1. Introduction

1.1 NHS Clinical Commissioners (NHSCC), the membership body of Clinical Commissioning Groups (CCGs), welcomes this opportunity to submit evidence to the Health Select Committee inquiry on the Impact of the Comprehensive Spending Review on health and social care. Established in June 2012, NHSCC has just over 90% of CCGs in membership and offers a strong national voice for our members on a number of national policy issues. We support our members to be the best they can be in order to commission effectively for their local populations.

1.2 Our evidence for this inquiry is based primarily on the views and perceptions of our members, where possible we have included wider research that supports our view. We therefore invite the Health Select Committee to read this submission as an insight from CCGs.

2. Main points for the Health Select Committee to be aware of:

- The Comprehensive Spending Review settlement provides the NHS with a unique opportunity to deliver the Five Year Forward View over the course of the parliament
- This opportunity should not be wasted on merely sustaining the current system, in order to deliver the £22bn efficiency savings required, transformation of the current health and care delivery model is essential.
- The challenge in achieving both transformation and increased efficiency at the same time should not be underestimated. This will not be helped by increased pressure on frontline services as a result of reductions in funding for public health and the increasing funding gap in social care.
- Clinical Commissioning Groups are best placed to successfully deliver the transformation required through their unique clinical and local perspective, indeed they are already taking a lead role in the delivery of change in local areas.

3. Background

3.1 CCGs were established by the Health and Social Care Act 2012 and have been in operation since 1 April 2013 replacing Primary Care Trusts. Subsequently they have made significant progress in transforming the delivery of services for patients and populations. However, there is a considerable ambition to achieve more, driving the change that the NHS needs to deliver efficient and effective health and care for the population in the future.

3.2 There is a large body of evidence which shows that CCGs are taking the lead in transforming the health service\(^1\), in England’s core cities\(^2\), in partnership with local authorities in health and wellbeing boards\(^3\), and through prevention of illness through early diagnosis of health issues.\(^4\)

4. Distribution, efficiency and transformation

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\(^4\) Forthcoming NHSCC publication.
4.1 In order to deliver the *Five Year Forward View* it is essential to have effective commissioning that takes the lead in delivering new approaches to health and care. The Spending Review settlement provides commissioners with an opportunity to address the systemic issues within the system and to transform services in local areas for the good of patients and the wider economy. CCGs are best placed to understand the improvements that can be made to the health of local populations since they are led by frontline clinicians and local GPs at the heart of their local communities.

4.2 The Spending Review provided an £8bn real terms increase in health funding by 2020/21 with the majority front-loaded over the first two years. This front-loading was welcome and something that CCGs requested in order for them to begin to tackle some of the key systemic issues.\(^5\) The clarity provided by the settlement gives CCGs the certainty to plan services over the parliament, delivering local efficiency and service transformation. This phasing means that the NHS cannot afford to simply do more of the same and will need to fundamentally transform the way in which health and care is delivered.

4.3 The impact of reductions in other areas that will have an effect on frontline services, specifically in public health and social care, will increase the challenge of successfully delivering both the requisite transformation and the efficiency savings. The phasing itself (£3.8bn in 2016/17 and £1.5bn in 2017/18) brings an added time pressure since there is a significant drop off in subsequent years.

**Delivering efficiency**

4.4 CCGs spend around £60 billion of public money each year, they therefore have a key role to play in delivering and driving efficiency within the system. Over the last parliament increases in the overall health budget were around 1% on average, whilst demand for health services has continued to increase. Therefore the NHS has been asked to do more with less.

- In order to better understand what the service should be delivering, there is the need for national discussion about what is achievable and what the public can reasonably expect from the health service.

4.5 Over the previous parliament around £20bn of efficiency savings were made, with these proving harder to deliver in the final years. The increasing rise in provider deficits, as a result of reduction in unit costs in the national tariff, has increased the need to change the approach from the technical to the allocative, ensuring that the way in which we distribute resources to meet differing needs is equitable and maximises value.

