CIPFA The Chartered Institute of Public Finance & Accountancy

HoC Health and Social Care Committee: Budget and NHS Long Term Plan

A Submission by:

The Chartered Institute of Public Finance and Accountancy

August 2019

the people in public finance

CIPFA, the Chartered Institute of Public Finance and Accountancy, is the professional body for people in public finance. CIPFA shows the way in public finance globally, standing up for sound public financial management and good governance around the world as the leading commentator on managing and accounting for public money.

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1. Executive summary

1.1 CIPFA welcomed the ambition and vision presented in the NHS Long Term Plan (LTP), while remaining concerned about the essential missing pieces – a long-term solution for social care funding, a funded workforce strategy, clarity on public health funding and the vision for prevention and capital investment.

The need for a spending review

1.2 Notwithstanding current uncertainties, CIPFA considers that a multi-year spending review is required, and that a single year spending round does not provide the long-awaited clarity on these four crucial areas on which the LTP is dependent.

NHS capital

1.3 The overall capital budget for DHSC was around £6bn in 2018/19, well below levels of investment in other developed nations. Total capital budgets have been reducing, in real terms, in recent years, partly due to repeated transfer of capital to support revenue spending.

1.4 NHS bodies have experienced increasing difficulty in accessing capital funding, either due to difficulty in accessing resources, or to constraints imposed by the need to centrally manage combined investment against the capital DEL.

1.5 Providing an increase to the overall capital limit would provide an immediate alleviation of the problem of accessing capital funding. There is an urgent need to set out a coherent longer-term capital settlement for investment and to address the backlog maintenance. Short-term approaches, such as transferring capital to revenue, must cease.

1.6 A new, simplified capital system should be developed which is fit-for-purpose

Social care

1.7 Without a sustainable settlement for social care, the NHS will be unable to deliver on the ambitions in the LTP.

1.8 It is critical that the challenges of funding social care are clear and understood in order to inform the development of strategic and sustainable solutions. We have previously set out a 5-point plan, which the development of a sustainable system should incorporate.

Public health

1.9 Persistent cuts to the public health grant are having a clear and significant impact on local services, and are restricting the ability of their local systems to deliver on the LTP.

1.10 The government's current consultation on prevention highlights the importance of 'place' as being integral to the implementation of preventative strategies, and the need to ask fundamental questions on how much we value prevention. CIPFA welcomes these areas of focus, and these are areas that we sought to explore in our collaborative work with Public Health England (PHE).

1.11 There is a need for a system-wide rethink on preventative investment. CIPFA recommends that the government addresses the issue of public health funding. Immediate funding should be provided to reverse the impacts of the reductions to the public health grant. In the longer term, clarification of wider preventative investment and how this can be appropriately evaluated and protected is required.

Education and training

1.12 Workforce is perhaps the biggest challenge in delivering the ambitions set out in the LTP. The budget for education and training has reduced substantially in recent years, and the development of a workforce plan is awaiting the outcome of the spending review allocation for education and training.

1.13 It is essential that levels of investment for education and training are clarified and made available as a matter of urgency. Without investment in training for current and future staff, the staffing crisis in the NHS will worsen and the ambitions of the LTP may not be realised.

2. The need for a spending review

2.1 In January this year, CIPFA welcomed the ambition and vision presented in the NHS long term plan (LTP), while remaining concerned about the essential missing pieces – a long-term solution for social care funding, a funded workforce strategy, clarity on public health funding and the vision for prevention and capital investment. At the time we stated:

> "…we can only hope these long-term plans do not turn out to be just pillars of sand. Local plans will be scaled up to national level by autumn – by which time we may have had a couple of green papers and perhaps even a Spending Review. The mists may have cleared by then."[1]

2.2 Eight months later, the situation remains unclear. The NHS Long Term Plan (LTP) Implementation Framework[2] promises a detailed national implementation plan in the autumn (or within two months of a spending review) that will be able to take account of the settlement for these four important areas, on which delivery of the LTP is dependent. However, neither a full spending review nor a proposed solution to the social care funding crisis has emerged. While a consultation on prevention and public health has quietly appeared, it lacks substance, and funding is again deferred to the spending review.

