if we reduce demand for services by getting care to people earlier.”¹⁵⁴

121. The programme of work being undertaken in Greater Manchester to integrate health, social care and other public services is highly impressive in scope and aspiration. ‘Devo Manc’ is the product of a long period of growing co-operation between the NHS, local authorities and others and appears to have been well-prepared and widely supported. There is confidence among those running the devolution programme that it will be financially sustainable by 2020–21.

122. Chris Hopson of NHS Providers warned against talking about transformation as purely “a money issue”. He said it was also “a capacity and a timing issue. Our members

147 Q100

148 UNISON ([CSR46](#)) para 11

149 County Councils Network ([CSR89](#)); NHS Clinical Commissioners ([CSR65](#)) para 4.7

150 Qq77-78

151 Q218

152 Q227

153 Q32

154 Q334

are currently being asked to keep a very unstable operational day-to-day ship upright, being asked to find their pretty stretching share of £22 billion-worth of savings and, at the same time, being asked to move to new care models, which, to be frank, in most other advanced western health economies have taken 10 or 15 years to deliver.”¹⁵⁵

123. The Royal Society for Public Health agreed that the key to success of health and social care integration “may not be a financial issue”. They stressed the importance of strong relationships built on trust between those who lead local bodies, something that would take time to build.¹⁵⁶ Such long-term relationships were seen as vital to the development of the Greater Manchester devolution model.¹⁵⁷

124. Doubt was also expressed about the capacity of the national body NHS Improvement to promote transformation; that body was described by Anita Charlesworth of the Health Foundation as “very distant” from local decision-makers, when it was important to understand the right solution for different areas will need to be “tailored”.¹⁵⁸

125. Several witnesses pressed for regular and rigorous evaluation of the vanguards and of transformation and integration projects more widely; it was seen as important to assess the impact of these schemes, to identify the ingredients of success, to communicate the lessons across the country and to find out what works. Professor Matt Sutton said: “Things like the Five Year Forward View are going to take a lot of very measured evaluations of what is being done and all the ideas in the vanguards so that you can see a sort of sustainable, generalisable solution rather than small ideas that appear to work.”¹⁵⁹ Professor Mays called for a “sustained” commitment to evaluation.¹⁶⁰

126. We heard some impressive evidence of the work going on to integrate health and social care services, and to incorporate other public services in ways that meet the needs of patients better and improve the local population’s health. These initiatives for integration have great potential. In many areas, patients are already benefitting from better integration and other transformation initiatives. This will however not necessarily save money in the short term, as this approach also identifies more individuals who could benefit from services.

127. Integration and devolution do not offer a quick solution to the financial problems facing the NHS and social care services. Such projects require substantial investment in preparation and during the early years of operation, and may in some cases add to costs in order to deliver long term savings. The Government needs to take a long term view in assessing their financial benefits and should define how the success of the vanguards will be evaluated.

128. With much of the upfront investment in the Spending Review being used to plug deficits, there is a real danger that greater integration and the move to the new models of care set out in the Five Year Forward View will be jeopardised by the shortage of transformation funds across the wider NHS outside the vanguards. At present the Sustainability and Transformation Fund is being used largely to ‘sustain’ in the form

155 Q99

156 Royal Society for Public Health ([CSR83](#))

157 Q227

158 Q68

159 Q28

160 Q43

of plugging provider deficits rather than in transforming the system at scale and pace. If the financial situation of trusts is not resolved or, worse, deteriorates further, it is likely that the overwhelming majority of the Fund will continue to be used to correct short-term problems rather than to support long-term solutions. We call on the Government to set out how it will protect the Transformation element of the Fund to ensure that the ambitions of the Five Year Forward View are realised.

Health education funding

129. The importance of substantial improvements to workforce planning for the achievement of the ambitions set out in the Five Year Forward View has already been noted.¹⁶¹ We took specific evidence on several aspects of the work of Health Education England, which “works across England to deliver high quality education and training for a better health and healthcare workforce”.

130. The Department of Health told us early in our inquiry that “Although Health Education England’s funding for 2016–17 is yet to be determined, the aim is to broadly maintain programme funding at current levels.”¹⁶² Later Health Education England Board papers confirm that position, stating that “HEE’s Programme allocation has been held at the 2015–16 cash level for the whole of the CSR period, with an increase of c£30 million to mitigate the effect of changes to employers’ National Insurance contributions.”¹⁶³ In their joint submission, the three health think tanks, the Health Foundation, King’s Fund and Nuffield Trust, note that of HEE’s £5 billion budget, “£3.5 billion goes straight back to the NHS front line to pay the salaries of doctors while they are undergoing training.” They comment that “Freezing this budget risks increasing pressure on hospitals if Health Education England is forced to reduce the subsidies it pays providers to cover these costs.”¹⁶⁴

Nursing bursaries and loans

131. One of the key changes announced in the settlement was the planned removal of nurse bursaries. The three health think tanks who gave evidence to us estimated that this would save £1.2 billion a year.¹⁶⁵ Nurses and other non-medical undergraduate students do not currently pay tuition fees; they receive a grant towards their living expenses and a means-tested bursary. This will change from 1 August 2017, when new nursing, midwifery and allied health students will no longer receive NHS bursaries. Instead, they will have access to the same student loans system as other students. The Government says that it will run a consultation on how best to implement these changes. We heard sharply contrasting views as to the merits of the new arrangements.

132. The Department of Health put the changes in the context of the Five Year Forward View, which “outlined the need for a modern NHS workforce, with the right numbers,

¹⁶¹ See para 35 above

¹⁶² Department of Health (CSR42) para 84

¹⁶³ Health Education England, “2016/17: Budget Setting & Business Plan: Paper 1: HEE Budget 2016-17”, para 4. Available from www.hee.nhs.uk (accessed 22 June 2016)

¹⁶⁴ The [Royal College of Surgeons and Faculty of Dental Surgery](#) agreed, indicating that the HEE funding changes could have “negative consequences for the health service”. Para 3.4.1

¹⁶⁵ Nuffield Trust, the Health Foundation and The King’s Fund (CSR 91) para 3.2

skills, values and behaviours to deliver it. Under the loans system, most students on nursing, midwifery and allied health courses will receive around a 25% increase in the financial support available to them for living costs.”¹⁶⁶

133. The Department said that the current system, with its limited number of bursaries, denies thousands of applicants a place to study health subjects at university, because the limited number of university places on offer is insufficient to meet demand. The new system “will ensure that there are enough health professionals for the NHS while reducing the current reliance on expensive agency staff and overseas staff and giving more applicants the chance to become a health professional.” This will “enable universities to provide up to 10,000 additional nursing, midwifery and allied health training places over this parliament, so more applicants will have the chance to become a health professional.”¹⁶⁷

134. The Royal College of Midwives told us that the impact of these changes on those studying to become midwives would be “sizeable.” The RCM says that student midwives starting their training in autumn 2017 could graduate with up to around £60,000 of debt. The RCM estimates that the NHS in England is short of the equivalent of around 2,600 full-time midwives. They commented “We are unaware of evidence that increasing the likely debt to be carried by graduates will lead to an increase in training numbers, as the Government suggests it will.”¹⁶⁸

