



The impact of the comprehensive spending review on health and social care
Supplementary written evidence by NHS Providers to the Health Select Committee
March 2016

About NHS Providers

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We have 224 members – 94% of all NHS foundation trusts and trusts – who collectively account for £65 billion of annual expenditure (two thirds of all NHS spend) and employ more than 925,000 staff.

We provided written evidence to the Committee in January 2016. This is outlined below in Appendix A. More recently, we provided supplementary written evidence with more recent analysis. This is outlined here:

1. This paper outlines a number of new developments which may have a bearing on the Health Select Committee's inquiry on the impact of the Comprehensive Spending Review for health and social care. It sets out further information on three areas:
 - a. The current financial performance for the NHS provider sector;
 - b. Lord Carter's review of NHS operational productivity;
 - c. Our assessment of the extent to which national policy commitments are funded by the spending review settlement.
- a. Current financial performance for the NHS provider sector**
2. The financial performance of the NHS provider sector is under considerable pressure. The net deficit over the first three quarters of this financial year was £2.26bn, and on current trajectory could increase to £2.8bn by the end of March. There are currently 179 providers in deficit, 75% of the sector and 95% of all hospital trusts.
3. These figures should not come as a surprise; the sector has been forecast a +£2bn deficit position this financial year for the past 18 months. There has been some further deterioration against the planned financial positions as a result of:
 - I. Ongoing necessitated high use of contract and agency staff (on which £2.7bn has been spent so far this year);
 - II. Significant impact of delayed transfers of care as a result of a lack of capacity in social and community care;

- III. Under-delivery of planned levels of savings as easy to release savings were largely delivered in the last parliament; and
 - IV. A level of efficiency requirement in the national tariff (reducing the prices paid for services), which NHS Improvement's Chief Executive has described as "unachievable"¹
4. Providers have been asked to take exceptional measures to improve their financial position in 2015/16. This may mean that on paper the deficit position reported at the end of the financial year is reduced from the £2.8bn currently forecast. However, many of the measures – such as capital to revenue switches and balance sheet adjustments – will do little to change the underlying financial position of providers, and therefore providers are likely to be entering the 2016/17 financial year with an actual deficit over £3bn.
 5. The NHS has received a £3.8bn real terms increase in its budget for 2016/17, in part to address the size and scale of provider sector deficits. The NHS only received an upfront settlement in exchange for a commitment to return the sector quickly to balance. The committee may find it useful to scrutinise proposals to support the provider sector back in to balance for 2016/17.
 6. Despite the additional investment in the NHS next year, combined with provider access to a sustainability and transformation fund and a more realistic efficiency requirement of 2% (as opposed to 4% as it has been in recent years) in the national tariff, substantial efforts will be required by providers to close the underlying deficit during 2016/17.
 7. This is why financial targets ("control totals") have been introduced for every NHS trust and foundation trust next year, to set a maximum deficit position or minimum surplus they must deliver next year. We estimate that around two thirds of providers have accepted their control total but most will have done so with conditions or with a heavy warning around the level of risk that is being run given the level of efficiency and savings being asked for in some cases.
 8. There has been a high degree of nervousness among NHS provider boards at signing up too definitively to the control totals at this point when so much still remains to be agreed; two such outstanding variables are:
 - a. clinical commissioning group and specialised services contracts;
 - b. availability of capital spend for maintaining existing estates and equipment, such as wards and diagnostic equipment.

¹ Independent (2015): <http://www.independent.co.uk/life-style/health-and-families/health-news/hospitals-could-run-out-of-money-for-wages-as-nhs-deficit-hits-15bn-experts-warn-a6741336.html>

9. In exchange for agreeing, and meeting, a control total, most providers² have been offered a share of the £1.8bn of the new sustainability and transformation fund, which NHS England has set up to support the provider sector to return to balance in the short term. In the medium term, it is intended that this fund be used transform local services in line with the Five Year Forward View.

