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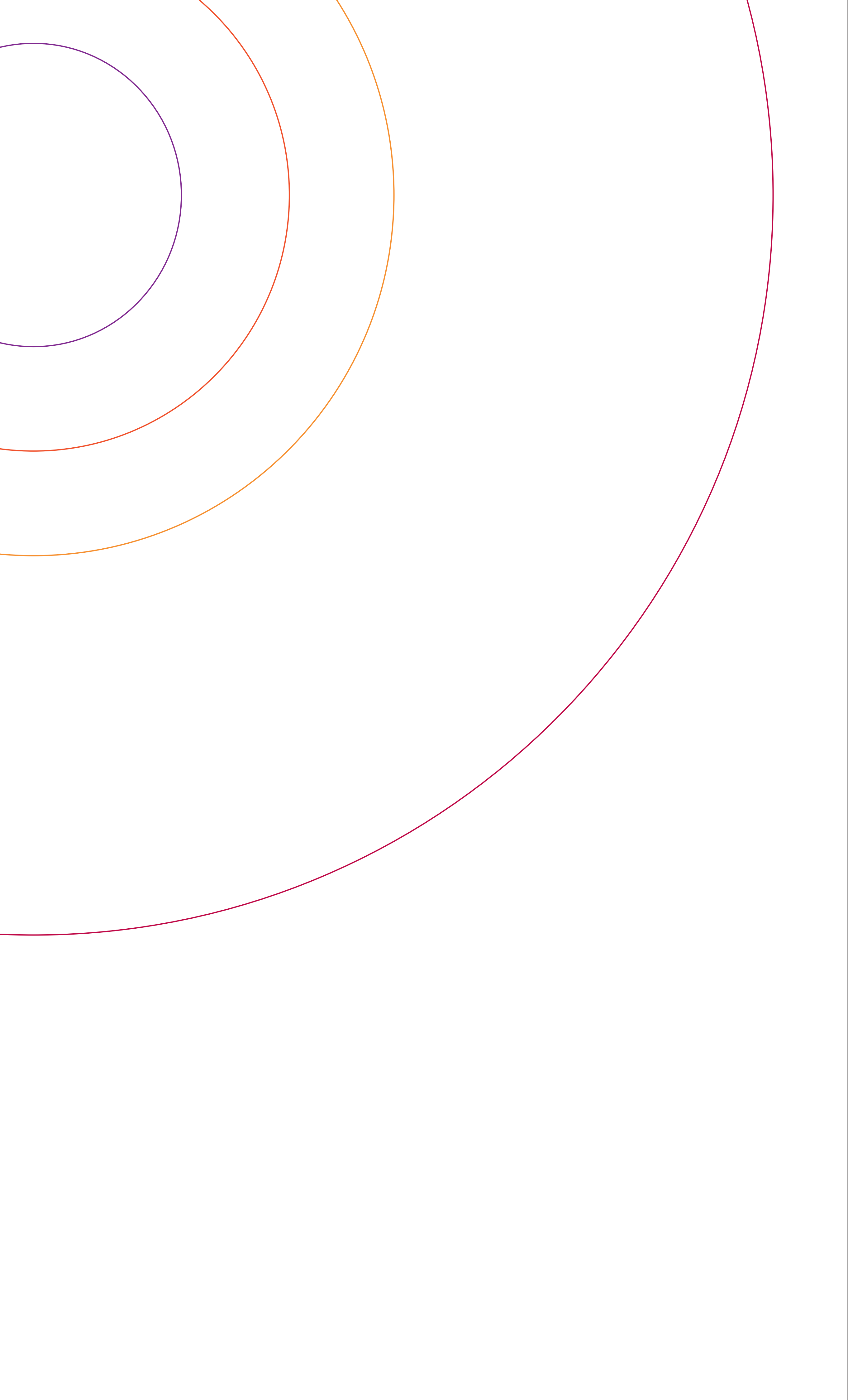
NHS Providers



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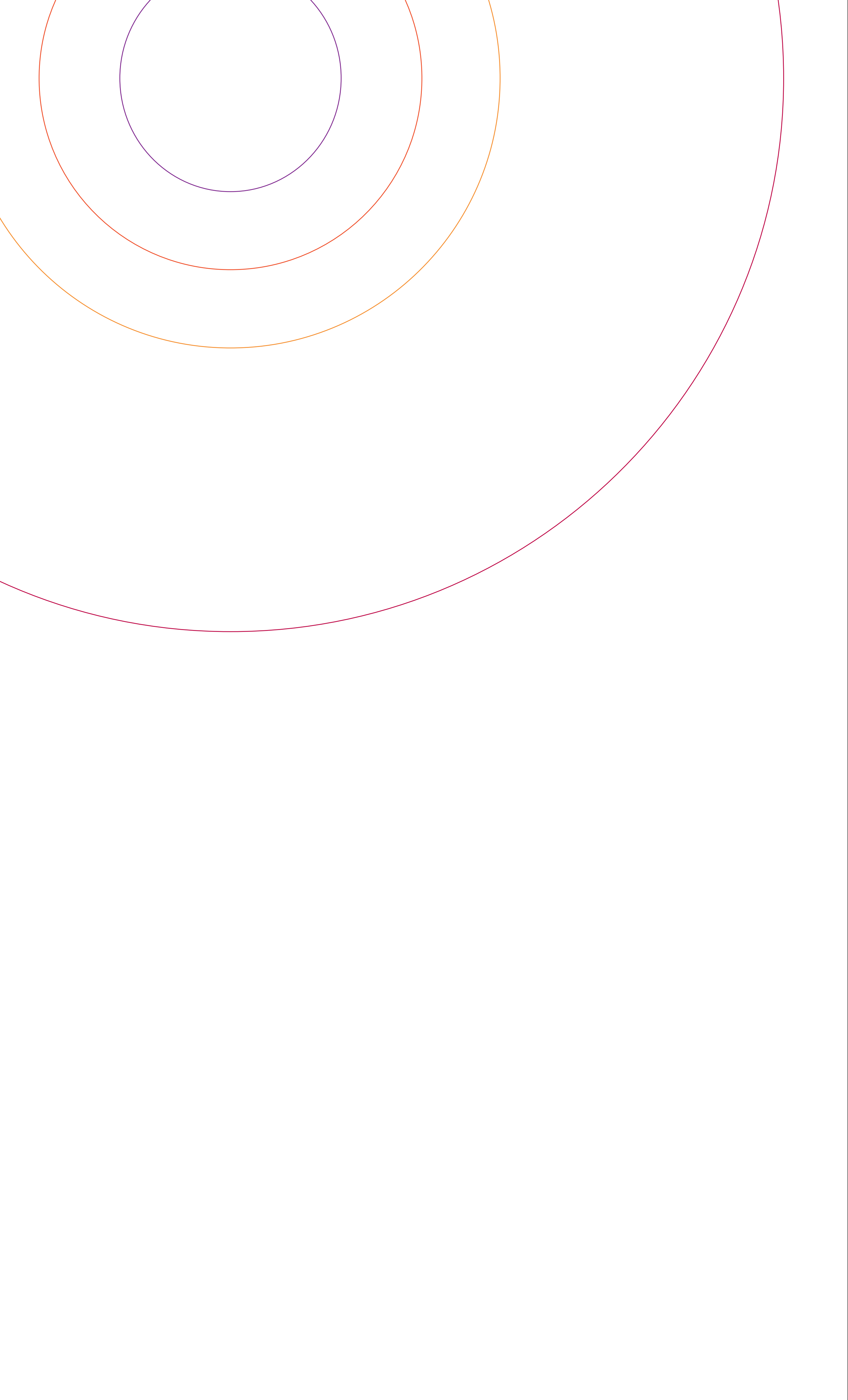


FOREWORD

This is the fourth in our series of reports that examines the state of the NHS provider sector. This year we publish at a time of considerable uncertainty for the NHS, and for public services more generally, as we stand on the brink of the third general election in five years, amidst a polarised debate about the country's relationship to the European Union.

Against this backdrop of political and social flux, the NHS, and the provider sector, are seeking to answer some big questions about the future which go to the heart of a much needed public debate about how we ensure the NHS remains sustainable and meets the expectations of the public in future years. How do we improve and sustain quality of care in a time of rapidly rising demand and constrained public finances? How do we build a positive culture of engagement across the health and care sector to attract, retain and develop talented and caring individuals at every level? How do we make a fundamental shift to population health and prevention using new and different models of service delivery? How do we develop an operating model for the NHS which takes account of national, regional and local responsibilities and reinforces agreed behaviours by leaders at all levels? And how do we move successfully to local collaboration within systems from a long-established approach based on individual institutions?

This report is a commentary on how the provider sector is performing, the challenges that trusts and their partners are facing, and the support they need as we look ahead to delivering the aspiration and the commitments set out in the NHS long term plan (the plan). *The state of the NHS provider sector* offers a unique combination of our own policy analysis and commentary, published data and, most importantly, the views of the chairs and chief executives who run hospital, mental health, community and ambulance services in England. It is they who are responsible for ensuring their trusts provide outstanding patient care 24 hours a day, 365 days a year, and they who are best placed to identify key trends. We hope it proves a helpful addition to the debate about the future direction of the NHS.

We are, of course, grateful to the trust chairs and chief executives who took the time to complete the survey and give us their views. This report would not be possible without them.

Chris Hopson
Chief Executive, NHS Providers

Saffron Cordery
Deputy Chief Executive, NHS Providers

KEY POINTS

Our analysis shows the following key issues need to be addressed in support of a sustainable NHS provider sector, well placed to play its role in delivering the long term plan. Trusts need:

- **Realism about the scale of the challenges facing the NHS, underpinned by an informed public debate on its future direction**
  The long term plan rightly sets out an ambitious vision for the NHS over the next ten years, but transformation at scale will take time and investment beyond the additional funding government has provided. As demand for services grows, current models of delivery are strained. Public satisfaction with the NHS is falling and many of the standards in the NHS constitution have not been delivered for some time. 91% of respondents to our survey said we need more public debate about the future direction of the NHS. Trust leaders would therefore welcome:
  - continued support from the national bodies, particularly NHS England and NHS Improvement, in making the case for sufficient and timely investment in the NHS to support the ambition of more integrated, personalised care
  - engagement from politicians in an open and informed public debate about the future direction of the health service, what it is expected to deliver and the level of investment required to ensure its sustainability
  - renewed political commitment to ensure a sustainable social care system.
- **A funded, credible NHS people plan**
  Only 29% of respondents were confident that their trust has the right numbers, quality and mix of staff in place to deliver high quality healthcare to patients and service users, and almost six in 10 (59%) were worried this was not in place. The interim people plan has been a positive step forward in prioritising and addressing these issues, however, solutions to longstanding issues in workforce planning will take time. The main barriers can be overcome by:
  - focusing nationally, regionally and locally on culture and modelling positive, inclusive leadership behaviours at all levels of the system
  - a significant increase in national funding to train up more people with the right skills, with an eye on new and more integrated roles
  - a flexible immigration system that ensures that trusts can continue to recruit all the staff that local services need, now and in the future.
- **Clarity around the quality standards the public can expect from the NHS, with the underpinning resources for trusts and their partners to deliver them**
  Despite trusts working flat out, the NHS has slipped back against all its key performance targets over the last four years. Although trusts were

positive about the quality of care they provide, concern about demand featured strongly in our survey, with 61% of respondents saying they were worried about whether their trust had the capacity to meet demand for services over the next 12 months. High-quality and safe care in the NHS can be supported by:

- a focus on developing open, 'no blame' cultures by trust boards in line with the national patient safety strategy, with investment in quality improvement methodologies
- ensuring learning from the clinical review of access standards is central to a debate with government, politicians, healthcare bodies, clinicians and the public about the funding required to ensure the health and care sector can meet the public's expectations.

- **Whole system investment**
  Despite the £20.5bn funding settlement, and welcome commitment to return the provider sector to balance by 2023/34, only 35% of respondents thought their trust's financial performance would improve over the next 12 months, with 23% predicting it would deteriorate. For the NHS to thrive and derive maximum value from the additional money it has received, there needs to be:
  - a multi-year capital settlement which brings investment in the NHS in line with comparable western countries; and a streamlined approach for providers to access capital
  - sufficient funding for public health and a sustainable social care system supported by a long term funding settlement.

