Further written evidence submitted jointly by the Department of Health, NHS England and NHS Improvement (CSR0108)

Impact of the Comprehensive Spending Review 2015 on Health and Social Care

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1 Capital: backlog maintenance

Q304 Chair: Simon, are you able to say more about it? Clearly, there are many of the new models of care that we want to put in place over the spending review that will rely on capital spending. How concerned are you that that will not be achievable?

Simon Stevens: Some of it is capital; some is revenue through the sustainability and transformation fund. On the capital point, as David says, yes, prospectively capital has been converted into revenue to support the front-loaded nature of the settlement, which we were clear we needed and that we have, but looking out over the next three to five years, we will have a clearer sense of what the reasonable capital requirements are in order to deliver the kinds of change programmes that the local sustainability and transformation plan groups come up with by the summer. One thing they are looking at is what it would take to lubricate change in their county, their geography or in their part of the city. 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.

Q305 Chair: Will you be able to set out for this Committee, when you have that information, what, if you like, the growing backlog of work is that needs to be done that has been deferred?

1 Data is collected annually on Backlog Maintenance at NHS trusts and their sites by the Health and Social Care Information Centre (HSCIC) on behalf of the Department. All this data is published at: http://hefs.hscic.gov.uk/ERIC.asp

2 The national summary for this data is provided below:
## Historic NHS Backlog Maintenance

![Bar chart showing maintenance backlog from 2010-11 to 2014-15 for low, moderate, significant, and high risk categories.](chart.png)

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<tbody>
<tr>
<td>Low risk (£m)</td>
<td>1,299</td>
<td>1,315</td>
<td>1,204</td>
<td>1,242</td>
<td>1,267</td>
</tr>
<tr>
<td>Moderate risk (£m)</td>
<td>1,524</td>
<td>1,485</td>
<td>1,477</td>
<td>1,427</td>
<td>1,551</td>
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<tr>
<td>Significant risk (£m)</td>
<td>1,022</td>
<td>926</td>
<td>1,002</td>
<td>1,017</td>
<td>1,062</td>
</tr>
<tr>
<td>High risk (£m)</td>
<td>322</td>
<td>296</td>
<td>353</td>
<td>357</td>
<td>458</td>
</tr>
</tbody>
</table>
2 Lord Carter efficiency savings

Q313 Chair: Are we on target to meet the efficiencies that were projected by Lord Carter?

Jeremy Hunt: I cannot answer that question today because we are collecting monthly data as of the start of this year, trust by trust, which will enable us to track progress in meeting those Carter objectives. There is a time delay on the data you collect, as inevitably there is usually a six-week lag. That is something on which I hope we can provide information to the Committee . . . .

3 Savings plans have been identified for the implementation projects which span workforce, clinical quality and efficiency, clinical and non-clinical areas. In order to track implementation key performance indicators for each project have been identified which will show how projects are progressing. These indicators are tailored to the specific projects and will be monitored on an ongoing basis by NHS Improvement and the Department of Health. Performance data will be shared by NHS Improvement when available.
3 Reductions in social care: Local Government Association figure of 33%

Q337 Emma Reynolds: But 33%, with respect, goes beyond efficiency savings, does it not? We have heard evidence that this had a real impact on delivery of care. I agree with you on some of the things you have said previously about having to drive efficiency savings, otherwise the budget is going to keep expanding, but I am saying that the degree of cuts to social care in the last Parliament has caused problems from which we are still suffering, and the nature of those cuts, which were a third of the budget, for me goes beyond efficiency savings. Of course, there are always some efficiency savings we can make.

Jeremy Hunt: I do not recognise the 33% figure, so I will happily take that away and look at it in more detail for you.

4 We do not recognise the 33% reduction in funding for social care mentioned by Emma Reynolds, MP. Ultimately it is a local decision as to how much councils spend on social care and we are pleased that local authorities have chosen to give relative protection to adult social care compared with nearly all their other services. Our understanding of the figures is that from 2010-11 to 2015-16 spending on adult social care in England was relatively flat in cash terms. This equates to a 10% real terms reduction in spending. Councils have made considerable savings over the past five years through both efficiencies and changes to the care services they offer. They have changed the services offered by focusing on prevention and enabling people to live independently for longer. This has helped councils rise to the challenge of achieving savings whilst setting balanced budgets, keeping council tax low and maintaining satisfaction in services.
4 Cost to the NHS of delayed discharge

Q343 Chair: Do you have a current cost for delayed discharges to the NHS? What would you estimate that to be at the moment?

Jeremy Hunt: I do not have a current cost. I have a figure in my mind that it is around 5,000 beds on any given day, and I am aware of that pressure on hospitals.

Q344 Chair: But it has not been costed. Bob, do you have a cost?

Bob Alexander: I do not have that, I am afraid, Chair. I could undertake to work with colleagues and give a response back to the Committee.

