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# HEALTH MJ

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The management journal for health and care

May 2017

# Parties urged to come clean on costs of health and care

By Michael Burton

Politicians must be honest about the challenges in funding the NHS and care during the general election campaign, health experts have urged.

The King's Fund has set out five tests for assessing the credibility of parties' pledges on health and care as well as the choices the next government has in managing rising demand. It points out that the Department of Health's budget will increase by £4.5bn between 2015/16 and 2020/21 on current spending plans, as opposed to the £10bn claimed by ministers. As a result it says patients will have to wait longer and care will have to be rationed.

Polls show that the NHS remains the most important issue to the public after Brexit and the future funding of health is a key battleground in the election campaign. Yet confusion remains over just what resources the NHS needs or whether budgets have been cut or increased.

The Fund calls on parties to commit to greater integration of care based in the community and in people's homes and



concentrate A&E in fewer hospitals to improve quality. It says those MPs who back local hospitals even if they are unfit for purpose are 'colluding in the continued provision of unsafe services.' It also urges better training and retention to plug shortages.

King's Fund chief executive Chris Hams said it was vital 'the parties do not constrain themselves by making

commitments on tax and spending that make it impossible to do what is needed to sustain and improve health and social care.'

• The Institute for Government, in a report on immigration, said ministers should maintain the current system and make changes over a period as there is no need for a 'cliff edge.' It pointed out that applying salary minimums to EU workers,

### The five tests for political parties set by the King's Fund. Do their manifestos:

Face up realistically to the funding challenges in the NHS and social care?

Commit to greater integration of community-based care?

Commit to prevention through better public health programmes and stop cuts to public health budgets?

Offer a greater role to the third sector and volunteers in the NHS and social care?

Commit to better training, recruitment and retention of NHS staff to plug shortages especially if Brexit means fewer immigrant workers?

such as applies to non-EU staff, would hit NHS recruitment.

One in 10 NHS doctors are EU nationals, and there are 55,000 EU nationals working in the NHS in total. In 2015/16, EU migrants made up 32% of new joiners to the Nursing and Midwifery Council.

Labour has pledged to halt sustainability and transformation plans arguing that they have been made 'behind closed doors' without the involvement of local residents.

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comment



By Michael Burton

Theresa May has decided to hold a General Election because she needs a big majority to ensure any Brexit deal gets past an unholy alliance of Labour, SNP, Lib Dems and disgruntled Brexiteer Conservative backbenchers. An election also means she can ditch the manifesto commitments made in 2015 by her predecessor, in particular the foolish pledge not to raise income tax, VAT or National Insurance – which together make up 62% of tax revenues and the so-called pensions triple lock.

Should Mrs May gain a big majority she has the opportunity of grasping the nettle of NHS and care funding. Polls continue to show the public regards preserving a free NHS as its most important priority, yet politicians are reluctant to be honest about what this means in extra taxes.

The MPs who call for greater efficiencies in the NHS are often the ones campaigning to preserve inefficient, under-equipped local hospitals in their constituencies. The same MPs who call for more spending on health then oppose raising taxes to fund it such as from the self-employed and personal interest companies. In its five tests for assessing party manifestos, the King's Fund calls for honesty about tax and spending policies, urging parties not to box themselves in with unaffordable pledges which then make vital funding commitments to health and care unaffordable.

However it will not be easy finding extra cash for the NHS. The Institute for Fiscal Studies (IFS) says under current plans the share of national income raised in taxes will be the highest since the 1980s by 2020. A greater proportion is coming from top earners with the top 10% (those earning over £59k) contributing 54% of taxes while the number of workers paying tax has fallen as the tax free allowance rises. There is scope however for increasing tax revenue, as the IFS pointed out in its recent tax report.

During the election campaign politicians should be honest: the voters want more money for the NHS and care but it will cost them.

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# NHS mental health trusts are 'relying more on private sector'

By Paul Dinsdale

Mental health NHS trusts are becoming increasingly dependent on private hospitals to provide care, according to an investigation.

NHS spending on private mental health inpatient beds went up 42% over five years across 40 mental health authorities which responded to Freedom of Information requests by the BBC *Breakfast* programme.

Health experts say there is a chronic shortage of NHS beds in many areas, and it can mean some patients are placed in private units far from home.