- **Support for integrated care and system working**
  The long term plan places system working at the heart of work to improve care quality and sustainability. However, the measures set out in the plan are ambitious and will pose challenges in areas where relationships between NHS organisations and other stakeholders are less well developed. Only 29% of respondents were confident that transformation activity in their local system would progress as well as it needed to over the next 12 months to deliver the plan's aspirations. Ensuring the success of system working relies on:
  - maintaining good governance as local health and care systems evolve, ensuring proposed changes to legislation are developed with the sector
  - holding trusts and local system partners to account through proportionate and efficient regulation and oversight which is aligned with the new model of system working
  - ensuring trusts have access to the investment and support they need to take advantage of new technologies and innovations to transform care.

OVERVIEW

There is much to be proud of within our NHS and within the NHS provider sector specifically. The NHS provides free care at the point of need for 56 million citizens and employs 1.2 million people (NHS Digital, 2019a). The NHS is the largest employer in the country and trusts act as anchor institutions in local communities, with a reach spanning far beyond healthcare in terms of the economic and social value they add for their population. The Commonwealth Fund ranks the NHS favourably relative to other countries on measures including quality of care, efficiency and equity (The Commonwealth Fund, 2017). Given the right resources, trusts have long shown how they can make huge gains in improving care quality including improving outcomes for heart conditions (British Medical Journal, 2016), improvements in cancer survival rates (Cancer Research UK, 2019), reducing infection (Gov.UK, 2016), introducing talking therapies across the country (NHS Digital, 2019b) and increasing access to perinatal mental health services (NHS England, 2019a). In fact, the provider sector has driven up Care Quality Commission (CQC) ratings over the last few years despite the significant challenges it faces (NHS Improvement, 2019a).

Yet we all agree there is much more to do. As our population changes and ages, demand for health and care services is increasing year-on-year with patients often presenting with greater acuity and more complex needs. Patients, service users and the public now expect different things of their health services, including more personalised care, effective use of the latest innovations and technologies, and access to more integrated services in convenient locations. There is a general consensus across the sector of the benefits of embracing population health management, of addressing the wider determinants of health and of moving to a more preventative model of delivery.

The long term plan sets out a welcome vision to deliver these future aspirations through a renewed focus on integrated care systems (ICSs) and sustainability and transformation partnerships (STPs), accompanied by a real terms funding uplift of £20.5bn a year over a five-year period, with a commitment to see the provider sector return to financial balance by 2023/24. However, questions remain as to how far this will stretch, as the NHS seeks to absorb additional demand in existing models of delivery, and simultaneously transform to offer more modern, integrated and personalised care.

Although the NHS settlement was generous relative to other public services, the size of the increase is smaller than the long run average and the average annual increase across the period between the establishment of the NHS in 1948 and 2010 (when 'austerity' began) (Institute for Fiscal Studies, 2018). NHS frontline care has been impacted by budget cuts in other areas of public expenditure in recent years, most notably in public health and social care, and remains dependent on those

services receiving sufficient funding to operate effectively. Repeated NHS capital to revenue switches have left a maintenance backlog of £6bn (The Health Foundation, 2019) in trusts across the country. There is a clear need for a doubling of the NHS' capital budget, a multi-year capital settlement and a more streamlined and transparent process by which trusts can access capital. Finally, a multi-year settlement for the education and training budget has yet to be confirmed, leaving trusts unclear as to how workforce planning will operate and be funded in coming years.

The long term plan contains over 300 commitments for providers and their partners to deliver as part of an ambitious vision to move to system working. While the vast majority of these have been individually welcomed by providers, in the current context, our survey this year indicates that greater prioritisation will be needed to enable the sector to deliver a realistic 'ask' within the resources available.

In fact, the question of how far NHS funding will stretch becomes all the more pertinent when we evaluate the backdrop of transformative change currently facing the NHS. This includes: the cultural shift required to support a new collaboration between NHS England and NHS Improvement at the national level and the potential for a targeted NHS Bill to support the delivery of more integrated care, the establishment of new joint NHS England and NHS Improvement regional teams with responsibilities for regulation, improvement and relationship management, the evolution of ICSs as they seek to take on more collective responsibilities, the fast paced consolidation of the commissioning landscape as clinical commissioning groups (CCGs) reduce dramatically in number, opportunities for trusts to work together in new ways, in alliances, groups and by consolidating and the formation of primary care networks (PCNs) and other collaborations with primary care, social care and other partners, at the neighbourhood level. The scale of this transformation, and the leadership capacity and resource required to deliver it successfully at all levels of the system, must not be under estimated.

This cocktail of constrained finances, coupled with over 100,000 vacancies across the NHS workforce (and more across primary care and social care) means there are signs that parts of the country remain under considerable strain as they seek to absorb additional demands for care. The mismatch between demand and available resources is putting the NHS delivery model under demonstrable strain, most evident perhaps in the fact that trusts and the wider health and care sector, can no longer deliver the constitutional standards around access to care set out in the NHS constitution. CQC has commented on the 'integration' lottery (Care Quality Commission, 2018) presented by the current system and this year public satisfaction with the NHS overall fell to 53% – a 3% point drop from the previous year and the lowest level since 2007 (The King's Fund, 2018).

Equally concerning are aspects of the NHS staff survey results (NHS Staff Survey Results, 2018) which show a rise in bullying and harassment and a need to support staff wellbeing and address stress in the workplace. The interim people plan rightly places priority on ensuring the NHS is 'a great place to work' by embedding a transparent culture of engagement at all levels of the system. However, supporting and developing the NHS' talented and dedicated workforce will remain a central priority as we enter a period of change.

In this report we have sought to set out the scale of the challenge and opportunity facing trusts, and the wider health and care sector, as they seek to deliver the worthy aspirations of the long term plan.

We know that the NHS is a vital and caring institution with huge strengths on which to build for the future. Shoring up its success will mean answering questions which go to the core of the quality of care we all wish to deliver for the public, the investment of tax payer funds required to ensure sustainable services and the delivery model trusts and their partners will be adopting as the NHS moves forwards with system working.

THE STATE OF THE NHS PROVIDER SECTOR

QUALITY AND PERFORMANCE

1

Summary

Trust boards' core priority remains the quality of care they provide to patients and service users. This key priority has been supported by almost a decade of national and local focus on improving patient safety, organisational learning and more recently, quality improvement methodologies. In the past three years, CQC quality ratings of trusts have improved overall despite a challenging context. Trust boards and their staff put in a considerable amount of hard work to raise standards and be recognised as well-led organisations. In 2018, CQC reported that despite the continued growth in demand for services, financial constraints and workforce shortages, quality overall had been maintained and in some cases improved, often thanks to "the focus and hard work of care staff and their leadership teams" (Care Quality Commission, 2018).

Despite this, in 2018 public satisfaction with the NHS fell to 53%, the lowest level since 2007 (The King's Fund, 2018). CQC has highlighted the variability in access to services across the country and an 'integration lottery' dependent on the strength of relationships between local partner organisations. Although the quality of patient care and clinical outcomes are now measurably better for key major conditions than they were a decade ago, research into cancer survival rates and other international comparators show where the UK is still lagging behind the health systems in many of our European and Commonwealth counterparts (OECD, 2017).

53%

of the public were satisfied with the NHS in 2018, the lowest level since 2007

Alongside a clinical review of access standards, the long term plan contains worthy but ambitious proposals and targets for improved outcomes spanning maternity and neonatal care, children and young people's mental health, learning disability and autism, cancer services, adult mental health, respiratory disease, stroke services, diabetes and cardiovascular disease. The successful implementation of these plans will depend on how far the health and care sector can address the mismatch between demand and capacity across the NHS, coupled with addressing workforce challenges, which have a direct impact on patient experience and access to timely care.

The provider challenge

Patient safety and culture

We know that quality of care is impacted by a trust board's ability to create a transparent, 'just' and inclusive culture in which staff feel empowered to both raise concerns and innovate. However, in its new patient safety strategy published in July, NHS Improvement warns that the NHS "does not know enough about how the interplay of how normal human behaviour and systems determine patient safety". The strategy highlights a tendency for people to fear blame and close ranks, rather than maximising what goes right and focusing on the need to improve (NHS Improvement, 2019d).

Trusts therefore face a challenge in seeking to create an environment in which staff feel empowered to raise issues of concern or to flag mistakes they have made, without fear of blame, despite intense operational pressures. In recent years, there has been much more focus from trust boards on developing 'bottom up' quality improvement methodologies to create a culture of continuous learning and improvement and to empower staff to take action to improve patient care.

One of the challenges facing trust boards as they seek to embed a transparent culture of continuous improvement, is the sheer number of competing priorities required by the national bodies, which are often ambitious, considering workforce and funding constraints. Trusts are expected to keep services running day to day and at the same time:

- facilitate cultural shifts across multi-site and multidisciplinary organisations
- improve and innovate in clinical practice
- build new relationships with local, regional and national system partners
- operationalise numerous elements of the long term plan, including playing an active role in system working and contributing to system plans which will transform the way that services are designed, commissioned and delivered for local populations.

Within the current operational context, it is also important that leaders at all levels of the system, nationally, regionally and locally model constructive, collaborative behaviours. In addition, the national policy and regulatory environment should be supportive of focusing on service improvement and innovation, as opposed to unnecessarily burdensome performance management approaches which can form a resource intensive distraction for boards and frontline staff who are already stretched to deliver multiple priorities.

The impact of rising demand

The demand for health and care services has been increasing year on year as the population grows and ages, resulting in a fundamental mismatch between capacity within the NHS and the number of people trying to access services. The issue is not limited to one part of the provide sector, nor is it just about increasing bed capacity in hospitals or in the community. The following figures illustrate clearly the pressures facing the provider sector as a whole:

- the number of people in contact with NHS funded secondary mental health, learning disabilities and autism services on 30 June 2019 was nearly 1.4 million, an increase of 50,524 compared to the average number of people in contact at the end of each month between June 2018 and May 2019 (NHS England, 2019c)
- there were 1.6 million new referrals to psychological talking therapy services in 2018-19; 11.4% more than in 2017-18 (NHS England, 2019c)
- in a survey of mental health trusts we conducted at the end of last year, an overwhelming majority (81%) of trust leaders said they are not able to meet current demand for community child and adolescent mental health services and 58% said the same for adult community mental health services (NHS Providers, 2019a)
- emergency admissions to acute hospitals increased by 6% from 2017/18 to 2018/19, resulting in an additional 352,530 hospital stays on the previous year
- the number of people on the waiting list for diagnostic tests has grown by 16% from June 2017 to June 2019
- there was a 4% increase in the number of calls received by ambulance services between April to August 2019 when compared to the same period last year
- demand in the community is harder to measure due to the lack of available data. However, in a survey of community trusts we conducted last year, 59% of trusts said their local community service provision was not able to meet the current demand for adult community services. Half of respondents also said the demand for planned community services such as physiotherapy and podiatry was not being met. One trust leader that we interviewed said that demand for some services had gone up by almost 50%.

The mismatch between capacity and demand was unsurprisingly a key concern in responses to this year's survey, with 61% of respondents saying they were worried about whether their trust had the capacity to meet demand over the next 12 months. Only a fifth of respondents were confident that this would be the case. Respondents from acute trusts (77%) were more likely to be worried about their capacity to meet demand over the next 12 months than those from other types of trust.

"We have seen massive growth in demand over the past year (18% elective referrals, 11% A&E) and it is not slowing down. Estate issues are a particular concern as we have now run out of space and can't get our pre-approved capital loans released. Workforce is the other concern as we cannot grow our staffing levels fast enough to keep pace with demand either."

CHIEF EXECUTIVE, ACUTE TRUST

"The main concern is workforce shortages but we also have bed capacity shortage and a capital case for a new ward which has been stalled for two years, first by lack of national capital and then by freezing of local capital."

CHIEF EXECUTIVE, ACUTE TRUST

The impact of rising demand and workforce challenges is evident in how the sector is performing against key waiting time standards. As demonstrated below, the sector has been performing more poorly against the ambulance, A&E, elective care, cancer and diagnostic constitutional standards in the past few years. Mental health trusts also tell us that waiting times for psychological therapies, and the use of out of area placements (OAPs) are increasing as demand for care outstrips the capacity trusts have to respond in a timely way.

