4 October 2019

To all Chairs, CEOs and Directors

Future Financial Architecture, System planning and FRF allocations

Dear Colleague,

As you know, NHS England/Improvement (NHSE/I) have been working to develop the NHS's future financial architecture. We have contributed to this work on behalf of members. Given the first results of this work have just circulated, we wanted to set out our understanding and view of what's been developed and the influencing work we have been doing.

Context

In the long term plan (LTP) NHSE/I committed to delivering a series of government set financial objectives to improve frontline NHS finances including:

- Continuing to balance the NHS national and aggregate provider/commissioner positions;
- Reducing the aggregate provider sector deficit each year, with the provider sector achieving overall balance by 2020/21; and
- Reducing the number of trusts in deficit year on year with every NHS organisation in balance by 2023/24. NHSE/I's initial aim is to more than halve the number of trusts in deficit this year, from 107 in 2018/19 to around 50 in 2019/20.

To support delivery of these objectives, NHSE/I is creating a new financial architecture. This reshapes financial support for the provider sector, moving from centrally set control totals and a provider sustainability fund (PSF) available to all trusts, to a financial recovery fund (FRF), targeted at trusts with deficits. The basic underlying NHSE/I aim is to:

- Set a more realistic financial task for providers, with a more deliverable efficiency requirement, enabling most trusts to deliver a surplus without central financial support;
- Move away from a centrally set control total regime to one where trusts in surplus set and deliver their own year end financial position – so that trusts in surplus explicitly get greater regulatory freedom;
- Over time, concentrate central financial support on trusts and systems in deficit to support their return to surplus. Support will be allocated in return for agreement of a financial recovery plan and at least a 0.5% higher level of efficiency saving delivery; and

- Over time, lower the amount of central financial support and enable appropriate delivery of recurrent efficiency savings to help providers return to financial balance.

NHSE/I's January 2019 board allocated future central provider financial support as follows:

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Provider Sustainability Fund (PSF)	£2.45bn	£1.25bn	0	0	0	0
Financial Recovery Fund (FRF)	0	£1.048bn	£2.048bn	£2.048bn	£2.048bn	£1.949bn
Marginal Rate Emerg. Tariff (MRET)	0	£442m	£442m	£442m	£442m	£442m
TOTAL	£2.45bn	£2.74bn	£2.49bn	£2.49bn	£2.49bn	£2.39bn

Although these top level principles were set out in the LTP, more work was needed to finalise details of how the new financial architecture would operate in practice including:

- How quickly to shift from a PSF regime, with financial support available to all, to an FRF regime with financial support concentrated on those in deficit;
- Which trusts would be able to access FRF support, to what extent and how the linked financial recovery plans and any other requirements for FRF access will work;
- More broadly, how future financial accountability and management will work, given the transition to a four tier structure of national NHSE/I, stronger NHSE/I regions, STPs/ICSs and individual providers/CCGs.

NHSE/I identified 2019/20 as a year of transition with a more reasonable financial task set for providers. This was delivered through a lower efficiency target, rebalancing the system by moving away from reliance on centrally-held risk reserves. Extra support for acute trusts was provided through compensation for the impact of the Marginal Rate Emergency Tariff (MRET). The 2020/21 PSF was reduced by £1.2bn, with £1 billion transferred into urgent and emergency care prices and £200m transferred to the new FRF, which totalled £1.048bn.

Future financial architecture review work over the last two months

Julian Kelly, NHSE/I's chief financial officer, and his team have been leading a process over the last two months to design the new financial architecture for 2020/21 to 2023/24. They have been consulting widely. For example, they created a working group of providers, commissioners and system leaders which we have sat on. They have also gathered wider views, such as via the King's Fund and directly from NHS Providers and the Shelford Group.

The work has sought to balance a number of requirements:

- The urgent need for greater clarity on future finances to enable the creation of effective four year strategic system plans, with the deadline for first drafts already passed;

- Balancing risks between moving too quickly to concentrate future financial support on trusts in deficit and tipping trusts only just in surplus back into deficit;
- Ensuring incentives work effectively across all types of trust – that all trusts are incentivised to maximise their financial position, the regulatory freedoms from returning to surplus are clear and management failure is not inappropriately rewarded;
- Delivery of overall provider sector financial balance given current dependence on, partially control total driven, trust level surpluses to offset deficits;
- In setting each qualifying trust's FRF allocation, assessing how much bespoke identification of each trust's position is needed versus use of a national formula; and
- How, given the move towards system working, the need to bring organisations into balance interacts with efforts to balance local systems.

There are, understandably, different perspectives on these issues. Trusts in deficit and trusts in surplus, for example, are likely to have different views on the speed of shift from PSF to FRF. The impact of these issues may also play out differently for different sectors, across acute, community, mental health and ambulance providers. While PSF was available to all organisations in all sectors, FRF will only be available to trusts in deficit.

Future financial architecture – initial outputs

NHSE/I has now issued each STP/ICS and constituent provider/CCG with a deficit reduction trajectory for each year between 2020/21 and 2023/24, set at a level and improvement rate that they believe is reasonably deliverable. They are also issuing FRF allocations by each year, making it clear that from 2020/21 FRF support will only be available to trusts in deficit. In addition, a "transitional reward payment" has been announced, worth 0.5% of turnover and available to trusts which are able to maintain breakeven or surplus positions – details are set out in the NHSE/I letter. We understand, if required, this will be funded separately, in addition to the existing amount set aside for the FRF.

NHS Providers influencing work over the last two months

Trusts will have different interests depending on their financial position but we have been pushing for solutions that support the sector, and the diverse range of trusts within it, as a whole. Our main arguments have been as follows.