4.6 The successful delivery of the *Five Year Forward View* is predicated on the ability of the system to deliver £22bn of efficiency savings by 2020/21. CCGs have led the way in driving savings locally over the previous parliament through prioritising spending in their local area and making difficult decisions on which services to fund in partnership with members of the public.\(^6\) As commissioners they are focussed on delivering value from the outset, reducing variation locally and investing in community care that will reduce emergency admissions. In primary care, as senior clinicians, they are best placed to accelerate changes that will release cash savings through co-commissioning for example around referrals, prescribing and more proactive management of people with long term conditions. Work is already underway on medicines optimisation, changing prescribing habits and looking to introduce social prescribing models. As clinical leaders they are able to develop collaborative approaches to change, especially in relation to services and

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estates, using local levers in Health and Wellbeing Boards to drive through new models of working with local authorities. It will be commissioners who will be expected to instigate any recommendations from the Carter Review, ensuring that providers are delivering efficiencies. Whilst some of these are short term solutions the majority will be delivered over the longer term, for example, the NHS Right Care programme. A realistic approach is required from government about the speed at which efficiencies can be delivered. The Five Year Forward View is a long-term plan that aims to transform health by the end of the period.

Support for transformation

4.7 There needs to be a shift change in how the NHS distributes resources to meet the needs of the population and maximises value for the services delivered - this is true transformation. The current CCG annual spending round mitigates against investment in services that will transform the NHS and make savings in the longer term. Regular monitoring of people with diabetes in the community, for example, can prevent complications developing and therefore reduce hospital admissions. However, it could take up to two to three years to deliver such a service and realise its full economic potential, whilst to close an existing service before a new one is established brings its own risks.

- 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.

4.8 In our response to the Spending Review we were clear that any additional funding should not be used to support business as usual. Any additional monies should be used to invest in transformation rather than filing any financial holes that already currently exist. The NHS England Planning Guidance provided further detail of Sustainability and Transformation Funding that will support providers in addressing current deficits and agreed Sustainability and Transformation Plans for local areas. This will amount to £2.1bn in 2016/17 rising to £3.4bn by 2020/21. In the first year the vast majority (£1.8bn) will be used to sustain the current system, specifically to address the estimated £2bn deficit in the provider sector. It is vital that in order for the system to deliver the efficiencies described above that the bulk of this money in the future flows towards transformational funding and is not merely used to fill financial holes in the current model. CCGs are best placed to deliver this £1.8bn to providers; a failure to include them in discussions would result in outcomes that were not reflective of local need, and indeed could undermine local strategies to achieve sustainability across the system. Our members are keen that providers should be supported to transform their services to make them more efficient and effective. However, this should be achieved through clear contracting and payments with conditions rather than direct financial bail-outs from the centre.

- The main national focus should be on transformation rather than sustaining the current model. If this is not achieved then the £22bn efficiency savings will not be delivered and the health system will be unsustainable in the current funding model

New models of care

4.9 The Five Year Forward View outlines the new models of care that the NHS should develop to drive the transformation of services. These are not expected to be universally applicable with local areas responsible for determining what the most appropriate way forward is for their health services. Commissioners are best placed to lead these conversations given their local footprint and knowledge of the population and clinical needs. However, this change will not be sustainable in the short term as cash-releasing savings, for example, by reducing stranded costs such as buildings and technology in the current

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model, will only be available once the new model is fully up and running. True transformation therefore requires ‘double-running’ with increased investment upfront.

- In order to support the new models of care a portion of the allocated finances should be set aside to allow double-running of services.

4.10 Historically, those areas that will support a shift in delivery of services out of hospital, such as primary and community care, have been underfunded.\(^8\) The announcement of £750m of investment was a welcome boost for the former, however, this will be used to support the introduction of evening and weekend working rather than delivering a more efficient future model.

Reform of the tariff

4.11 We believe that the tariff payment system needs fundamental reform in order to support efficiency and transformation. Currently this works against long-term priorities by concentrating money and resources on hospital activity. The tariff was originally introduced to address hospital waiting list times, therefore rewarding for activity rather than keeping the population healthy and out of hospital. This can actively prevent the transformative work that CCGs are looking to undertake. A multi-year tariff coupled with multi-year allocations and a greater granularity of financial provision would allow for a model that reflects local need and allows CCGs to plan over the longer term more effectively.