81%

of mental health trust leaders said they are not able to meet current demand for CAMHS

Figure 1
Trust sector delivery against NHS constitutional standards 2012-19

Year	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Ambulance red 1 calls Standard: 75% responded to within eight minutes	74%	76%	72%	73%	69%			
Ambulance category 1 calls Mean response time of seven minutes						Transition year of new standards	7 mins 18 secs	7 mins 5 secs
A&E Standard: 95% treated, admitted or discharged within four hours, all units	96%	96%	94%	92%	89%	88%	87%	78%
Elective treatment Standard: 92% begin treatment within 18 weeks	94%	94%	93%	92%	91%	89%	89%	89%
Diagnostic treatment Standard: <1% waiting more than 6+ weeks	1%	1%	2%	2%	1%	2%	3%	4%
Cancer waiting time Standard: 85% of patients receive first treatment within 62 days following urgent referral from GP	87%	86%	83%	82%	82%	82%	80%	79%
Cancer waiting time Standard: 93% of patients to wait two weeks between an urgent GP referral and seeing a specialist	96%	95%	94%	94%	94%	94%	93%	92%

(NHS England, 2019)

Delivering key access standards is difficult for the majority of trusts. For example, in April 2014, 61 providers with a type 1 A&E department met the four-hour standard in A&E. By April 2019, this figure fell to just

five as shown in figures 8 and 9. For mental health trusts, we also know that increasing numbers have to resort to placing service users out of area as they do not have capacity. These operational challenges are not confined to one sector or region.

Figure 2

Percentage of all A&E attendances less than four hours from arrival to admission, transfer or discharge in April 2014

81.8	82.3	83.6	84.1	84.6	84.6	84.9	85.2	85.7	86.1
86.5	87.0	87.6	87.9	88.2	88.3	88.3	89.1	89.1	89.5
89.6	89.8	90.2	90.4	90.5	90.6	90.6	90.6	91.0	91.1
91.2	91.5	91.5	91.8	92.0	92.1	92.3	92.3	92.3	92.5
92.7	92.8	92.9	93.0	93.3	93.4	93.4	93.4	93.5	93.6
93.7	93.7	93.8	93.9	93.9	94.0	94.1	94.1	94.1	94.1
94.2	94.2	94.2	94.2	94.3	94.3	94.4	94.4	94.5	94.5
94.6	94.6	94.6	94.6	94.7	94.7	94.8	94.8	94.8	94.8
94.8	94.9	94.9	95.0	95.0	95.0	95.0	95.1	95.1	95.1
95.1	95.2	95.2	95.3	95.4	95.8	95.8	95.9	95.9	95.9
95.9	96.0	96.1	96.1	96.1	96.2	96.2	96.3	96.3	96.4
96.4	96.5	96.6	96.7	96.7	96.8	96.9	97.0	97.2	97.3
97.4	97.4	97.5	97.6	97.6	97.6	97.7	97.8	97.9	97.9
97.9	97.9	98.0	98.0	98.0	98.0	98.2	98.3	98.4	98.5
99.0	99.1	99.2	99.2						

Figure 3

Percentage of all A&E attendances less than four hours from arrival to admission, transfer or discharge in April 2019

50.6	53.5	55.1	56.4	57.2	59.6	59.9	60.2	62.0	62.3
62.5	62.8	63.7	64.7	65.5	65.7	66.0	66.1	67.5	67.6
68.0	68.1	68.5	69.4	69.4	69.6	69.6	69.7	69.7	69.7
70.0	70.3	70.3	71.1	71.2	71.3	71.4	71.5	71.7	71.8
71.8	71.9	71.9	72.5	72.5	72.7	73.3	73.3	73.5	73.6
73.9	73.9	74.1	75.3	75.3	75.4	75.8	76.2	76.5	76.7
76.9	77.0	77.3	77.7	77.9	78.1	78.3	78.5	78.6	78.7
78.8	79.0	79.2	79.4	79.6	79.6	80.0	80.1	80.1	80.5
80.6	80.6	80.7	80.9	81.0	81.1	81.1	81.6	81.9	82.1
82.2	82.6	82.6	82.7	83.1	83.6	83.9	84.2	84.6	84.7
85.2	85.4	85.5	86.0	86.0	86.0	86.2	87.7	87.7	88.4
88.6	89.0	89.1	89.3	89.4	89.5	89.7	90.0	90.1	90.2
90.6	91.1	91.4	92.6	92.9	93.0	93.1	93.6	95.2	95.5
96.0	96.5	97.8							

However, trust leaders remain relatively optimistic for the future. When asked to consider whether their trust's performance against targets would improve or deteriorate in the next 12 months, 48% of respondents thought it would improve, 30% felt it would stay the same and 21% said it would deteriorate. Results for this question were broadly similar to 2017, and markedly higher than in 2016, when only 30% of respondents thought performance would improve. This may be a reflection of the additional funding for the sector provided via recent changes to the funding balance between CCGs and providers or the additional funding provided for the NHS overall within the long term plan.

"We have turned a corner, and have foundations on which to build, but the continuing pressure and need to react means that it is hard to get ahead of the curve. Refreshed executive leadership is providing added impetus, and there is a rising mood of confidence and positivity."

CHAIR, ACUTE TRUST

"Our cancer waits will improve considerably as we are redesigning all our main pathways, we won't be able to afford additional capacity, so performance is dependent upon redesign work rather than buying people or kit."

CHIEF EXECUTIVE, ACUTE TRUST

Recovering performance and delivering the long term plan

The long term plan contains a large number of proposals and targets for improved outcomes across a wide range of clinical areas and implementing these plans, while at the same time recovering performance, will be a critical task for trust leaders in the coming years.

Transformation at scale will take time and investment beyond the additional funding government has provided. The sector will need support from national bodies to prioritise and their success will depend to a significant extent on service transformation, system working and efforts to better manage demand across health and care.

NHS England and NHS Improvement launched a clinical review of NHS access standards in February 2019 (NHS England, 2019d), with a commitment to review existing constitutional standards and to seek to develop new measures for mental health. Alongside this, the long term plan makes a commitment to introduce new standards for community services including investment to improve the responsiveness of community health crisis response within two hours of referral (where judged clinically appropriate) and reablement care within two days of referral for those patients judged to need it. The aims and objectives of the review are commendable, and it is right that we reflect modern

clinical practice in the access standards the service sets out to the public in the NHS constitution. However, it will be important to ensure the process of reviewing the standards is transparent, rigorous and inclusive. It will also be key to ensure any new measures are fully resourced and do not unintentionally add further pressure to overstretched frontline services.

What does this mean for patients and service users?

Use of quality improvement methodologies by trusts, such as Leeds Teaching Hospitals NHS Trust, and Surrey and Sussex Healthcare NHS Trust, has the potential to help build a culture of continuous improvement which will be of direct benefit to patients, service users and staff. We know there is a clear link between staff engagement and the quality of care provided, so the more trusts can do to support and empower every member of their staff team, the better the environment in which to provide high quality care.

However, without a clearer sense of the future direction of the NHS, and a more public debate about what can be delivered within the funding envelope available, frustrations with the service may continue to rise. Growing waiting times and an over stretched workforce seeking to care for rising numbers of patients both have a clear and very direct impact on patient experience, timely access to care and outcomes.

How providers are responding

Over the past few years, the provider sector has significantly deepened its understanding of how organisational conditions such as good leadership, a just culture, an engaged and diverse workforce all serve to improve patient outcomes and patient experience.

Trust boards are continuing to develop cultures where people are encouraged to innovate and speak up in line with the national patient safety strategy. Trusts are innovatively using quality improvement methods and applying human factors and nudge theories to better understand human behaviour. This is enabling trusts to improve patient flow, adapt patient pathways, define new care models, change patient behaviour and improve staff engagement.

61%

of trusts were worried about whether they had the capacity to meet demand over the next 12 months

Part of the important necessary culture shift within the NHS is the need to create a diverse and inclusive workforce. There are a range of barriers that trusts face in this area, including the make-up of the board itself not reflecting the diversity of the wider workforce or the local population. Updating trust HR and working policies, engaging with staff through equality and diversity forums or inclusion cafes, implementing initiatives such as reverse mentoring or coaching, are just some of the steps NHS leaders are currently taking to build the foundations to foster an inclusive workplace and begin to provide inclusive leadership.

WORKFORCE

Summary

The greatest asset the NHS has is a committed and caring workforce. Colleagues across the health and care sector agree on the need for cultural change to ensure the NHS workforce is as diverse as the population it serves, to address bullying concerns and to ensure leaders model collaborative and supportive behaviours within national bodies and regional teams, as well as at the frontline. Yet, workforce challenges are among trust leaders' greatest concerns (The King's Fund, 2019) with staff shortages and a historically confused approach to national strategic workforce planning affecting providers' ability to offer sustainable services.

June 2019 saw the publication of the NHS interim people plan (NHS Improvement, 2019c) which will be consolidated into a final people plan. The interim people plan sets out approaches for improving the NHS working environment, strengthening the leadership culture, tackling nursing shortages and future-proofing the workforce.

Provider leaders also have a significant role as key players in new health systems working to articulate local workforce requirements and implement more locally rooted workforce strategies. As part of this task, they will ensure that workforce strategies reflect new ways of providing health and care, and that organisations are able to deploy staff in a way that best reflects the skills mix needed to provide effective and efficient services for their communities.

The provider challenge

Making the NHS the best place to work

Reflecting the challenge of high vacancy rates and worrying signs of stress and burnout at the frontline, the starting point for the interim people plan is that the NHS needs to be a better place for staff to work. This relies on leaders at all levels modelling the right behaviours. It also means ensuring the NHS offers attractive package of pay, terms and conditions, flexibility, work-life balance, and career progression to new joiners and those within the service.

Building an inclusive culture built on staff engagement

The interim people plan has made a commitment to set out what staff can expect from the NHS as an employer. This includes fostering a healthy workplace culture, a focus on promoting inclusion and widening participation, action to tackle bullying, harassment, violence and abuse,

and career development and education goals. Importantly, there will be an emphasis on whistleblowing and speaking up, as well as work to improve physical and mental health, and to reduce sickness absence. It also emphasises work to improve the leadership culture within the NHS and proposes that as the NHS shifts to greater system collaboration, it will necessitate "systems-based, cross-sector, multi-professional leadership, centred around place-based healthcare that integrates care and improves population health".

A diverse and inclusive workforce is critical to providing high-quality care. Different studies demonstrate the strong link both between diverse and inclusive leadership (Harvard Business Review, 2019), with a diverse and inclusive staff team, and quality of care (The King's Fund, 2015). To date there have been a number of initiatives and approaches – such as the workforce race equality standard (WRES) – to seek to improve representation of black and minority ethnic groups in our workforce which have made some progress. The WRES approach is now being extended across other protected characteristics, including implementation of the disability equality standard (DES).

However, we need to go further and faster in ensuring that NHS boards and staff across the health and care workforce are reflective of the diversity within our population. The forthcoming NHS people plan therefore needs a strong focus on inclusion and diversity, with clear and specific actions and proposals.

Aspects of last year's NHS staff survey (NHS staff survey, 2018) with regard to bullying and harassment and stress and wellbeing make for worrying reading:

- Although almost 72% staff respondents said they received the respect they deserved from colleagues, less than half (45%) said relationships were never or rarely strained at work.
- Almost one in five respondents (19%) experienced bullying by a colleague in 2018 – an increase of more than 1% on the previous year's figure of 18%. The proportion of staff experiencing bullying by a manager was 13%, slightly up from the previous year's 13%, and 28% of respondents reported bullying by a patient, service user, family member or other member of the public, compared with 28% the previous year.
- Almost four in 10 staff (39.8%) reported feeling unwell at work in the last year as a result of stress and 27.6% experienced musculoskeletal problems in the last 12 months as a result of work activity. Only a minority (29%) said their trust definitely takes positive action on health and wellbeing.
- Three in 10 staff (30%) said they often thought about leaving their organisation.

Maintaining morale and wellbeing at work is central to recruitment and retention across the service but continues to prove a challenge to many trusts as demand for services rises relentlessly year-on-year, with widespread vacancies, pressing shortages in particular professional groups, and staff members becoming increasingly stretched (The Health Foundation, 2019). Anecdotal feedback from trust leaders this year has consistently reflected the fact that the NHS is reliant on the discretionary effort of its committed staff to function at times of pressure. Trust leaders say that this winter, they do not expect to rely on that discretionary effort as individual members of staff, quite understandably, can no longer sustain the additional hours they have offered to patient care.

"We have significantly reduced our agency spend and increased the usage of our own bank staff who like to work flexibly. However, there remains a shortage of qualified nurses in mental health, learning disability and community/district nursing which is being outpaced by the numbers of experienced nurses retiring or leaving the NHS because of work pressures."

CHAIR, COMBINED MENTAL HEALTH, LEARNING DISABILITY AND COMMUNITY TRUST

Pay, terms and conditions

Ensuring appropriate pay, terms and conditions is central in enabling the NHS to recruit and retain the talented and committed workforce it needs to sustain high quality patient care. We continue to make the case to the pay review bodies for appropriate uplifts for senior staff and those on Agenda for Change. Recent movement in renegotiating the junior doctors' contract has also been welcome.

