

Impact of the 2015 Spending Review on health and social care

Written evidence for the Health Select Committee, on behalf of the Nuffield Trust, the Health Foundation and The King's Fund

The outcome of the 2015 Spending Review will profoundly shape NHS and social care services in England over the rest of this decade. Our three organisations have come together to provide the Health Select Committee with a clear, objective, and independent view of its implications.

This joint submission presents our shared view on five elements of the Terms of Reference drawn up by the Committee for its inquiry into the impact of the Spending Review. These are: the distribution of funding over the Spending Review period; efficiency and transformation; cuts to non-NHS England budgets; social care funding; and quality and access to care. Each of our three organisations will also submit supplementary evidence, drawing more directly on selected research we have carried out individually and addressing the remaining Terms of Reference.

Summary

- In the context of deficit reduction and significant cuts to some departmental budgets, the NHS has received a comparatively favourable settlement and pressures on social care have been acknowledged. However, it is now clear that health spending will not rise by nearly as much as initially implied when the NHS settlement was announced. Social care funding will continue to fall short of meeting need, with the sector facing huge pressures in the short term.
- Total health spending in England will rise by £4.5 billion in real terms between 2015/16 and 2020/21, an increase of around 0.85 per cent a year. This will be almost identical to the rate of increase over the last parliament.
- £4.5 billion is much less than expected. This is because the Spending Review defined 'NHS' spending as NHS England's budget,^[1] not the whole of the Department of Health's budget – the definition used by previous governments. While NHS England's budget will rise by £7.6 billion in real terms over the period, other health spending will fall by more than £3 billion.
- We welcome the fact that the additional investment going to NHS England will be front-loaded with most of the increase coming in 2016/17. However, much of this money will be absorbed by dealing with deficits among NHS providers (officially planned to be

^[1] NHS England oversees the commissioning of health services in England and is responsible for the bulk of health spending.

£1.8 billion in 2015/16) and by additional pension costs. With much smaller increases in later years, the NHS will struggle to maintain services let alone deliver an expanding range of commitments.

- Public health spending will fall by at least £600 million in real terms by 2020/21, on top of £200 million already cut from this year's budget. This will affect a wide range of services including health visiting, sexual health and vaccinations.
- Overall, the NHS is halfway through the most austere decade in its history. Funding is not keeping pace with the rising demand for health care services. Public spending on health in the United Kingdom as a proportion of GDP is projected to fall significantly to 6.7 per cent by 2020/21, leaving us behind many other advanced nations on this measure of spending.
- Spending on social care is subject to some uncertainty, but looks set to remain roughly flat in real terms over the parliament. New powers to raise Council Tax by up to 2 per cent to spend on social care will provide flexibility for local authorities but are unlikely to raise as much as the government suggests and could disadvantage deprived areas with low tax bases.
- Additional money for social care provided through the Better Care Fund from 2017/18 is welcome, but risks arriving too late.
- This will not be enough to close the social care funding gap, which we estimate will be somewhere between £2.8 billion and £3.5 billion by the end of the parliament, when the impact of the National Living Wage is taken into account.
- Public spending on social care as a proportion of GDP will fall back to around 0.9 per cent by 2019/20, despite the ageing population and rising demand for services. This will leave thousands more older and disabled people without access to services.
- The Spending Review sets a course for continued pressure on quality and access to health and social care services.

1. Distribution of funding over the Spending Review period

1.1 The Spending Review announced that the NHS will receive a real-terms funding increase of £10 billion over the period from 2014/15 to 2020/21. It also announced that £6 billion of this funding would be front-loaded by 2016/17. The government argued that this delivers the £8 billion it had promised to fund the NHS Five Year Forward View. The rest of the stated increase comprises additional funding for the current year announced in last year's Autumn Statement.

1.2. These figures rely on a significant change in the interpretation of NHS spending. Previous governments have defined this as the totality of the Department of Health's budget (TDEL), worth £116.4 billion in 2015/16. However, this Spending Review effectively redefines NHS spending to mean NHS England's budget only, which stands at £101.3 billion in 2015/16. Other health spending not included in NHS England's budget – for example, spending on public health, education and training, capital and national bodies such as the Care Quality Commission and the National Institute for Health and Care Excellence – is excluded.

All three of our organisations will continue to use the previous definition in our analysis of NHS funding. Using this definition, and taking 2015/16 as the baseline,¹ NHS funding in England will in fact increase in real terms by £4.5 billion by 2020/21. While this is still a welcome increase, it is clearly much less than was expected when the NHS settlement was announced. The difference is largely accounted for by a reduction of more than £3 billion in spending that falls outside NHS England’s budget. This is set out in more detail in the table below which estimates health spending in real terms up to 2020/21.

