Written evidence submitted by the NHS Confederation (CSR0049)

Summary of our submission

- Health and care is not only a public good, it is a public priority. There is a strong moral case for transforming how care is delivered to better suit the needs of people today. There is an equally compelling economic case for investing in the NHS and social care services, so they can better support our society to live healthier lives with less need for medical care.

- This submission is an assessment by the NHS Confederation of the impact of the Comprehensive Spending Review (CSR) on the health and care system. It highlights the views of our members, bringing together the full range of organisations that make up the modern NHS. We are the independent membership body that represents all types of providers and commissioners of NHS services and we speak for the whole of the NHS on the issues that matter to those involved in health care.

- Our evidence shows that public spending on health and care in England will diminish in this Parliament as a percentage of our national income, from 6.6 per cent to 6.3 per cent. This is a political decision which will impact on the sector’s ability to deliver high quality care in the future. In addition, we outline concerns on the impact funding gaps in both public health and social care will have on the NHS’s ability to deliver NHS England chief executive, Simon Stevens’ plan for the NHS. This plan was outlined in the Five Year Forward View, which the Government has committed to supporting.

- The Stevens Plan is our chance to transform care and it is dependent on having the right conditions in place to support new models of care. Funding for social care and public health are two conditions we believe have not been met in full, but we also need to ensure additional resources that have been delivered are used to drive transformation. This year will be crucial in developing place-based plans that will inform where best to allocate funding to deliver best value.

- Alongside this, we reflect on the need for a renewed agreement between the health and care system and society. This would underline the importance of the NHS remaining free at the point of use and help to consider how to ensure resources match the expectation of what is delivered. This should start by encouraging cross-party agreement on the challenges facing health and care, while exploring the options for how to meet these.

- There is unprecedented recognition and a determination that services need to change amongst local leaders and national bodies. In this submission, we are clear on what we are asking for from national bodies and politicians to support local leaders – our members - to improve services for the long-term.

- Our main suggestions are:
  
  o We need to develop shared plans for how the NHS will deliver savings and transform care in the next four years
  
  o We must address the concerns on cuts to public health and underfunded social care services, by working with the Government to explore how funding for social care can be brought forward
We should bring political parties together to review funding and delivery of health and care and how politicians can support a more sustainable social contract for the future.

The settlement for health and care

1.1 It is not logical to consider health and care as distinct public services and the line drawn between them is an artificial one created by separate structures and funding streams. The need for both the NHS and social care services in combination is obvious locally, yet the national discourse is fixed on managing these services individually. This reinforces inefficiencies and hinders the capacity to establish a more integrated and effective public service that delivers better value for taxpayer funding.

1.2 Cuts to social care funding have a negative impact on the NHS. This is no longer a statement we make in theory because the last five years demonstrates the effect in reality. Over that period, adult social care spending has reduced by £4.6 billion, around a third of the total budget, and tighter eligibility thresholds mean 400,000 fewer people now have access to state-funded care. These are people with social care needs and will be more likely to turn to other public services, such as the NHS, for support. They are also more likely to stay in hospital longer because of the increased risk of being at home without the support of social care services.

1.3 NHS and local authority leaders are in agreement that recent cuts to social care have increased the pressure on the NHS with the most prominent impact being increased time people remain in hospital. This is why we came together with national organisations from across the public, private and voluntary sectors in an unprecedented alliance to submit a joint representation to HM Treasury on the CSR. We demonstrated the depth of shared concern and called on the Government to protect social care funding alongside its commitment to additional funding for health.

1.4 The CSR acknowledges the potential social care funding gap and the Government accepts the impact it could have on the NHS in this parliament. It proposes a new social care precept and estimates this being worth up to £2 billion a year by 2019-20, yet further analysis from the King’s Fund suggests realistically this will raise only £800 million a year. Furthermore, the CSR confirms an additional contribution to increase the Better Care Fund by £1.5 billion, however this will not reach local systems until the final years of this Parliament. We have stood alongside care and support organisations again to respond to the CSR and made clear that without concerted action across government and the sector, the settlement for social care is not sufficient, targeted at the right geographies and will not come soon enough to resolve the care funding crisis.