19%

of staff experienced bullying by a colleague in 2018

For senior medical and managerial staff, the most pressing issue this year has been NHS pension arrangements (British Medical Association, 2019). Significant tax bills arising from the interplay of the annual and lifetime allowances and the annual tapering tax relief threshold introduced in 2016 have acted as a disincentive to taking on more hours and even driving people to reduce their hours, reject promotion or take early retirement. The impact on trusts has been to reduce the size of the pool of clinicians available to take on extra work to sustain urgent and emergency care and other seven-day services, and to keep waiting lists down.

However, the issue equally impacts managers within the NHS who are taking on complex leadership positions, including at board level which carry significant accountability and responsibility. It is also relevant to all staff within the NHS, including more junior members of the scheme and to ensuring an equitable approach across the NHS family. While the government's current consultation on the NHS pension (Gov.UK, 2019a) offers much greater flexibility, and the Treasury's review of the annual

taper is welcome, there is much more to do to ensure NHS pensions arrangements do not directly impact trusts' ability to staff and provide sustainable services.

"We are seeing increased pressure in parts of the clinical workforce – notably doctors, due to actual or perceived pension tax issues. This is on top of significant supply challenges in a number of key specialties. While we are creating innovative ways to respond, these will take time to resolve."

CHIEF EXECUTIVE, ACUTE TRUST

Tackling workforce shortages

Although there are staffing shortages across the NHS, including in key areas such as learning disability services, mental health and for some community services, the lack of nurses across all services is the most concerning. In March 2019, there were 39,520 full time equivalent nursing vacancies in NHS trusts and foundation trusts (NHS Improvement, 2019b), and probably thousands more across general practice, social care and the independent sector. This compares to slightly fewer than 9,183 medical staff vacancies in the trust sector. The Health Foundation, The King's Fund and the Nuffield Trust have projected that on current trends, in 10 years' time, the NHS will have a shortfall of 108,000 full-time equivalent nurses. Additionally, successful applications to undergraduate nursing courses have lagged behind government targets, with the number of placed applicants in 2018 4% lower than in 2016 (The King's Fund, 2019).

A number of factors influence the 'pipeline' of professionals entering the NHS. These include funding for education and training, political and national policy decisions such as subsidies for nursing and medical degrees, and the sophistication of national, regional and local workforce planning.

Immigration policy from within the European Union (EU) and beyond is also critical for the NHS and wider health and care system. The health think tanks point out that concerns about Brexit have created extra short- and medium-term risks. A net inflow of nurses from the EU turning into a net outflow – between July 2017 and July 2018, 1,584 more nurses and health visitors from EU countries left their roles than joined (NHS Digital, 2018).

In response to these challenging figures, the migration advisory committee recommended in May 2019 (Gov.UK, 2019b) that all medical roles should be placed on the shortage occupation list, and that nurses should remain on the list. However, a new level of uncertainty has been introduced with the committee's decision to review both salary thresholds and – crucially – a potential points-based future immigration

system, favoured by the current government. The criteria for "points" in a future system, and the overall nature of migration into the UK from 2021 and beyond, is unclear.

For a trust, a shortage of nurses and other staff groups has the potential to affect the quality of patient care significantly, with increased waiting times, potential risks to safety and patient experience. In order to counter these risks, provider organisations find themselves spending increasing sums on bank and agency staff, which is an expensive solution to an enduring problem. In the 12 months ending March 2019, the provider sector spent £3,445m on bank staff (£666m or 24% more than planned) and £2,401m on agency staff, which was £201m or 9.1% above plan (NHS Improvement, 2019b).

Finally, the development of system working, and PCNs at a neighbourhood level has the potential for local partners to develop more flexible working models with the possibility of offering staff 'passport' arrangements to work across sites within a geographical area, and more innovative career paths to attract people to join and stay in the NHS. However, these developments also raise a challenge for ambulance and community providers in particular who are keen to ensure well intentioned recruitment by colleagues in primary care does not destabilise the local labour market and existing recruitment strategies.

Concerns over staffing were reflected in trust leaders' responses to our survey. Only 29% of survey respondents were confident that their trust currently had the right numbers, quality and mix of staff in place to deliver high quality healthcare to patients and service users, and almost six in 10 (59%) were worried that they did not have this in place. This is a slight worsening compared with 2017 when 56% were worried. Levels of confidence decreased as respondents were asked to look forward to future years, with only 18% saying they were confident of the right numbers, quality and staff mix in two years' time.

"Staffing remains a concern for the board. The current staffing position, particularly on nursing overall, is good with very low agency use, but there are specific skills shortages, particularly in paediatric nursing. There are also skill shortages in other professional groups. A range of factors including the potential impact of EU exit and the impact of tax policy on NHS pensions are also significant concerns in terms of the trust's ability to deliver patient services."

DIRECTOR OF CORPORATE AFFAIRS, ACUTE TRUST

"Removal of the nursing bursary hasn't helped. Attracting and retaining high-quality registered staff is difficult."

CHIEF EXECUTIVE, MENTAL HEALTH / LEARNING DISABILITY TRUST

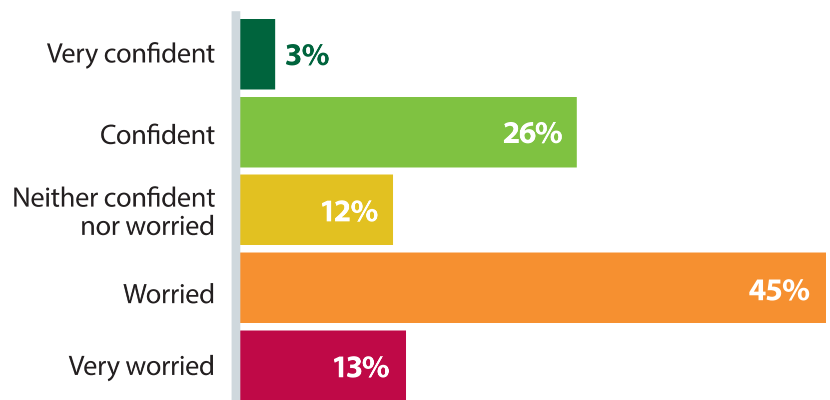
"With the plan to recruit large number of paramedics into primary care there is a major risk this will lead to significant workforce and skills mix challenges in ambulance trusts."

CHIEF EXECUTIVE, AMBULANCE TRUST

Figure 4

How confident are you that your trust currently has the right numbers, quality and mix of staff in place to deliver high quality healthcare to patients and service users?

(n=126)



Workforce devolution

Trust leaders have generally had limited opportunity to intervene in workforce strategy beyond their own organisations. The interim people plan opens the door to significantly increasing devolution of strategic decision-making about workforce. The mechanism for achieving this devolution is a "new operating model" that would see responsibility for different aspects of workforce strategy shared between the arm's length bodies, the regions, ICSs and local areas within ICSs.

This shift in focus is likely to be good news for provider organisations wanting to work with peers to ensure that approaches to workforce development are better suited to local and regional need. But although the plan recognises the need for extra resources to flow to ICS level alongside the extra responsibilities, the detail of how this will work is yet to be confirmed, and part of the engagement work underway under the umbrella of the people plan. Providers have also expressed concern about the lack of focus in the plan on the role of local government, and by extension social care, particularly if workforce plans are to reflect long-term population health trends.

Transformation and skill mix

The interim people plan also seeks to increase the flexibility of the NHS' approach to workforce planning by enabling professionals from different disciplines to work more closely together. Providing care in a more joined-up way becomes particularly important as the number of people living with multiple long-term conditions increases, as these patients will access services provided by different organisations and teams at different points in their treatment.

NHS England and NHS Improvement has recognised through its interim strategy that to move to a multidisciplinary way of working will require changes in how staff are trained and deployed, as well as cultural changes to ensure that mutual trust, respect and understanding can exist across different settings, and between services provided by the NHS and organised as part of local authorities' social care provision.

It is proposed in the plan that the skill mix of the health workforce will be enhanced through scaling up the development and implementation of new roles and models of advanced clinical practice, and by providing clear career pathways to enable people to continue developing professionally. The introduction of both new technologies and more personalised care will also require new skills. NHS England and NHS Improvement acknowledge that to achieve this will require investment in new roles and regulatory attention in the form of amended professional standards and systems of professional regulation.

They propose the development of multi-professional credentials to help staff widen their knowledge and develop new skills. These are to be used alongside the apprenticeship levy, which it is hoped will expand the number of routes into healthcare careers, and a further 7,500 spaces will be made available to train for the new nursing associate role.

59%

of trusts were worried that they did not have the right workforce to deliver high-quality care

However, these plans follow a prolonged period of cuts to the budget for continuing professional development, which is critical in enabling trusts to retain and upskill their staff. That budget dropped from £205m to £83m in 2015 (NHS Employers, 2018) and now stands at £119m (Gov.UK, 2019c). Moreover, recent data shows a drop-off in levels of participation in the government's apprenticeship scheme – a decreasing of 9.8% across the board in 2018/19 – compared with the previous year (Gov.UK, 2019d).

What does this mean for patients and service users?

Committed and caring staff are the bedrock of the NHS. We owe every member of the NHS staff team a duty of care and must invest sufficient leadership and management time, and resource, to protect their wellbeing, and support them to manage the inevitable stresses and emotional strains of working within a care setting. We also know that there is a clear correlation between investment in staff engagement and wellbeing, and the quality of patient care.

The number of workforce vacancies facing the NHS, gaps in particular skill sets, growing reports of bullying and harassment and a growing concern about 'burn out' therefore has a very direct impact on the quality of care which patients and service users experience.

Gaps in rotas and vacancies have a direct impact on patient care including delays to elective procedures, a poorer patient experience and even safety risks. Use of bank and agency staff to fill rota gaps, can carry associated quality implications and crucially eats into trusts' funding for other priorities.

However, sufficient investment in a 'just' and transparent culture within the NHS has an equal, if not greater, direct relevance to quality of care. All staff should feel supported and empowered to raise and act on issues of concern without fear of blame, and to support their colleagues in a culture of learning and continuous improvement.

How providers are responding

Providers are working collaboratively, and with other local partners within STPs and ICSs to create innovative career pathways in support of staff recruitment and retention, and to ensure staff can work flexibly across a local area to meet demand. The trusts and partners within Greater Manchester developed a health and care workforce strategy for the system to help address workforce challenges across ten localities. Other examples include the development of collaborative arrangements for staff passports by a group of six trusts in the west Yorkshire and Harrogate integrated care system, or the use of a shared nursing bank and a medical collaborative bank in south Yorkshire and Bassetlaw.

24%
of trusts spending above plan on bank staff

Trusts continue to address vacancy rates with innovative recruitment approaches. Yeovil District Hospital NHS Foundation Trust has been recruiting nurses from Dubai and the Philippines successfully for the past two years, without outsourcing, and is now supporting 12 other trusts with international recruitment.

Trust boards are fully committed to supporting their staff through a range of initiatives including quality improvement programmes which empower staff to lead quality improvement from the frontline and support staff wellbeing. Examples include Sheffield Teaching Hospitals NHS Foundation Trust's initiatives to support staff wellbeing which have in turn had a positive impact on retention (The Guardian, 2019) and the work undertaken at Milton Keynes University Hospital NHS Foundation Trust to offer staff a range of non-pay benefits and support (Health Service Journal, 2019).

FUNDING AND FINANCES

3

Summary

The NHS is in a relatively privileged position compared to other public services in having a five-year revenue settlement confirmed with an extra £20.5bn real terms funding increase in annual funding by the end of the five-year period to support the delivery of the long term plan. However, trusts and the wider health and care system are still operating under severe financial constraints. The additional funding provided with the plan equates to a real-terms increase of on average 3.4% per year for five years. However, this is lower than the average increase of 4% across the period between the establishment of the NHS in 1948 and 2010 when the period of 'austerity' began and comes at the end of a prolonged period of efficiency savings. While the 3.4% average increase will allow the NHS to keep up with the growth in demand at existing levels, it will not be enough to recover performance and finances, and cover the additional costs of transforming services to deliver integrated, personalised care for the public (Institute for Fiscal Studies, 2018).