10. The release of this funding in 2016/17 is contingent on providers meeting their control total, and agreeing a trajectory for improving performance against quality and access standards, such as the 62 day referral to treatment time for cancer patients.

11. This something-for-something approach is understandable, but the committee may wish to assure itself that this plan is realistic and deliverable for getting the sector back to a surplus position by the end of 2016/17. Current issues are:
 - I. Every control total provided an additional 2.5% efficiency target on providers' 2015/16 financial forecast, which has translated to increased savings requirements providers must make next year.
 - II. For some trusts, their savings plans will need to increase to between 4 and 6% of their total income, compared to a current average of around 3%.
 - III. Although the majority of providers have accepted their 2016/17 control total, our recent survey of provider Finance Directors suggests that around 60% are not confident they could meet their target, suggesting that a majority of trusts are concerned about how deliverable it is.
 - IV. An improvement in financial position will also be contingent on providers complying with capital restrictions on how much they are able to spend on maintaining or upgrading estates and facilities. Although restricting the use of capital in the short term might be understandable, the implications of continuing to ask providers to delay capital expenditure need to be carefully appraised.
 - V. The provider sector returning to balance next year is in part reliant on the success of recently announced controls on agency staff spend. Although there is early evidence of the impact this is having on reducing the number of shifts carried out by agency staff off agreed frameworks, we believe that further strong mechanisms might be required to ensure savings are realisable and recurrent.

b. Lord Carter's review in to NHS operational productivity

12. Since the deadline for written evidence to the committee's inquiry, Lord Carter's review in to NHS operational productivity has now reported. This report is a key pillar of the government's plan to close the £23.5bn funding gap by 2020. We are still waiting for

² Only trusts providing emergency services received a share of the sustainability fund.

detail from the national bodies and system leaders about how their plan to close the funding gap translates to different parts of the NHS, and what the relative share of the savings will be for the provider sector, compared to commissioners and other organisations.

13. The Carter review confirms that eliminating unwarranted variation could generate £5bn of efficiency savings by 2020, and that acute providers have in principle agreed to £3bn of this. However, it is clear that the savings identified in this review only make up a small proportion - less than a quarter - of the £23.5bn of savings required by the NHS in this parliament. Further savings might be identified from variation within community, mental health, ambulance, primary care and specialist acute services, but work has not yet started with these sectors.
14. Eliminating variation within the acute sector will only be possible if the least efficient providers are able to catch up to the most efficient providers. However, the variation in productivity between acute hospitals has changed little between 2009/10 and 2014/15,³ suggesting that efficiencies dependent on organisations catching up to the best performers are hard to unlock.
15. This is a view confirmed in Lord Carter's final report, which suggests that although hospitals can do more to improve productivity, much greater support will be required at a national and whole-system level if we are to realise these savings:
 - I. System leadership is required to address shared health and social care issue of delayed transfers of care, which is having a significant impact on the NHS achieving efficiency savings.
 - II. Further efficiencies might only be unlocked through changing the way hospitals deliver their clinical services, necessitating reconfiguration within and between organisations – this will require concerted national and political support.
 - III. A single reporting framework needs to be created which pulls together all clinical quality and resource performance data, in turn reducing and rationalising the significant reporting burden currently placed on providers.
16. Lord Carter's review also recommends the introduction of targets on hospitals to ensure they are managing their resources appropriately, including spending no more than 6% on corporate and administration costs by 2020 and having a maximum of 35% of non-clinical floor space at a site. Caution should be exercised over the introduction of hard targets in this area – the Carter review has buy-in from the provider sector for its emphasis on benchmarking, shared learning and collaboration, rather than top-down

³ Health Foundation publication

grip and regulation. Unlocking efficiencies needs to be a shared agenda between local and national organisations, rather than an initiative imposed on local organisations.