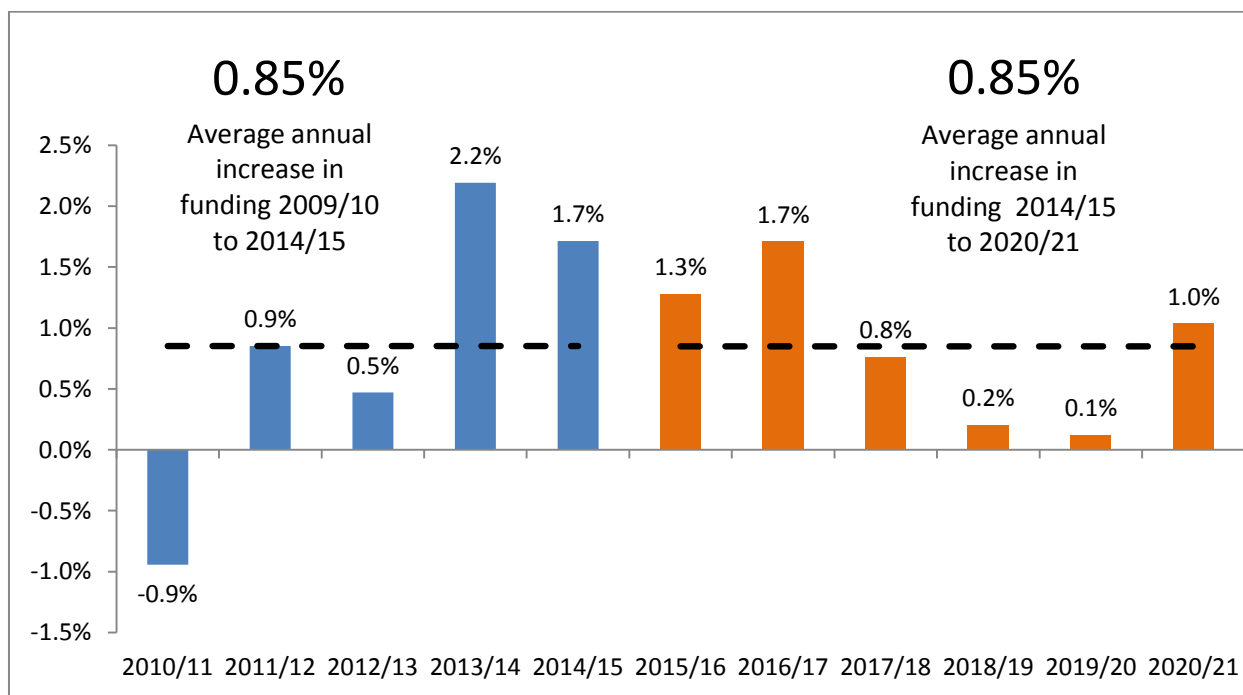
Funding in £billion, 2015/16 prices	2015-16	2016/17	2017-18	2018-19	2019-20	2020-21	Change 2015/16 to 2020/21
NHS England	101.3	105	106.4	106.8	107.5	108.9	7.6
Other Department of Health	15.1	13.4	12.8	12.7	12.2	12	-3.1
Department of Health (TDEL)*	116.4	118.4	119.3	119.5	119.7	120.9	4.5

*Departmental Expenditure Limit – the total budget allocated to the Department of Health

1.3. As Figure 1 below shows, this means that health spending will increase in real terms by an average of around 0.85 per cent a year over the parliament (using 2014/15 as the baseline), mirroring the rate of increase over the last parliament. However, the context is very different this time. This flat rate of growth comes after a sustained funding squeeze, with growing deficits among NHS providers, waiting times rising and several key performance targets being regularly missed. The impact of a further period of pay restraint is also unclear, with the service already struggling to recruit and retain enough staff, very high expenditure on agency staff and low staff morale.

¹ The Spending Review used 2014/15 as the baseline.