In the investigation, FoI requests were sent to all 81 NHS mental health authorities in the UK. From the 40 authorities able to respond in full, figures show the cost of treating patients privately went up from £71m in 2012 to a projected £101m for the 2016 financial year.

The number of NHS mental health patients treated privately rose from 1,842 in 2012 to



3,323 in 2015, across 30 authorities able to respond.

Demand for inpatient beds on NHS mental health wards is high. According to responses from 32 mental health trusts in England, the average occupancy rate of inpatient beds rose by 3.2% in the five financial years to April 2016, from 86.3% to 89.5%, excluding patients that were on leave from their ward.

The Royal College of Psychiatrists recommends that wards should ideally be no more than 85% full.

Dr Ranga Rao, a spokesman for the Royal College of Psychiatrists, told the BBC: 'It's clear that there are not enough acute inpatient beds or teams providing crisis care in the community.'

'Clearly, it's not good for the NHS to be spending more money, but as a clinician my concern is for the patient, and it's not good for their recovery.'

An NHS England spokesman said it was 'committed to cutting the number of people travelling long distances, so they receive the best mental health care and treatment at home or as close to home as possible'.

He said: 'We are investing £400m in crisis resolution home treatment teams to increase alternatives to hospital admission as part of our plans for the biggest expansion of mental health services in Europe.'

## NHS England to identify 'black spot areas'



Bristol is amongst the areas predicted to fall short of financial control targets

NHS England is drawing up a list of areas with health economies that must make 'difficult choices' to cut back so-called 'unaffordable' services, according to reports.

An analysis has highlighted those with the greatest overspends both against financial 'control total' targets, and against allocations and income for 2016-17, and so likely to be targeted. Over-spenders highlighted by both methods include Staffordshire; Cambridgeshire and Peterborough; south west London; and Bristol, North Somerset and South Gloucestershire.

NHS England is believed to have started identifying regions that are 'significantly out of balance'. One method likely to be used is the combined performance of a region's NHS organisations against their 2016-17 financial targets.

Bristol, North Somerset and South Gloucestershire are set to fall £45m short, with Gloucestershire £28m short. Both these figures represent 3% of income.

The figures do not take account of significant deteriorations that have yet to be reported in official forecasts, such as those known in Northumberland and Coastal West Sussex clinical commissioning groups. These will be taken into account by NHS England and NHS Improvement in their final judgements.

*The Next Steps for the Five Year Forward View*, published by NHS England last month, said some areas had been 'living off bailouts arbitrarily taken from other parts of the country or from services such as mental health'.

## Nurse to patient ratios 'can reduce mortality risk'

Nurse to patient ratios can have a 'significant' effect on mortality rates for patients, according to interim findings from a new study believed to be the first of its kind in England.

Earlier research has been disputed because it has not been possible to show how nurse staffing levels directly links to mortality, only showing an association, and has also been based on studies from other countries.

But in the latest study, researchers from the University of Southampton showed that over the first five days of hospitalisation, for every day a patient was on a general medical or surgical ward with nurse staffing below required levels, the risk of death increased by 3%.

High-risk patients (those with an early warning score above six) were also more at risk of their observations not being taken when on a ward with lower numbers of nurses.

The researchers found that, for every additional hour of care provided to a patient by a nurse in a 24-hour period, there was a 2% decrease in the likelihood of vital signs observations being missed.

'These latest findings... suggest that having sufficient numbers of professional nurses... providing direct care will result in the best outcomes,' say the researchers.

Health MJ is produced by the publishers of *The MJ* as a monthly supplement.

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The Treasury has approved £160m of funding for 16 flagship ‘digital trusts’, but critics say the funds may still be raided for other purposes.

The 16 acute global digital exemplar trusts have reportedly been sent a letter by NHS Digital saying the Treasury has approved their funding, but it also says some ‘obstacles and conditions’ remain before the funds are released to trusts.

## Treasury approves funding for flagship ‘digital trusts’

The exemplar programme was in response to Professor Robert Wachter’s recent review of NHS IT.

An NHS England spokesman confirmed the funding, of up to £10m per trust, had been approved and would start being

released in the first half of 2017-18. A separate funding arrangement on seven mental health digital exemplars is also planned. If that is approved, it would take total central funding for the exemplars to £195m.

