September 2017

NHS Providers

BUDGET REPRESENTATION

ABOUT NHS PROVIDERS

NHS Providers is the membership organisation and trade association for the 233 NHS acute, ambulance, community and mental health secondary care providers that interact with a million patients and service users in the NHS every 36 hours. We help those NHS foundation trusts and trusts to deliver high quality patient care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has 97 per cent of all NHS foundation trusts and trusts in membership that collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.

KEY ISSUES

- **The Government now has a clear choice between increasing NHS funding to a level that enables recovery of the key NHS constitutional performance standards or maintaining current proposed funding levels and setting performance standards at a lower level.** Despite significant demand, workforce and financial challenges, NHS providers have continued to do all they can to deliver high quality patient care within the allocated NHS budget. The provider sector deficit has been reduced; productivity gains much greater than the whole economy average have been realised; spending on agency staff has been significantly cut; and the quality of patient care has been maintained. However we have now reached a point where the NHS is no longer able to deliver all that is being asked of it. Despite best efforts, all four key NHS performance targets were missed last year, for the first time ever; the elective surgery waiting list is now nearing a length last seen in 2007; and trusts are warning they will struggle to recover the 95% A&E 4 hour target. The NHS now needs a realistic, prioritised, plan for the rest of the parliament that sets out what can be delivered for the funding available. The November Budget provides an ideal opportunity to set out this plan.

  On the funding element of this plan, we welcome the additional revenue funding for the NHS set out in the Conservative manifesto, and assume the Budget will set out the profile of this extra spending across the rest of the parliament. However, even taking this additional funding and an ambitious performance stretch into account, the current demand and workforce pressures mean that the existing NHS funding settlement is insufficient to enable the NHS to recover constitutional performance standards. The Government therefore needs to decide whether it will increase NHS funding to a level that enables recovery of those performance standards or stick to current funding plans and accept a lower level of performance.

  In setting this plan, it is particularly important that, unlike the 2015 spending review process, NHS trusts feel a sense of ownership of any delivery commitments made on behalf of the NHS. This sense of ownership can only be created if trusts are properly and fully engaged in the setting of any such delivery commitments. It is also vital that any NHS delivery commitments are assured to the greatest extent possible. This will avoid the unhelpful and frustrating cycle of NHS over commitment and under delivery that has dogged the last three years.

- **We welcome the Government's indication of its intention to end public sector pay restraint, and encourage the Government to now set out a plan for how this will apply to the NHS. Given the pressures outlined above, it is vital that any extra pay is fully funded or patient care will be adversely impacted.** The Government has faced a difficult choice over the last seven years in balancing investment in extra staff with restraining NHS pay. Trust leaders are now clear that workforce challenges are their biggest problem. Their view

is that pay restraint is now an important factor adversely impacting recruitment, retention and staff morale and, that after seven years, further pay restraint has become unsustainable. Trusts are looking for a clear plan on when and how pay restraint will be ended and they endorse the Government's view that the Pay Review Body structure is the best way to generate the detailed recommendations required. Trusts are clear, however, that given the pressures described above, any increase in pay must be fully funded or patient care will be adversely impacted.

- Additional capital funding provided directly by Government is required to allow providers to deliver transformation and to address a growing and concerning maintenance backlog. Trusts welcomed the Government's commitment in the March Budget to announce a multi-year capital programme to support STPs in the Autumn Budget, and further welcome the confirmation of that commitment in the Conservative manifesto. We acknowledge that there may be a number of sources of funding, but would emphasise the need for realism about how much capital funding trusts will be able to raise, at what speed, through land sales and private financing. There is also need for realism about the maturity of Sustainability and Transformation Partnerships who have been the primary forum for generating local capital plans. There will be many STPs who are still relatively immature but have legitimate capital requirements.