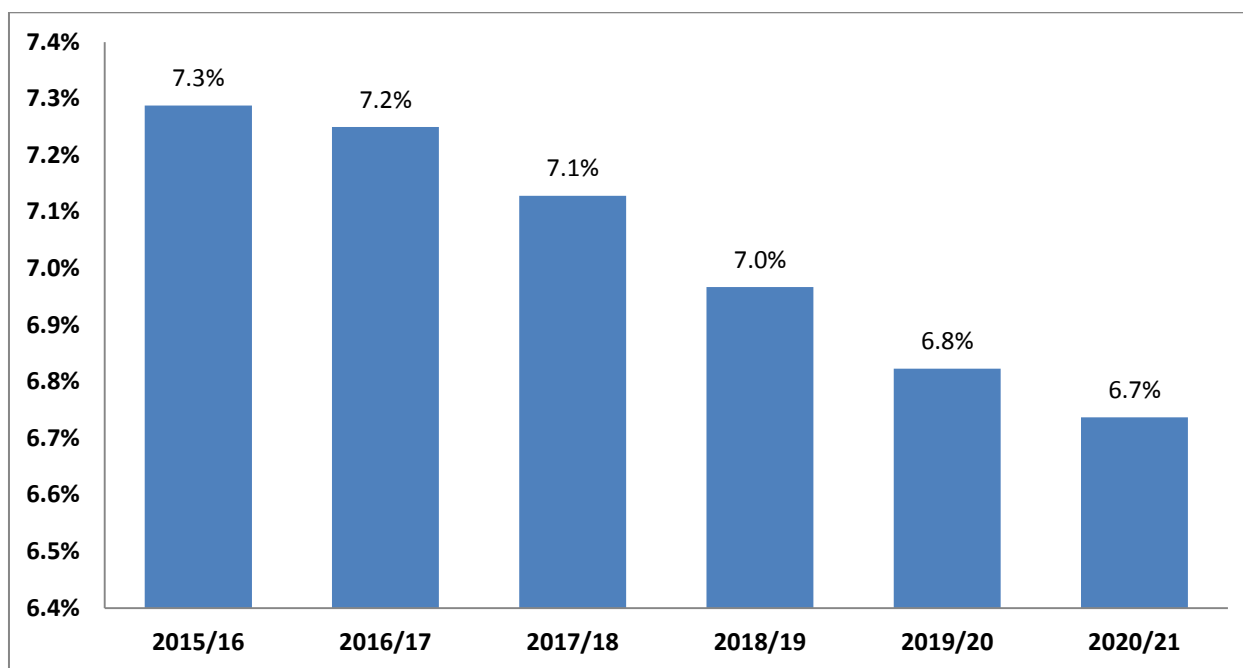
Figure 1 English NHS spending 2009/10 to 2020/21, real annual changes



The underlying reason for these signs of stress is that this slower growth in funding is being outpaced by faster growth in the cost of providing health care for the English population. This is a result of long-term trends such as pressure on wages, an aging, growing population, and the rising cost of new technologies. Although measurements and estimates will differ, there is every reason to expect cost and demand will continue to outpace funding throughout the Spending Review period.

1.4. Since it was established, NHS funding has risen by 3.7 per cent a year on average, meaning the NHS is now halfway through by far the most austere decade in its history. By the end of the parliament, public spending on health as a proportion of GDP is projected to fall back to 6.7 per cent, as shown in Figure 2 below. Internationally this pushes the United Kingdom further into the bottom half of Organisation for Economic Co-operation and Development countries in terms of health spending, leaving us well behind many other advanced nations.

Figure 2 Public spending on health care in England as a proportion of GDP, 2015/16-2020/21



1.5. The government responded to calls for the additional funding to be front-loaded early in the parliament. The Department of Health (DH) budget will increase by £2 billion in real terms in 2016/17.² While this is welcome, around £1 billion will be absorbed by additional pension costs incurred by the NHS as a result of the abolition of the second state pension. The projected provider deficit in 2015-16 may also impact on the resources available next year. In 2014/15, the Department funded part of the provider deficits through a transfer of £640 million from the DH capital budget to revenue. It is anticipated that the larger provider deficit projected for 2015/16 will result in a further transfer from the capital budget. This however raises potential problems in future years as the revenue costs which have been funded by such transfers are not one-off and unless there are further capital to resource transfers over this spending review will impact on the amount of resource funding which is available to meet new cost pressures.

Within the Department's overall increase, NHS England's budget is set to rise by £3.8 billion in real terms in 2016/17. We now know that a substantial proportion, officially planned to be £1.8 billion in 2016/17, will also be set aside as a fund to cover rising deficits among NHS providers, and support improving services (discussed in more detail below). By the time rising demand for services is factored in, only a limited amount will be available for investing in the essential changes to services outlined in the *NHS Five Year Forward View*.

While the front-loading of the additional funding will help to stabilise services in the short term, smaller increases will follow later in the parliament, with real-terms increases of just 0.2 per cent and 0.1 per cent in 2018/19 and 2019/20. This will stretch budgets to the

² The discrepancy between this and the £3.8 billion uplift planned for NHS England is explained by reductions in other health budgets, discussed below.

limit, especially as the NHS will also be required to implement seven-day services – an additional commitment not fully factored into the *NHS Five Year Forward View*.