It had been reported that

concerns over delays meant the funding had already been raided for other parts of the NHS. All four of the previous flagship digital funds set up by NHS England have been cut, some quite severely.

The Government announced the first 12 global digital exemplars in September following recommendations in the review of IT in the NHS by Prof Wachter.

# Two in five GPs in South West England are ‘planning to quit’

By Paul Dinsdale

As many as two in five GPs in the South-West of England are planning to quit, which could lead to a potential crisis in the NHS, according to a survey.

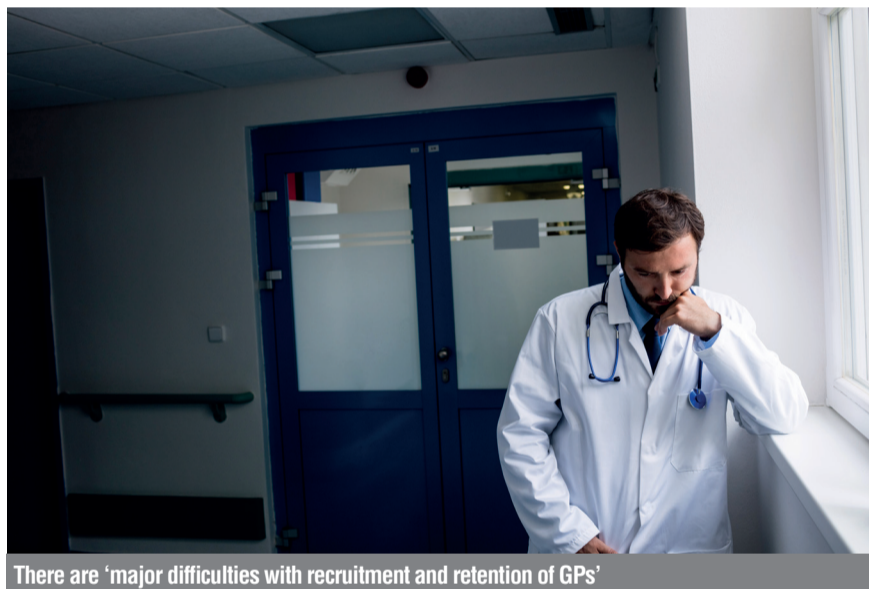
The study of more than 2,000 GPs in the region revealed the looming crisis in healthcare. Figures published last month showed there had been a drop in the number of GPs working in the NHS despite the Government’s aim of recruiting 5,000 more by 2020.

The latest survey, carried out by the University of Exeter, also found that seven in 10 GPs intended to change their working patterns in a way that would mean less contact with patients, including leaving patient care altogether, taking a career break or reducing their hours.

The researchers said the data provided a snapshot of low morale which, if duplicated in other regions, could point to a deeper and more imminent crisis than previously anticipated in relation to the worsening shortage of GPs nationwide.

Professor John Campbell, who led the research, published in *BMJ Open*, has called for a move away from ‘sticking plaster solutions’ towards robust, joined-up, action to avert the crisis nationwide.

Prof Campbell, a practising GP, said: ‘We carried out this survey because of a nationally recognised crisis in the shortage



There are ‘major difficulties with recruitment and retention of GPs’

of GPs across the country, and our findings show an even bleaker outlook than expected for GP cover, even in an area which is often considered desirable, and which has many rural communities.

‘If GPs have similar intentions to leave or reduce their hours in other regions, as many are reporting, the country needs to take robust action more swiftly and urgently than previously thought.’

The research team sent surveys to 3,370 GPs across the region and received

responses from 2,248, with 54% reporting low morale.

Prof Campbell said: ‘While numerous government-led initiatives are under way to address recruitment, there is a need to address the underlying serious malaise which is behind this data. We are in a perilous situation in England, with poor morale of the current GP workforce, and major difficulties with recruitment and retention of GPs reflected in the stark overall reduction in the workforce.’

## Four NHS Trusts placed in special measures

Four NHS trusts have been placed in special measures in the same week.

Kettering General Hospital Foundation Trust is one of four trusts to enter the regime this month. Isle of Wight Trust was also put in special measures, following United Lincolnshire Hospitals Trust and Northern Lincolnshire and Goole Hospitals FT last Thursday.

The Kettering trust was placed in special measures after a Care Quality Commission (CQC) inspection uncovered ‘serious’ problems with the care provided. The CQC found ‘insufficient staffing levels’ in Kettering’s A&E department.