- The Government can do more to help the NHS respond to the challenges it faces. In particular, there are two practical steps Government could take:

    a. The work arising from the Carter Review and the Getting it Right First Time (GIRFT) programme has been at its most effective when trusts have been given the right support and time to deliver. The national NHS bodies should lead an exercise to scope in detail what further support trusts require to accelerate their work in identifying and delivering efficiencies. We believe that a low level of investment in extra change and project management, analytical and clinical liaison resource at trust level could release significant amounts of faster savings.

    b. Given sustained and deepening pressure on NHS resources, the NHS must ensure that it devotes as high a proportion of the NHS budget to front line care as possible. We believe a formal urgent review of non-frontline spend in the NHS should therefore be undertaken. This should include commissioning costs and further reductions to administration budgets from the Department of Health and its arm's length bodies. The review should target a specific amount of money to reallocate to the frontline by the start of 2018/19 or the half year point.

- The NHS is a key driver of local investment, skills and employment, and research and innovation. For too long, investment in the NHS has been seen as a "drag" on the national economy. The Government is rightly focussing on creating a vibrant, high skill, 21st century economy with jobs spread across the country, not just concentrated in London and the South East. We would therefore urge the Government to consider extra investment in the NHS as investment in its economic vision. The NHS offers a gateway into the labour market for young people, with significant opportunities for new skills and career development. It is a major employer right across the country, including areas of economic deprivation. In addition, investment in the NHS is investment in the life sciences industry, a crucial strategic sector which contributes £14.5 billion a year to the UK economy, with an additional £16 billion through the supply chain and employee spending.

THE CURRENT CONTEXT

1. The Comprehensive Spending Review allocated the NHS an additional £8bn between 2010 and 2020, amounting to a significantly lower spending increase each year on health than the long term average in the UK. The operational challenges of the remainder of this period will be considerable, and all resources that could potentially support frontline care must be deployed.

2. The provider sector has found significant efficiencies and made significant savings in recent years, and continues to do so. More than £20.5bn of Quality, Innovation and Productivity savings were made during the 2010-15 Parliament.[1] Providers achieved savings of £3.1bn through cost improvement programmes (CIPs) in 2016/17 alone - £200m more than in 2015/16. [2] The Health Foundation found that the NHS improved its productivity between 2009/10 and 2014/15 at more than four times the rate of the wider economy. [3] Trusts continue to deliver improvements in their operational productivity, but report that they frequently lack the project and change management capacity to make even greater progress.

3. While the provider sector has delivered substantial reductions in spending on agency staff and the deficit has been reduced, NHS constitutional standards are now routinely being missed, and the four hour A&E target and referral to treatment target have not been met since July 2015 and February 2016 respectively.[4] Figures for June 2017 show 3.8 million people are now on the waiting list and 92% of patients are waiting 19.5 weeks for treatment. On current resources, the NHS cannot recover the delivery of constitutional standards.

4. Alongside a funding imbalance, providers are struggling to recruit and retain the staff needed to deliver safe, high quality patient care. Growing demand and staff shortages mean NHS roles are becoming more pressured and difficult, with staff increasingly overworked and stressed. Seven years of pay restraint compound this situation.

5. As a result of these contextual factors, there is now, more than ever, a need for a system wide focus on transformation as well as sustainability. But wholesale transformation cannot be externally or nationally imposed: transforming the NHS relies on local leadership. Government should explore how best to secure a new relationship between national policy makers and local health leaders, creating the conditions and flexibilities for innovation and the delivery of care tailored to the needs of local communities, underpinned by the principles of autonomy and local accountability.

6. The pressures facing the NHS have been exacerbated by the wider challenges in other parts of the public sector, in particular social care. While the additional £2bn investment in social care until 2018/19 was welcome, the capacity and resilience of the social care sector remains an area of significant concern. An NHS Providers survey of trusts carried out at the end of May 2017 found that only 18% of NHS trusts reported they were confident that the commitments they had received from local authorities would help them meet the NHS England Mandate

[1] (https://health.org.uk/sites/health/files/FundingOverviewCurrentNHSSpendingInEngland.pdf)

[2] *Performance of the NHS Provider Sector year ended 31 March 2017*, NHS Improvement (https://improvement.nhs.uk/uploads/documents/M12_201617_provider_sector_performance_report_-_Fin_Accts_-_FINAL.pdf)