2. Efficiency and transformation

2.1. With a challenging settlement agreed, attention will now turn to the need to find £22 billion in efficiency savings by 2020/21, for which there is, as yet, no clear national plan. While there are significant opportunities to improve productivity in the NHS, this will be a huge challenge, especially in a context where limited funds are available to support service change, the budget for prevention is being cut and funding for social care is falling short of meeting need, as discussed below.

2.2. The NHS Planning Guidance 2016/17–2020/21 clearly states that NHS organisations are expected to restore financial balance and deliver the *Five Year Forward View* while maintaining quality standards for patients (NHS Improvement, 2015). Achieving these goals during the most austere decade in the history of the NHS requires a new approach to change.

The King's Fund and the Health Foundation, in a joint report published last July made the case for a dedicated Transformation Fund for the NHS. The fund's purpose would be to accelerate change - including a drive for efficiencies - across the NHS at scale and pace. The fund would operate as an active investor by providing proactive support to local areas to realise efficiencies and transform the delivery of care – enabling them to invest in staff time, programme infrastructure, physical infrastructure and double-running costs.

Both organisations argued that for transformative change to be successfully implemented at scale across the NHS, the Fund would need to comprise around an additional £1.5–2.1bn a year between now and 2020/21. Not all of this would be additional public expenditure (for example, the report highlighted the opportunity to raise some funds through better use of the NHS estate), but it would be additional to the £8 billion identified in the *NHS Five Year Forward View* as being necessary to maintain services (The King's Fund and The Health Foundation 2015).

2.3. In December 2015 the government announced that in 2016/17 NHS England would put £1.8bn of the front-loaded funding it received in its settlement into a new "Sustainability and Transformation Fund" to be used to restore financial balance in the provider sector, replacing the current scale of direct Department of Health funding. Additional NHS England funding for transformation, totalling £339 million, will be added to this, giving a total Sustainability and Transformation Fund of £2.1 billion for 2016/17. The Fund will be repeated in later years of the parliament but the amount of funding is likely to change. NHS bodies have been asked to come together locally to produce joint plans to bid for STF funding from April 2017.

The transformation element of the national Sustainability and Transformation Fund (STF) is intended to cover initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, as well as

other clinical priorities. It will bring together different funding streams dedicated to supporting change – a sensible approach.

However, the decision to combine deficit support funding and money for transformation as opposed to ring-fencing the latter, and the confirmation that £1.8 billion will be set aside primarily to cover deficits in 2016/17, raise the risk that this funding will be used largely to bail out struggling providers over the Spending Review period as opposed to funding real transformation. We are also concerned that transformation is often focused on too limited a range of initiatives – most specifically new models of care. Substantially improving providers efficiency is a major transformation task and needs to be managed, supported and resourced as such.

3. Cuts to non-NHS England budgets

3.1. As set out above, spending on activity that falls outside NHS England’s budget will decrease by more than £3 billion in real terms by 2020/21 – a reduction of more than 20 per cent. The reductions will be more substantial in the earlier years, totalling more than £1.6 billion in 2016/17.

3.2. How this decrease will be managed is not yet clear and it remains to be seen whether the Department of Health exactly follows the allocations outlined in the Spending Review when it sets other organisations’ budgets. However, some details have emerged.

- While the Spending Review commits to holding capital spending at £4.8 billion a year in cash terms until 2020/21, this represents a significant real-terms reduction over the period.
- Local authority public health budgets will be cut by an average of 3.9 per cent a year in real terms over the Spending Review period.
- The Spending Review announced reforms to the funding system for student nurses which will see grants for tuition fees replaced by student loans. This is projected to save £1.2 billion a year, although most of these savings will not be realised until the end of the parliament.
- In addition to these savings, it has been reported that the remainder of Health Education England’s budget is likely to be frozen in real terms (Lintern 2015).
- The Care Quality Commission has signalled that it expects significant reductions to its Grant in Aid from the Department of Health. As a result, it is consulting on changes to its approach to regulation and inspection, and has proposed large increases to the fees it charges to providers – which will ultimately need to be funded by NHS England.

While we await further details of the impact on specific budgets, it is clear that a large amount of the additional increase in NHS England’s budget has come at the expense of other areas of health spending.

3.3. Reducing the capital budget in real terms means investing less in buildings and equipment. This may be sensible if the money is used to support changes to services but we are concerned about the growing tendency in recent years to re-direct capital spending to shore up the revenue budget – reducing investment to meet short-term needs is not a sustainable strategy if maintained over a number of years.

3.4. Of Health Education England's £5 billion budget, £3.5 billion goes straight back to the NHS front line to pay the salaries of doctors while they are undergoing training. Freezing this budget risks increasing pressure on hospitals if Health Education England is forced to reduce the subsidies it pays providers to cover these costs.