2.3 What we do have is a new Prime Minister, a new Chancellor and Cabinet. While a key priority must be to set a clear direction for the public finances over the medium (and ideally longer) term, a full spending review has

[1] Public Finance, NHS Long Term Plan: Let's hope this vision holds action over ambition, Dr Eleanor Roy, 9 January 2019

[2] NHS Long Term Plan Implementation Plan Framework, June 2019

been delayed until 2020, with only a one year spending round to set departmental revenue budgets for next year scheduled for September.[3]

2.4 A spending review covering multiple years is long overdue and is much needed to support financial planning for delivery of the LTP and wider health and care services, to bring clarity and focus to the core challenges and the ability to deliver sustainable services.

2.5 The national implementation plan for the NHS LTP was expected to be published in the autumn – or "within 2 months of a spending review" to allow it to "take full account of both the SR settlement for public health, adult social care, capital and workforce education and training budgets…"[4]. In the absence of a multi-year spending review this will not be possible.

2.6 Notwithstanding the current uncertainties, CIPFA considers that a multi-year spending review is required, not only to provide long-awaited clarity on these four crucial areas on which the LTP is dependent, but to encourage a focus on long-term outcomes and foster more integrated and cross-government preventative initiatives.

2.7 CIPFA have outlined a series of high-level priorities to set a new agenda for planning and supporting better outcomes from the spending review process.[5]

3. NHS capital

Declining capital budgets

3.1 The overall capital budget for the Department of Health and Social Care (DHSC) was around £6bn in 2018/19. Research shows this is much lower than comparable investment internationally. To bring capital investment in healthcare services into line with that in other developed nations would require an additional £4bn per year – an increase of almost 75% of the annual capital budget.[6]

3.2 Total capital budgets have been reducing, in real terms, in recent years, and there have been repeated calls for this to change.

3.3 Although the NHS received a 70th birthday present of additional funding – it provided no capital for investment in infrastructure to provide the transformational programmes required to support integration, nor the £6bn required to eradicate backlog maintenance.[7,8]

3.4 The government accepted the call from the Naylor Review in 2017 that an additional £10bn should be invested in transformation and maintenance backlogs, and suggested that a third of the funding would come from public spending, a third from private investment and a third from existing

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[3] HM Treasury, Chancellor fast-tracks Spending Round to free up departments to prepare for Brexit, 8 August 2019

[4] Board paper on Long Term Plan Implementation Framework, NHS England and NHS Improvement Board meetings held in common, 27 June 2019

[5] CIPFA, Spending Review Manifesto Briefing.

[6] The Health Foundation, Failing to capitalise, March 2019

[7] NHS Digital, Estates Returns Information Collection, England, 2017-18, October 2018

[8] This represents to estimated cost to eradicate backlog maintenance, and half of this relates to work assessed as being high or significant risk. The true cost may be higher, but awaits the outcome of the delayed NHS Estates and Facilities Backlog Maintenance and Critical Infrastructure Risk Review announced in 2017.

estate sales.[9] However, there has been no significant increase in the overall DHSC capital departmental expenditure limit (DEL), and no significant increase in land sale receipts. Indeed, where assets are sold, the proceeds are not always available for re-investment, as this is constrained by current rules.[10]

3.5 The 2018/19 DHSC accounts[11] show that NHS provider organisations invested £3bn in local priority schemes (an increase of around £0.6bn on the previous year). This reflected increased availability of locally generated funding, and resulted in a £340m overspend on the NHS capital DEL budget; offset by underspend in the non-NHS sector to give a £42m underspend across the overall capital DEL budget. This is an indication that the capital regime is not making provision in line with the need for investment.