1 The current planning process is proving very difficult as a range of key, national level, elements have been missing, including the future financial architecture. NHSE/I should calibrate their expectations of how good the first draft plans, which have now been submitted, can be.

2 The work on future financial architecture must be fully co-created with the sector.

3 The needs of all types of trusts, and each individual trust, need to carefully considered:

- While the acute sector may contain by far the highest proportion of trusts in deficit, it is vital to ensure the financial success and sustainability of the mental health, community and ambulance sectors and to address funding requirements for specialised services;
- Particular groups of trusts are also likely to have particular needs. We have, for example, worked with a group of multi-site district general hospital and small rural acute trusts in deficit, at their request, to highlight the particular issues they face;
- In determining individual trust FRF allocations, NHSE/I needs to ensure that trusts have the ability to discuss proposed allocations, for instance if trusts think they are dramatically wrong or are creating an undeliverable task. This is particularly important since they set the individual trust level financial task for the next four years. We need to avoid the "That's it, take it or leave it" approach adopted in relation to control totals. Clearly this needs to be done without creating a free for all negotiation or creating incentives for trusts to try to game the system, given that there is a fixed pot of financial support, creating a zero sum game if any trust wants to change its agreed FRF allocation. How this might work in practice, and the governance around any such discussions or decisions, has not yet been set out.

4 Given the complexity and importance of these issues, clarity and frequency of NHSE/I communications on what they are doing, and why, is key. NHSE/I should be over- rather than under-communicating here. "Showing the workings" of any centrally determined figures is important.

5 Given the growing importance of NHSE/I regions, appropriate consistency between regions is important. Full explanation and opportunity for debate is needed if individual regions take individual approaches – for example creating regional risk reserves.

6 We have also flagged that we are concerned about any move from managing finances at individual provider level to local system level. We recognise that some advanced ICSs are ready to move in this direction and they should be supported to move voluntarily in this direction as fast as they are able. But, in many systems, trying to force this move too quickly is likely to cause confusion and increase risk. Formal legal and accounting officer accountability for provider finances lie with a unitary trust board and the trust chief executive and it would be wrong to blur these without an approach that has been co-created and agreed with the sector.

7 If local systems and regions are to be the setting for discussions about adjusting initial, centrally created, deficit reduction trajectories and FRF allocations, there is a need for realism about their present capability and capacity to perform this task. NHSE/I need to work with the sector to identify what support, resource and system or process is needed to enable meaningful and effective discussions of this type.

NHS Providers view on the approach adopted

We welcome the degree of consultation on the overall approach and NHSE/I's desire to understand the perspectives of different types of trust. We welcome the clarity that is brought by having indicative figures.

While we recognise NHSE/I's desire to avoid opening a negotiating free for all, it is difficult to determine how much room there now is for providers to discuss and debate their deficit reduction trajectories and FRF allocations if they believe they are dramatically wrong. This feels particularly important given that these allocations have been made via central formula, with some regional input, rather than a bespoke identification of each trust's needs. While the recent NHSE/I letter does include an appendix breaking down the various factors underpinning a trust's recovery trajectory, such as MRET funding, efficiency and other impacts, it is not clear that this will result in a trajectory that providers and local systems agree is achievable. We'd like to hear your feedback on how this progresses.

The decision to create a reward fund for trusts who achieve a balanced position or better will be welcomed by members who had been concerned about the impact of losing PSF, as it mitigates the 'cliff edge' effect of moving to an FRF-only world in a single year.

We were unaware that the FRF would be available to CCGs as well as providers. We understand this will be funded by rolling in the existing commissioner sustainability fund, and will want to see sufficient resources made available to providers. We also think that the move to system financial management underpinning the approach here needs further collaborative discussion and work. We're also keen to understand the basis of, and rationale for, the regional risk reserves that some regions are now creating and whether this is being done consistently or not.

In short, this was always going to be a difficult process given the competing interests involved. It's definitely a good and important step forward to get some indicative figures. But we need your feedback on whether you think what's being asked for is deliverable and whether you get sufficient scope to discuss that ask if it's impossible to deliver. This is clearly a new process, with new bodies such as local systems and NHSE/I regions involved, so we will need to develop clear, new governance accordingly. It is critical that the right governance framework is put in place to enable the new architecture to work effectively and to set out clear lines of accountability.

Capital

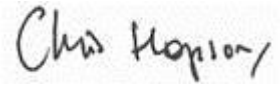
It is worth adding that we continue to push hard on capital issues. You will have seen the launch of our "Rebuild the NHS, creating a 21st century healthcare system" campaign. There has been good and welcome progress on hospital rebuilds and reversing the proposed 2019/20 20% cut in capital spend. But these announcements have been piecemeal and the overall strategic context is missing. There are also very obvious gaps – we will be pointing this weekend, for example, to the complete absence of longer term investment in mental health estate in the most recent high-profile announcement. We are also arguing that capital investment is often the key to delivering maximum value out of revenue funding, and that it is very difficult for local systems to create meaningful four year strategic plans without knowing how much capital will be available and how it will be allocated.

There is promising collaborative work under way to design a new capital prioritisation and allocation system, to which we are contributing. The latest letter on the future financial architecture includes an

explicit mention of the Department of Health and Social Care's Health Infrastructure Plan (HIP), published on 30 September. Our briefing on the plan can be found here. Broadly, we welcome the government's acknowledgement of the need for a new capital settlement for the NHS but are concerned a lot of detail and gaps remain to be filled.

We hope you find this letter/briefing helpful. Your feedback would, as ever, be very useful. Please email David Williams, our senior policy adviser, on david.williams@nhsproviders.org.

Yours sincerely,



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