17. With these developments in mind, the committee may wish to explore with representatives of the government and national bodies:
 - I. When NHS national bodies and system leaders are going share their plan for meeting the savings required in this parliament, given the Carter review can only meet £5bn out of the £23.5bn efficiency challenge.
 - II. Whether the savings plans will be developed in collaboration with NHS frontline organisations.
 - III. How the requirement to lower administration and corporate costs be reconciled with the resources and leadership required to meet the unprecedented challenges providers are facing.
 - IV. Whether providers will be able to put in place sufficient non-clinical capacity and resource to turn finances around, meet increased demand and activity pressures, and rapid, large scale service transformation across local systems. Many of our members tell us that they have already reduced middle manager capacity in response to savings required in the last parliament.

c. Our assessment of the extent to which national policy commitments are funded by the spending review settlement

18. Since the publication of the spending review, detail is starting to emerge over which policy commitments will be funded as part of the £8.4bn real term investment in the NHS – we have outlined our assessment of these commitments in the below table.
19. The committee may wish to ask for further detail from the government and national bodies about how funding for these policy priorities match to the additional investment. As the situation currently stands, we question whether the spending review settlement meets all national policy commitments and priorities in full.

This table identifies a number of recent policy commitments and raises questions about how some of them are being funded that require clarification

Policy commitments and priorities	Details of funding allocated
Increased investment in commissioning allocations for local clinical commissioning groups (CCG), primary care and specialised commissioning allocations	<ul style="list-style-type: none"> • An additional £10bn (in cash terms) will be allocated to commissioning budgets over the between 2016/17 to 2020/21⁴. • This translates to a: <ul style="list-style-type: none"> ○ 2.7% average annual increase to CCG budgets ○ 5.2% average annual increase in specialised commissioning budgets ○ 4.6% increase in primary care budgets⁵.
Implementing the recommendations from the mental health task force ⁶	<ul style="list-style-type: none"> • The government has committed £1bn out of the spending review settlement for health to implement recommendations from the mental health taskforce, published in February 2016. • It is not clear whether this is: <ul style="list-style-type: none"> ○ A real or cash term increase in funding for mental health ○ A recurrent or cumulative allocation ○ To be funded through CCG allocations or the sustainability and transformation fund. • It would also be helpful to understand whether this includes or is in addition to: <ul style="list-style-type: none"> ○ £600m funding for mental health originally announced in the Autumn Statement for 2015/16 ○ £1.25bn previously announced for perinatal, and children and young people’s mental health over five years.

⁴ NHS England (2015): https://www.england.nhs.uk/wp-content/uploads/2015/12/04.PB_17.12.15-Allocations.pdf

⁵ NHS Providers analysis of NHS England Board paper (December 2015).

⁶ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

Supporting sustainability and transformation	<ul style="list-style-type: none"> • NHS England has announced the creation of a £14bn sustainability and transformation fund. £2.1bn will be available in 2016/17, rising to £4.3bn in 2020/21.⁷ • In 2016/17, the majority of this fund (£1.8bn) will be used to support sustainability in the provider sector, helping providers back to financial balance. In future years, it is envisaged that a greater proportion of the fund will be used to support transformation, but this is contingent on NHS finances stabilising in 2016/17 and 2017/18⁸.
Investing in improving technology in the NHS	<ul style="list-style-type: none"> • The government has committed £4.2bn to NHS technology, including £1.8bn to create a paperless NHS and £1bn on cyber security.⁹ • It is not clear whether any of this will be funded through the sustainability and transformation fund or commissioning budgets.
Improving maternity services	<ul style="list-style-type: none"> • The government has not yet committed funding to meet the recommendations outlined in the national maternity review¹⁰, published in February 2016. • The cost implications identified in the report's recommendations would necessitate an additional investment of around £10m in maternity services over the course of this parliament.
Implementing recommendations of the cancer taskforce	<ul style="list-style-type: none"> • The government has committed to fund in part the recommendations from the cancer taskforce¹¹, published in 2015: £300m a year will be invested to support recommendations on earlier GP diagnosis for cancer, including investment in additional staff and diagnostic capacity by 2020. • It is unclear whether the other recommendations from the taskforce (worth an additional £700m) will be implemented in full, and how the £300m will be made available to frontline providers.