1.5 If social care funding is not protected in this parliament then this will have a significant impact on the ability of our members to deliver the Simon Stevens Plan set out in the Five year forward view (5YFV). The Stevens Plan describes how the funding gap for health can be closed through a combination of additional funding and increased productivity. The plan identifies the need for social care services to be sustained and this was one of the five tests set by Simon Stevens in

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1 Association of Director of Adult Social Services (ADASS), Budget Survey 2015 (June 2015)
2 NHS Confederation, Annual Member Survey 2015 (June 2015) and ADASS Budget Survey 2015
3 Spending Review 2015: A representation from across the care and support sector (September 2015)
4 HM Treasury, Spending Review 2015 (November 2015)
5 “Using council tax to offset care cuts ‘will widen gap between rich and poor” in The Guardian (December 2015)
6 NHS Confederation, “Health and care sector calls for ‘care crisis’ talks with the Treasury and other Whitehall Departments” (December 2015)
7 NHS England, Five year forward view (October 2014)
assessing the CSR relative to the 5YFV. This test has not, in our view, been met and Simon Stevens himself has highlighted, following the CSR, that a widening gap between growing need for social care and available services remains.\textsuperscript{8}

1.6 Another test for the Stevens Plan which hasn’t been met is the need for the Government to commit to a “radical upgrade in public health and prevention”. Our joint letter with royal colleges, local authorities and directors of public health demonstrates the extent of concern around the cuts to the public health grant and how they will impact on the NHS.\textsuperscript{9} Our members have told us about the direct impact cuts will have to front-line services, including local cuts to the treatment of substance misuse, smoking cessation and sexual health.

1.7 Gaps in public health and social care funding will intensify existing gaps in health spending. We recognise that NHS spending has been protected, yet the CSR defines this as spending through the NHS mandate by NHS England. This is an important distinction because the health budget overall is therefore not protected and this means cuts to vital areas of spending, such as public health and clinical training. Added to this is a £1 billion a year obligation on NHS providers to implement the new state pension for 1.4 million workers in the NHS\textsuperscript{10} and the fact that providers are forecasted to carry over a £2 billion budget deficit from the current year.\textsuperscript{11} It is also unclear if funding is sufficient to meet the costs in delivering new policy priorities, for example the expectations around expanding access to health services seven days a week. Each of these pressures indicates the need to re-evaluate how far £8 billion additional funding can go and what impact this has on the ability of the NHS to deliver £22 billion in productivity improvements.

1.8 Taken together, public spending on health and social care in England is £124.9 billion in 2015-16.\textsuperscript{12} This represents 6.6 per cent of the UK GDP.\textsuperscript{13} Assumptions in the CSR suggest public spending on health and social care in England could rise to at most £140.7 billion.\textsuperscript{14} As outlined above, this would be an ambitious estimate of how much could be spent on health and care, nonetheless it would still represent a reduction in public spending on health and care as a portion of UK GDP. In fact, public spending on health and care in England would fall from 6.6 per cent to 6.3 per cent as a portion of UK GDP. This is a significant shortfall, worth around £8 billion a year, and it demonstrates how health and care spending is not planned to grow relative to the wider economy. Additional analysis by the King’s Fund on both public and private spending on health across the whole UK tells a similar story, with a fall from 7.3 per cent of GDP in 2014-15 to 6.6 per cent of GDP in 2020-21.\textsuperscript{15}

1.9 It is worth recognising that while public spending on health and care is expected to fall as a portion of national income, it will increase as a share of department resource spending from 39.6 per cent in 2015-16 to 42.9 per cent in 2019-20.\textsuperscript{16} This follows a similar trend seen in other