135. The Royal College of Nursing, while recognising “the need for a new funding model for nursing students”, was also concerned about the effects of student debt, and told us that it was “deeply disappointed” by the announcement that NHS nurse bursaries were to be replaced by a loans based system”. There had been “no prior consultation or evidence gathering” by the Government before the decision. The RCN said that “the purported benefits” of such a change had been “overstated”.¹⁶⁹

136. These views contrasted with those of Universities UK and the Council of Deans of Health. In evidence submitted for our inquiry into primary care, they said this measure would provide the financial headroom to be able to loosen controls on student numbers. They added that it would provide a framework for long-term planning as the current system of bursaries creates a rigid dependence on Health Education England’s annual budget. They stressed, however, that such reforms would need to be handled carefully to manage the risk of reducing demand from applicants.¹⁷⁰

137. Professor Cumming of Health Education England identified “opportunities and disadvantages in both the current system and the new system.” The current system was “cash constrained” and did not allow recruitment of enough nurses. He recognised that the new system would result in individuals incurring debt through the student loan system, but “if people are willing to incur that debt, then there will definitely be more opportunities.” He said that he was currently talking to universities that were planning to increase their intakes on nursing, physiotherapy and other courses. Professor Cumming

166 Department of Health ([CSR42](#)) para 86

167 Ibid. para 87

168 Royal College of Midwives ([CSR56](#)) para 19. See also the Committee of Public Accounts, Fortieth Report of Session 2015-16, Managing the supply of NHS clinical staff in England, HC 731, p.7

169 Royal College of Nursing ([CSR81](#)) para 2.3

170 Universities UK and the Council of Deans of Health ([PRI0224](#)) paras 13-14

also said that HEE had examined the impact of the introduction of the previous student loan system and “it did not seem to have a huge impact on the number of students applying in those days.”¹⁷¹

Effect of HEE’s budget on hospital finances

138. The BMA said that, by freezing the budget of Health Education England, 70 per cent of which currently goes on subsidising the salaries of doctors in training, the Government was only increasing the financial pressure on hospitals.¹⁷² Similar concerns were expressed by the Royal College of Surgeons and Faculty of Dental Surgery and the Shelford Group of major academic healthcare organisations. The Shelford Group said there was a risk that restricting the HEE budget would affect “the transformation of the workforce, which is key to underpinning the delivery of a transformed NHS.”¹⁷³

Health education funding: conclusions

139. **The failure to train and retain an adequate supply of clinical staff is causing great strain in many parts of the NHS. This is undermining patient care, driving up the use of more expensive agency staff to fill rota gaps and diverting resources away from other important priorities. We expect Health Education England to set out their strategic plan and state whether they expect it to be achievable, and whether it will deliver the staff needs of the NHS, within their current budget. As we return to this subject through the spending review period we intend to examine the progress which HEE is making in improving workforce planning and effecting the transformation of the workforce at the heart of achieving the aims of the Five Year Forward View.**

140. **We have heard concerns about the potential impact of the proposed abolition of NHS bursaries on the supply of nursing staff and other allied health professionals. We recommend that the Government review the impact on those training as a second degree and examine a transitional approach to support this section of the future workforce. We welcome the introduction of new routes to Associate Nurse and degree level nursing for those working as Health Care Assistants. We plan to return to this issue.**

The Government’s aspirations for service improvement

141. The Government also has a number of ambitious and specific aspirations for service improvement in the NHS. In particular it has made it clear that it wishes to see:

- more NHS services available at the weekends, and
- parity of esteem being given to mental health services.

142. However, it was not clear to us that the Government had fully considered the expenditure implications of these aspirations. Given the financial situation described in Chapter Two, there is a risk that the funds will not be available to make them a reality.

171 Q157

172 British Medical Association ([CSR63](#)) para 1.5

173 The Shelford Group ([CSR93](#)) para 4.4

Seven-day services

143. We heard a great deal of evidence about the Government's ambitions for a seven-day NHS. In its written evidence to this inquiry, the Government said that it had

set the NHS the objective of guaranteeing that, by the end of this parliament, anyone who needs urgent or emergency hospital care will have access to the same level of consultant assessment and review, diagnostic tests and consultant-led interventions, whatever day of the week it is. Hospitals will deliver this for 25% of the population by March 2017, 50% by March 2018 and everyone by 2020.¹⁷⁴

144. A 2015 Conservative Party election manifesto commitment under the heading "We will make the NHS more convenient for you", said: "We want England to be the first nation in the world to provide a truly seven-day NHS. Already millions more people can see a GP seven days a week, from 8am-8pm, but by 2020 we want this for everyone. We will now go further, with hospitals properly staffed, so that the quality of care is the same every day of the week."¹⁷⁵

145. The pledge on hospitals was apparently motivated by what the Government claimed was evidence of higher mortality at 30 days among patients who are admitted to hospital at weekends. During our inquiry, we heard conflicting evidence about the so-called 'weekend effect'. The Secretary of State for Health told us that the evidence showed that: "there is a weekend effect ... the standard of care we give at weekends is different because you have to be more ill to get a decision to admit you ... there are, I think, internationally 15 studies that show that there is a weekend effect."¹⁷⁶ Other studies suggest that such an effect is at most very limited. We note that there are a variety of views on this question and whilst there is a statistical increase in mortality at 30 days for those admitted at the weekend, there is no consensus about the cause, which is likely to be complex and multifactorial, and neither is it clear to what extent these are preventable deaths. For this inquiry we have focused on the financial implications of the policy and whether it represents best value for patients from a limited resource.

146. There has been confusion about the range of services which would be provided at the weekends under the Government's plans, confusion perhaps prompted by the broad wording of the manifesto pledge. There have been suggestions that this implied complete replication of weekday services across the weekend in all areas of the NHS. When we took evidence from him in February, Professor Matt Sutton of Manchester University urged the Government to be clear about its priorities for seven-day working. "Instead of having this extremely large-scale plan for a major overhaul, we need to identify the individual things that will make a difference to patient outcomes and that can be afforded within the existing budget."¹⁷⁷ The BMA noted that the money to pay for a seven-day service "was not factored into the funding scenarios in the Five Year Forward View."¹⁷⁸

174 Department of Health (CSR42) para 10

175 Conservative Party General Election Manifesto 2015 : [Strong Leadership, A Clear Economic Plan, A Brighter, More Secure Future](#), April 2015, p. 38

176 Q365

177 Q24

178 BMA (CSR63) para 1.2

147. Research suggests that trying to provide a full range of services over seven days would not be a good use of scarce resources. While acknowledging that there appeared to be higher mortality at the weekends, Professor Sutton said that “There is as yet no clear evidence that seven-day services will reduce weekend deaths or can be achieved without increasing weekday deaths.” In oral evidence, Professor Sutton said “if we took the most optimistic scenario, where we assumed we could save all of those excess deaths, because the NHS, we think, is planning to spend £1.1 billion to £1.4 billion, it cannot be cost-effective. I think that, because of a concern about what might be a genuine problem, we have a very large response, but that response is only going to divert money away from better things that the NHS could be doing with that money.”¹⁷⁹

148. Since we began this inquiry, the Government and NHS England have clarified their aims for seven-day working. On 25 April, the Secretary of State for Health told the House that “there is a concern that the Government may want to see all NHS services operating seven days a week. Let me be clear: our plans are not about elective care, but about improving the consistency of urgent and emergency care at evenings and weekends.”¹⁸⁰ Simon Stevens of NHS England gave us more detail in oral evidence of what is considered “the appropriate clinical standard of care for any emergency in-patient on a weekend”. Mr Stevens said that the Service was guided by the Academy of Medical Royal Colleges, which, listed “four things that emergency patients on a weekend, just as on a weekday, should expect:

One is that they should get an assessment of their need and their treatment by a senior doctor within 14 hours at the latest; the second is that there needs to be diagnostic back-up available on a weekend, including CT, MRI, ultrasound and pathology ... The third is that there should be consultant-directed treatments available for emergency patients on a weekend, including in critical care, interventional radiology, interventional endoscopy, emergency general surgery. The fourth is that there should be ongoing review for acutely ill patients.¹⁸¹

149. Asked about the extra costs of these changes, Mr Stevens said “There will be a smart way and an unaffordable way of doing this, so the reason for doing this ... on a phased basis is precisely to figure out what is the smart, most cost-effective way of implementing this.” He told us that “a quarter of the country will be covered by these standards from next March at really very modest incremental cost—indeed, a number of trusts are already providing services to these standards.”¹⁸²

150. The Government says it is also “committed to improving access to GP services as part of our plan for a seven-day NHS. Achieving improved access not only benefits patients but also has the potential to create more efficient ways of working, which benefits GPs and practice staff.”¹⁸³ Mr Hunt gave more details of how this would work:

When it comes to GP care, we have also been very clear that, yes, we do want people to be able to make routine appointments at the weekend. We think that is an important thing for the NHS to offer people who work during the week

179 Q22

180 HC Deb, [25 April 2016](#), column 1152

181 Q368

182 Q378

183 Department of Health ([CSR42](#)) para 11

and may not be able to take time off work ... We have said we would like them to be able to make appointments until eight in the evening and at weekends, but we are not asking every GP surgery to open at weekends.¹⁸⁴

151. Mr Hunt suggested that “networking arrangements”, involving a number of surgeries, could help provide a service enabling patients to see a GP, if not their usual GP, at weekends.¹⁸⁵

152. Asked whether the GP changes would be funded from the £2.4 billion package for GP Services announced as part of the General Practice Forward View in April 2016, Mr Stevens suggested that they would be. He said that the money was “a comprehensive package of support for GPs ... [the package] is a range of things which is, frankly, all about implementing the strength of out-of-hospital new care models that were envisaged in the forward view, so I think delivering the GP forward view is one and the same as delivering that pillar of the Five Year Forward View.”¹⁸⁶ When we asked him whether the Treasury would be providing any extra money for the £2.4 billion package, Mr Stevens said: “It is coming from the overall funding increase available to the National Health Service over the next five years”. It will, therefore, be important to understand what other spending commitments will be re-prioritised to release the funds for this package of support.

153. The Government and NHS England have now produced a clearer account of their intentions for seven-day services in hospitals and GP surgeries. We welcome the more realistic vision for seven-day hospital services, focussing on urgent and emergency care. We will continue to monitor progress on seven-day services across the Spending Review period, with the aim of assessing whether the Government’s ambitions are achievable and delivering value for patients given the constraints on available resources and the risk of displacing measures which would be more cost effective.

Parity of esteem for mental health

154. ‘Parity of esteem’ means mental health is valued as much as physical health, for example in terms of access to care and allocation of resources on the basis of need. The principle of parity of esteem was enshrined in legislation as part of the Health and Social Care Act 2012. The Spending Review made explicit reference to mental health, pledging to “improve quality, choice and clinical outcomes in areas such as cancer, dementia and mental health”.¹⁸⁷

155. The NHS shared planning guidance for 2016–17 to 2020–21 made it clear that Clinical Commissioning Groups must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. The main source of published information on how much clinical commissioning groups spend on mental health comes from annual ‘programme budgeting’ data. However, the information is not up to date, with the most recent published data, released in June 2015, relating to spending in 2013–14.¹⁸⁸ The Department of Health’s evidence to this inquiry, which does not include audited figures, suggests spending on mental health increased by

184 Qq 371–72

185 Q374

186 Q373

187 HM Treasury, [A country that lives within its means: Spending Review 2015](#), July 2015 (Cm 9112) para 3.7

188 NHS England, [Programme Budgeting data](#), accessed on 17 June 2016.

3% between 2013–14 and 2014–15, from £11.4 billion to £11.7 billion. It reports that its in-year information for 2015–16 is showing that spending on mental health is continuing to increase.¹⁸⁹

156. A number of organisations told us that there was limited accurate information on how much the NHS currently spends on mental health services. Rethink Mental Illness expressed concern at what it called “the lack of a robust, transparent national picture of mental health funding. This means accurate and accessible data about spending on mental health is not available.”¹⁹⁰ Julie Wood of NHS Clinical Commissioners told the Committee that the data suggest the majority of Clinical Commissioning Groups have met their commitment to increase their investment in mental health by the overall increase in their allocation.¹⁹¹ In contrast, Chris Hopson at NHS Providers said its members feel strongly that they have not seen an increase. He explained that “There is a bit of a sense that CCGs are using some slightly weird and wonderful calculation methodology to prove they have delivered this increase, when our members are saying it is not coming to the front line where it really is needed.”¹⁹²

The spending review settlement and its impact on mental health

157. The Spending Review committed the Government to spend an extra £600 million on mental health over the course of the spending review period. The Department of Health clarified in written evidence that the funding is in addition to funding already announced in the March 2015 budget and Autumn Statement 2014, meaning the Government will have invested an additional £2 billion in mental health by 2020–21.¹⁹³ The sum is however included in the overall figure of the £8.4 billion increase to NHS England’s budget (by 2020–21, in 2020–21 prices), a point made clear by three leading health think tanks during oral evidence to us. The £2 billion for mental health is made up of:

- £150 million for young people with eating disorders (announced in Autumn Statement 2014);
- £1.25 billion for system-wide transformation of children and young people’s mental health and perinatal mental health (announced in March 2015 budget); and
- £600 million for mental health, which will particularly focus on improving access to psychological therapies, perinatal mental health and crisis care (announced in the Spending Review for 2015).¹⁹⁴

158. NHS Providers, the King’s Fund and Mind were all concerned about the risk that additional funding set aside for mental health will be diverted to alleviate financial pressures in the acute sector. Mind noted that some 98% of the NHS’s estimated £1 billion deficit lies in the acute sector. It said that the solvency of mental health budgets had been achieved through cuts to services, which has “severely impacted the care available to people needing support”.¹⁹⁵ Julie Wood of NHS Commissioners told the Committee that

189 Department of Health (CSR42) para 153

190 Rethink Mental Illness (CSR24) para 1.4

191 Q143

192 Ibid.

193 Department of Health (CSR42) para 152

194 Q84

195 Mind (CSR52) para 2.4

in the case of mental health, she would support the introduction of a ring-fencing on funding so that spending could be guaranteed, “because of where it is starting from—very much a Cinderella service”.¹⁹⁶

159. There was also concern about the impact of public health cuts on mental health. The Mental Health Foundation argues that “achieving better mental health and wellbeing for the nation cannot be achieved purely through crisis care investment, and the focus needs to be moved upstream to prevention and early intervention, particularly for those most at risk”. It therefore says the cuts to public health budgets for mental health are “a clear missed opportunity for the government”.¹⁹⁷ Geoff Heyes at Mind shared these concerns, adding that its analysis of freedom of information requests suggests just 1% of public health budgets are currently spent on mental health.¹⁹⁸

160. Similarly, the LGA is concerned that pressures on spending by councils will have an impact on funding for mental health services. It explains that most people who receive support from mental health services do so within the community and do not need hospitalisation. It therefore considers that council funding reductions will have an impact on funding for mental health.¹⁹⁹

The Mental Health Taskforce findings on mental health

161. As part of the NHS Five Year Forward View, NHS England commissioned a Mental Health Taskforce to produce a strategy for improving mental health. In February 2016, the Taskforce published its Five Year Forward View for Mental Health, setting out a series of recommendations for the government and NHS. The report says that significant progress had been made in areas such as public attitudes, improved outcomes, and developing services like psychological therapies. However, there were also huge challenges.²⁰⁰

162. The report called for improvements in the three main areas of prevention, seven-day services for people in crisis and integrated physical and mental health. It set out an ambition to make mental health services available to one million more people by 2021, stating that the Government would need to invest an additional £1 billion in 2021 to make this a reality.