[3] *Election Briefing: NHS and social care funding*, Health Foundation, May 2017 (http://www.health.org.uk/sites/health/files/Election%20briefing%20NHS%20and%20social%20care%20funding.pdf)

[4] (https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/08/Monthly-performance-statistics-summary-Jul_Aug-17.pdf) (https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/06/RTT-statistical-press-notice-PDF-231K.pdf)

requirement to reduce delayed transfer of care levels to 3.5%, creating the required capacity of an extra 2,000-3000 beds.[5]

7. The modelling of the demand pressures set out in the Five Year Forward View, on which the 2015 Comprehensive Spending Review settlement was predicated, relied on what was referred to as a 'radical upgrade in prevention and public health'. [6] Recent analysis by the King's Fund found that, on a like-for-like basis, local authority spending on public health between 2013/14 and 2017/18 will fall by 5.2 per cent.[7] This follows a £200 million in-year cut to public health spending in 2015/16. Services with clear impact on the provider sector including sexual health, drug and alcohol services, and tobacco control initiatives are facing significant cuts as a result of constrained budgets in local authorities. Trusts therefore continue to be vulnerable to demand pressures, which are likely to continue unabated unless substantial investment is made in public health services.

8. The NHS is the biggest employer in the country, providing more than a million full-time, high-skill jobs. NHS trusts can play an important role in ensuring wages earned stay within the local economy. Providers are committed to delivering the best possible care for patients, meeting the NHS constitution performance standards and achieving financial balance, including an appropriate degree of stretch. Their strong and clear preference is for the NHS to be funded at a level that enables the average trust to deliver that aggregate task and provide safe, high-quality care.

SECURING A SUSTAINABLE REVENUE SETTLEMENT FOR THE NHS

9. While the front-loading of the £8bn allocated at the 2015 Comprehensive Spending Review mitigated the financial and operational pressures facing providers in the very short-term, the current planned increase in funding available to NHS England of 0.4% in 2018/19 and of 0.7% in 2019/20 is insufficient to recover NHS constitutional standards, meet unfunded demand and inflationary pressures, and deliver safe, high-quality patient care.[8]

10. The Government must make the difficult decision to fund the NHS at a level that allows the provider sector to recover constitutional standards, or set performance standards at a level that are deliverable. It is critical that we match the service offering to the funding now available and avoid overcommitting the NHS to an impossible delivery plan. In particular, we would note that:

a. The reality of the cost and demand pressures on the frontline mean that any decision to seek the recovery of NHS constitutional standards must be funded from new money. For example, we estimate that recovering sector delivery of the RTT target - where 92% of people are seen within 18 weeks - would have cost a minimum of £2bn to 2.5bn in 2017/18. [9] Once the backlog has been cleared, trusts would also need to have sufficient operational capacity in place to maintain performance.

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[5] *The State of the NHS Provider Sector*, NHS Providers, July 2017 (https://nhsproviders.org/media/3281/state-of-the-nhs-provider-sector_07-17.pdf)

[6] *Five Year Forward View,* NHS England, October 2014 (https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf)

[7] (https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health)

[8] (https://www.gov.uk/government/news/department-of-healths-settlement-at-the-spending-review-2015)

[9] *Mission Impossible?* NHS Providers, March 2017 (http://nhsproviders.org/mission-impossible)

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b. We welcomed the recommendations of the cancer and mental health taskforces but they add further requirements on trusts, not all of which are funded. The extra cost of the cancer and mental health recommendations in 2017/18 alone is estimated at £90-120 million and £60-80 million respectively.[10]

c. The Government has already committed to seeking a recovery of the four hour A&E standard in 2017/18. This will require significant investment given major accident and emergency departments have not met this standard consistently for more than five years.