The provider sector is also still in need of an appropriate multi-year settlement for capital investment. The additional injections of capital announced in August 2019 alongside 20 'hospital upgrades' and the subsequent government commitment in late September 2019 of £3bn to be spent between 2020 and 2025, to rebuild six hospitals, invest in new diagnostic equipment such as CT scanners and provide seed funding for a further 21 hospital schemes, are of course extremely welcome. However, the 10% uplift on the NHS capital this provides still falls short of what is required to clear the maintenance backlog and invest for the future. We are yet to understand the allocations annually up to 2025, and the spread of the schemes to be allocated seed funding, across acute, mental health, community and ambulance providers.

In addition, severe funding constraints and uncertainty for key services outside of the core NHS budget such as social care and public health, risk exacerbating the pressures on the NHS by driving further increases in demand for secondary care which could be better met through appropriate investment in a preventative approach, in primary care, social care and in additional capacity within the community.

35%
of trusts thought their financial performance would improve over the next 12 months

3

The provider challenge

Reducing the provider deficit and improving the financial framework

The financial position of the provider sector has deteriorated considerably in recent years as demand for services has risen. The funding mechanisms for services such as A&E have been a core driver of acute trust deficits. There is also clear evidence of under investment over a period of years in services such as community services for adults and children, gender identity services and crisis home treatment teams (NHS Providers, 2019a). Fundamental community services like health visiting and sexual health services have come under pressure from local authority cuts.

While all providers face financial pressures, trust deficits are largely concentrated in the acute sector. Nearly half of trusts (107) were in deficit at the end of the 2018/19, a small minority of which had small, structural deficits. The provider sector's outturn position for 2018/19 was a £571m deficit, increasing to £827m when technical adjustments are taken into account. In fact, the "underlying" deficit for the provider sector is estimated at £5bn taking into account one off payments, loans and technical measures (NHS Improvement, 2019b).

The long term plan describes a recovery trajectory requiring the number of trusts in deficit to be reduced by half in 2019/20, the provider sector as a whole to be in balance by 2020/21, and no providers in the red by 2023/24. We are currently working closely with NHS England and NHS Improvement as they develop their proposals to amend the financial policy framework to better support trusts to recover and maintain financial balance. This year's planning guidance (NHS England, 2018) begins to set out an approach towards using the new money to deliver financial recovery: increasing funding for accident and emergency services, which are driving most deficits, strengthening the mental health investment standard to come good on the government's commitments to parity of esteem, establishing a new financial recovery fund (FRF) to help challenged providers stabilise their finances, and removing central risk reserves to increase core funding.

However, resolving trust deficits will take time. It will require the provider sector to make savings and efficiencies at roughly the same rate as during the lean years at over £3bn a year in addition to receiving additional funding from the £20.5bn, which will be routed through payment mechanisms. NHS Providers has said many times that this rate of cost reduction is simply unsustainable, not least because the efficiency improvements capable of generating the largest impacts with lowest impact on service delivery will already have been made, early in trusts' efficiency programmes. The need to contain costs may force trusts to

make non-recurrent savings (which are increasing as a proportion of the total provider sector cost improvement programme as providers exhaust the most easily achievable recurrent savings). This could take the form of delayed maintenance work, staff vacancy freezes, or delayed investment in service transformation.

Finding cost improvements at the same time as transforming care to deliver the aspirations of the plan will be a considerable ask of any trust board.

"I am concerned about the scale of the transformation that is required, the nature of the shift in mindset that is needed at all levels within the NHS when we will be held to "old world" performance measures, all at a time when the system is under immense and unsustainable pressure."

CHIEF EXECUTIVE, ACUTE TRUST

"Our capital programme is very limited and significant transformation and improvements in efficiency require a reasonable capital investment."

CHIEF EXECUTIVE, ACUTE TRUST

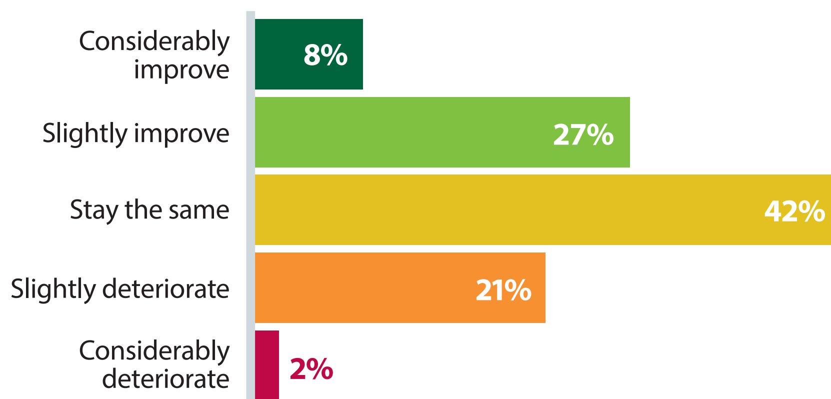
Only 35% of respondents to our survey thought their trust's financial performance would improve over the next 12 months, with 23% predicting financial performance would deteriorate.

Respondents from acute trusts were more likely to predict that their finances would improve (51%) than all other types of provider, possibly because of changes in payment mechanisms and financial flows within the system.

Figure 5

Over the next 12 months, do you think the financial performance of your trust is likely to improve, stay the same or deteriorate?

(n=129)



3

Capital investment in the NHS

The cumulative impact of years of under investment

The NHS requires significant capital investment to maintain buildings, modernise facilities, and invest in new treatments and IT, but capital spending by trusts has been severely constrained since 2010. Capital has not been given the same protection as day-to-day spending, in fact the NHS has suffered in recent years from repeated capital to revenue transfers to support day to day running costs for providers. According to The Health Foundation, the Department of Health and Social Care's (DHSC) capital budget fell by 7% in real terms between 2010/11 and 2017/18 (The Health Foundation, 2019). Meanwhile, the share of the department's capital budget available to NHS providers fell even more sharply, by 21% in real terms between 2010/11 and 2017/18. The decade-long squeeze on revenue funding also added to the pressures, as trusts have been unable to generate surpluses which could have been used to make capital investments.

Successive years of inadequate capital funding have created a severe backlog and providers now need to make a wide range of safety-critical investments that they can no longer delay. At the same time, partly due to national allocation mechanisms, there is a danger of a mismatch between where funding available sits at individual provider level, and the places most in need of capital investment. In addition, it is now harder than ever for trusts to access private capital as the government has declared the private finance initiative (PFI) no longer an option, without setting out alternative arrangements beyond additional injections of government funding.

Furthermore, the NHS capital regime – that is, the capital bidding, prioritisation, allocation and approvals process – is in need of rapid reform. The Treasury asked DHSC to conduct a review of the regime in January 2018 which has yet to be published. All capital spending, irrespective of whether it is funded by DHSC or a trust's own funds, counts against the department's capital departmental expenditure limit (CDEL). There is, therefore, a risk that foundation trusts could collectively overspend the DHSC's capital budget, raising pressure on NHS England and NHS Improvement to control spending. Furthermore, trusts in long-term deficit have already used up their cash reserves and would require several years in surplus before their balance sheets are in a sufficiently healthy state that money could once again be invested in estates and facilities.

As a consequence, the provider sector has struggled to make the necessary investments in new buildings, equipment, IT and digital technology, and many providers have been unable to invest in ways

that will enable them to become more efficient, deliver transformational changes, and match physical capacity to increasing demand. The most recent figures available show that in 2017/18, there was a £6bn capital maintenance backlog, of which £3bn relates to high – or significant – risk maintenance.

"The trust has two significant capital developments that will enable it to secure services and meet demand in the next three to five years. It's incredibly difficult to progress these in the current climate and with STP service reviews taking place. I'm worried that these are not going to deliver significant change and that estates transformation will only be delayed while this becomes obvious, leading to significant capacity problems."

CHIEF EXECUTIVE, ACUTE TRUST

Feedback from trusts demonstrates the very direct and significant impact this has on patient care, shown in responses to the NHS Providers survey of trust finance directors, July 2019 to the question: "If your actual capital spend was less than plan, what was the impact?"

"Anti-ligature works delayed. Impact on service delivery, impact on staff, additional revenue costs."

FINANCE DIRECTOR, MENTAL HEALTH / LEARNING DISABILITY AND COMMUNITY TRUST

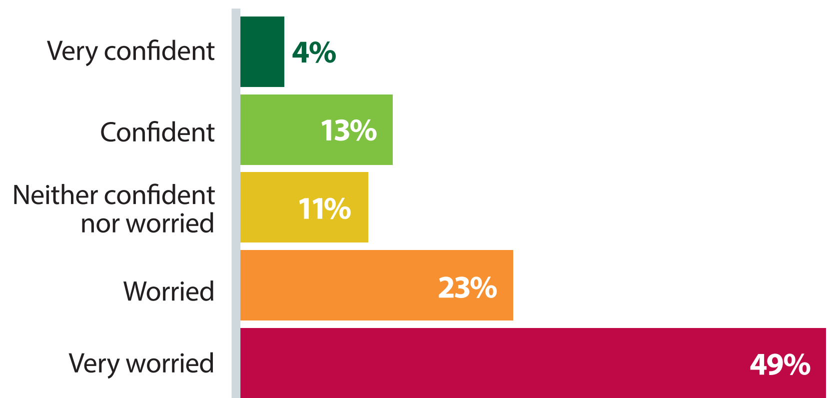
"Delays to implementation of reconfiguration of high-risk general surgery and major trauma pathways."

FINANCE DIRECTOR, COMBINED ACUTE AND COMMUNITY TRUST

When asked how confident they were that their trust could make appropriate capital investment to transform estates, equipment and infrastructure, more than seven in 10 respondents to our survey (72%) said they were worried, with only 17% indicating that they were confident they would be able to do this. A greater proportion of respondents from acute trusts (82%) and combined acute and community trusts (85%) were worried than the other types of trusts, possibly because of the greater requirement for expensive specialist equipment at these providers.

10%
cut to public health funding since 2015/16

Figure 6
How confident are you that your trust can make appropriate capital investment to maintain and transform estates, equipment and infrastructure?
(n=129)



The impact of recent announcements on increasing capital funding

Prime minister Boris Johnson recently announced £1bn additional spending power for the NHS to spend on vital improvements to facilities in 2019/20, plus an additional £850 to cover 'upgrades for 20 hospitals'. In September 2019, this was supplemented by a welcome commitment from government to rebuild six acute hospitals, invest £200m in new diagnostic equipment and provide seed funding for a further 21 hospital schemes between 2021 and 2025. However, it was deeply disappointing that no mental health, ambulance or community investment was announced.

We are extremely pleased to see the priority the government is now placing on NHS capital investment. However, welcome as this is, the estimated 10% uplift on the NHS capital (our estimate based on government's announcement of new £3bn for capital over 5 years), these announcements still fall short of what is required to clear the maintenance backlog and invest in modern, innovative care for patients for the future. We calculate that the current NHS capital budget of circa £6bn a year needs to double over the next five to 10 years to address the maintenance backlog and meet patient need. This would match current capital spend in comparable countries, ensure safe care and help create the right environment for staff (OECD, 2017).

We are also keen to understand the annual allocations of the additional £3bn investment, in the period 2021 to 2025. As the NHS does not have a

capital budget set beyond 2020/21, it will be important to ensure that the extra funding for 2020-25 does translate into a £3bn increase to the current CDEL baseline over that time. While investment in acute estate is very welcome, mental health, community and ambulance providers have equal needs for capital funding. We are therefore keen to understand the spread of the schemes to be allocated seed funding.

Finally, there remains a need for reform to the process by which all trusts access capital investment. Welcome as recent announcements have been, the NHS needs a long term, sustainable approach to capital allocation and prioritisation.

As we have set out in our *Rebuild our NHS* (NHS Providers, 2019f) campaign, despite these announcements, which mark a real step forwards, the NHS still needs:

- a multi-year NHS capital funding settlement
- a commitment from government to bring the NHS' capital budget into line with comparable economies
- an efficient and effective mechanism for prioritising, accessing and spending NHS capital based on need.

Residual gaps in funding

The NHS will not be on a sustainable footing until there are also long-term settlements for social care, public health, and education and training. Underfunding these areas has the potential to increase demand for NHS services:

- Social care – funding for social care has been reduced over the past decade in the face of an ageing population and increasing numbers of adults with more severe needs. The Association of Directors of Adult Social Services' (ADASS) most recent budget survey describes a £7bn cut in social care funding since 2010 (ADASS, 2019). Lack of capacity within the social care sector places additional strain on all health services, including primary care (ADASS, 2019).
- Public health – funding for public health has been cut by 10% since 2015/16. (ADASS, 2019) As our *The state of the NHS provider sector* report on community services sets out, local authority budget cuts have had a direct impact on the commissioning of community and mental health services. This has meant reductions in some areas in services such as school nursing, drug and alcohol services and health visiting for example (NHS Providers, 2018), all of which play a key role in prevention as well as treatment.
- Education and training – since these budgets have been defined as being outside the NHS ring-fence, there have been cuts to spending

on staff development over the past five to 10 years. With around 100,000 vacancies in the service with particular recruitment pressures on nursing and services including learning disability. Major shifts in the model of care planned such as non-consultant led outpatient services, more specialist clinicians working in primary care settings, more imaginative use of the allied health professions and more community care, DHSC will need sufficient resource to fund an adequate and reshaped workforce to deliver the plan. The interim people plan represents a positive step forward in this regard but we are still awaiting a multi year settlement for education and training.