The two trusts in Lincolnshire had previously been removed from the regime but were put back in special

measures after their latest inspections.

Kettering was rated inadequate overall and for how safe and well led it is. It was rated as ‘requiring improvement’ for being effective and responsive, and ‘good’ for being caring. It had been previously reported that the trust was in difficulties after care quality and financial

concerns were raised.

In the trust’s emergency department, the CQC found inadequate staffing levels and ‘no effective processes’ to ensure that patients who arrived at A&E were safe to wait up to two hours to see a clinician. It also found there were not enough registrars or junior doctors to cover weekend or out of hours shifts.

### briefs

■ A financially troubled hospital trust has launched an ‘extremely challenging’ plan to save nearly 10% of its income in the next year.

Plymouth Hospitals Trust, which is part of the Devon success regime, plans to save £40m in 2017-18 through a variety of projects, including workforce redesign. Its income in 2015-16 was £432.8m. Details of the savings plan have been published as the trust is set to end 2016-17 with a deficit of £35.6m. The trust had expected this figure would fall through an injection of £11.9m of sustainability and transformation funding, but this has been withheld because the trust did not agree its 2016-17 control total with regulators.

■ GPs who advise patients on the benefits of a low carbohydrate diet to manage type 2 diabetes should be entitled to keep all or part of any resulting savings in their drugs bill, an independent forum of MPs and peers was told.

David Unwin, a GP in Southport and the Royal College of General Practitioners’ champion for collaborative care and support planning in obesity and diabetes, made the proposal at the All Party Parliamentary Food and Health Forum. The forum is carrying out an inquiry on diabetes and diet, chaired by the Labour peer Nicholas Rea.

Dr Unwin (pictured) said that his practice’s spending on type 2 diabetes drugs (excluding insulin) was £4194 less per 1000 patients due to dietary advice given to patients.



briefs



■ The Care Quality Commission (CQC) will appoint a new chief inspector of hospitals in June, according to reports.

A job description by the CQC to recruit to the role of chief inspector of hospitals, said applications would close this month with final interviews held on 31 May. The salary from the CQC for the new chief inspector of hospitals between £161,000 and £191,000 a year. The new inspector also needs the approval of the health secretary Jeremy Hunt.

Sir Mike Richards (*pictured*) announced in January that he will be retiring this summer after four years as chief inspector. No date has been yet set for his departure.

■ Only 500 of the extra medical school places pledged by the Government to ensure 'self-sufficiency' in homegrown doctors will come on stream in 2018, it has been revealed.

A health minister has said just a third of the 1,500 promised places will be funded next year, while the Department of Health consults on 'how to make available' the remaining 1,000 places from 2019/20.

Health secretary Jeremy Hunt first announced the plans at the Conservative Party conference in October last year, when he said boosting places by a quarter would be 'the biggest annual increase in medical student training' in NHS history when it happened from 2018.

# Social care spending 'varies widely by region' study says



Councils are making big cuts to care for the elderly according to a study

By Paul Dinsdale

Some areas of England and Wales spend a third more on elderly care than others, with local needs explaining only some of the variation, says a think-tank report.

The study by the Institute for Fiscal Studies (IFS), found that the East of England region has the highest spending and the East Midlands the least. It also found that councils are making big cuts to care for the elderly.

One in ten has cut spending on social care by more than a quarter in the past six years, with eight in ten making some cuts. Big cities and the North have seen the most severe cuts, the IFS said.

Across England as a whole, spending by councils on social care per adult resident fell by 11% in real-terms between 2009–10 and 2015–16. Figures suggest that around six in seven councils made at least some cut to their social care spending per adult resident, and one in ten made cuts of more than a quarter.

Spending fell by most on average in London (18%) and metropolitan districts (16%) covering urban areas like Greater Manchester, Merseyside and Tyneside. More generally, cuts

were larger in the North of England than the South. Cuts were also larger on average in areas that in 2009–10 spent more on adult social care, had higher assessed spending needs and were more dependent on central government grants.

These are among the main findings of the new report by researchers at the IFS, funded by the Health Foundation, which analyses official spending data on councils' social care spending.