163. Following the publication of the Taskforce’s report, NHS England declared there would be the “biggest transformation of mental health care across the NHS in a generation”. It said it would spend more than a billion pounds to support the vision outlined in the Taskforce’s report and committed to a series of recommendations.²⁰¹ In oral evidence to this inquiry, the Secretary of State for Health said that “Broadly, we agree with all those recommendations. It is a very ambitious programme ... and something we are very much committed to delivering”.²⁰²

196 Q143

197 Mental Health Foundation ([CSR27](#))

198 Q275

199 Local Government Association ([CSR15](#)) paras 9.1-9.2

200 [The Five Year Forward View for Mental Health: A report from the independent Mental Health Taskforce to the NHS in England](#), February 2016

201 NHS England press release: [NHS commits to major transformation of mental health care with help for a million more people](#), 15 February 2016

202 Q381

164. Chris Hopson of NHS Providers told us that the funding of the implementation of the recommendations of the Mental Health Task Force was “all rather foggy.” Mr Hopson asked for “absolute clarity on how much extra money is going to be given to mental health to deliver priorities; secondly, a very clear instruction to CCGs ... about how much extra will be spent; thirdly, a completely transparent methodology so that we can see if, in the case of each individual CCG, that commitment has truly been met.”²⁰³

165. ‘Parity of esteem’ is about more than simply funding commitments. The Mental Health Task Force has rightly identified “a cross-society consensus on what needs to change [in mental health provision] and a real desire to shift towards prevention and transform NHS care.”²⁰⁴

Funding for mental health: conclusions

166. Delivery of the funding commitments the Government has made for mental health is crucial to the delivery of meaningful parity of esteem. As we return to this subject through the Spending Review period, we will be looking for clear, verifiable evidence that the additional funding for mental health is being delivered to the front line, as well as evidence of sustainable progress towards the culture change across the NHS, from commissioners to providers, necessary to deliver genuine parity of esteem.

203 Q144

204 The [Five Year Forward View for Mental Health](#), p.3

5 Conclusions

167. The Five Year Forward View looks beyond immediate pressures and sets out a vision for the future of the NHS. However, while the Forward View sets out the vision, it does not say how to get there. The scale of that challenge is colossal, especially given the timescale for achieving it.

168. There are grave doubts about the capability and capacity in both the NHS and the social care system to achieve the vision set out in the Five Year Forward View, especially given the acute and increasing financial pressures which are apparent in the hospital sector and in social care. With much of the upfront investment flowing from the Spending Review being used to address deficits, there is a real danger that greater integration and the move to the new models of care set out in the Five Year Forward View will stall.

169. Some parts of the system—such as those we visited in Salford—are performing well and making progress towards achieving the aspirations of the Five Year Forward View and the Government's plans for seven-day services. This has been made possible by the determination of teams working together in the best interests of their communities, and has in many places been supported by extra money made available from the centre.

170. New models of care and the measures to achieve demand reduction which are crucial to the achievement of the Five Year vision are not being embedded across the whole system. These changes are not happening at sufficient scale and pace across the wider NHS and social care. The integration of health and social care—not just the integration of funding, as in the Better Care Fund, but getting commissioners and service providers in each sector to work more closely together to deliver a service to their local population—is not proceeding at the required pace. Furthermore, there is a risk that cuts to funding outside NHS England, such as public health and social care, will put the achievement of the Five Year vision at risk.

171. The Forward View needs to be accompanied by strategic thinking from Ministers about what priorities will best support achievement of the vision when resources are constrained. They should be prepared to set out the evidence as it develops on the value delivered by seven-day services and how that compares with other priorities such as action on prevention and public health.

172. Given the scale of rising demand and costs we are not confident that the efficiency challenge is achievable. We are concerned about the failure to plan for the consequences if the current plan for savings is not achieved.

173. We believe it is time for the Government and NHS England to set out how they will manage the shortfall in NHS and social care finances and the decline in services to patients if the measures proposed in the Forward View fail to bridge the funding gap. If the funding is not increased, there needs to be an honest debate about what that will mean for patient care.

174. As we have noted at various points through this report, we will continue to monitor the situation closely throughout the Spending Review period. **We expect to return to the**

subject of the impact of the Government's spending decisions on health and social care on a regular basis and hold Ministers, NHS England and NHS Improvement regularly to account over the course of the Spending Review period.

6 Our inquiry, and acknowledgements

175. We announced our inquiry into the impact of the Spending Review settlement for health and social care on 10 December 2015. We noted that we would be looking in particular at:

- The distribution of funding for health and social care across the spending review period;
- Achieving efficiency savings: their source, scale and impact;
- Achieving service transformation set out in the Five Year Forward View at scale and pace through transformation funds;
- The impact and management of deficits in the NHS and social care;
- The effect of cuts to non-NHS England health budgets e.g. public health, health education and Department of Health, and their impact on the Five Year Forward View;
- Social care funding, including implications for quality and access to services, provider exit, funding mechanisms, increasing costs and the Care Act provisions;
- Impact of the spending review on the integration of health and social care;
- Quality and access in health and social care including the cost and implications of new policy objectives such as 7 day services; and
- Progress on achieving parity of esteem through funding for mental health services.

176. We received over 100 pieces of written evidence from a wide variety of individuals and organisations with an interest in health and social care. All the written evidence we received is available on our website, together with the transcripts of the oral evidence we took. We heard oral evidence from academics and think-tanks with an interest in health and social care; representatives of providers and commissioners of both health and social care; Public Health England and Health Education England; representatives of users of health and social care and of staff working in the health and social care sector; and finally the Chief Executive of NHS England, the Deputy Chief Executive of NHS Improvement (the economic regulator of NHS trusts and foundation trusts), and the Secretary of State.

177. We also visited Salford Royal NHS Foundation Trust, to see the pressures affecting hospital trusts on the ground and to hear how a high-performing trust is coping with them. In the course of our visit we held a round-table meeting with representatives of voluntary sector organisations working in the health and social care sectors. The notes of our visit are included as an Annex to this report.