More broadly, our recent report on mental health services, *Addressing the care deficit* (NHS Providers, 2019a) showed clearly the impact of a lack of investment in wider public services during the years of austerity. For example, 92% of trusts told us that changes to universal credit and benefits are increasing demand for services, as are loneliness, homelessness and wider deprivation (NHS Providers, 2019a).

"Main impact is from high and increasing levels of deprivation in this post-industrial area – so the main determinant is economic. Locally, substance misuse is rising rapidly and funding of provision for care and treatment via local authorities has more than halved – the consequences were and are self-evident. Also provision is a lottery with, for example, one CCG funding adult eating disorder care and the adjacent one not."

CHAIR, MENTAL HEALTH / LEARNING DISABILITY TRUST

"Cuts to local authority and voluntary sector budgets have dramatically reduced the availability of services – The NHS is the only one still "open"!"

CHIEF EXECUTIVE, MENTAL HEALTH / LEARNING DISABILITY TRUST

Trust leaders had significant concerns about public health and social care services – 90% of survey respondents were worried that sufficient investment was not being made in social care in their area, with only 2% being confident that sufficient investment was in place. 77% were worried about public health funding (again only 2% were confident).

"The widespread erosion of social care and community infrastructure is having a huge impact on NHS services. We need to look at different models of collaboration that allow NHS providers to inject capital and other forms of investment into non-NHS care."

CHIEF EXECUTIVE, COMBINED MENTAL HEALTH / LEARNING DISABILITY AND COMMUNITY TRUST

"Public health budgets are continually being cut and not enough is being spent on prevention. Our health visiting service and school nursing service were recently tendered and we had to deliver significant cuts to services to win the contract."

CHAIR, COMBINED MENTAL HEALTH / LEARNING DISABILITY AND COMMUNITY TRUST

Figure 7
How confident are you that sufficient investment is being made in social care in your local area?
(n=129)

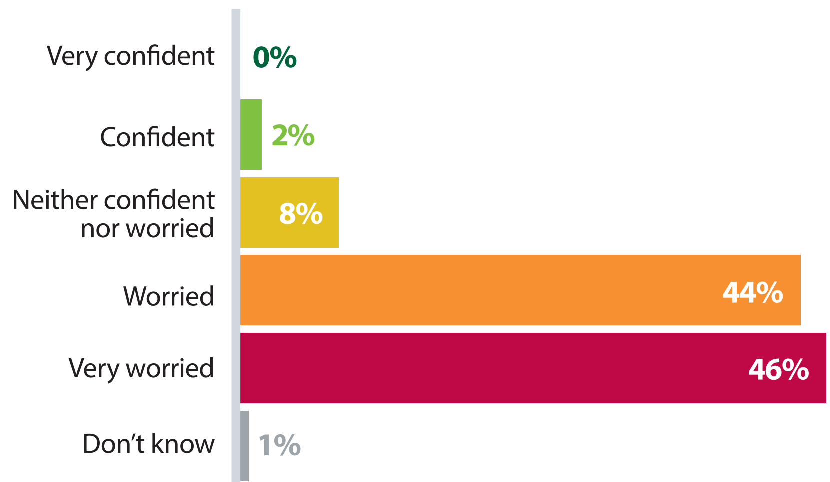
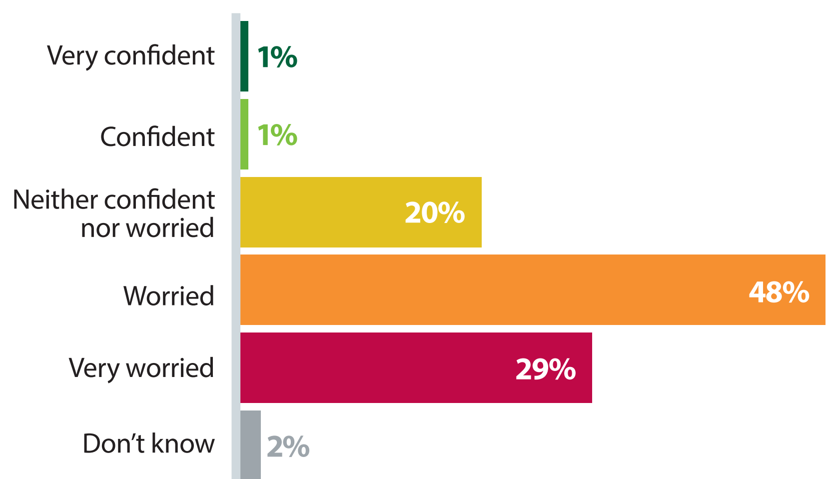


Figure 8
How confident are you that sufficient investment is being made in public health and prevention in your local area?
(n=128)



Most telling, given the scale of challenge, and opportunity, facing the NHS, more than nine in 10 respondents (91%) did not feel there was sufficient high-quality public debate about the challenges and opportunities facing the NHS and its long term future.

"Public debate at the moment is as awful as I can remember it being in my life. There is some good quality discussion within the service, but politically the quality of discussion about the service and about social care is an embarrassment."

CHIEF EXECUTIVE,
COMBINED MENTAL HEALTH / LEARNING DISABILITY AND COMMUNITY TRUST

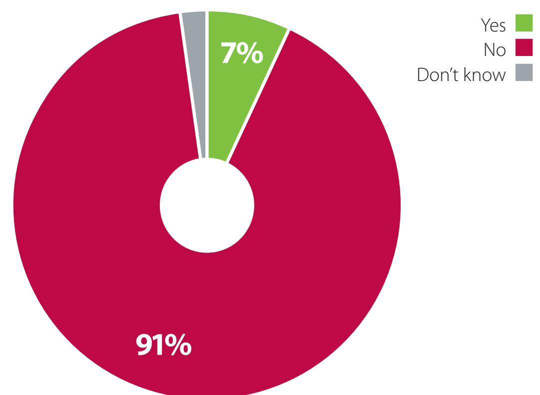
"There is debate but given the focus on Brexit I don't think we are anywhere near having the sort of conversation we need with the communities we serve about the choices and challenges ahead."

CHAIR, COMMUNITY TRUST

Figure 9

Do you feel there is sufficient, high quality public debate about the challenges and opportunities facing the NHS and its long-term future?

(n = 128)



What does this mean for patients and service users?

The additional £20.5bn funding provided alongside the long term plan clearly supports the NHS to maintain good quality care for patients in the medium term. However, the scale of the deficit reduction task facing providers, the gaps in funding for services outside of the core NHS budget, and capital constraints will equally have clear consequences for the nature of the services available to patients and the public, and the staff who work within the NHS.

We expect demand to continue increasing faster than the NHS' capacity to respond across the acute, specialist, community and mental health sectors. This risks an overstretched NHS workforce seeking to support high bed occupancy rates, with longer waiting lists for care and longer ambulance response times, all of which can carry associated safety risks. With increasing pressure on our A&E departments and inpatient beds, trusts will struggle

to balance their commitments to urgent and emergency care, and elective care. Our recent reports into the state of care within mental health and community services revealed concern around adequate investment in community services for adults and children such as gender identity services and crisis home treatment teams (NHS Providers, 2019a). Fundamental community services like health visiting and sexual health services are also under pressure from local authority cuts.

Without a multi-year settlement for capital funding which sees a doubling of the funding available, providers will struggle to maintain estates and equipment, and be unable to invest in innovative and specialist technology. This has a direct impact on the experience of patients, service users and staff and can impact on patient safety as providers become unable to meet fire safety requirements or to respond to issues raised in CQC inspection. It can mean use of outdated CT scanners, lack of the latest equipment available for paramedics and community services, over crowding in A&E departments simply not designed for the volume of patients trusts see today, or lack of investment to tackle ligature points within a mental health setting.

Without sufficient investment in public health and a shift to a more preventative model of care, the health and care sector will remain trapped in current models of delivery. Additional funding for public health could radically transform how we address the impact of the wider determinants of health in England such as housing, education and transport, support individuals to make healthier choices, and increase the success of health focused, preventative campaigns, be that to increase screening for particular conditions or to raise awareness of health risks.

Without sufficient investment in social care to stabilise the system, users of social care services and their relatives will continue to find the capacity of those services to respond in a timely way, the level of personalisation, and the care packages available limited until a more sustainable approach to the funding and provision of social care can be achieved by government through a cross party endeavour.

Within this context we must be realistic about how far the NHS can meet rising demand within existing models, and seek to transform and develop more integrated models of care which could improve patient experience and outcomes.

How providers are responding

NHS Providers is actively engaged with NHS England and NHS Improvement in helping to reshape the national financial policy framework in support of a sustainable trust sector. This involves a range of detailed engagement on payment mechanisms, financial incentives within the system, the operation of the FRF and the process by which trusts access capital investment.

While revising the financial architecture to ensure more funding flows directly to trusts will be key in returning the provider sector to financial balance, trusts have historically delivered significant efficiency savings, and continue to find savings wherever possible without damaging patient care. Examples include East Midlands Ambulance Service (HFMA, 2017) adopting a more efficient approach to refuelling ambulances, the growth of collaborative working to deliver back office services such as a collective of acute trusts in west Yorkshire under the West Yorkshire Association of Acute Trusts partnership and the use of telemedicine in the Morecambe Bay area involving 11 partner organisations including University Hospital Morecambe Bay NHS Foundation Trust who explored how to reduce unnecessary patient and ambulance journeys (NHS Providers, 2017).

91%

of trusts felt there was insufficient public debate about the challenges and opportunities facing the NHS

Trusts are also making the most of innovative and collaborative partnerships in local systems to ensure they make the most of the collective pound in any given local area. This may include making the most of the available estate to deliver integrated services with partners such as primary care and working closely with local authorities which have more flexible access to funding.

Trusts also continue to generate non-NHS income where appropriate to reinvest in NHS care. This may stem from a private patient ward within an NHS building, growth of the charitable arm of their business or commercial partnerships. We know that financial pressure is one driver of the development of new business models including subsidiaries and wholly owned subsidiaries.

SYSTEMS, TRANSFORMATION AND INTEGRATION

4

Summary

The long term plan places system working and population health at the heart of work to improve care quality and ensure services remain sustainable. The plan gives ICSs, whose membership comprises local NHS organisations and local government, a central role in leading this system working. There is a target for the whole of England to be served by an ICS by April 2021, and at the local 'place' level, primary care networks are being set up across the country to drive integrated working.

However, the measures set out in the long term plan to embed system working are ambitious, and rest on the ability of local partners to forge new relationships and to embed new ways of working within an existing legislative framework based on institutions not local systems. Success also depends on the national bodies' ability to ensure that national policy and regulatory frameworks consistently support system working rather than the established, organisational focus.

The provider challenge

Risks and opportunities presented by system working

The development of system working is the core driver of change within the long term plan and presents an exciting opportunity for trusts and their partners to work together to adopt a population health based approach, better integrate services and ensure more sustainable care which makes the most of the collective pound in a locality. However, the scale of the change, and the support required, for trusts and their partners to move towards a new 'operating model' framed around system working must not be underestimated.

There is much more to do to ensure that policy and regulatory frameworks appropriately and coherently support system working and to embed the development of new regional NHS England and NHS Improvement structures (NHS Providers, 2019b). This will be a complex endeavour given that statutory responsibilities rest in the component organisations within an STP and ICS – and given that the STP and ICS footprint will not always be the logical footprint for service delivery. In addition, patient flows often cross system boundaries, including for key services such as cancer networks, and the footprints for specialised services and ambulance services cover a much wider geography.

The shift to system working involves a radical transformation of the commissioning landscape to accommodate fewer, more strategically focused CCGs. It also creates a backdrop for different forms of provider

collaboration, and new integrated partnerships and alliances, which cross traditional organisational boundaries to form.

NHS Providers has been pleased to support emerging thinking around the development of a new operating model for the NHS which reflects agreed values and behaviours between national, regional and local leaders, and is reflective of this fundamental shift away from competition and towards a more collaborative way of working. However, it is hard to overstate the scale of the transformational challenge ahead for the health and care sector as a whole, as well as for providers specifically.