Other key findings include:

- A significant variation in councils' social care spending across the country – spending was less than about £325 per adult resident in a tenth of council areas, while it was more than about £445 per adult resident in another tenth of council areas in 2015–16, a difference of more than a third.
- Councils where there are relatively more people over pension age (particularly those entitled to means-tested benefits), and where levels of disability benefit claims and deprivation are higher, tended to spend more on social care. Higher local earnings levels are also associated with higher levels of social care spending.

See p8 for more details on the report

## NHS Improvement chief admits trusts' financial problems

The chief executive of NHS Improvement has said that a key financial target seen as 'critical' to the progress of the Five Year Forward View will not be met.

In an interview, Jim Mackey said the NHS provider sector will not break even again in 2017-18, and reaching financial balance in 2018-19 will depend on factors outside trusts' control.

Mr Mackey said suggestions that NHS trusts' deficit would be between £500m and £600m in 2017-18 were 'not miles out', though efforts were being made to reduce this.

Last year, NHS England said it was 'critical' for the sector to move out of deficit in 2017-18 to remain on track to

close the [£30bn] funding gap described in the Forward View.

He agreed there needed to be more detailed financial information given than that in NHS chief executive Simon Stevens recent report *Next Steps on the Five Year Forward View*. Mr Mackey said: 'I would have liked to have seen some of that detail completely signed off by our board, signed off by NHS England's board, and the Treasury and Department of Health comfortable with it...'

He noted that external factors may make the financial recovery uncertain, such as the level of benefit that trusts will experience through the uplift in social care funding, and that breaking even in 2018-19 would also be a big challenge.

## Former Scottish health minister calls for reform

A former SNP minister has set out his own rescue plan for the service, including a radical demand for a health tax to pay for improvements.

Alex Neil also criticised the Scottish Government's recent delivery plan for health and social care which he said needed to be 'more specific, detailed and much broader in scope'.

His latest challenge will embarrass his successor as health minister, Shona Robison, at a time when health professionals have repeatedly raised concerns about issues including

investment, a one per cent pay cap and a shortage of GPs.

Mr Neil said in his 10-point discussion paper that powers should be transferred to the Scottish Parliament at Holyrood to allow it to introduce what he admitted would be a 'deeply controversial' health levy.

Launching the plan in Glasgow, he said he supported the efforts made by the SNP government to improve the NHS, but added: 'Much more needs to be done, including the injection of more cash to avoid a long-term crisis of the type we are witnessing south of the border.'

Mr Neil served as health minister from 2012 to 2014 before being moved in a cabinet reshuffle. He resigned from government in May last year and sits as a backbencher for Airdrie and Shotts.

The number of patients who were placed in mixed-sex hospital wards has trebled in two years, according to new figures.

Almost 8,000 people were treated on mixed-sex hospital wards in the 12 months to March, according to figures from NHS England, obtained by the Liberal Democrats.

Over the past two years there has been a rise in the number of breaches of NHS rules that say men and women should be treated on different wards. Overall,

## Number of patients in mixed-sex wards rises

7,771 patients were admitted to mixed-sex wards between April 2016 and the start of last month. This compares with 5,309 in 2015-16 and 2,655 in 2014-15, the analysis showed.

NHS rules say men and women should be treated on different wards. It follows repeated pledges from the Conservatives to end the practice, with four manifesto promises. The Government announced a

crackdown on the practice in 2010, and introduced a fining system the following year. Hospitals must now pay out up to £250 for every mixed-sex breach, defined as a night spent by a patient on a mixed-sex ward.

Almost half of the breaches in March occurred in the South of England. In total, there were 395 cases, compared with 105 in the Midlands and the East of England, 106 in London, and 170 in the North of England.

# Racial discrimination and bullying still a problem in NHS, says report

By Paul Dinsdale

Patient care is suffering because ethnic minority NHS staff are badly affected by routine discrimination and bullying, says a report.

NHS England's second *Workforce Race Equality Standard* (WRES) report found that black and ethnic minority (BME) staff in the NHS are over 50% more likely to be disciplined compared to their white counterparts, while more than a quarter said they had been bullied by their colleagues in the past year.

One in seven also said their manager had discriminated against them. However the report also reveals some positive changes, including the number of nurses and midwives who have progressed from lower grades into senior positions (Band 5 entry level to Bands 6-9), and in BME representation at very senior management and executive board level.