\textsuperscript{8} NHS England, Chief Executives Report to the Board (December 2015)
\textsuperscript{9} NHS Confederation, “NHS Confederation calls for an end to public health cuts in the upcoming spending review” (October 2015)
\textsuperscript{10} This figure is based on NHS Employers/NHS Confederation analysis of the 2014/15 NHS Pension Scheme Accounts and the impact of removing a 3.4 per cent rebate on the NHS pay bill
\textsuperscript{11} Monitor and NHS Trust Development Authority, Quarterly reports on the performance of the NHS foundation trust and NHS trusts (September 2015)
\textsuperscript{12} Health spending based on DEL of Department of Health in Spending Review 2015 and social care spending based on ADASS Budget Survey 2015 (June 2015)
\textsuperscript{13} UK GDP taken from HM Treasury and total department spending taken from Spending Review 2015
\textsuperscript{14} This is based on adult social care remaining at 35 per cent of local government spending, net £3.5 billion (plus inflation) additional funding specifically for social care
\textsuperscript{15} The King’s Fund, “How does NHS spending compare with health spending internationally” (January 2016)
\textsuperscript{16} Based on Spending Review 2015
Western countries in which ageing populations push up public spending on health and care.\textsuperscript{17} It is also a consequence of the political choice to reduce total government spending for most of this Parliament. International comparisons indicate that the UK spends less on health, as a percentage of GDP, than the OECD average\textsuperscript{18} and on social protection overall, which includes the totality of spending on health, benefits and care, it is at best an average spender across all EU countries.\textsuperscript{19}

1.10 We believe health and care is not just a public good, but a public priority. It is right that spending on the NHS is a fiscal priority for the Government, although we are concerned as to whether the CSR sufficiently supports the Stevens Plan. We understand that funding for health and care is a political choice and our evidence demonstrate to the Committee some of the consequences for these decisions, which we believe need to be part of a wider public debate on the delivery of services in the future.

Transforming care in this Parliament

2.1 The Stevens Plan creates a blue-print for transforming how care is delivered so that it better suits the needs of people today. A large part of this vision rests on a community-based model, yet primary, community and mental health care spending has been declining as a share of expenditure. The CSR makes a case for backing this plan and additional funding is front-loaded as a down payment on delivery. This up-front investment of resources is crucial and was a central recommendation in our representation to the CSR. It gives the NHS a fighting chance to invest in the Stevens Plan while stabilising provider finances to ensure they remain sustainable.

2.2 We welcome the specific commitments to improving mental health, both in the CSR and in ensuing statements from the Government.\textsuperscript{20} We look forward to gaining clarity on the detail of this funding and on how it will translates into real change and focused investment on the ground using the right mechanisms. This parliament must see the delivery on the political commitments to prioritise mental health funding and ensure a transformation in care for patients with mental health needs. Budgets for mental health trusts were cut, in real terms, by 8 per cent in the last parliament and we must see faster progress in this parliament to establish genuine parity of esteem between mental and physical health.\textsuperscript{21} We believe the recommendation from the independent Mental Health Taskforce will be crucial to setting the conditions needed to drive transformation in this area.

2.3 The transformation of care needs to be central focus for the NHS in this Parliament and will be an important factor in meeting the £22 billion efficiency challenge set by the CSR. The efficiency plan from the last parliament, known as the Nicholson Challenge, set out to deliver just 20 per cent of the savings needed through transformation and these were back-loaded to the end of the Parliament. Ultimately, most savings were made through the national tariff and prices to providers were cut by a net 6.2 per cent between 2011/12 and 2014/15.\textsuperscript{22} The effect of relying too heavily on this technical approach to efficiency was a decline in provider finances and the inability of providers to balance their budgets.\textsuperscript{23} This decline has to be stemmed and while Lord Carter’s work suggests there are still savings in operational productivity, the Government will need to pay

\textsuperscript{17} Alastair Gray, “Population Ageing and Health Care Expenditure” in Ageing Horizons, Issue 2 (Spring 2015)
\textsuperscript{18} The King’s Fund (January 2016)
\textsuperscript{19} Eurostat, Expenditure on social protection (March 2011)
\textsuperscript{20} Prime Minister’s Office, “Prime Minister pledges a revolution in mental health treatment” (January 2016)
\textsuperscript{21} The Mental Health Policy Group, Improving England’s mental health: The first 100 days and beyond (May 2015)
\textsuperscript{22} Various tariff documents across the period by Department of Health, Monitor and NHS England
\textsuperscript{23} Department of Health, Annual Accounts and Report (July 2015)
more attention to allocative savings made through effective commissioning and service transformation.