178. We are very grateful to all those who gave us written or oral evidence, to the voluntary sector representatives who we met in Manchester, and to all those who were involved in our visit to Salford Royal NHS Foundation Trust. Our appreciation of the impact of the Spending Review on health and social care has been very much enhanced not only by the written and oral evidence which we have taken, but also by the conversations we had during the visit to Salford. We are also very grateful to our specialist adviser for this inquiry, Professor Andrew Street, Professor of Health Economics, Director of the Health

Policy team in the Centre for Health Economics at the University of York, and Director of the Economics of Social and Health Care Research Unit, for his very welcome assistance throughout our inquiry.²⁰⁵

²⁰⁵ Andrew Street declared the following interests to the Committee: Professor Andrew Street has been awarded research contracts from the National Institute of Health Research and the Department of Health's Policy Research Programme.

Conclusions and recommendations

The current financial situation in health

1. The financial situation in the NHS has become increasingly tight. Health spending rose at a historically low rate of 1.1% in real terms between 2009–10 and 2015–16. NHS provider deficits have become so widespread that there is a risk that running a deficit is no longer taken seriously as a sign of poor financial management. The need to manage deficits also risks skewing attention and draining resources from other NHS priorities. (Paragraph 26)
2. We have heard compelling evidence that the current payment system does not drive greater efficiency or support the transformation that is required across the system. The payment system needs to be reformed, so that it does not continue the perverse incentives which can drive inappropriate hospital admissions. It must however ensure that hospitals are paid a fair price, and that the system encourages them to manage their costs appropriately, with care being carried out in the right settings. Whilst we recognise that reforms of this scale cannot be rushed, we note that we and our predecessor Health Committees have been hearing concerns about the payment system for many years. We therefore recommend that NHS England and NHS Improvement set out a clear timetable for reforms to the payment system, and clarify the underlying problems that the changes will address. (Paragraph 27)

Staff costs

3. There is no doubt that spending on agency staff on the scale seen since 2009–10 has been a major contributor to provider deficits. The cap on agency costs and rates has helped to turn the corner, but this may be undermined by the widening gap between NHS pay and that for comparable jobs outside the NHS. Over the previous Parliament, much of the efficiency gain was achieved thanks to a pay freeze, but a long-term pay squeeze has unintended consequences for recruitment and retention, which may drive higher costs. The problems with agency spending are likely to remain until the underlying issues of workforce supply and staff shortages are addressed. We therefore call on the Government to set out its plan for how it will recruit and retain the NHS future workforce, including by making working as a permanent member of staff a more attractive option. (Paragraph 36)

Managing the financial situation

4. We are concerned that the Government has resorted to short-term measures to deal with the financial situation. Capital was transferred to revenue for the second year running in 2015–16 and trusts were encouraged to review their accounting estimates for savings. We are concerned that these measures are masking the true scale of the underlying financial problems facing the NHS. We are also concerned about the consequences of repeated raids on the capital budget to meet current spending, especially as that budget is already set to reduce in real terms over the spending review period. (Paragraph 42)

5. The conclusion we draw from the evidence we have heard is that the proposed strategies for reducing costs—cutting the tariff price (albeit at a lower rate), strict pay restraint, imposing agency price caps and reducing capital spending—are not sustainable ways of securing long-term efficiencies. The NHS will need a new approach if it is to adapt to increasing patient demand and funding constraints. (Paragraph 44)

The current situation in social care

6. We are concerned about the effect of reduced access to adult social care as a result of the cuts to funding and the impact of this on the NHS. Given the evidence of the linkages between health and social care, we were concerned that none of the senior officials giving evidence from the Department of Health, NHS England or NHS Improvement were able to quantify the financial cost of one of the most visible interfaces between health and social care, namely delayed transfers of care as a result of not having adequate social care packages in place. The supplementary evidence sent to us by the Department, NHS England and NHS Improvement following the session was able only to refer us to estimates from a recent National Audit Office report. (Paragraph 53)
7. We recommend that the Government urgently assess and set out publicly the additional costs to the NHS as a result of delayed transfers of care, and the wider costs to the NHS associated with pressures on adult social care budgets more generally. That assessment should be accompanied by a plan for adult social care which demonstrates that the Government is addressing the situation in social care and dealing with its effect on health services. (Paragraph 54)

The Spending Review announcements on health

8. Health spending will not increase by as much as expected from official pronouncements. In previous years, spending reviews have defined health spending as the entirety of the Department of Health's budget, but the 2015 spending review defines spending in terms of NHS England's budget, which excludes, for example, spending on public health, education and training. Excluding these aspects of spending—which are being cut over the spending review period—is misleading, as these organisations play a vital role in providing front line services to patients, reducing demand through prevention and in training the future workforce. We call on the Government to set out the rationale for changing the definition of health spending. Until there is a clear case for the change, we will continue to use the previous definition of health spending, and we call on the Government to do likewise. (Paragraph 61)
9. Using the original definitions, and taking 2015–16 as the base year, total health spending will increase by £4.5 billion in real terms by 2021. This is a welcome increase, particularly in the context of the financial constraints faced by other Government departments, but is clearly far less than the £8.4 billion implied by the Spending Review announcements and does not in our view meet the commitment to fund the Five Year Forward View. (Paragraph 62)

The impact of the spending review on future efficiencies

10. We welcome the Five Year Forward View, which provides NHS England's assessment of the challenge and proposes a way forward for the NHS to be able to meet the widening funding gap. (Paragraph 74)
11. NHS England published further details of where the £22 billion of savings will come from on the day of our final oral evidence session, but we consider that it falls short on detail. It is still not sufficiently clear how or when the stated efficiencies will be achieved, or the contribution that individual organisations and sectors are expected to make. (Paragraph 75)
12. The Department and NHS England now need to set out a detailed plan for realising the savings and demand reductions that are needed to realise the aspirations of the Five Year Forward View, so that bodies understand the contribution they need to make. The plan needs to be seen to be realistic, show the profile of savings and include metrics and milestones for monitoring progress against a trajectory. We will return to this subject on a regular basis through the spending review period to monitor progress against achieving the plan. (Paragraph 76)

Opportunities for efficiencies in health

13. We are encouraged by the progress that has been made to build on good practice in the NHS, including through the work of Lord Carter and Professor Briggs. We heard mixed views on whether addressing unwarranted variation can realise sufficient efficiency savings but we are hopeful about what might be achieved with the engagement of providers and clinicians. The NHS must now set out how it will tackle variation within community, mental health, ambulance, primary care and specialist acute services. We recommend that the NHS publish details of the profile of saving targets within each sector so that we can assess progress when we next return to this subject. (Paragraph 84)

Opportunities for efficiencies in social care

14. Cuts to social care funding over a number of years have now exhausted the capacity for significant further efficiencies in this area. We have heard that the savings made by local councils in the last parliament have gone beyond efficiency savings and have already impacted on the provision of services. Based on the evidence we have heard we are concerned that people with genuine social care needs may no longer be receiving the care they need because of a lack of resource. This not only causes considerable distress to the individuals concerned but results in significant additional costs to the NHS. (Paragraph 86)

Funding for public health

15. Cuts to public health budgets threaten to undermine key parts of the vision set out in the Five Year Forward View, which are predicated on, among other things, a "radical upgrade in prevention and public health". Failing to promote prevention

with sufficient vigour will mean increasing operational and financial pressure on the NHS. The overwhelming view amongst our witnesses is that the public health cuts will turn out to have been a false economy. (Paragraph 102)