- The current tariff system will not effectively support the delivery of transformation programmes since it rewards hospital activity rather than keeping the population healthy and out of hospital.

4.12 In 2015/16 CCGs were disappointed that a minority of organisations that provide services to the NHS were able to object to the proposed tariff at the expense of the wider system. Therefore we were encouraged that the government recognised the disruption that this had caused, raised the objection threshold and removed the objection mechanism by share of supply, something that our members supported.\(^9\)

5. The impact and management of deficits in the NHS;

5.1 Historically CCGs have maintained financial stability ensuring value for money for the taxpayer. It would therefore seem inequitable for them to have to take on the costs associated with deficits accrued by providers. Whilst there are some CCGs that have delivered deficits the majority have balanced their budgets delivering a surplus of £182 million in 2014-15 (amounting to 0.3% of their allocations).\(^10\) This is in contrast to other parts of the commissioning system, for example the NHS England held specialised commissioning budget which overspent by almost £600 million in the last two years.\(^11\)

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\(^8\) In 2009/10 investment in general practice was £8,321.187m, in 2013/14 this had risen by 5.19% to £8,752.9m. At the same time the Department of Health Budget rose by 9.38% from £101,259m to £110,756m. Department of Health Annual Accounts 2009/10 and 2013/14. Health and Social Care Information Centre Investment in General Practice 2009/10 to 2013/14 England, Wales, Northern Ireland and Scotland September 2014. Between 2003 and 2013 the number of hospital consultants increased by 48 per cent while GP numbers increased by only 14 per cent. HEE The future of primary care Creating teams for tomorrow July 2015


\(^11\) Ibid.
• Deficits incurred in one sector of the NHS will have a significant impact on the ability of CCGs to deliver change locally and on the wider system to transform nationally. The delivery of NHS services cannot be viewed in isolation.

6. Social care funding, including implications for quality and access to services

6.1 Whilst the increase in funding for the NHS is welcome, there are a number of external pressures that will impact on the ability of the service to successfully deliver the efficiency savings, foremost amongst these is reductions in social care spending. Social care cuts have a negative impact on health services with the needs of thousands of people, particularly frail and older people, going unmet. People will increasingly turn to health services to meet this need and transfers out of hospital into the community could be slowed.

6.2 There is an estimated shortfall in social care funding of £6bn in 2020/21.\(^{12}\) The spending review grants local authorities the ability to raise council taxes by 2% to cover this cost although this is estimated to only amount to £1.7bn with political pressure on councils to maintain current council tax levels making increases harder to introduce. In addition, Local Authorities with more challenged local health economies will have less opportunity to raise resources through this route. The social care budget is also included in the overall Local Authority budget, rather than being ring-fenced as public health budgets are. Announced increases to the Better Care Fund, although welcome, will not cover the predicted shortfall, and of course ‘additional’ funding is taken directly from NHS budgets. This is coupled with government commitments to introduce the living wage for around 900,000 employees. These pressures in other sectors make the £22bn efficiencies seem unreachable. It is essential that expectations are realistic when such reductions in funding in other parts of the system are being introduced.

• The reduction in social care funding, coupled with the introduction of inadequate methods to address this shortfall, will increase pressure on frontline NHS services at the time they will be looking to transform.

6.3 To view social care in isolation from the wider health system fails to take into account the impact of reduced availability and increased variability on local populations. This will increase pressure on hospital services, specifically Accident and Emergency departments, which as part of wider emergency care provision requires significant transformation in order to make it sustainable in the longer term.