⁷ NHS England (2015): https://www.england.nhs.uk/wp-content/uploads/2015/12/04.PB_.17.12.15-Allocations.pdf

⁸ Nuffield Trust (2016): <http://www.nuffieldtrust.org.uk/blog/transformation-fund-or-deficit-mop-time-honest-conversation>

⁹ BBC (2016): <http://www.bbc.co.uk/news/health-35514382>

¹⁰ NHS England (2016): <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

¹¹ Independent Cancer Taskforce (2016): http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

Delivering seven day services	<ul style="list-style-type: none">• From a recent evidence session with the Public Accounts Committee, there is uncertainty over how much the spending review settlement provides sufficient funding for a comprehensive seven day service across primary and secondary care by 2020¹².• Previous studies have suggested that implementing seven day services would increase provider costs by 1.5%-2%¹³.
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¹² Public Accounts Committee (2016): <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/managing-nhs-clinical-staff-numbers/oral/29531.html>

¹³ HFMA (2013): <https://www.england.nhs.uk/wp-content/uploads/2013/12/costing-7-day.pdf>

Appendix A: Written evidence submission by NHS Providers to the Health Select Committee – January 2016

About NHS Providers

1. NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We have 224 members – 94% of all NHS foundation trusts and trusts – who collectively account for £65 billion of annual expenditure (two thirds of all NHS spend) and employ more than 925,000 staff.

Overview and summary

2. The Spending Review sits in the context of the NHS facing its biggest financial challenge in a generation¹⁴. NHS costs and demand are conventionally described as rising by, on average, between 3.5% and 4% a year. However, health funding has only increased by 0.9% a year in the last parliament and, alongside this, the NHS has added an estimated extra £1.5 billion of unfunded staff costs in response to the recommendations of the Francis inquiry. The result is that three-quarters of providers are likely to be in deficit by April 1 2016 with an underlying sector wide deficit of at least £2.5 billion.
3. The spending review represents a comparatively generous settlement for health at a time of national deficit reduction, when compared to other public services such as local government. The front loading of the settlement to the NHS (an extra real terms £3.8 billion in 2016/17 and £1.5 billion in 2017/18) addresses the immediate financial threat facing the service and provides a credible, albeit very challenging, path to return the provider sector to balance in 2016/17.
4. It does not, however, provide a sustainable longer term funding framework:
 - The settlement translates to a 1.5% average annual increase to the NHS's budget, and a 0.9% annual increase to the Department of Health's budget. This means we are only half way through a decade of the longest and deepest financial squeeze in NHS history – with the annual funding increase for health running at significantly less than half of its

¹⁴ “The financial problems we had from 2005 until 2006 were minuscule compared with the challenges that you are dealing with now” Sir David Nicholson, NHS Providers 2015 Annual Lecture.

long term historic average of 3.7%. This is despite the UK spending below the OECD average on health¹⁵;

- The extra funding falls short of the demand increases the NHS is likely to experience – for example the Nuffield Trust calculates that health spending as a share of GDP after adjusting for the ageing population, will decrease 0.3% by 2020/21 – reflecting the significant increase in older people who consume an increasing share of NHS resources;
- We are concerned by the proposed real term increases to NHS funding dropping to only £0.5 billion and £0.9 billion in 2018/19 and 2019/20 respectively;
- The gap between NHS providers' costs and income needs to be closed by efficiency savings and demand reductions. NHS system leaders have developed a central plan to meet the savings / growth in demand reductions required in this parliament, which have increased from £22 billion to £23.5 billion. But this plan needs validation with the NHS frontline and our members need pinpoint clarity on what savings / demand reductions they will be responsible for. This task has begun, with the savings of up to £5 billion identified by the Carter Review, but needs to be rapidly completed. Given the size of the task; the fact that the more easily realisable savings have already been taken over the last five years; and the NHS's poor record on demand reduction, the £23.5 billion target carries significant risk;
- The understandable need to channel £1.8 billion of funding into addressing provider deficits in 2016/17 means there is less funding available for the transformation the service needs and to invest in other areas such as mental health and community services. The Five Year Forward View (FYFV) provides a compelling vision of the gaps the service needs to address and the alternative care models the NHS might adopt. This 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. We should be cautious about the extent to which transformation will deliver meaningful savings this parliament. Local leadership capacity must also be significantly increased if our members are to deliver both the transformation and the "must do" day to day operational tasks they are being asked to deliver;