16. Given that even greater responsibility for public health has been transferred to local authorities, monitoring what is spent, how it is spent, and what it has achieved is of great importance. The Government needs to analyse and closely monitor the effects of the public health cuts on the aspirations set out in the Five Year Forward View. The Government should set out clearly, with measurable objectives and milestones, what it expects public health spending to achieve over the next five years, in terms of improved health and savings in NHS expenditure. We will return to this issue in future consideration of the financial situation in health and social care. (Paragraph 103)
17. By the time this report is published, a new Prime Minister will have taken office. We are concerned about the future of the childhood obesity strategy. We call on the Government under Theresa May as Prime Minister to publish and implement the strategy at the earliest possible opportunity, and on the Chancellor of the Exchequer to implement the existing plans for a levy on the manufacturers of sugary soft drinks. (Paragraph 104)

Transformation, integration and devolution

18. We expect the Government to clarify the situation for CCGs wanting to adopt integrated commissioning with local authorities including through “most capable provider” approaches. During the passage of the Health and Social Care Act, the then Secretary of State assured our predecessor committee that integration would trump competition where that was in the best interests of patients. All those working towards the goal of providing an integrated service need clarity about the legal avenues open to them in order to do so. (Paragraph 116)
19. We heard some impressive evidence of the work going on to integrate health and social care services, and to incorporate other public services in ways that meet the needs of patients better and improve the local population’s health. These initiatives for integration have great potential. In many areas, patients are already benefitting from better integration and other transformation initiatives. This will however not necessarily save money in the short term, as this approach also identifies more individuals who could benefit from services. (Paragraph 126)
20. Integration and devolution do not offer a quick solution to the financial problems facing the NHS and social care services. Such projects require substantial investment in preparation and during the early years of operation, and may in some cases add to costs in order to deliver long term savings. The Government needs to take a long term view in assessing their financial benefits and should define how the success of the vanguards will be evaluated. (Paragraph 127)
21. With much of the upfront investment in the Spending Review being used to plug deficits, there is a real danger that greater integration and the move to the new models of care set out in the Five Year Forward View will be jeopardised by the shortage of transformation funds across the wider NHS outside the vanguards. At present

the Sustainability and Transformation Fund is being used largely to ‘sustain’ in the form of plugging provider deficits rather than in transforming the system at scale and pace. If the financial situation of trusts is not resolved or, worse, deteriorates further, it is likely that the overwhelming majority of the Fund will continue to be used to correct short-term problems rather than to support long-term solutions. We call on the Government to set out how it will protect the Transformation element of the Fund to ensure that the ambitions of the Five Year Forward View are realised. (Paragraph 128)

Health education funding

22. The failure to train and retain an adequate supply of clinical staff is causing great strain in many parts of the NHS. This is undermining patient care, driving up the use of more expensive agency staff to fill rota gaps and diverting resources away from other important priorities. We expect Health Education England to set out their strategic plan and state whether they expect it to be achievable, and whether it will deliver the staff needs of the NHS, within their current budget. As we return to this subject through the spending review period we intend to examine the progress which HEE is making in improving workforce planning and effecting the transformation of the workforce at the heart of achieving the aims of the Five Year Forward View. (Paragraph 139)
23. We have heard concerns about the potential impact of the proposed abolition of NHS bursaries on the supply of nursing staff and other allied health professionals. We recommend that the Government review the impact on those training as a second degree and examine a transitional approach to support this section of the future workforce. We welcome the introduction of new routes to Associate Nurse and degree level nursing for those working as Health Care Assistants. We plan to return to this issue. (Paragraph 140)

The Government’s aspirations for service improvement

24. The Government and NHS England have now produced a clearer account of their intentions for seven-day services in hospitals and GP surgeries. We welcome the more realistic vision for seven-day hospital services, focussing on urgent and emergency care. We will continue to monitor progress on seven-day services across the Spending Review period, with the aim of assessing whether the Government’s ambitions are achievable and delivering value for patients given the constraints on available resources and the risk of displacing measures which would be more cost effective. (Paragraph 153)

Funding for mental health

25. Delivery of the funding commitments the Government has made for mental health is crucial to the delivery of meaningful parity of esteem. As we return to this subject through the Spending Review period, we will be looking for clear, verifiable evidence that the additional funding for mental health is being delivered to the front line, as

well as evidence of sustainable progress towards the culture change across the NHS, from commissioners to providers, necessary to deliver genuine parity of esteem. (Paragraph 166)

Conclusions

26. New models of care and the measures to achieve demand reduction which are crucial to the achievement of the Five Year vision are not being embedded across the whole system. These changes are not happening at sufficient scale and pace across the wider NHS and social care. The integration of health and social care—not just the integration of funding, as in the Better Care Fund, but getting commissioners and service providers in each sector to work more closely together to deliver a service to their local population—is not proceeding at the required pace. Furthermore, there is a risk that cuts to funding outside NHS England, such as public health and social care, will put the achievement of the Five Year vision at risk. (Paragraph 170)
27. The Forward View needs to be accompanied by strategic thinking from Ministers about what priorities will best support achievement of the vision when resources are constrained. They should be prepared to set out the evidence as it develops on the value delivered by seven-day services and how that compares with other priorities such as action on prevention and public health. (Paragraph 171)
28. Given the scale of rising demand and costs we are not confident that the efficiency challenge is achievable. We are concerned about the failure to plan for the consequences if the current plan for savings is not achieved. (Paragraph 172)
29. We believe it is time for the Government and NHS England to set out how they will manage the shortfall in NHS and social care finances and the decline in services to patients if the measures proposed in the Forward View fail to bridge the funding gap. If the funding is not increased, there needs to be an honest debate about what that will mean for patient care. (Paragraph 173)
30. We expect to return to the subject of the impact of the Government's spending decisions on health and social care on a regular basis and hold Ministers, NHS England and NHS Improvement regularly to account over the course of the Spending Review period. (Paragraph 174)

Annex 1: Note of visit to Salford Royal NHS Foundation Trust, 21 March 2016

Presentation by Sir David Dalton, Chief Executive of Salford Royal NHS Foundation Trust

Sir David Dalton provided the Committee with a presentation about Salford Royal NHS Foundation Trust ([see slides published on the Committee's website](#)). He also expressed the following views in response to questions from the Committee:

- Sir David agreed that the health services should provide 7 day services with the focus being on the reliable delivery of the 10 NHS Clinical Standards associated with urgent/emergency care and timely clinical assessment. He noted that reliable delivery would take several years to achieve.
- Sir David emphasised that technology is a key enabler of successful transformation. Salford Royal NHS Foundation Trust's electronic health record (HER) system is integrated with primary care and has improved the effectiveness and coordination of its care. He is convinced that standardising care pathways, to the evidence of best practice, through digital HER approaches allows the best means of reducing variation in care standards and achieving economies of scale.
- However, he said that too often the NHS procures IT in the wrong way and continues to implement systems that do not deliver the expected results. He believes that improvement could be achieved by designating Trusts, who have a track record of successful implementation and delivery, as the project managers of implementation in other Trusts. He favoured a hub and spoke approach rather than every Trust retaining its independent approach to digital improvement.
- For devolution to deliver better care at a lower cost, Sir David suggested Greater Manchester needed to ensure that its hospitals collectively served larger population bases so that they can deliver single-shared services across multiple hospitals and consolidate inpatient services which are currently provided by more than one provider. This would enable standardisation of care to be delivered at scale.
- He believed that a significant proportion of NHS expense is consumed by asset renewal ambitions of Trusts and that as more care is provided out of hospital, then the estate will need to be reduced by prioritising the removal of NHS estate which was considered to be in the worst condition.
- The NHS has too many provider organisations, which often act in the interest of their own organisation instead of in the interest of the wider population that they should serve. He believes that there are significant patient and population health benefits to be achieved by creating Groups of Trusts where the Group HQ would undertake strategic and capital planning on behalf of Trusts who collectively would serve a population of between 1 and 2 million. The Group HQ would create the standardised operating models and care pathways which the Trusts would be required to implement. He believes that this would ensure that Trusts were focussed on delivering operational excellence and improving local services.