3.6 The accounts also state that the department has been supporting capital investment in sustainability and transformation partnerships (STPs) in 2018/19 from central sources, including £1bn this year, in addition to previously announced £1.4bn to be delivered by 2023/24. However, it has recently been suggested that only 3% (around £100m) of this has actually reached the front line.[12]

3.7 Part of the reason for the continued decline in total capital budgets is the repeated transfer of capital to support revenue spending.[13] Since 2014/15, the total amount of capital transferred to revenue is some £4.46bn, and there has been no adequate investigation as to how this may have impacted in a wider sense.[14]

A complex system in need of reform

3.8 In theory, the system permits NHS bodies to invest in their own capital priorities using cash reserves and capital loans from DHSC, although the powers and frameworks involved differ between NHS bodies.[15] The combined capital spending incurred by the NHS must be contained within the overall DHSC capital DEL, regardless of the framework involved.

3.9 In recent years, NHS bodies have experienced increasing difficulty in accessing capital funding. Many of them have been in deficit, and so unable to build up resources with which to fund capital spending. Those who have resources available to invest in capital are constrained from doing so by the need for the DHSC to manage the overall investment against the capital DEL.

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[9] DHSC, Naylor review: Government response, 30 January 2018
[10] HSJ, Three-quarters of money from NHS land sales went into revenue, L Dunhill, 19 July 2019
[11] DHSC, Annual Report and Accounts 2018 to 2019, HC 2344, 11 July 2019
[12] HSJ, Exclusive: Capital billions promised by Ministers fail to reach 'front line', 30 July 2019
[13] At the 2015 Spending Review, a decision was made to move capital funding to support revenue spending.
[14] House of Commons, Committee of Public Accounts, Sustainability and Transformation in the NHS, Twenty-Ninth Report of Session 2017–19, HC 793, 27 March 2018
[15] Foundation trusts (FTs), except those deemed to be in financial distress, have greatest flexibility and can incur capital spending using internally generated resources to the limit of those resources. NHS trusts (and FTs in financial distress) must work within delegated limits for capital investment, which they cannot exceed. CCGs are perhaps less likely to incur capital spending, so are funded from DHSC's capital and given an entity level capital limit which they cannot exceed.

3.10 Earlier this year it was reported that combined capital spending plans in the NHS were significantly higher than the overall capital limit. Trusts were asked to defer projects voluntarily, resulting in a 3% reduction to combined capital plans. However, this was not enough to meet the overall DHSC capital DEL, so trusts were subsequently asked to cut combined spend by 20%, or run the risk that capital loan funding (for those who required it), may be held back.[16] This clearly illustrates the problems associated with the central requirement to meet a statutory spending limit and the dependence on forecasts for capital spend.

3.11 The capital funding systems for the NHS are complex; the system for prioritising capital programmes is unclear and there is confusion around whether capital programmes are reviewed and approved nationally, or as part of a system.

3.12 Part of the issue is undoubtedly the bidding process. In 2017/18 STPs were required to prioritise and submit bids on a system-wide basis, which were then approved at national level – effectively trusts had to submit capital bids via their STP. When funding is allocated, they must then submit two business cases, requiring approval by NHS England, DHSC and HM Treasury – a process that is complex and prone to delays, and has been widely criticised by NHS leaders.

3.13 It is widely accepted that the current system for capital funding needs to be redesigned; indeed the DHSC accounts for last year stated: "Recognising that the current capital regime presents challenges both nationally and locally in effectively planning and forecasting capital investment, the Department is working closely with NHS Improvement, NHS England and HM Treasury to review the capital regime of the NHS to ensure funding is deployed in the most effective manner. The proposed reforms will be set out in detail alongside the capital settlement at the 2019 Spending Review and will look to remove the existing fragmentation of funding sources, short-termism of capital decision-making and uncertainty for local health economies."[17]

Increasing the capital spending limit is a quick and obvious solution

3.14 Providing an increase to the overall capital limit would provide an immediate alleviation of the problem of accessing capital funding. However, this should not be a one-off short-term 'sticking plaster' approach. The recent announcement of a £1.8bn increase in capital[18] is undoubtedly a good start. However, over half of this is an increase in the capital DEL limit, allowing providers to utilise cash they already have, rather than additional funding.