¹⁵ See, for example: John Appleby (2015): <http://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally>. "UK GDP is forecast to grow in real terms by around 15.2 per cent between 2014/15 and 2020/21. But on current plans, UK public spending on the NHS will grow by much less: 5.2 per cent. This is equivalent to around £7 billion in real terms – increasing from £135 billion in 2014/15 to £142 billion in 2020/21. As a proportion of GDP it will fall to 6.6 per cent compared to 7.3 per cent in 2014/15. But, if spending kept pace with growth in the economy, by 2020/21 the UK NHS would be spending around £158 billion at today's prices – £16 billion more than planned".

- Whilst a heavily front loaded 2016/17 and 2017/18 settlement should ensure the provider sector returns to surplus, credible, realistic savings and long term transformation / sustainability plans are needed to prevent providers heading back towards deficit once the extra initial funding has been consumed;
- The settlement does not address the rapidly growing financial problems faced by the social care sector either sufficiently or sufficiently quickly and, it is difficult to reconcile public commitments to prioritising public health with proposed budget reductions in this area. These are causing serious concern to our members who have public health related contracts.

5. A long term sustainable financial framework for the NHS requires:

- Honesty and realism about what can be delivered for the available settlement;
- Full ownership of the £23.5 billion savings by those who have to deliver them;
- A clear, costed, plan to deliver the required transformation including building the required local capacity to deliver transformation alongside operational objectives;
- Appropriate funding of social care and public health;
- Recognition that, if we are to maintain the integrity of a taxpayer funded NHS, we need to build a new national consensus on whether we increase NHS funding or ration care.

The distribution of funding for health and social care across the spending review period

6. In the context of a national deficit reduction programme, we recognise that the NHS's funding settlement was relatively generous compared to other public services¹⁶.

2016/17 and 2017/18

7. Front loading the settlement provides a credible, albeit very challenging, path to return the provider sector to surplus in 2016/17 via a net 1.1% tariff increase¹⁷ and a £1.8 billion sustainability fund. The front loading continues, to a lesser extent, in 2017/18. Whilst this front loading is welcome and essential, it should not disguise the difficulty of the task needed to be undertaken by the NHS in 2016/17:

- Absorb £1 billion additional cost from National Insurance pension changes;

¹⁶ For example, according to the LGA, local government's "flat cash" settlement over the parliament (compared to the NHS's 1.5% p.a. real terms increase) requires 4% annual council tax increases each year.

¹⁷ The tariff is shorthand for the national tariff, the payment system governing the allocation of funds in the secondary care sector. By comparison, in 2015/16, providers opting for the enhanced tariff offer had their prices reduced by 1.6%; the 2016/17 tariff proposed to increase prices by 1.1%.

- Fund up to £750 million new, specialised treatments due to receive NICE approval for NHS use;
- Reverse an underlying provider deficit estimated to be at least £2.5 billion by the end of 2015/16.

2018/2019 and 2019/20

8. The distribution of funding over the middle of the spending review period is a cause for concern. Additional funds for the NHS level off in the middle years with real terms increases of only 0.4% in 2018/19 and 0.6% in 2019/20. There is every reason to believe that the NHS will continue to see its 'usual' 3.5% to 4% cost and demand increases¹⁸ and during these years, the service will also be expected to:
- Deliver the bulk of £23.5 billion of efficiency savings;
 - Consistently implement new care models;
 - Make progress towards delivering seven day services;
 - Implement the recommendations of the cancer and mental health taskforces; and
 - Move to a paperless NHS.
9. It is, at this point, difficult to see how all these demands can be funded from the proposed settlement in these years.