7. Preventing ill health and promoting well-being

7.1 Effective integration and partnerships across health and social care at a local level will drive improved health outcomes. We feel CCGs have a unique role in improving the health and wellbeing of local populations which support the local economy, many are already at the fore of joint partnerships/programmes that do this.\(^{13}\) The recent devolution deals in areas like Greater Manchester offer some way of achieving more place-based approaches to integrated commissioning and preventing ill health, but may not be the right approach for all areas, particularly if they do not recognise or exclude the contribution of the NHS. For some localities better joint working arrangements between the CCG and Local Authority at, for example, Health and Wellbeing Board level can achieve the same objectives. What must be recognised across the

\(^{12}\) Filling the gap: Tax and fiscal options for a sustainable UK health and social care system, Health Foundation, November 2015

\(^{13}\) Leading local partnerships: How CCGs are driving integration for their patients and local populations, NHSCC, October 2014,
public sector is the contribution that CCGs make to creating healthy populations and how this impacts on the economic development of an area.

7.2 The Spending Review announced a 20.5% cut in Local Authority public health spending by 2020/21 amounting to £3.9bn annual real term reductions over the next 5 years. These funding cuts conflict with the ambitions of the Five Year Forward View and gives a clear indication that the government is prioritising funding over local need and prevention. The failure to adequately resource public health will impact on partnership working between the CCGs and local authorities. Vital services will become fragmented as procurements are driven by cost saving as opposed to delivering the best quality service. In some cases CCGs will need to step in to fill these voids, leading to increased costs for CCGs. This will make the efficiency savings and the new models of care more challenging to deliver, and could lead to increased fragmentation and variability.

7.3 Maintaining the general public’s health has clear economic benefits, allowing people to stay in work and reducing the burden on the state. To reduce funding for these services will not only impact upon the health and care system, but also on other governmental services and the wider economy. Furthermore the impact of these cuts will be felt long term, affecting the population health in forthcoming years and increasing pressure on the health service in the future.

- Public Health is focussed on prevention, and reducing the budget for this area will increase pressure on health and social care services, making transformation and efficiencies harder to deliver.

7.4 Reductions to local authority budgets coupled with reductions to CCG allocations as a result of a shift to new funding formula will create areas that are subjected to health and care funding reductions on two fronts. These localities would face reduced local authority budgets for public health services focussed on prevention, and reduced CCG allocations that will impact on those services provided by the NHS. This would have a significant impact on the health and wellbeing of a specified population.

8. Quality and access

8.1 CCGs have acted as the drivers of quality in their local area, since their wide-ranging and clinical perspective allows them to make decisions that are of the most value to patients. However, they would benefit from clear direction and prioritisation from the government. The recent mandate to NHS England and subsequent response set out several areas to be delivered over the course of the parliament and in the next year. It would be helpful if it was clear what the main priorities and deliverables are, and more significantly the specified associated costs.

8.2 A particular area of concern is around the delivery of seven day services. Whilst our members would accept the value and benefit of delivering some services on all days of the week, this would only be appropriate in certain circumstances. There was welcome recognition of the need for this to be based on local requirements in the NHS England Planning guidance. To mandate delivery of all services over a seven-day timescale may result in an unnecessary financial burden and increased workforce pressures. It is unclear whether the introduction of these services has been fully costed, and whether it is included as part of the Sustainability and Transformation Funding. We would advocate for the introduction of seven day services only where appropriate and when it is in the best interests of local populations.

9. Parity of esteem through funding for mental health services

9.1 The £600m allocation for mental health services will allow continued support for the services that CCGs understand the value of and have continued to invest in over the course of the previous parliament. CCGs are committed to delivering parity of esteem through funding for mental health services. However, the proposed blanket increase that CCGs are expected to deliver in line with their yearly increases in allocations does not take into account local variability of need. For example, where due to pace of change alignments a CCG receives a 10% increase in its overall allocation, this would necessitate an equivalent increase in the mental health budget which may not be appropriate for the local population.

9.2 It must also be recognised that increased investment in Mental Health services does not necessarily equate to increased investment in NHS Trusts/FTs providing Mental Health services, given the fact that the majority of Mental Health care is provided by primary care and third sector organisations.

25 January 2016

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192 of the 209 CCGs achieved a real terms growth in mental health planned spend measured against the 1.4% Gross Domestic Product (GDP) deflator for 2015-16. Mental Health Services: Finance: Written question - HL4681, January 2016
http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2015-12-16/HL4681/