3.15 While this is welcome, it does not address the scale of the problem. There is an urgent need to set out a coherent longer-term capital settlement for investment in the NHS to achieve the transformation required to meet the ambitions of the NHS Long Term Plan, and to address the backlog

[16] HSJ, Trusts told to cut a fifth off capital spending plans, L Dunhill, 2 July 2019
[17] DHSC, Annual Report and Accounts 2018 to 2019, HC 2344, 11 July 2019
[18] DHSC, Press Release, PM announces extra £1.8 billion for NHS frontline services, 5 August 2019

maintenance. The need for the NHS to invest in both building infrastructure and IT is critical for the delivery of the LTP. However, many organisations are facing either/or decisions due to capital restraints. Specific allocations for each of these areas may be helpful to prevent such trade-offs.

3.16 Short-term approaches, such as transferring capital to revenue, must cease. Although these may relieve immediate pressures elsewhere, they act to continue the decline in capital spending and store up problems for the future. These actions have contributed to the build-up of backlog maintenance and the difficulty of planning capital programmes due to uncertainty on the levels of funding available.

3.17 Other options should be explored as part of the review of capital funding. Possibilities include the recent suggestion of a government 'bond' for infrastructure investment in health,[19] or capital collaborations between NHS bodies and local government.[20] However, all such options would require careful consideration in order to ensure that they are not merely instruments to provide funding, but can also work alongside the capital DEL restrictions.[21]

The overall capital system needs to be simplified and made fit-for-purpose

3.18 In order to enable the NHS, and partner organisations, to appropriately plan and fund capital investment programmes, a new, simplified capital system should be developed that is fit-for-purpose and incorporates the following characteristics:

- Long-term certainty and sustainability – capital programmes take time to plan and implement, and certainty of funding is essential, as are timely decisions on funding allocations. Organisations must be able to plan for the medium to long term and have certainty on the amount of funding available to them.
- Transparency – any system must be clear, understandable and transparent to all involved. Clear guidance should enable all parts of the system, not only those directly affected, to understand the pressures on their partners.
- Clarity, fairness and simplicity – there will always be demand for limited resources, and thus a need for criteria to be set to satisfy national priorities without stifling local need, yet the system need not become overly complex.

3.19 For example, a system approach based on capital allocations (rather than loans) at STP level would enable investment in local priorities in their capital programmes. This could be allocated taking account of financial circumstances/demography/population/need within each system. It could be simple, transparent and provide a level of local accountability. Regional/national approval of a single business case could provide for

[19] HSJ, NHS England seeks £50bn bond for 'capital starved' health service, D West, 4 June 2019
[20] As previously explored in HFMA/CIPFA, Capital collaborations between the NHS and local authorities, June 2017
[21] In addition to other accounting changes planned which may have a significant impact on restricting options available to NHS bodies to support capital spend – for example IFRS 16 and treatment of leases.

more central management and accountability. Within this, organisational allocations for backlog maintenance could be made on the basis of need, to ensure the system allocations are not diverted for this purpose.

4. Social care

4.1 It is essential to maintain a view of social care as part of the interdependency between spending on the NHS, public health and adults' and children's social care in totality. Without a sustainable settlement for social care, the NHS will be unable to deliver on the ambitions in the LTP. Indeed, 90% of NHS leaders surveyed stated they are not confident they can deliver on the LTP without a long-term solution for social care.[22]

4.2 The failure to address this issue is now having severe impacts on people needing care, their families and those involved in the delivery of care. 74% of adult social care directors surveyed were pessimistic about the financial state of the wider health and care economy in their area – higher than last year and largely reflecting the disappointment at the lack of the long-awaited green paper.[23]

4.3 As recently as July, the DHSC again stated that a green paper on adult social care remains a priority and would be published at the earliest possible opportunity. More recently it appears that this has been abandoned in favour of a white paper, with the new Prime Minister keen to add urgency to the process.[24]

4.4 While we welcome the sense of urgency, this raises concerns as the lessons from the many previous attempts at social care reform have taught us that they will fail without consensus – and when they fail they are not attempted again for a long time. Rushing headlong into a white paper runs the risk of proposals lacking on consultation and the opportunity to garner support to introduce reforms which will stand the test of time.