- Sir David also believes that 240 independent Trusts is an unsustainable overhead which the NHS can no longer afford and which mitigates against better care being provided across a wider geographic base. He believes Providers should share back office functions and high-performing trusts should take over those that are underperforming.

Tour of Emergency Village

The Committee was shown around the 'Emergency Village' which brings together the Trusts A&E department together with the adjacent emergency assessment unit (EAU). The ward is designed to accommodate early assessment and diagnostic, with a multidisciplinary approach to planning patient discharge from hospital. The Committee was shown the following features:

- The emergency department walk-in entrance and triage system.
- An electronic display of A&E attendance for clinicians to understand and prioritise patients on the basis of their needs.

The Committee spoke to an Advanced Practitioner – a trained nurse with a master's qualification that allows them to assess patients in a specialised field in a similar way to a qualified doctor.

Tour of Neurosciences Centre

The Committee visited Salford Royal's Neurosciences Centre, which is already the recognised tertiary centre covering patients within Greater Manchester for Neurosurgery, Neurology, hyper acute and acute Neurorehabilitation, Neuropsychiatry, Neuropsychology and Complex Spinal Surgery. The Unit also provides Hyper acute stroke services 24/7 on behalf of Greater Manchester, supported by two other trusts which provide hyper acute access between 7am and 11pm only.

The Trust expects that the Greater Manchester Combined Authority will continue to recognise SRFT's unit as the established Neurosciences centre for Greater Manchester (and a catchment beyond Greater Manchester for many specialist neuroscience subspecialties). The unit has an excellent reputation for high performance, excellent quality outcomes and innovation, and the Trust expects full support from GMCA in continuing to develop these services in the years ahead.

The GMCA has not affected the planning of Neurosciences up to this point. However, going forward the Trust will be looking towards GMCA to support further service reconfiguration for service areas such as Neurorehabilitation and stroke services, with the aim of ensuring that it can continue to improve equity of access and the standardisation of high quality care for the population of Greater Manchester.

Tour of hospital wards

The Committee were divided into three groups and shown the following three wards by the ward matron:

- Trauma and Orthopaedic.
- Ageing and Complex Medicine.
- Urology and Short Stay Surgery Ward.

Annex 2: Note of meeting with voluntary sector organisations, Salford Royal NHS Foundation Trust, 21 March 2016

At the meeting between members of the Health Committee and representatives of voluntary organisations at Salford Royal NHS Foundation Trust on 21 March 2016, these were among the main points made by the voluntary and other bodies attending:

- Reliable housing was important for those with mental health problems, but recent changes had meant that there was less certainty. The risk was that these vulnerable people would end up requiring drastic and expensive interventions.
- The Spending Review had failed to provide the not-for-profit sector with any long-term assurance on public funding. Local authorities were in fact making more and more decisions on funding for contracted services at a late stage, sometimes just a few days before the start of the relevant financial year. Although many non-profit organisations could raise funds through donations from the general public, income from local authority and other contracts was vital to maintaining services.
- In many areas established providers are dropping out of the provision of services because they simply can't afford to provide the service for the amount of money now being offered. A number of examples were also given of services which were now simply not being commissioned by the local authority: the "stop smoking" service in Manchester was one; another was a sexual health/HIV centre in Oxfordshire. In another case mentioned, the local authority was now tendering for only 48 weeks' care in a year, where previously it had funded a full 52 weeks.
- A number of participants suggested that the disinvestment in public health and other services, especially social care, was having knock-on effects and resulting in higher costs to other public services, particularly the NHS, but also other services such as criminal justice.
- The ability to secure Lottery funding is compromised because preference is for innovative projects not for established practice proven to work. Nor is Lottery funding provided as a substitute for government funding.
- There were concerns that, if voluntary organisations were to base contracts on the newly published Grant agreement, then they would be subject to VAT. Had NHS England asked HMRC to assess the model agreement before it was published? <https://www.england.nhs.uk/nhs-standard-contract/grant-agreement/>
- Far from having multi-period budgets, local authorities now regularly renegotiated contracts with service providers, including non-profit bodies, a few months after they had started. One body said that this instability meant that 25 percent of its services for the public sector were now provided without any relevant contract being in force. The Committee was told that the security of core contracts for third sector providers enabled additional services to be provided as well from charitable funds: the loss of those core contracts put the charitably-funded services at risk as well.

- The late timing of the Spending Review statement, with its radical changes to local authority funding, had meant that decision-making in councils had been pushed back by two months. In these circumstances, local authority commissioners deserved some sympathy when they found it hard to provide suppliers of services with a settled contract. But without clarity about income streams, voluntary organisations are unable to invest in new services.
- There were likely to be regional differences in the impact of the introduction of the National Living Wage (NLW). In addition, local authorities were not adjusting their funding for contracted services in light of the NLW; they tended to tell service providers that the NLW was ‘their problem’. The operation of the ‘Transfer of Undertakings (Protection of Employment)’ (TUPE) regulations could cause particular problems for smaller non-profit organisations; in some cases they were now walking away from invitations to tender for local authority contracts.
- The pressure on social care budgets was likely to continue to increase. The eligibility bar for access to social care had been raised, meaning that many people with less severe needs no longer received social care. However, those who remained eligible for social care were likely to have more complex needs and these would be more expensive.
- There was a general recognition of the potential benefits of integration of health and social care, but in order to make it work there needed to be serious investment in social care services, which had become run down. There were many examples of the benefits of early intervention and the provision of services, including palliative care, in the community; these examples contrasted with the more expensive (but not necessarily more effective) provision of care in acute hospitals.
- The aspirations of social services for older people, as expressed for instance in personal budget documents, were often very unambitious compared with services’ aspirations for younger people. This suggested that there was ageism at work. On the other hand, it was suggested by others that discussion about social services often focussed too narrowly on services for the elderly, to the detriment of thinking about those of working age.
- There were difficulties about the funding of palliative care services. For example, there was no clear agreement on when “the end of life” started and it was suggested that around 25% of people don’t receive the palliative care they need. Related to this was uncertainty about the level of funding currently devoted to “end of life” services. This lack of an agreed baseline would make it difficult to identify future progress on spending.
- It was said that the benefit of the 2 percent precept for social care would be more than wiped out by the impact of the National Living Wage and increased pension and NI contributions on budgets.
- Some participants said that the Greater Manchester Combined Authority needed to involve the not-for-profit sector more closely with the process of health and social care devolution. The sector could offer a new and positive perspective, but did not

always feel that it was integrated enough with the development of devolution. There was wide variation in the extent of involvement of the sector in the ten localities into which Greater Manchester was divided.

- A suggestion that each local authority and clinical commissioning group should have a “link person” for the voluntary sector was agreed as a good idea in principle, but only if that person was sufficiently senior to be influential.