3.5. As we understand, there have been no cuts to the 2016/17 budget for public health services within NHS England's remit, such as immunisation and screening programmes. However complex changes to what this budget covers – such as the transfer of child public health duties to local government - make it difficult to be exact about the net effect.

3.6. However, the reductions to local authority public health budgets add up to a real-terms reduction of at least £600 million in public health spending by 2020/21, on top of £200 million already cut from the 2015/16 budget. This will affect a wide range of services including health visiting, sexual health and vaccinations, and will have a significant knock-on effect on the NHS. This is a false economy, undermining the government's commitments on prevention and the *NHS Five Year Forward View* which was predicated on a 'radical upgrade in prevention and public health'. For example, 22 per cent of the NHS budget, according to latest estimates, is spent treating ill-health related to obesity, poor diet, smoking, alcohol and inactivity (Scarborough and others 2011).

4. Funding for social care

4.1. The Spending Review announced a number of key changes that will have an impact on adult social care funding.

- A new social care precept will enable local authorities to increase Council Tax by up to 2 per cent a year to fund social care. The government estimates this could raise £2 billion a year in cash terms by the end of the parliament if all councils use it to raise the full amount every year.³
- An increase in funding for social care through the Better Care Fund which will see an additional £1.5 billion a year in cash terms (£1.4 billion in real terms) provided by 2019/20.
- A reduction in grant funding for local authorities of £6.1 billion by 2019/20 and significant changes to local government funding which will see councils retain all income from business rates, as grant funding from central government is phased out.
- A commitment to integrate health and social care across the country by 2020.

As with the NHS settlement, it is important to look beyond these headline claims and figures.

4.2. The new powers to increase Council Tax will provide some financial flexibility for local authorities. However, it seems unlikely that all councils will choose to levy the full 2 per cent, every year for the next four years, on top of any other rises for other services. To put this into perspective, around half of councils chose to increase Council Tax this year. And without measures to address the wide variations in how much councils can raise through their tax base, this will disadvantage deprived areas – often areas with the

³ Estimates published by the Office for Budget Responsibility indicate that the precept could raise up to £1.6 billion.

highest needs for publicly funded social care – which will be able to raise less income through the precept than wealthier areas.

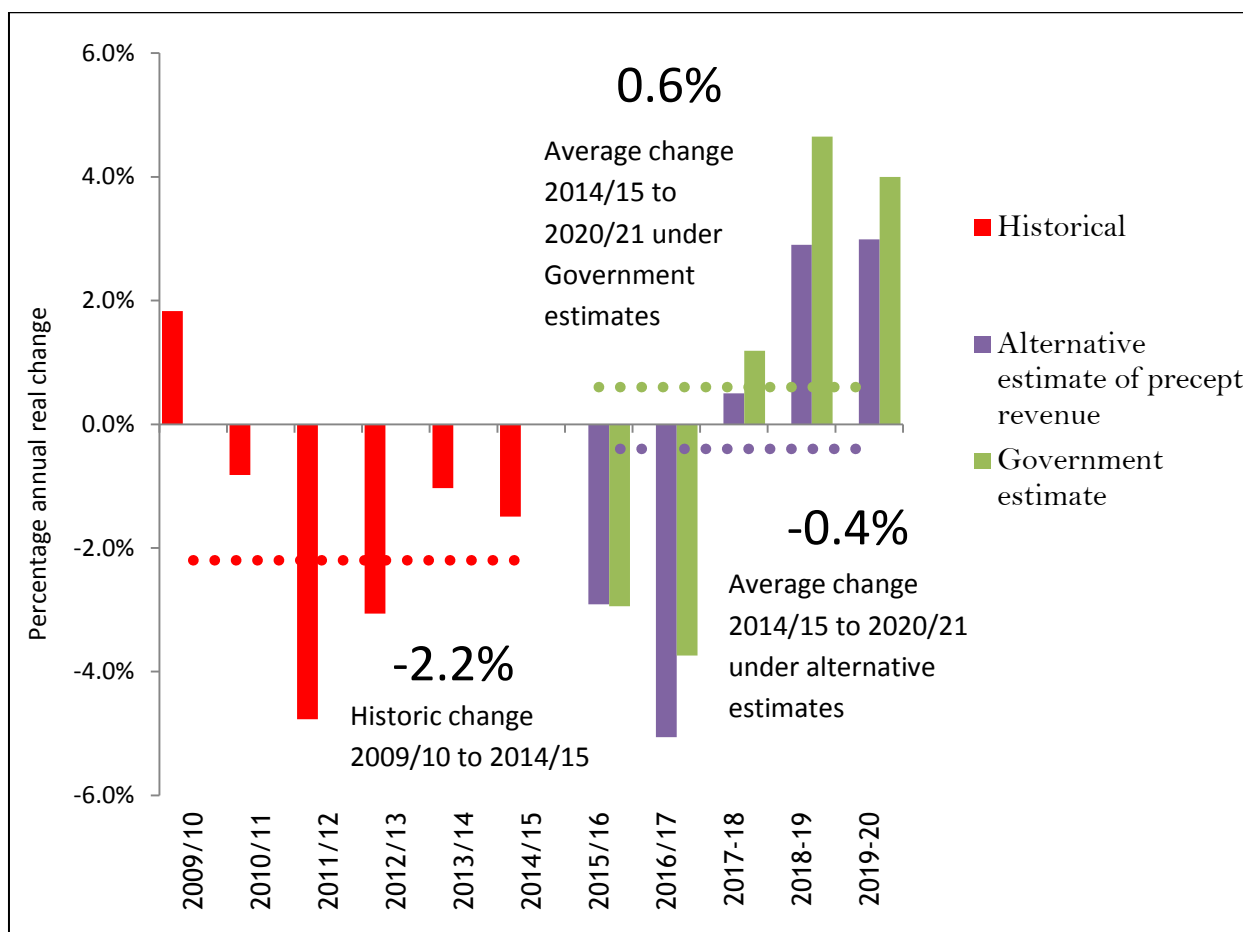
4.3. We therefore welcome the additional money provided through the Better Care Fund (which is genuinely new money for social care rather than being transferred from the NHS) and the recent proposal to give a greater share of it to those councils with limited ability to raise additional funds through the precept. However, we are concerned that as well as adding a further level of complexity to funding arrangements, this money is back-loaded – it will not begin to come through until 2017/18 when reports suggest it will only deliver £100 million (Stothart 2015). This will increase in 2018/19 before the full £1.5 billion is delivered in 2019/20.