4.5 CIPFA considers it critical that the challenges of funding social care are clear and understood in order to inform the development of strategic and sustainable solutions. Given the many years in which action has been restricted to short-term fixes, such solutions are now more important than ever, and should lead to long-term, strategically-informed, financially sustainable and equitable changes.

4.6 CIPFA has previously set out the key challenges that we believe have recently made it difficult to respond appropriately to social care needs. While we do not recommend any given level of spending, nor any particular system for organising the split between state and individual contributions to the costs of social care, we have recommended a 5-point plan, which the development of a sustainable system should incorporate.[25]

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[22] NHS Confederation, Unfinished business: The need to invest in the whole health and care system, 18 June 2019

[23] ADASS Budget Survey 2019, July 2019

[24] Financial Times, Boris Johnson set to pledge billions for new hospitals and social care, 30 July 2019

[25] CIPFA, Submission to HoL Economic Affairs Committee Inquiry on Social Care Funding in England, 14 November 2018

4.7 Until any long-term sustainable solution to the issue of social care funding can be implemented, it is essential that adequate funding is provided in the meantime. Spending pressures on social care have continued to rise, while local authorities have attempted to maintain levels of spending. Non-social care spending has reduced by over 30% in real terms between 2010/11 and 2017/18, as opposed to around a 5% reduction on social care services.

4.8 Recognition of the role of local government in the integration of health and social care is essential if we are to ensure social care does not place additional pressures on the NHS. Any forthcoming spending review, or budget, must provide local government with adequate funding for social care to alleviate these pressures and encourage further integration.

4.9 Certainty should also be provided around the future of those time-limited sources of social care funding that make it difficult for local government to plan for longer-term preventative solutions to reduce demand for social care services.

5. Education and training

5.1 The workforce is widely recognised as being the biggest challenge in delivering the ambitions set out in the LTP. The LTP itself states: "the NHS will need more staff, working in rewarding jobs and a more supportive culture".[26] NHS leaders have expressed concern on their ability to meet staffing needs, and state there is a compelling case for increased investment in education and training.[27] Analysis suggests that £900m investment is required over five years to deliver the policy measures outlined in the LTP.[28]

5.2 NHS trusts currently have an estimated shortfall of 100,000 full-time equivalent staff (representing around one in ten posts). This includes a shortage of around 70,000 nurses across hospital and community services and 7,000 GPs. The number of nurses working in mental health and community settings has reduced in recent years. Given the focus in the LTP on primary, community and mental health services, this is a serious concern.

5.3 Health Education England (HEE) is responsible for education and training of clinical staff and the development of wider NHS staff. HEE's budget has been reduced by £1bn, to £4.2bn in 2019/20 from the £5.3bn budget when it was established in 2013/14. Some of this reduction in HEE's budget can be attributed to there no longer being a need to pay bursary costs for nursing students. The scrapping of the nursing bursary scheme was announced in 2015, to be replaced by student loans, with the intention of increasing numbers of nursing students by lifting the

[26] NHS Long Term Plan, January 2019
[27] NHS Confederation, Unfinished business: The need to invest in the whole health and care system, June 2019
[28] The Health Foundation, The King's Fund & Nuffield Trust, Closing the gap: Key areas for action on the health and social care workforce, March 2019

perceived 'cap' created by the bursary system.[29] The changes came into effect in 2017.