44%
of trusts are confident the shift to system working will support them to deliver high-quality care

Trusts and their partners must therefore find the leadership capacity to invest in new relationships and a transformative agenda for patient care, at the same time as tackling financial constraints, rising demand and workforce vacancies. Trusts also face sustained pressure from the regulators to focus on improving their own performance against organisationally framed measures (including the NHS constitutional standards). This means that trust boards and their staff are stretched thinly across multiple priorities.

Providers' views of system working as a driver of change

Although there is widespread support across the sector for greater collaboration within local systems (rather than the competitive approach initiated by the 2012 reforms), there are mixed views, and a mixed evidence base, as to how far integration in local systems will prove to be the solution to all of these issues. Our survey results show clearly that trust leaders lack confidence in how far system working alone can address some of the fundamental issues facing the NHS, particularly the need to address workforce shortages and to place the system on a financially sustainable footing.

On a more positive note, nearly half of respondents (44%) were confident that the shift to system working via STPs and ICSs would support them and their partners to deliver high quality, more integrated care in the next two years.

"The STP is a good vehicle for us as a specialist trust to ensure best pathways of care across primary and secondary care ensuring equity and good quality services across the region. There has been some good work on organisations working together for improved patient pathways in a number of conditions in several speciality areas and priority areas of work."

CHIEF EXECUTIVE, ACUTE SPECIALIST TRUST

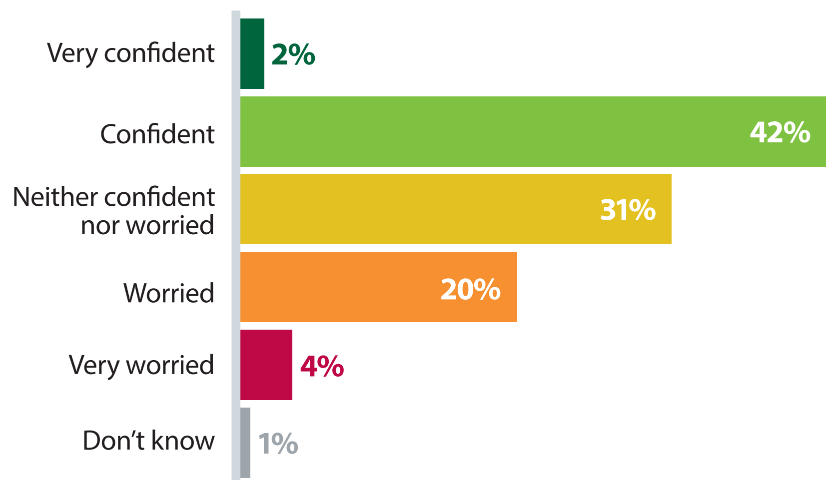
"If we allow place models with lead providers to develop then we have a chance of progressing integration more rapidly without the negative impacts of CCG procurement."

CHIEF EXECUTIVE, COMBINED ACUTE AND COMMUNITY TRUST

Figure 10

How confident are you that the move to system working via ICSs and STPs will support your trust and its partners to deliver high quality and more integrated care in the next two years?

(n = 127)



However, only 29% of respondents were confident that transformation activity in their local system would progress as well as it needed to over the next 12 months in order to deliver the long term plan's aspirations.

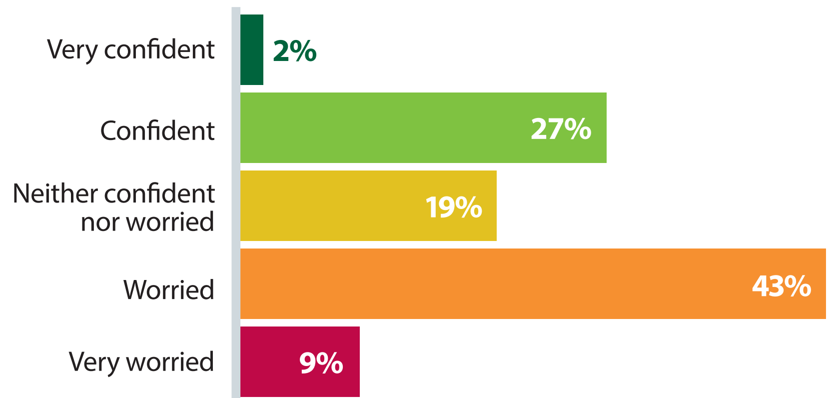
"Very recent relationship building and some new players have, at long last, created a basis for new confidence. However, underlying deficits are deep and intractable and the absence of any level of certainty about workforce and capital availability cast significant doubt."

CHAIR, MENTAL HEALTH / LEARNING DISABILITY TRUST

Figure 11

How confident are you that transformation activity in your local system will progress as well as it needs to over the next 12 months to deliver the aspirations set out in the long term plan?

(n=131)



Only 23% of respondents overall were confident that the support and infrastructure was in place locally to enable more integration between primary and secondary care.

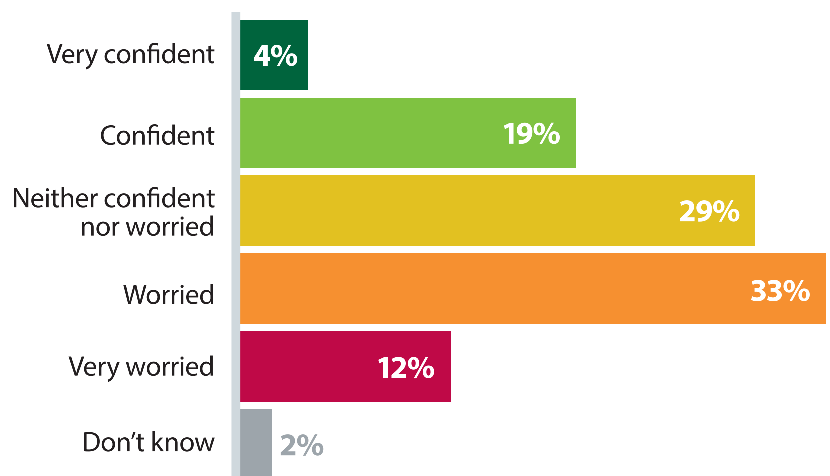
"I think the creation of PCNs is a double-edged sword and potentially a missed opportunity. It would be very frustrating if in the move towards greater integration and a rationalisation of CCGs we end up with a more fragmented system if the PCNs are not aligned with the transformation required."

CHIEF EXECUTIVE, ACUTE TRUST

Figure 12

How confident are you that support and infrastructure is in place locally to enable a more integrated service between primary and secondary care?

(n=129)



Only 17% of respondents were confident system working would support their health economy to become more financially sustainable over the same period. Only 13% of respondents were confident that system working would support the ability of their trust and its partners to recruit and retain an appropriate workforce over two years.

"I can't see yet that the STP has any control over finances. That stays with the CCG(s) and their commitment to 'system' remains uncertain."

CHAIR, COMBINED MENTAL HEALTH, LEARNING DISABILITY AND COMMUNITY TRUST

"I don't think that an ICS will help in any way. Conversely, it feels like a strategy to push more of the problems down to local leaders. As a strong foundation trust, I also worry that this is simply a strategy to seek to use efficient organisations to bale out those less so. While this may be necessary, we need to have a strategy to improve the weaker organisations not just simply dilute them."

CHIEF EXECUTIVE, COMBINED ACUTE AND COMMUNITY TRUST

The role of the trust unitary board in system working

ICSs and STPs currently have no statutory basis and their success rests on the ability of their component organisations – trusts, CCGs, local authorities, primary care and the community and voluntary sector – to work together to plan how to improve health and care. Crucially, accountabilities within the system therefore continue to rest with the component statutory organisations within an ICS or STP, primarily the NHS trust or foundation trust, CCG and local authority.

This creates new opportunities and new risks for trust boards as system working relies on the development of robust, local relationships, which will take time to develop in those areas where close partnership working is new. It also means that trust boards must work with their partners to develop governance mechanisms which allow for collaboration and collective responsibility without blurring a line of clear accountability to the public, to parliament (for foundation trusts) and to other bodies for board level decisions.

However, providers have a strong history of collaboration and innovation with different partners and there is nothing within the current legislative framework which prevents collaboration. Indeed, taking a broad view of a foundation trust's duties to "maximise the benefits" of the NHS to the public as a whole – not just those who come through their doors – means providers arguably have a duty to ensure the good of all NHS services, not just those that run themselves (NHS Providers, 2019c).

There are questions yet to be answered about how best to ensure non-executive oversight and challenge of system level decisions. Trusts and their partners will welcome new forms of support as boards scrutinise and contribute to their organisation's contribution to wider system plans. However, on balance, bringing together different parts of the NHS should present the opportunity to build on what is best about corporate governance in the NHS. Within that the retention of the unitary trust board is essential to achieve best practice in corporate governance (NHS Providers, 2019d).

A population health based approach

The stated aim of the long term plan was to transform how care is delivered and to move towards a more preventative approach to healthcare. If we are to do this, government will need to invest appropriately in public health, and give equal attention to those services which address the wider determinants of health. Trusts are embracing the prospect of moving to population health based approaches, but will require time and support to embed and make use of the data and analytics which underpin this.

New neighbourhood level partnerships including primary care

Community service providers play a key role in the development of integrated local systems (NHS Providers, 2019b). Users of community services often have multiple conditions and frequently receive social care support. Therefore, due to the nature of these services, the community workforce tends to be highly aware of the role of other providers in caring for patients and service users. Some of the changes set out in the long term plan have the potential to further deepen the community sector's links with other parts of the health and care system.

One such area of opportunity is the development of PCNs. For historic and contracting reasons, primary care has tended to operate relatively independently from other parts of the NHS. PCNs aim to bridge this long-established divide between primary and community care by building out from a core of primary care provision to a network that involves working with community services, social care, the voluntary sector, mental health, pharmacy and acute hospitals.

However, there are challenges inherent in creating these new neighbourhood level systems. Notably, community providers in many areas have been working with colleagues in acute and mental health trusts for some time to provide integrated services at locality level.

Some community providers have already reported difficulties in working out how to align existing multi-disciplinary team structures and workforce arrangements within new PCN boundaries.

Second, some of the staffing requirements that have been placed on PCNs, in particular to have specific roles such as paramedics, pharmacists and social prescribers, could place local labour markets under pressure if trusts and their partners within PCNs do not work closely together. As PCNs are not bound by Agenda for Change remuneration requirements, they are potentially able to pay staff higher wages, which could disadvantage existing community providers (NHS Providers, 2019e).

Forging strong local relationships will be critical to the success of this new way of coordinating care. The tight timescale for getting PCNs up and running will make establishing these relationships early even more critical.

Integration with social care

The NHS relies on a healthy social care sector to operate efficiently and vice versa. Cutting social care places has increased pressure on NHS services, and can result in delays for patients who are ready to leave hospital, as well as increasing the number of people relying on health services who could live within the community with additional support to undertake daily tasks. In fact, analysis by the Institute of Fiscal Studies found that reductions in social care spending on people aged 65 and over led to increased use of accident and emergency services, both in terms of the average number of visits per resident and the number of individual patients visiting A&E each year (Institute for Fiscal Studies, 2018).

29%

of trusts were confident that transformation in their system would progress as well as needed over the next 12 months

Closer working between health and social care services has the potential to make care more streamlined and personalised for patients and service users. Nevertheless, integrating services across health and social care is complex because the services have different funding routes, cultures and lines of accountability. Despite this, local services can work more closely together via structural integration, alliances and local partnerships, but solutions work best when locally led.

4

The provider landscape

Against the backdrop of system working, and in response to severe workforce shortages and financial restraints, many trusts are considering how they can best work together within, and across boundaries. The options for trust to trust collaboration are hugely varied. They might include:

- partnerships and alliances – involving agreements for staff passports for example
- more formal alliances to share or standardise back office services
- collaboration on clinical pathways
- shared posts including chief executive and/or chairs
- a group model
- a merger.

As organisations work more closely together, further questions about structural integration are bound to arise – for instance, should provider organisations explore formal mergers or develop informal grouping arrangements? Would it be helpful for provider chairs to have dual roles within other organisations? Should providers pursue 'vertical' integration arrangements between primary or community care and acute services, or 'horizontal' arrangements between community and mental health services, and are these terms even still helpful when integration is being explored at the level of the system and the care pathway?