4.4. More broadly, the changes to local government funding will see central government support for local authorities fall by 56 per cent by 2019/20, on top of a reduction of 37 per cent over the last parliament. Although the ability to retain income raised through business rates will compensate for this, these changes will leave councils more dependent on their tax base, raising significant issues about equity given the wide disparities in local authority income-generating potential between richer and poorer areas of the country. The government is consulting on how these changes are implemented – it will be important that this results in some kind of equalisation mechanism to protect poorer areas.

4.5. We welcome the commitment to integrate health and social care across the country by 2020. However, the shift towards a social care system based on locally-raised revenue risks deepening the fault line in the way the two systems are funded, with the NHS continuing to be funded largely through general taxation and social care more reliant on local levels of property wealth and economic activity.

4.6. The uncertainty about the impact of these changes makes the settlement for social care difficult to gauge. The full picture will not become clearer until local authorities set their budgets next year. Figure 2 below estimates changes in spending on social care over the current parliament using two scenarios. The first is based on the projections used by the government and the Office for Budget Responsibility in the Spending Review, the second assuming only half of local authorities raise council tax by the full 2 per cent each year.

Figure 3 Social care spending 2009/10 to 2019/20, real annual changes



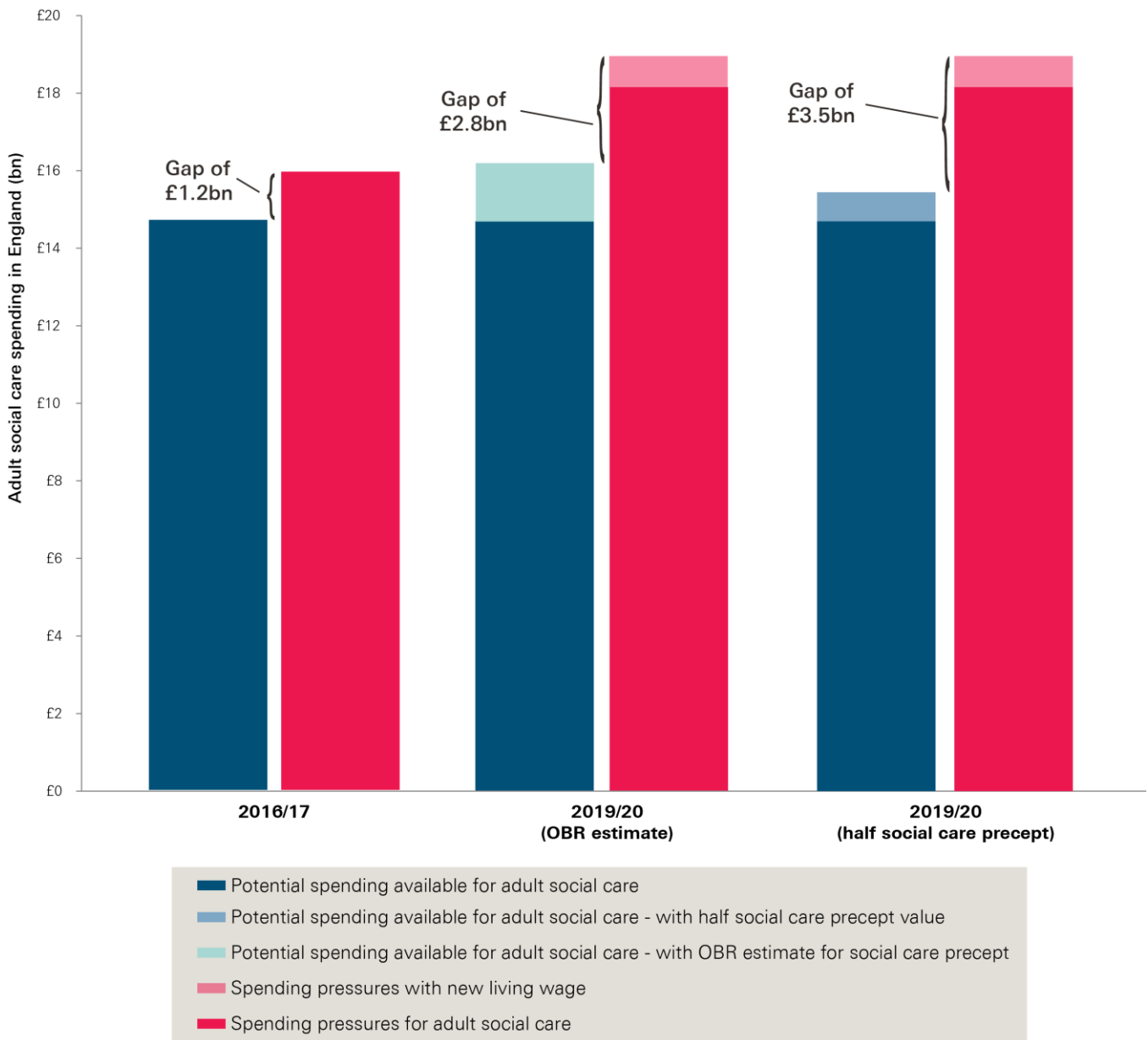