It is difficult to calculate an exact net cost for delayed discharge to the NHS because this requires knowing the difference between the hospital costs that were incurred because of delayed discharge, and costs that would have been incurred in the community or from other forms of care had discharge not been delayed.

However, recent work undertaken by the National Audit Office (NAO) and published in its report, Discharging older patients from hospital\(^1\) does try to estimate the gross costs of delayed discharge relating to patients aged over 65. The NAO estimate this as being in the order of £820 million per year. This estimation is subject to several caveats on both the data and the methodology used.

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\(^1\) National Audit Office (May 2016) *Discharging older patients from hospital (HC18)*
Q353 Emma Reynolds: My question was not really about that; I should have made that clear. I welcome the move that public health teams are now in local authorities, and we heard some very good evidence from public health teams in different local authorities that they much preferred being in the local authority setting for lots of different reasons. My question was about the broader spending by local government, not so much the public health part of local authorities but overall spending by local authorities in deprived areas, which is being hit, which is higher for deprived areas, and I know the Government often talk about this as spending per head. Obviously, it is higher in places like Liverpool, Birmingham and Wolverhampton precisely because there are higher levels of deprivation, but the Government in the last six years—and they are continuing to do this—are moving to decreases in spending per head in these more deprived areas. I am wondering what the conversations are between DCLG and your Department on the impact of the spending decisions, because there is an impact on public health and health inequalities.

Jeremy Hunt: Perhaps it would be helpful if I asked the communities secretary Greg Clark to write to you on that very specific point because I know he would challenge that as being the basis on which allocations are made . . . .

The Department for Communities and Local Government will respond on this issue separately.
6 Bursary versus loan system

Q360 Chair: Could you set out what would be the cost to the NHS of a standard system where somebody takes a loan out and pays tuition fees and the cost of somebody training through the bursary route? If there is not a huge extra net cost if people are paying tuition fees and taking out a loan, what would be the problem of introducing that in parallel to increase the number of training places you need but cannot afford to fund through the current bursary system?

Jeremy Hunt: Let me write to you with the detailed costings that you asked for with that information . . . .

8 The cost to the taxpayer of funding one nursing degree student for one year at 2016-17 rates is as set out in the table below.

9 Costs of loans (items marked *) are presented firstly as cash outlay and secondly in net present terms. The latter is an estimate to take account of the cost of the portion of the loan that is not expected to be repaid by the student.

10 The cost varies depending on the student’s place of residence. The example shown is for a student living away from the parental home, but not in London which covers the vast majority of healthcare students.

11 The table shows the maximum rates of bursary funding, assuming students claim their full entitlement and have a household income below the means testing threshold. Under the current bursary system, healthcare students may optionally apply for a Reduced Rate Maintenance Loan (RRML) as a top up to the NHS Bursary. This has also been presented in net present terms.

12 Maintenance loan rates are an estimate provided by the Department for Business, Innovation and Skills (BIS) for the average student.

13 In addition to the living cost support, students with children and other dependents will receive allowances for childcare and travel, etc. but these vary depending on individual circumstances and so have been excluded from this analysis.

Annual cost to the taxpayer per student under NHS Bursary versus student loan system; 2016-17 rates for a 42-week course
<table>
<thead>
<tr>
<th>Outside London</th>
<th>Unit cost of a Bursary (£)</th>
<th>Loan outlay costs (cash) (£)</th>
<th>Loan net present costs (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance</td>
<td>3,643</td>
<td>6,300*</td>
<td>2,079*</td>
</tr>
<tr>
<td>Extra weeks</td>
<td>1,008</td>
<td>1,056*</td>
<td>348*</td>
</tr>
<tr>
<td>RRML</td>
<td>465*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tuition</td>
<td>8,700</td>
<td>9,000*</td>
<td>2,970*</td>
</tr>
<tr>
<td>Clinical placement</td>
<td>3,175</td>
<td>3,175</td>
<td>3,175</td>
</tr>
<tr>
<td>Teaching Grant</td>
<td>0</td>
<td>769</td>
<td>769</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>16,991</strong></td>
<td><strong>20,300</strong></td>
<td><strong>9,341</strong></td>
</tr>
</tbody>
</table>

Items marked * are loans. Costs are presented outlay (cash terms) and in estimated net present terms.

RRML = Reduced Rate Maintenance Loan, a student loan currently taken by NHS Bursary students to top up NHS Bursary maintenance payments. This is also represented in net present terms for consistency with the other loan elements.

**Advice received**

There is zero cost to the NHS of funding a student via the standard student loan system versus the NHS Bursary system. The funding is from the taxpayer via DH and HEE budgets (for NHS Bursary) and the BIS budget (for student loans). Therefore we have interpreted this question to mean “what is the cost to the taxpayer?”

*June 2016*