2.4 A key condition for this is certainty and stability and the multi-year funding settlement agreed in the CSR must now be placed in the context of planning, performance and regulation in the NHS. We welcome how national bodies have wasted little time in agreeing joint planning guidance to set out the expectations on the NHS and outline a plan for how the centre intends to support the service in developing multi-year plans across local health systems. This includes details on a new Sustainability and Transformation Fund that focuses on shoring up provider finances in 2016-17. It is important that stabilising the acute sector does not come at the price of reinforcing unaffordable models or disinvesting in community services. Planning and regulation across health and care needs to be focussed on a place instead of simply considering individual organisations. We need this “place based” approach to come sooner rather than later and be used to inform the best way to balance the funds need to sustain services with investment needed for transformation. Flat growth in the middle of the period reinforces the need to make change happen as early as possible in the cycle.

2.5 Greater certainty on funding helps manage financial risk across years and sectors. It can help promote better working across the NHS and local government; the NHS and the independent sector; and the NHS and the third sector. Developing better collaborative relationships will mean, for example, the independent sector can support the delivery of waiting list targets and support the principles of patient choice, while continuing to preserve the NHS as free at the point of delivery. In 2014-15, a total available capacity of 125,156 surgical procedures and diagnostic tests were made available by independent providers over the winter and for winter 2015/16 this was increased to 250,000. Organisations like Macmillan Cancer Support, Virgin Care and Age UK are now providing community resilience and helping to turn the curve on demand in some parts of the country. There is a willingness to continue these partnerships. Investment from the independent sector has also proved effective in improving access to much needed capital and helped in areas such as diagnostic imaging and pathology to establish partnerships spanning a decade delivering more than £80 million of capital investment in one contract alone.

Our society and health and care – a renewed contract

3.1 We have consistently made representations to the Committee on the connection between politics and the NHS. Last year, we described the benefits for health in establishing a funding cycle that goes beyond parliamentary terms to challenge the notion of the two needing to be intrinsically linked. It is now worth noting that NHS finances have declined at a time when NHS organisations have had the least certainty on funding, due to the wait for the result of the General Election and consequent programme of the new Government to be announced. We believe certainty and stability on funding are important factors for supporting the NHS to plan for making savings and it is to be expected then that, in the absence of this, there will be greater unplanned spending, as has been reported in the last two years.

3.2 We call on the Committee to recognise the impact political cycles have on the NHS. Furthermore, we believe there is a need to consider how to manage this impact and establish a stronger

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24 NHS Partners Network, “NHS waiting lists are too long and not enough is being done reveals new poll ahead of winter” (November 2015)
25 Macmillan Cancer Support, Building Resilience in the Cancer Workforce (January 2016)
26 Alliance Medical, National PET/CT contract (January 2016)
27 NHS Confederation, Submission to Health Select Committee Inquiry into Public Expenditure on Health and Care (October 2014)
evidence base to decisions on funding. An independent body, akin to an Office for Budgetary Responsibility in Health, could be established to set evidence-based forecasts and provide an expert assessment of realistic efficiencies, likely costs pressures and additional money from economic growth. It would therefore offer a definitive answer to a common uncertainty for the public as to whether the NHS has enough resources.

3.3 A strong independent basis to the funding we invest in health and care services would help improve the link between expectations and resources, so that the NHS has more confidence in what it is being asked to deliver and the public have more assurance about what will be delivered. It could also help to renew an implicit agreement between the NHS and society on the role of health as a public service. This agreement goes beyond the interactions between patients and health services, to consider the relationships between health and care services with their local economies and communities. It should also look to support staff and engage them in transformation of care and how they can fulfil their potential in new models of care. Refreshing this social contract should be based on the collective objective of protecting the NHS as free at the point of use and considering all the resources needed to do this.

3.4 An important part of this will be bringing political parties together on the challenges facing the NHS, which the Committee has a key role in enabling. We support the renewed interest in this, including the recent call from Simon Stevens28 and the proposed bill led by Rt Hon Norman Lamb MP which is garnering support from across the House.29 There is a pressing need to explore the relationship between the public and the NHS, which is one of its most important public services, and we believe this is best addressed as a cross-party effort.

22 January 2016

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28 The Guardian, “NHS chief demands political consensus on funding elderly and social care” (January 2016)
29 Houses of Commons, National Health Service and Social Care (Commission) Bill 2015-16 (January 2016)