As Figure 3 shows, spending on social care is likely to be broadly flat in real terms over the parliament, with the extent of any small increase or decrease depending on how much is raised through the council tax precept. Based on the first scenario, spending would rise by an average of 0.6 per cent a year. Under the second scenario, spending would fall by an average of 0.4 per cent a year.

The graph also highlights the extent to which the social care settlement has been back-loaded. With social care already on the brink of crisis and a heightened risk of provider failure, 2016/17 – which will see a significant reduction in funding – will be particularly difficult. Further reductions to services are certain to follow and unmet need will increase.

4.7. Although this is an improvement on the past five years, when spending on social care fell by an average of 2.2 per cent a year, it will not be enough to meet projected cost pressures of 4 per cent a year (Wittenberg and Hu 2015). Under the first scenario, we estimate there would be a funding gap of £2 billion by 2019/20. This would increase to £2.7 billion under the second scenario. On a conservative assessment, implementing the National Living Wage will add another £800 million to these estimates (ADASS and LGA 2015). Overall, the social care funding gap is likely to be somewhere between £2.8 billion and £3.5 billion by the end of the parliament (see figure 4) meaning that, despite a growing older population and increasing demand for services, spending on social care as a proportion of GDP will slip back to around 0.9 per cent by the end of the parliament.

Figure 4 Potential funding gap for adult social care in 2019/20, with likely impact of new living wage*

Potential funding gap for adult social care in 2019/20, with likely impact of new minimum wage, based on projections from the government, OBR and PSSRU



*based on projections from the government, the Office for Budget Responsibility and the Personal Social Services Research Unit