Formal Minutes

Tuesday 12 July 2016

Members present:

Dr Sarah Wollaston, in the Chair

Julie Cooper

Maggie Throup

Dr James Davies

Dr Philippa Whitford

Paula Sherriff

Draft Report (*Impact of the Spending Review on health and social care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 178 read and agreed to.

Annexes agreed to.

Summary agreed to.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 18 July at 4.00pm.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 23 February 2016

Question number

Professor Matt Sutton, Professor of Health Economics, University of Manchester, **Dr José-Luis Fernández**, Deputy Director and Associate Professorial Research Fellow, London School of Economics, and **Professor Nick Mays**, Professor of Health Policy, London School of Hygiene and Tropical Medicine [Q1–45](#)

John Appleby, Chief Economist, The King's Fund, **Nigel Edwards**, Chief Executive, Nuffield Trust, and **Anita Charlesworth**, Director of Research and Economics, The Health Foundation [Q46–85](#)

Tuesday 8 March 2016

Chris Hopson, Chief Executive, NHS Providers, **Julie Wood**, Chief Executive, NHS Clinical Commissioners, and **Professor Tim Briggs**, Consultant Orthopaedic Surgeon at the Royal National Orthopaedic Hospital Trust, National Director for Clinical Quality and Efficiency [Q86–145](#)

Michael Brodie, Finance and Commercial Director, Public Health England, **Professor Ian R Cumming OBE**, Chief Executive, Health Education England, and **Christina McAnea**, Head of Health, UNISON [Q146–193](#)

Monday 21 March 2016

Sarah Pickup, Deputy Chief Executive, Local Government Association, **Professor Martin Green**, Chief Executive, Care England, and **Ray James**, President, Association of Directors of Adult Social Services [Q194–212](#)

Lord Smith, Leader, Wigan Metropolitan Borough Council, Greater Manchester Combined Authority, **Sir Howard Bernstein**, Head of Paid Service, Greater Manchester Combined Authority, and **David Slack**, Managing Director, Somerset Clinical Commissioning Group [Q213–265](#)

Neil Tester, Director of Policy and Communications, Healthwatch, **Elliott Dunster**, Interim Group Head of Public Affairs, Policy and Research, Scope, and **Geoff Heyes**, Policy and Campaigns Manager (Mental Health Services), Mind [Q266–294](#)

Monday 9 May 2016

Rt Hon Jeremy Hunt MP, Secretary of State for Health, **David Williams**, Director General of Finance, Department of Health, **Simon Stevens**, Chief Executive, NHS England, and **Bob Alexander**, Executive Director of Resources and Deputy Chief Executive, NHS Improvement [Q295–394](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

CSR numbers are generated by the evidence processing system and so may not be complete.

- 1 ABHI ([CSR0026](#))
- 2 Action Cerebral Palsy ([CSR0022](#))
- 3 Action on Hearing Loss ([CSR0070](#))
- 4 Action on Smoking and Health ([CSR0088](#))
- 5 ADASS ([CSR0086](#))
- 6 Advisory Group on Contraception ([CSR0047](#))
- 7 Age UK ([CSR0085](#))
- 8 Alzheimer's Research UK ([CSR0011](#))
- 9 Bournemouth University ([CSR0012](#))
- 10 British Heart Foundation ([CSR0069](#))
- 11 British In Vitro Diagnostics Association (BIVDA) ([CSR0002](#))
- 12 British Medical Association ([CSR0063](#))
- 13 Bupa UK ([CSR0034](#))
- 14 Cancer Research UK ([CSR0077](#))
- 15 Care & Support Alliance (CSA) ([CSR0040](#))
- 16 Care England ([CSR0005](#))
- 17 Carers Trust ([CSR0001](#))
- 18 Carers UK ([CSR0078](#))
- 19 CBI ([CSR0045](#))
- 20 Centre for Mental Health ([CSR0028](#))
- 21 Chartered Society of Physiotherapy ([CSR0058](#))
- 22 Cheshire West and Chester Council ([CSR0073](#))
- 23 Children's Food Trust ([CSR0013](#))
- 24 County Councils Network ([CSR0089](#))
- 25 Department for Communities and Local Government ([CSR0109](#))
- 26 Department of Health ([CSR0042](#))
- 27 Department of Health ([CSR0103](#))
- 28 Department of Health, NHS England and NHS Improvement ([CSR0108](#))
- 29 Dimensions ([CSR0066](#))
- 30 Equity Release Council ([CSR0032](#))
- 31 Essex County Council ([CSR0051](#))
- 32 Faculty of Sexual and Reproductive Healthcare ([CSR0025](#))
- 33 FPA ([CSR0030](#))

- 34 Health Education England ([CSR0104](#))
- 35 Inclusion London ([CSR0075](#))
- 36 Independent Age ([CSR0055](#))
- 37 Independent Clinical Services (ICS) ([CSR0071](#))
- 38 Institute and Faculty of Actuaries ([CSR0010](#))
- 39 Institute of Physics and Engineering in Medicine ([CSR0018](#))
- 40 Joint submission: Nuffield Trust, The Health Foundation, The King's Fund ([CSR0091](#))
- 41 Learning Disability Voices ([CSR0038](#))
- 42 Lifeways Group ([CSR0061](#))
- 43 Local Government Association ([CSR0015](#))
- 44 Local Government Association ([CSR0101](#))
- 45 London Councils ([CSR0048](#))
- 46 Macmillan Cancer Support ([CSR0016](#))
- 47 Marie Curie ([CSR0037](#))
- 48 Mental Health Foundation ([CSR0027](#))
- 49 Mind ([CSR0052](#))
- 50 Miss Julia Buckingham ([CSR0003](#))
- 51 NAT (National AIDS Trust) ([CSR0064](#))
- 52 National Ankylosing Spondylitis Society ([CSR0008](#))
- 53 National Children's Bureau ([CSR0044](#))
- 54 National Voices ([CSR0082](#))
- 55 NHS Clinical Commissioners (NHSCC) ([CSR0065](#))
- 56 NHS Confederation ([CSR0049](#))
- 57 NHS England ([CSR0107](#))
- 58 NHS Improvement ([CSR0105](#))
- 59 NHS Providers ([CSR0036](#))
- 60 NHS Providers ([CSR0095](#))
- 61 NSPCC ([CSR0017](#))
- 62 Nuffield Trust (supplementary submission) ([CSR0092](#))
- 63 Nutricia: Advanced Medical Nutrition ([CSR0062](#))
- 64 Optical Confederation and LOCSU ([CSR0072](#))
- 65 Paediatric Continence Forum ([CSR0021](#))
- 66 Parkinson's UK ([CSR0041](#))
- 67 Professor Andrew Street ([CSR0094](#))
- 68 Public Health England ([CSR0059](#))
- 69 Recovery Focus ([CSR0054](#))
- 70 Regional Asylum Activism Project ([CSR0098](#))
- 71 Rethink Mental Illness ([CSR0024](#))

- 72 Royal College of General Practitioners ([CSR0096](#))
- 73 Royal College of Midwives ([CSR0056](#))
- 74 Royal College of Nursing ([CSR0081](#))
- 75 Royal College of Physicians ([CSR0014](#))
- 76 Royal College of Physicians of Edinburgh ([CSR0004](#))
- 77 Royal College of Psychiatrists ([CSR0060](#))
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All publications from the Committee are available on the [publications page](#) of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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