5.4 In the first year under the new model there was a reduction in the number of nursing students, which could have been attributed to uncertainty around funding arrangements. However, the further reduction in 2018 suggests that this is driven by the change to student finance arrangements – in particular in comparison to the increase in student numbers seen in Scotland and Wales where bursary arrangements were retained.[30]

5.5 Recently there have been signs that the debate on nursing bursaries may be reopened. It was also revealed that some clinical placements are being funded outside the tariff system using funds given directly to nursing directors.[31]

5.6 An alternative has been proposed, with a 'cost-of-living' grant for all those studying a nursing degree to provide students with an income equivalent to the national living wage, and the exemption from tuition fees of those studying nursing via postgraduate routes. Together these measures are estimated to cost around £560m in 2023/24 – just over half the reduction in HEE's budget resulting from the reforms.[32]

5.7 At the beginning of this year, the NAO clearly stated in relation to the additional funding for the NHS: "There is a risk that the NHS will be unable to use the extra funding optimally because of staff shortages."[33] The concern is that more expensive agency staff would be required to deliver services, thus not using the additional money to best effect, or that it would go unspent if commissioners have resources to purchase additional activity, but providers are unable to deliver due to staffing levels.

5.8 The Interim People Plan has recognised the scale of the workforce challenge and the need to increase the undergraduate supply for nursing.[34] On wider CPD and workforce development, the interim plan commits to review how to increase national and local investment to achieve a 'phased restoration' of previous funding levels over the next five years.

5.9 The interim plan clearly stated: "workforce expansion plans will also need to take account of future levels of investment in education, training and workforce development, as determined through the Spending Review". So again the fully-costed People Plan, on which delivery of the LTP will depend, is awaiting the outcome of the spending review.

5.10 Investment in education and training will determine the nature of the future workforce. It is essential that levels of investment for education and training are clarified and made available as a matter of urgency.

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[29] DHSC, Department of Health's settlement at the Spending Review 2015, November 2015
[30] The Health Foundation, A critical moment: NHS staffing trends, retention and attrition, February 2019
[31] HSJ, Stevens: Nursing bursary question 'clearly back in play', Annabelle Collins, 15 July 2019
[32] The Health Foundation, The King's Fund & Nuffield Trust. Closing the gap: Key areas for action on the health and social care workforce, March 2019
[33] NAO, Report by the Comptroller and Auditor General, Department of Health & Social Care: NHS financial sustainability, HC 1867, 18 January 2019
[34] NHS Improvement, Interim NHS People Plan, June 2019

Without investment in training for current and future staff, the staffing crisis in the NHS will worsen and the ambitions of the LTP may not be realised.

6. Public health

Public health grant

6.1 Recent analysis has shown that there has been a real terms reduction in public health grant of £850m since 2014/15, a 23% reduction in real terms per person spend over the same time period.[35] The current year's public health grant stands at £3.1bn, an £85m cash reduction on last year,[36] and local authorities are expecting to spend £72m less on public health in 2019/20 than they did in 2018/19.[37]

6.2 These persistent cuts are having a clear and significant impact on local services, as was reported by the Committee in their report on sexual health.[38] 80% of NHS leaders surveyed stated that reduced public health funding has restricted the ability of their local systems to deliver on the LTP.[39]

6.3 There is wide agreement that these reductions are a false economy, creating demand pressures elsewhere in the system and storing up problems for the future. There is clear evidence of the value of spending through the public health grant, with a recent study suggesting is up to four times as cost-effective as spending by the NHS, and that therefore "the squeeze on the public health grant, while protecting NHS expenditure, over recent years is likely to have reduced health outcomes".[40]

6.4 The public health grant requires an immediate allocation of £1bn to restore real terms funding accounting for demographic change.[41] However, this would merely restore the purchasing power of the grant. It has been suggested that to ensure that the public health grant is adequate to allow for additional investment in the most deprived areas, it would require an allocation of £3bn per year over current levels.[42]

Investment in the wider prevention agenda

6.5 Last year, the DHSC committed to a green paper in their vision for prevention.[43] The resulting consultation was disappointing in terms of firm