5. Quality and access in health and social care.

5.1. The Spending Review sets a course for continued pressure on quality and access to treatment in the NHS.

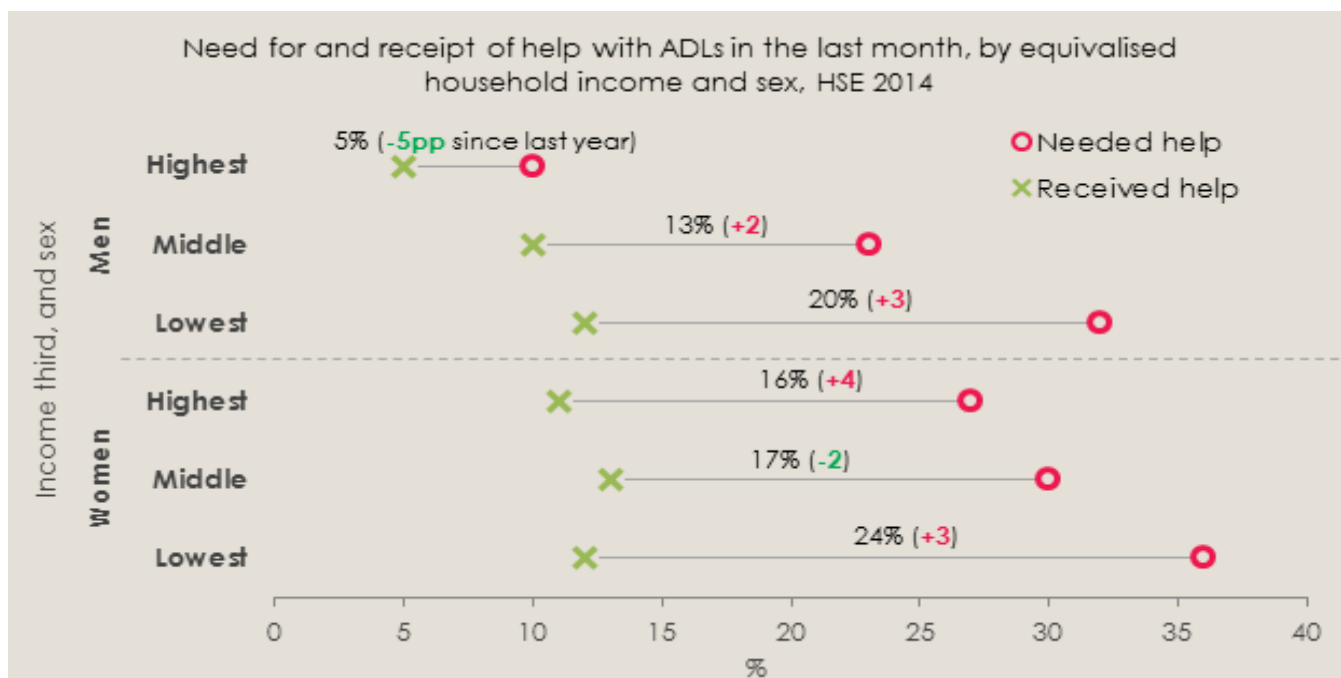
Since the middle of the last parliament, as financial pressures began to bite, the historic trend of improving quality has come to a stop in some important areas, according to findings from the QualityWatch annual statement – a joint programme between the Nuffield Trust and the Health Foundation. Patients now wait longer for both urgent and

planned treatment across the board. Some key measures of staff engagement appear to be deteriorating, a cause for concern since this is strongly associated with standards of patient care. A full understanding of any impact of the financial squeeze on quality, however, is complicated by gaps in the data available, especially in the increasingly important field of care outside hospital (Nuffield Trust & Health Foundation, 2015).

The Spending Review sets a similar funding trend for the rest of the decade. As a result, the health service will find it very difficult to maintain and improve quality, while delivering balanced budgets and the *NHS Five Year Forward View* changes. Additional commitments, like seven day working in general practice, will intensify the pressure.

5.2. The Spending Review has also provided some recognition of the pressures facing adult social care and the impact this is having on access and quality. Reductions in services have seen more than 400,000 people denied access to the care they need over the past five years. For example, older people on lower incomes say that they do not receive support for everyday activities such as getting in or out of bed, eating, washing and taking medicines, despite needing it - as described in Figure 5. Reflecting the fragility of the provider sector, the latest annual market survey from the healthcare market research company LaingBuisson shows that for the first time since they started collecting figures in 1990, more care home beds for older people closed than opened. In the six months to March 2015, there was a net loss of 3,000 from the total of around 487,000 beds spread across the United Kingdom (LaingBuisson 2015).

Figure 5: Need for and receipt of help with Activities of Daily Living (for instance getting in or out of bed, eating, or taking medicine).



5.3. It is important that the government is honest with the public about the implications of the settlement for what the NHS and social care can deliver. Both services are now set for a decade-long funding squeeze which will see spending as a share of GDP fall and leave the United Kingdom behind many other advanced nations on this measure of

spending. In the face of unprecedented financial pressures and rising demand for services, this is not sustainable. We reiterate the call we all made before the Spending Review for a new settlement which places health and social care on a sustainable footing for the future.

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