When we asked which types of collaborative approach were under consideration locally, the most common response was "working with primary care in different models, including primary care networks, structural integration and other approaches", which two thirds (66%) were considering, and 'shared services – back office' (60%). Only a fifth said they were exploring a merger or acquisition with another trust (19%) or buddying with another trust (21%).

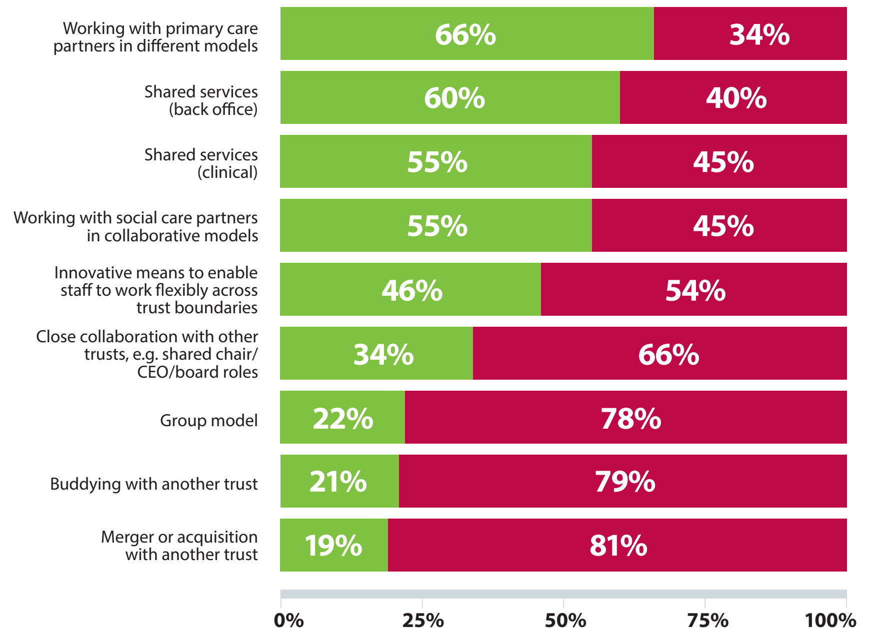
"We have shared a chief executive from July 2019, and have been in a buddy relationship since April 2019 and this is working well so far – working with PCNs and social care through the community services redesign programme."

CHAIR, COMBINED MENTAL HEALTH / LEARNING DISABILITY AND COMMUNITY TRUST

Figure 13

Is your trust progressing or considering any of the following collaborative approaches with other providers?

(n = 129)



Taking advantage of technology to transform

The digital agenda presents immediate opportunities for greater efficiency and quality improvement in healthcare. However, in order to deliver the objectives of the plan, trusts are also laying the foundations for full digital transformation which will fundamentally change the way services are delivered. More effective use of digital technology and approaches enables better decision making, whether this means using digital population health tools to inform large decisions on service configuration, or using clinical decision support tools to answer more granular questions about the care provided to individual patients.

Much of the potential for improvement is data driven, as new digital technologies tend to lead to better data being captured and more effective utilisation. However, other improvements will be driven by the introduction of new systems which lead to different ways of working. For example, electronic patient records standardise and formalise certain processes that sometimes are missed when using paper and pen. Shared care records, such as those used by local health and care record exemplar sites, will play an important role in ensuring all professionals have a full picture of the care an individual is receiving.

Digital is also changing the way patients receive care and interact with the NHS. One of the big shifts here is telemedicine, which is transforming the outpatient model, particularly in more rural areas, meaning patients are spared having to travel long distances to hospital sites. In addition to this, new apps such as online booking systems are changing the way patients engage with providers.

Digital technologies are also improving patient flow, and boost the productivity of inpatient departments. For example, new radio frequency identification technology can help staff to process beds much more quickly, improving overall bed capacity and maximising the use of equipment. Digital technology is also playing a role in driving greater clinical engagement by changing the way clinicians think about health and how they deliver care. In the community sector, nurses and carers are able to use technology to deliver care by video-link in remote settings and within patients' homes.

This progress puts providers on the path to the target level of digitisation set out in the long term plan. In delivering these changes and putting in place more sophisticated IT infrastructure, the sector can prepare itself for full transformation which will include artificial intelligence, robotics and machine learning.

What does this mean for patients and service users?

A population-based approach to health has the potential to ensure that local populations receive services which are much more appropriately targeted to their health needs. Services that are more supportive of a preventative approach and address the wider determinants of health (via services such as education, transport, housing) and support individuals to make healthy choices.

A more collaborative approach to delivering services within, and across, local systems has the potential to develop much more integrated and personalised care for patients and service users who frequently experience services that are disjointed, particularly when their condition requires them to access services from multiple providers. Disjointed care manifests itself for patients when information such as notes and test results are not shared effectively between different organisations, when staff involved in a patient's care are not sufficiently informed of the activities of colleagues working with the same patient in different teams or organisations, and when there is no overall coordination of management of the patient's care across the different bodies involved in providing the care (University of York, 2013).

Digital technology offers the opportunity for more efficient care, ensuring the tax payer gets better value for money, better outcomes from the latest innovations in medical technology, and more personalised care from digital technologies enabling individuals to interact better with the professionals providing their care.

How providers are responding

Trusts are playing an active leadership role within ICS and STPs, often leading key areas of pathway redesign, and helping to navigate arrangements for specialised services and ambulance footprints which cross the boundary of the ICS and STP.

Many trusts are exploring new arrangements with local and national commissioners, as CCGs seek to become more strategic in their focus, and the national commissioners seek to devolve both budgets and responsibility closer to where services are delivered and with greater involvement from clinical experts in the field who are employed by providers. This has been particularly noticeable in the mental health specialised commissioning pilots where lead providers have worked with a network to deliver tertiary services to a population covering a number of STP areas, often realising significant efficiencies and improving quality.

At a more local level, trusts are adopting different approaches to support the delivery of more integrated care. These range from structural solutions, such as the Royal Wolverhampton NHS Trust (The Royal Wolverhampton NHS Trust, 2019) which has acquired a number of GP practices, and now offers an integrated service with primary care, or Torbay and South Devon (Torbay and South Devon NHS Foundation Trust, 2015) which operates an integrated model for acute, community and social care services – to alliances such as the Harrogate and Rural Alliance (NHS Providers, 2019d) in which Harrogate and District NHS Foundation Trust are working with its local partners to keep people out of hospital, and keep them well in the long term, through a set of jointly managed core services.

17%

of trusts were confident system working would support them to become more financially sustainable

Appendix

This report examines the state of the NHS provider sector – the 223 hospital, mental health, community and ambulance trusts in England. It examines how they are performing, the challenges they face, how they are responding and the support they need to consistently deliver outstanding patient care.

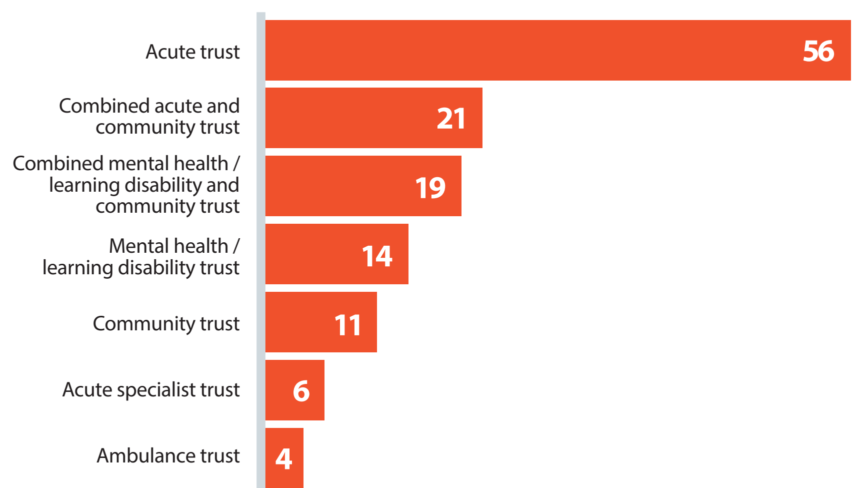
It combines our own analysis and commentary, published data and the views of 131 chairs and chief executives from 121 NHS trusts that responded to our survey in June and July 2019. The responses cover more than half (54%) of all trusts, with all regions and trust types well represented.

In light of the long term plan published earlier in 2019 we revised the report's four themes to:

- quality and performance
- workforce
- funding and finances
- system working, transformation and integration.

We also considered how the challenges and opportunities trusts are grappling with are affecting patients and service users, and how individual trusts and systems are responding to the challenges highlighted.

Figure 14
Respondents by trust type
(n=131)



We would like to thank Helen Crump, Cogency Ltd director, for her contribution to drafting this year's publication on our behalf.

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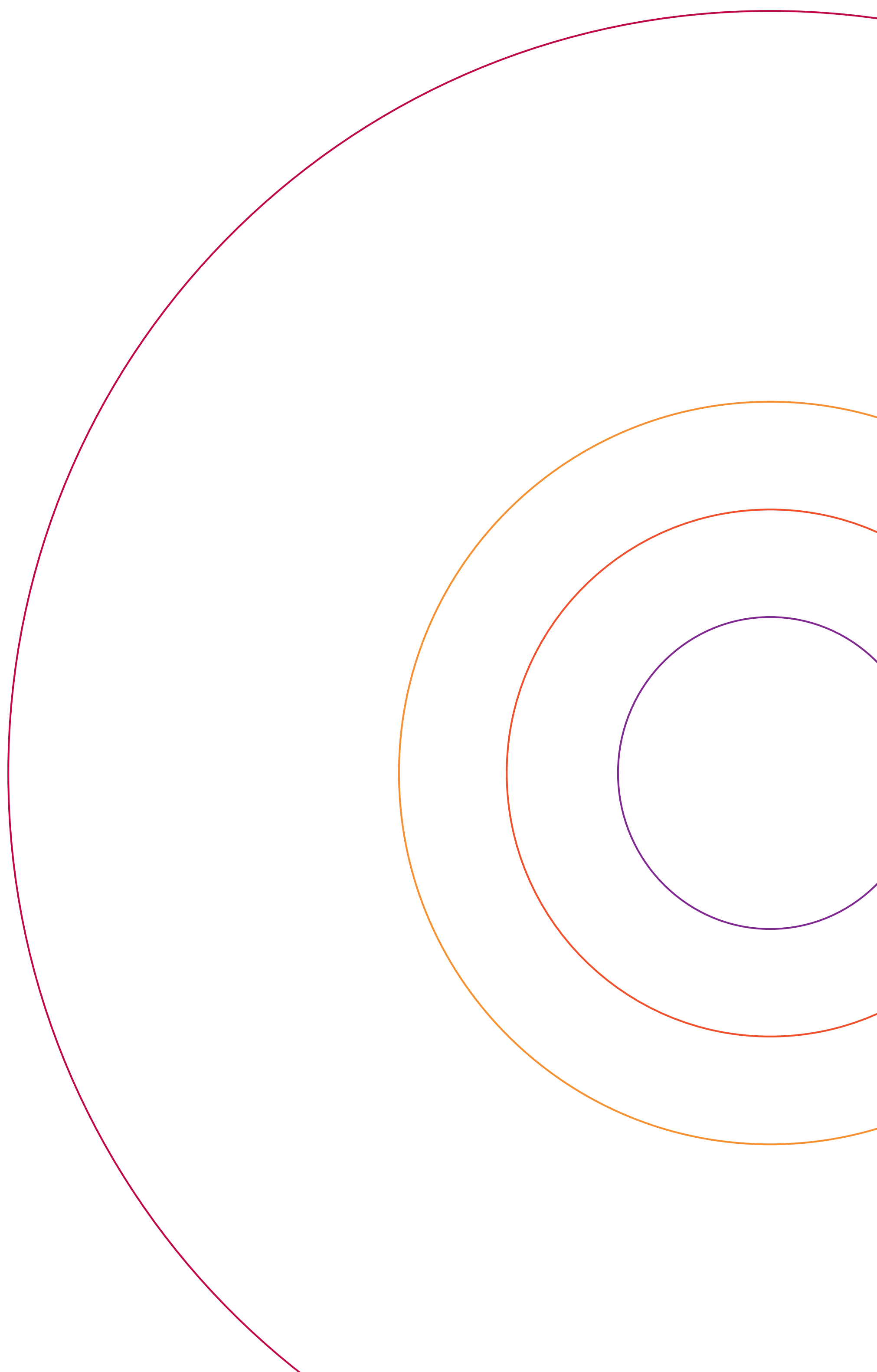

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in membership, collectively accounting for £84 billion of annual expenditure and employing more than one million staff.

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