11. We understand that the minimum additional investment of £8bn announced in the Government's 2017 manifesto relates to NHS England's budget only, which would require further reductions from non-NHS health budgets, potentially including public health and education and training.[11] This is likely to lead to implications for frontline services in the following ways:

a. *Health Education England's budget*. Government has made a commitment to increase the number of health professionals, including through training more doctors and nurses. Further cuts to HEE's budget will have substantial implications for Government's ability to meet this objective, and could withdraw essential education and training funding from frontline providers. Any reduction in education and training placements would exacerbate existing workforce shortages.

b. *Funding for arms-length bodies, including the CQC*. As we have seen with the introduction of CQC fees for providers, further cuts to the arms length bodies could lead to additional costs being shifted to the provider sector to subsidise the regulatory regime. Efforts must focus on ensuring that the regulators use available resources as efficiently as possible, rather than passing the costs of regulation on to providers.

c. *Public health budgets*. Provider trusts are already seeing substantial reductions in the critical public health services commissioned by local authorities. This has severe implications for the NHS's ability to manage demand for services.

12. The preference of NHS trust leaders is for the NHS to be funded at a level that enables the average trust to deliver against the requirements placed on them. There is now a strong case to once again frontload the £8bn investment in the NHS for the next two years to best enable the health service to deliver the requirements and commitments being asked of it.

13. In the absence of that funding there are pragmatic and proportionate steps that Government can take to maximise the limited resources available:

a. Trusts report that they lack capacity to transform as previous rounds of cost improvement programmes have stripped out the analytical and project management resource required to support changes to clinical and other practices. We would encourage the national NHS bodies, therefore, to provide the appropriate project and change management support to enable providers to deliver ever more complex work and competing priorities.

[10] *Mission Impossible?* NHS Providers, March 2017 (http://nhsproviders.org/mission-impossible)

[11] *Forward, Together,* May 2017 (https://s3.eu-west-2.amazonaws.com/manifesto2017/Manifesto2017.pdf)

b. Building on work already undertaken, the NHS should carry out an urgent exercise to examine whether money could be reallocated from local and national commissioning functions, and the arms-length bodies, to frontline care. The NHS spends an estimated minimum of £5.65 billion on non-frontline care through spend on the DH, NHS England, NHS Improvement, the Care Quality Commission, Public Health England, and Health Education England.[12] 2018/19 and 2019/20 are critical years for the NHS in which all resources must be mobilised appropriately. We recommend that the review is completed by the end of quarter 3 2017/18, and should target a specific amount of money to reallocate to front line care.

THE NEED FOR CAPITAL INVESTMENT

14. There is not currently a robust capital plan for the NHS. The capital budget for the DH has been reduced over the period 2010 to 2015 from £4.8 to £4bn, and is set to reduce in real terms during the term of the 2015 Comprehensive Spending Review (flat in cash terms at £4.8bn per annum).[13] The current capital budget available to the NHS is insufficient to enable trusts to make the necessary investment in infrastructure and assets. As we seek a world class health service for the 21st century, the upgrade of NHS estate and diagnostic equipment is essential to patient safety and operational efficiency.

15. We need to take a realistic view of the capital funding trusts will be able to raise through land sales and private financing. For example, the Naylor Review calculated that 57% of the total gross risk adjusted potential financial opportunity for the sector was accounted for by the London STPs.[14] Likewise, private financing cannot be the solution for the majority of providers. Therefore, there is a strong case for the majority of capital investment required in the NHS to be sourced directly from the Government, focusing specifically on:

a. *Backlog maintenance*. Urgent repairs are required within the provider sector, which have been constrained and delayed due to capital to revenue switches in previous years and budgetary pressures. Many trust capital maintenance schemes continue to be deferred in order to support the Department of Health in managing its expenditure limit. High risk capital backlog maintenance for buildings and equipment has increased to over £775m in recent years (NHS Digital estates data 2015/16) and the Naylor Review suggests a conservative estimate to address all backlog maintenance in the provider sector would be £5bn.[15] There is a clear benefit to the taxpayer in addressing the capital backlog before further deterioration occurs, leading to greater costs later.

b. *Transformation capital.* This includes both single site reconfiguration in those areas that have identified urgent capital requirements and STP level reconfiguration. Providers who are part of STPs with substantial capital requirements (for example, delivering IT infrastructure and clinical reconfiguration projects) must be given the necessary investment to allow them to deliver.