Longer term

10. NHS Providers is strongly committed to the principle of a taxpayer funded NHS but this principle can only be maintained if there is national consensus around the level of funding the NHS receives and the amount and quality of care delivered for that funding. The current consensus is already being tested by growing public expectations that the service will not be able to keep up with demand, particularly given the longest and deepest financial squeeze in NHS history. We need a full, cross party, national debate on how, long term, we either increase NHS funding or ration access to NHS care.
11. We support calls for a one off national commission but believe this must be accompanied by a means of stimulating a permanent, informed, national discussion of these issues in the way that the Office of Budget Responsibility has stimulated a similar debate on the overall pattern of public spending. Any arrangements must also take full account of the Barker

¹⁸ In our recent oral evidence to the NHS Pay Review Body, for example, we said we believed it would be difficult, on current trajectory, for the proposed 1% NHS pay limit to last for the life of the parliament.

Commission reports on integrating health and social care funding¹⁹ and the need for a clear, long term, plan to deliver this integration.

The impact and management of deficits in the NHS

12. The NHS's 2016/17 financial framework, funded by the frontloaded settlement, should allow the provider sector as a whole to return to surplus. However there are important nuances.
13. In many 'challenged' local health economies with well known structural issues like high rurality, insufficient patient flow, over provision, or recruitment difficulties, deficits will remain. There is a welcome recognition across NHS Improvement and NHS England that the service must, finally, develop the right long term structural solutions for these economies, however difficult this may be. We can provide more detail in further evidence on progress with developing these solutions in the first success regime areas of Cumbria, Devon and Essex, if needed.
14. Deficits are a health and care system-wide issue and should be treated as such. Given the projected 2015/16 deficit of at least £2.5 billion deficit for providers versus a likely aggregate surplus for commissioners, the 2016/17 tariff rightly shifts financial risk from providers to commissioners but this will need careful management. We encourage the Committee to examine the added complexity and inefficiency of the new approach, adopted this year, to levying fines against providers²⁰ which might reach up to £250 million this financial year. Our members tell us that, in most cases, these fines, sometimes totalling tens of millions of pounds and representing the difference between surplus and deficit, have been the subject of prolonged dispute and uncertainty, adding unnecessary complexity.
15. Realism is also needed on the efficacy and long term sustainability of current cost containment measures such the introduction of price caps for agency staff; limitations on management consultancy spend; and capital to revenue switches:
 - Consultancy spend only makes up a small proportion of NHS trust expenditure (less than 1%), and will only make a marginal impact on efficiency savings;

¹⁹ <http://www.kingsfund.org.uk/projects/commission-future-health-and-social-care-england>

²⁰ CCGs were mandated to levy fines from providers for missed constitutional performance targets, irrespective of whether the provider was truly responsible for the breach or whether the CCG wanted to levy the fines (in previous years many CCGs deliberately chose not to levy them).

- The agency cap will take time to bed down and was introduced half way through the financial year. We welcome recently announced further measures to support our members in reducing this spend²¹; and
- 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.
- The Committee may want to explore, through oral evidence, our members' reaction to the new regulatory approach being adopted by NHS Improvement to ensure the return to surplus, based on centrally determined control totals for each provider.

Achieving efficiency savings

16. The NHS is entering the sixth year of a decade-long efficiency drive. The service has been set the task of saving £43.5 billion in the ten years to 2020. Over the last parliament the service delivered £19.8 billion, largely from non-recurrent savings such as pay restraint. Evidence suggests²², and our members report, that easily realisable savings have now been taken and that a different approach is needed to realise further savings in this parliament.
17. The FYFV estimated the scale of efficiency savings / demand reduction required for the service to 'stand still' as £22 billion over this parliament, now raised to £23.5 billion. System leaders have created a central plan to realise this but the service now needs to move to full and effective implementation of this plan.
18. There has been effective work by the Carter Review to identify up to £5 billion of savings which could be realised by 2019/20. Our members have welcomed the review's granular, data driven, collaborative approach. The initial 32 pilot sites report that the data generated has stimulated the different type of discussion needed, particularly around more efficient and effective use of staff who account for 60 - 80% of trusts' expenditure. We await the imminent publication of Lord Carter's final report with interest.

²¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493131/Policy_update_-_agency_controls_FINAL.pdf

²² For example, Monitor and TDA quarterly reporting of increasing under delivery of planned savings.

19. Our members tell us that they now need further detail on the remaining savings: what further savings / demand reductions they will be responsible for; how responsibility for delivery will sit across primary, secondary and tertiary care services, and between local and national levels; and, what role commissioners will play in delivery.

20. The overall size of the task is clearly challenging and there are further risks to the delivery of the required efficiency savings including:

- The understandable but systematic failure of the NHS to deliver substantial and sustained demand reductions. The Better Care Fund, for example, was based on the assumption that the local initiatives it funded would decrease emergency admissions by 3.5% in 2015/16. Admissions have, in fact, increased by 3% in the first two quarters of this year, compared to the same period last year.
- NHS productivity will need to increase from its long run average of approximately 1% a year to 2 - 3%, recovering from a dip of less than 0.5% in recent years, as the service has added significantly more staff²³;
- New ways of working and new care models, have the potential to deliver savings but the evidence for this is weak. Savings will not be realised to any significant extent over the life of this parliament – they will come in the next parliament.

21. The overall risk to the delivery of the required savings / demand reductions therefore seems high.

Achieving service transformation set out in the FYFV at scale and pace through transformation funds

22. The FYFV has highlighted that trying to run harder within the existing NHS delivery model is no longer sustainable and that long term sustainability therefore requires the NHS to transform. The FYFV identified the gaps the service needs to address and the alternative care models the NHS might adopt. The vanguard programme is supporting a number of local economies to develop new care models. Overall, our members welcome the different way this programme is being run, with a strong emphasis on effective spread and replication, underpinned by local determination of what central support is needed.

²³ Financial Times (2015): <http://www.ft.com/cms/s/0/76570808-d7b9-11e4-849b-00144feab7de.html#axzz3xpX3JzH8>

23. However more support is needed if the NHS is to consistently transform in the way and at the speed the FYFV envisages including:

- A clear, realistic, costed plan of how all local health and care economies will be supported to deliver the transformation envisaged;
- Appropriate funding. The Kings Fund and the Nuffield Trust argued that a fund of £1.5 - £2.1 billion would be required for each year in this parliament to support transformation²⁴. It is unclear how much funding will be available for transformation but:
 - In 2016/17, the year of the highest real terms increase, £1.8 billion will be used to support providers to eliminate deficits in 2016/17, leaving little left for transformation;
 - In 2017/18, it seems likely that further deficit reduction support will be required from the £1.9 billion real terms increase in that year, again leaving a small proportion for transformation;
 - In 2018/19 and 2019/20, the proposed real terms increases are so low, it is difficult to see how any money can be allocated to transformation;
 - It is therefore difficult to avoid the conclusion that, for understandable reasons, the short term need to stabilise provider finances has trumped the need to fund long term transformation.

24. Our members tell us that, by a considerable margin, they have insufficient local leadership and management capacity to deliver both the transformation and “must do” day to day operational delivery tasks NHS system leaders are currently asking them to deliver. This gap must be filled to deliver the required transformation.