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[35] Health Foundation & the King's Fund, Urgent call for £1bn a year to reverse cuts to public health funding, 12 June 2019
[36] DHSC, Public health grants to local authorities 2019-20, December 2018
[37] MHCLG, Local authority revenue expenditure and financing England: 2019 to 2020 budget , June 2019
[38] HoC, Health and Social Care Select Committee, Sexual health, 14th Report of Session 2017-19,HC 1419, 2 June 2019
[39] NHS Confederation, Unfinished business: The need to invest in the whole health and care system, 18 June 2019
[40] Centre for Health Economics, University of York, CHE Research Paper 166, Is an ounce of prevention worth a pound of cure? Estimates of the impact of English public health grant on mortality and morbidity, S Martin, J Lomas and K Claxton, July 2019
[41] Health Foundation & the King's Fund, Urgent call for £1bn a year to reverse cuts to public health funding, 12 June 2019
[42] The Health Foundation, Taking our health for granted: Plugging the public health funding gap, October 2018
[43] DHSC, Prevention is better than cure: our vision to help you live well for longer, 5 November 2018

proposals seeking to shift the prevention agenda forward.[44] Indeed, the detail of how specific challenges will be met is promised in a more detailed response from the government in spring 2020.

6.6 While the consultation highlights the important role of local government in public health, confirming the outcome of the DHSC's review,[45] and recognises the important of collaborative commissioning with the NHS, it fails to address the issue of adequate funding – again deferring this to a spending review. The focus appears to be more towards how to make best use of existing funding, something that local government has been doing for many years, and with little capacity to improve upon.

6.7 The consultation highlights the importance of 'place' as being integral to the implementation of preventative strategies, and the need to ask fundamental questions on how much we value prevention. CIPFA welcomes these areas of focus, and these are areas that we sought to explore in our collaborative work with Public Health England (PHE) on evaluating preventative investments in public health.[46]

6.8 This work estimated that in 2014, only around 4.7% of total health spending was on prevention. It identified existing tools and resources that could be used to evaluate preventative investment across different types of intervention and different organisations at local, regional or national level, thus allowing investment levels to be transparently and consistently reviewed and evaluated within a local system (e.g. an STP). This would enable the development of a robust evidence-base for place-based investment in prevention to ensure resources are used to provide the best possible outcomes.

6.9 Given the current climate and demands on public services and their budgets, there is a growing consensus that a stronger case needs to be made for preventative interventions, in order to compete with other priorities for valuable resources.

6.10 There is a need for a system-wide rethink on preventative investment – for it to be considered as a true investment, and for it to be reported and protected as such, yielding benefits across place and time, rather than as a way to generate savings. With the policy agenda focused firmly on population health, integration of services and prevention, the time to make this case is now.

6.11 CIPFA recommends that the government addresses the issue of public health funding – initially by providing immediate funding to reverse the impacts of the reductions to the public health grant, but also in the longer term to clarify the position for wider preventative investment, and how this can be appropriately evaluated and protected.

7. Conclusion

7.1 In our view, the ambitions of the LTP are clearly dependent on these four essential areas for which funding levels have yet to be determined:

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[44] DHSC/Cabinet Office, Advancing our health: prevention in the 2020s, 22 July 2019
[45] DHSC, Government review confirms local authorities will continue to commission public health, 7 June 2019
[46] CIPFA & PHE, Evaluating preventative investments in public health in England, May 2019

- If we want to maintain and build more NHS infrastructure to improve services, then we need to fund the capital programme appropriately.
- In order to staff these facilities and build on services provided then we need to invest in educating and training to safeguard the future workforce.
- Integrated health and social care requires adequate funding for social care to be taken into account alongside health.
- Prevention is fundamental to the vision for integrated place-based care, so levels of public health funding need to be prioritised.

7.2 The interdependencies are clear, and to expect that the LTP can be delivered without sufficient investment in these four key areas, or even certainty on levels of funding available in the short to medium term, seems unreasonable.