Key findings from the report were:

- BME nurses in bands 6 – 9 increased by 4,187 between 2014 and 2016.
- BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers, although the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work from staff fell slightly from 15% in 2014 to 14% in 2015.
- BME staff remain less likely than white staff to believe that their trust provides equal opportunities for career progression. However, the gap between white and BME staff on this indicator fell from 14.5% in 2014 to 12.6% in 2015.
- White and BME staff are equally likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months.
- Very senior managers from BME backgrounds increased by 4% during 2015-16, resulting in an



BME NHS staff are more than 50% likely to be disciplined than their white counterparts

additional nine appointments.

Simon Stevens, NHS chief executive, said: 'For the first time we have a full national picture of how equality standards are beginning to take effect, with some early signs of progress, and some organisations

clearly showing what is possible. But no one should yet be comfortable or satisfied with what these figures show overall, and many employers still have much to do before the NHS can declare mission accomplished on this critical agenda.'

## CCGs aim to make 'huge savings' in next year amidst current deficit

A group of clinical commissioning groups (CCGs) with severe financial problems is seeking to make £82m in savings, as their current plans amount to a £90m deficit for 2017-18.

Bristol, North Somerset and South Gloucestershire have said that current plans would amount to a £90m combined deficit for the current

financial year. Their combined control total for 2017-18 is an £8m deficit, and they have announced new joint plans to find £82m in savings.

The combined deficit of South Gloucestershire and North Somerset CCGs at the end of 2016-17 was £47m, while Bristol achieved a small surplus, according to board papers.

South Gloucestershire's deficit deteriorated late in the year from a £15m plan to £32.9m. It attributed nearly £10m of the decline to over-performance in acute expenditure. Its deficit amounts to around 11.7% of its 2016-17 allocation (£279m).

NHS managers in the area have been warned by national regulators that they

must make large savings in 2017-18. According to South Gloucestershire's board papers for April, NHS England and NHS Improvement have written to the CCG accountable officers and trust chief executives, as the health economy 'has not been able to agree a set of affordable operating plans or agree financial control totals'.

# Lords call for quick action

Paul Dinsdale looks at the recent Lords report on the long-term sustainability of the NHS

A major report on the long-term sustainability of the NHS says that a 'culture of short-termism' is preventing ministers and NHS managers from looking at the longer-term picture.

The report by a House of Lords committee *The Long-Term Sustainability of the NHS* says that the 'short-sightedness of successive governments is reflected in a Department of Health that is unable or unwilling to think beyond the next few years...Almost everyone involved in the health service and social care system seems to be absorbed by the day-to-day struggles, leaving the future to "take care of itself".'

The committee says 'a new political consensus on the future of the health and care system is desperately needed' and this should follow government-initiated cross-party talks and a national debate.

It recommends the establishment of an Office for Health and Care Sustainability, which should be given the independence to speak freely about issues relating to its remit, in a similar way to the Office for Budget Responsibility (OBR). It should look 15–20 years ahead and report to Parliament, initially focusing on three main areas:

- the monitoring of and publication of significant data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand;
- the workforce and skills mix implications of these changes;
- the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding.

It calls for the body to be established in statute before the end of this Parliament.

The committee recognises service transformation is at the heart of securing the long-term future of the NHS and social care, and that this depends on long-term planning, wide consultation, good systems of governance and local accountability.

It says the model of primary care will need to change, that secondary care will need to be reshaped and specialised services consolidated further, adding 'a renewed drive to

realise integrated health and social care is badly needed'. But it notes that 'the statutory framework is frustrating this agenda and in order for real progress to be made reform is needed to reduce fragmentation and the regulatory burden'.

The report says that with policy now increasingly focused on integrated, place-based care 'we see no case for the continued existence of two separate national bodies and recommend that NHS England and NHS Improvement are merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government.'

## The Lords heard evidence that publicly-funded adult social care is in crisis, and say that additional funding for social care announced in the 2017 Budget is welcome

The committee says it is 'clear' that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for the delivery of sustainable health services, but that in coming years this will require a shift in government priorities or increases in taxation. Health spending beyond 2020 needs to increase at least in line with growth in GDP in real-terms, it says.

The Lords heard evidence that publicly-funded adult social care is in crisis, and say that additional funding for social care announced in the 2017 Budget is welcome, and means funding for social care will increase by more than 2% a year for the next three years, more than the increase for NHS funding. But this is 'clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system.'