Social care, integration and new policy initiatives

25. We believe the social care settlement in this parliament falls short of what is needed to achieve stability in this sector, even when taking in to account local councils new ability to raise additional funds through a 2% social care precept.²⁵ From an NHS provider perspective, under investment in social care is a significant cause of instability. The impact of the deteriorating scope and coverage of care services has to be absorbed by NHS trusts

²⁴ <http://www.kingsfund.org.uk/press/press-releases/making-change-happen-transformation-fund-nhs>

²⁵ Research conducted by the Local Government Association in January 2016 indicates that 65% of eligible local authorities assessed are intending to levy the social care precept. Further information available at: <http://www.lgplus.com/politics-and-policy/finance/top-tier-plans-for-4pc-hikes-lgc-council-tax-tracker-2016/7001389.article?blocktitle=Top-stories&contentID=20100>

and foundation trusts acting as 'provider of last resort'. This can be seen most clearly through the rapidly increasing number of delayed transfers of care, which in acute care increased by 96,600 in October 2014 to 104,100 in October 2015²⁶. We note and endorse the particular emphasis Lord Carter has placed on this issue in his work²⁷ and would commend the work of the Commission NHS Providers initiated on this issue, led by Rt. Hon. Paul Burstow²⁸.

26. We fully support the ambition to move towards a seven day service in the NHS. At this point it is not clear, however, that the settlement provides sufficient funding for a comprehensive seven day service across primary and secondary care by 2020 or that sufficient planning has been undertaken at national levels to budget for, recruit and train the workforce required. NHS Providers were members of the original seven day services forum and we can share detail of our perspective on behalf of members in further evidence if the Committee requires.
27. Our members tell us that it is vital that the new policy initiatives are fully funded and fully impact assessed before they reach the frontline. Given how tight the NHS financial settlement is, these controls need to work effectively and Ministers need to carefully weigh the impact and cost of new policy versus the need to allow the service time, space and resource to deliver against existing objectives to 2020.

Progress on achieving parity of esteem through funding for mental health services

28. The explicit and aligned references to mental health in the spending review, the new NHS mandate and the most recent NHS planning guidance create a policy framework that enables the service to take important further steps towards achieving parity of esteem for mental health. This is backed up by £600 million over the spending review period to improve access to mental health services, funded from the extra £10 billion real terms funding the NHS will receive by 2020.
29. NHS Providers is working closely with the Mental Health Taskforce to ensure recommendations for mental health payment systems, commissioning and data will

²⁶ NHS England, *Monthly delayed transfers of care data, England, October, 2015*

²⁷ "A significant proportion of the £5bn [savings identified] cannot be unlocked unless delay in transfers are managed more effectively". Letter from Lord Carter to Jeremy Hunt 11/1/16.

²⁸ <https://www.nhsproviders.org/resource-library/reports/right-place-right-time-better-transfers-of-care-a-call-to-action>

support providers to improve mental health services. Given the Taskforce has yet to report, it is not currently clear how the money allocated to mental health will be distributed and how the mental health priorities, including perinatal health, talking therapies and crisis care, will be prioritised.

30. Assurance is also needed that allocated additional funding will reach the frontline. Previous commitments to support parity of esteem through funding for providers have not been delivered in a timely or effective manner. Our members tell us, for example, that funding increases for mental health mandated in 2015/16 planning directive did not fully reach them in the way they expected. We note with concern that a target percentage uplift for mental health services expenditure has not been set in the latest planning guidance.
31. Existing and additional funding for mental health needs to reach relevant providers through a payment system which supports transformation. With new payment approaches due to be introduced at the start of 2016/17, we have concerns about the capacity and capability of some commissioners to support these important changes. Whether new payment approaches will be used as a tool to drive further efficiencies rather than to improve patient care is unclear.

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 FYFV

32. We recognise the case for Government seeking savings from the non-NHS element of the health budget as part of the overall deficit reduction programme. We support the setting of ambitious cost reduction targets for the administration budgets of the Department and its arm's length bodies to maximise spending on front line care. Whilst we recognise the case for the transfer of student nurse bursaries to the student loan book, the impact on student nurse numbers must be carefully monitored and adjustments made accordingly if needed.
33. We find it difficult, however, to reconcile public commitments to prioritising public health (for example in the FYFV) with proposed budget reductions in this area. These reductions are causing serious concern to our members who have public health related contracts. It is difficult to see how we can close the public health gap identified in the FYFV, without

appropriate legislation, funding and local authority prioritisation, all three of which appear to be lacking on current plans.