[12] *Mission Impossible?* NHS Providers, March 2017 (http://nhsproviders.org/mission-impossible)

[13] *A Year of Plenty?* Health Foundation, March 2017 (http://www.health.org.uk/sites/health/files/YearOfPlenty.pdf)

[14] *NHS Property and Estates,* Department of Health, March 2017 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607725/Naylor_review.pdf)

[15] Ibid

16. There are some early positive signs that the government will invest in the future of the NHS. The first tranche of £325m allocated to STPs was welcome. However, STPs are at varying stages in their development, and given the relative newness of arrangements in some areas, it is not clear that all of them would be assessed as ready and able to receive capital funding. NHS Providers recognises the value that highly developed STPs could add in providing strategic oversight of capital spend, but this is not a substitute for giving trusts timely access to the capital they need to maintain existing assets and deliver transformation.

ADDRESSING THE NHS WORKFORCE CHALLENGES

17. Workforce is the biggest long term challenge providers are currently facing. An NHS Providers survey from July 2017 found that over half of chairs and chief executives are worried or very worried that their trust does not have the right numbers, quality and mix of staff to deliver high-quality care.[16] Even if money were not a constraining factor, insufficient staff have been trained within the UK to meet current and projected demand.

18. Trust leaders tell us that seven years of pay restraint is now one of the factors preventing them from recruiting and retaining the staff they need to provide safe, high-quality, patient care. Recent analysis by the Health Foundation found that between 2010 and 2017 the real value of health and social care staff pay fell by 6%, while in the economy as a whole it has fallen by only 2%.[17]

19. We welcome the Government's recent decision to review the public sector pay cap. NHS Providers believes that it has become unsustainable to maintain NHS pay restraint for the rest of this parliament and supports the role of the NHS pay review bodies in setting the pay awards.

20. However, the funding pressures facing the sector require a balance between the need to increase the number of staff with the need to address the factors contributing to the workforce challenges facing frontline staff and employers. An average NHS acute trust's pay bill accounts for between 60% and 70% of its costs, with this proportion rising to as high as 85% for some community and mental health providers. Pay awards are a key determinant of the provider sector's financial sustainability and as such, a delicate balance must be struck to mitigate cost pressures on providers.

21. Any end to NHS pay restraint must be fully funded and cannot be covered by the current Comprehensive Spending Review settlement. For example, the Institute for Fiscal Studies has calculated that a 1% increase in NHS staff pay would add approximately £0.5bn of cost each year. Increasing NHS pay in line with inflation in 2017/18, 2018/19 and 2019/20 would cost around £2 billion more in 2019/20 than increasing pay by 1% each year in cash terms. [18] Given the existing unfunded gap between provider income and cost and demand pressures NHS Providers does not believe it would be in the best interests of patients or taxpayers for any future NHS pay award to be backdated.

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[16] *The State of the NHS Provider Sector*, NHS Providers, July 2017 (https://nhsproviders.org/media/3281/state-of-the-nhs-provider-sector_07-17.pdf)

[17] *In short supply: pay policy and nurse numbers*, Health Foundation, April 2017 (http://www.health.org.uk/sites/health/files/Workforce%20pressure%20points%202017%20FINAL_0.pdf)

[18] *UK Health Spending*, Institute for Fiscal Studies, May 2017 https://www.ifs.org.uk/uploads/publications/bns/BN201.pdf

22. Recognising the challenging timescales involved, the pay review bodies should be given enough time to conduct a full evidence gathering process ahead of any recommendation they may be asked to make for Government to consider ahead of the 2018/19 financial year. Further, any end to NHS pay restraint must be part of a wider national workforce strategy.

23. As a result of the scale of potential impact on the financial sustainability of the provider sector, a detailed plan is required for any ending of pay restraint. This would need to reflect the constraints imposed on the provider sector as a result of the 18/19 tariff already being fixed. In due course, the pay review bodies will need to consider whether any new pay award should be targeted to shortage areas - for example, by pay band, role or location. Throughout the process, the autonomy and specialist expertise of the pay review bodies should be respected and acted on by Government.

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