The report says the Government needs to provide further funding between now and 2020. Beyond then, a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding'.

It finds funding for health and adult social care over the past 25 years has been 'too volatile and poorly co-ordinated' between the two systems, and recommends that the budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the 'Department of Health and Care', allowing money and other resources to be marshalled within a unified policy setting at national level. The report accepts the difficulties with integrating budgets at a local level but says it is achievable.

With respect to social care, the Lords says that those who can afford it should pay for the care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission. They also call on the Government to implement as quickly as possible new mechanisms to make it easier for people to save and pay for their own care. It says the Government should, in the development of its forthcoming green paper on the future of social care, 'give serious consideration to the introduction of an insurance-based scheme which would start in middle age to cover care costs.'

In a strong warning, the committee also says it is concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, and well-trained workforce that the health and care system will need over the next 10–15 years, and that this represents the biggest internal threat to the sustainability of the NHS. It says Health Education England has been 'unable to deliver' and needs to be substantially strengthened and transformed into a new single, integrated strategic workforce planning body for health and social care which should always look ten years ahead, on a rolling basis.

Commenting on the report, Royal College of Physicians president Dr Jane Dacre said: 'The report's focus on transformation and call for a long term strategy on how we care for a changing population are essential and agrees with much of our own *Future Hospital* work. If we are to improve the care for patients we treat, as clinicians, in collaboration with patients, we need to reshape the secondary and specialist care we provide.

'As we highlighted in our recent report *Underfunded, Underdoctored and Overstretched*, our hospitals and NHS

## Regulatory environment 'improving' but still a big burden for trusts

The third survey into views on regulation by NHS Providers found that over half of respondents still regard the regulatory system as poor value for money

Most NHS trusts feel that demands from regulators are still too high in number and provide poor value for money according to a survey from NHS

Providers which represents foundation trust hospitals.

Two thirds of trusts (68%) reported an increase in demand from regulators



including NHS Improvement, set up in April 2016 as a merger of Monitor and the NHS Trust Development Authority,

and the Care Quality Commission (CQC). More than half (56%) of respondents said the regulatory system

# to help co-ordinate care



staff are only just coping and we cannot underestimate either the time or effort needed to make these fundamental changes. Therefore, the recommendation to increase funding for the NHS before 2020 is welcome.’

‘We would also agree with the long term ambition to move the NHS from an ‘illness’ service to a ‘wellness’ service, but as we outlined in our own evidence the current failure to protect and enhance the public health budget is at

best short-sighted and at worst counterproductive.’

[www.publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf](http://www.publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf)

provided ‘poor’ or ‘very poor’ value for money. A similar proportion (55%) reported that regulatory requirements including requests for information and inspections ‘felt disproportionate to the level of risk they were managing’ and did not help them to overcome the underlying challenges they face.’

The report, the third by NHS Providers into views on regulation, concluded: ‘It is crucial in the current environment for the regulators to recognise that the improvement agenda is most effectively owned and led at a local level by provider boards and that regulation alone cannot drive improvement, overcome financial challenges or act as substitute for strong and effective leadership.’

An NHS trust chair told the survey: ‘Regulators must not be seen by the

Government as a sticking plaster to handle the huge financial and operational risks that the NHS faces. The big issue is to recognise and address these risks either by appropriate funding or changes in services requirements.’

Trusts received more *ad hoc* requests for information (69%) at a time of unprecedented pressure in terms of demand, restoring performance against targets, transforming services and balancing their books.

Although trusts welcome steps taken by regulators to create a more supportive approach, many are concerned that they are having to absorb the costs. As the CQC moves towards a new inspection regime ‘it has the opportunity to strengthen the value of and sustainability of its regulatory approach’ says the survey report published in April.

Respondents felt that more consistent messages do not always shape regulators’ actions in practice. Respondents also called for regulators to take a more joined up system-wide view rather than working within organisational silos. It was also clear that the different thresholds of proportionality that various regulators apply were also having an impact on consistency. It was also emphasised that mixed messages from NHS England and NHS Improvement remain an issue.

There is however, according to NHS Providers, ‘a prevailing view that sustainability and transformation plans (STPs), now moving from planning to implementation, have the potential to transform delivery of care in the direction set by the Five Year Forward View.’

Commenting on the findings, Saffron Cordery, director of policy and strategy at NHS Providers, said: ‘Trusts appreciate the changes that regulators have made to improve how they work together...but there is much more to do to reduce the demands from regulators and to improve the value they deliver. For the third time, trusts are telling us that the burden is still increasing in terms of the costs and staff time associated with meeting regulators’ requests.’

There were 76 responses to the survey (22 NHS trusts and 54 NHS foundation trusts), representing 32% of NHS trusts. Just over a third (38% of respondents) had received an ‘outstanding’ or ‘good’ rating from the CQC, with two thirds rated as ‘requires improvement’ or ‘inadequate’.

# Council social care spend ‘not dictated by needs assessment’

A new study from think-tank the Institute for Fiscal Studies (IFS) has found variations of up to a third in social care spending across England, reports **Paul Dinsdale**

A major report on the variations in spending on social care in England by geographical region has highlighted some significant differences, even between areas that have been assessed as having the same levels of spending needs by the Government.

Following years of central government cuts in allocations to councils, spending was less than about £325 per adult resident in a tenth of council areas, while it was more than £445 per adult resident in another tenth of council areas in 2015–16 – a difference of more than a third.

Councils where there are relatively more people over pension age (particularly those entitled to means-tested benefits), and where levels of disability benefit claims and deprivation are higher, tended to spend more on social care. Higher local earnings levels are also associated with higher levels of social care spending.

Even so these ‘spending needs factors’ only explain a small proportion of the variation in spending across councils. The IFS says that councils’ ‘scores’ in the last official needs assessment in 2013–14 would only explain around 13% of the variation in what they actually spent on social care per person in 2015–16.

It says that, in part, this may reflect inaccuracies in that needs assessment, and the fact that by 2015–16, the assessment was two years out of date. But it also reflects that, given similar needs, different councils are likely to make different trade-offs between spending on adult social care and spending on other services. They also have different overall budgets (from council tax, business rates, and grants) from which to fund their service spending, it says.

In addition to council spending, care recipients often contribute towards the cost of their care through fees and charges. These raise an average of £63 per adult resident, but the amount varies widely: one-in-ten councils raise less than £35 per adult resident, while a further one-in-ten raise £95 or more.

However, the IFS says there is no clear



relationship between local authorities’ own spending and fee income. The report says it is not the case that all high spenders charge lower fees, nor that all low spenders rely on high income from co-payments to meet costs.

‘The spending cuts analysed in our report have been accompanied by a substantial fall in the number of people receiving social care: down 25% across England, between 2009–10 and 2013–14 alone,’ said Polly Simpson, a research economist at the IFS and an author of the report. ‘Cuts have therefore been delivered, in part, by removing care from many people, with those still receiving care presumably those with the highest needs. What all this means for the quality of care received, the welfare of those no longer receiving care, and other services like the NHS requires further research to answer.’

David Phillips, an associate director at the IFS and another author of the report, commented: ‘One thing that stands out in these figures are the big differences in spending per adult on social care among councils assessed to have very similar spending needs by the Government.

‘Whether this means spending needs assessments are inaccurate, or reflects differences in available funding or the priority placed on social care relative to other services or council tax levels, is unclear. But it emphasises that the Government has got its work cut out in its ‘Fair Funding Review’ of how to measure different councils’ spending needs from 2019 onwards. That debate could get quite fraught.’

The table (right) shows the wide geographical spread of current spending on social care:

**Real-terms levels of social care spending in 2009–10 and 2015–16 (both in 2016–17 prices), and changes between these years by region and council**

Area	Spend per adult in 2009–10 (£)	% Change	Spend per adult in 2015–16 (£)
<b>Region</b>			
London	475	-18%	389
North East	479	-18%	395
West Mids	440	-17%	366
North West	448	-13%	389
East Mids	394	-10%	356
East of Eng	435	-9%	396
Yorks & Humber	388	-7%	361
South East	407	-7%	380
South West	401	-2%	395
<b>Authority type</b>			
London Borough	475	-18%	389
Met District	453	-16%	380
Shire County (North/Midlands)	395	-10%	357
Unitary Authority (North/Midlands)	420	-10%	379
Shire County (South)	414	-7%	387
Unitary Authority (South)	412	-5%	392
England	429	-11%	381



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