

Budget representation

Introduction

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation 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 voluntary membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

The NHS long term plan sets out a welcome and ambitious vision to create a 21st century health service. Trust leaders and their staff are committed to creating world class health services, continuously improving patient outcomes and transforming the way they provide care to reflect changing needs. However, the current mismatch between increasing patient demand and the resources available raises serious questions over whether the NHS will be able to deliver the aspirations set out within the plan. The NHS is no longer able to deliver the constitutional standards around access to care, and is grappling with a 'care deficit' in mental health and some children's services following years of underinvestment. In addition, the health and care sector faces significant workforce pressures and is in need of a substantial capital settlement. The extra revenue provided alongside the long term plan, recent announcements from the government on pensions, and the £1.8bn of additional capital spending power announced in August 2019 are welcome, but the scale of ambition and the current challenges facing the NHS means greater realism is needed about whether the long term plan can be delivered within the funding envelope available.

Key messages

- Despite the challenges created by growing demand and increasingly complex patient needs in a time of financial restraint, trusts continue to improve their productivity and make progress to transform services and integrate care¹. Trusts are improving care² for patients and services users and delivered £6.9bn efficiency savings in the three years up to 2017/18³. They are also taking the opportunities presented by system working to improve how care is delivered and make best use of available resources through closer collaboration across primary, secondary and social care.

¹ For all major conditions, results for patients are now measurably better than a decade ago. Childbirth is the safest it has ever been, cancer survival is at an all-time high, deaths from cardiovascular disease have halved since 1990, and male suicide is at a 31-year low – p7, [The NHS Long Term Plan](#).

² CQC ratings are showing improvement in trusts, with 24 rated Outstanding and 107 rated Good in August 2019 compared to 2 rated Outstanding and 29 rated Good in August 2015.

³ <https://nhsproviders.org/media/518505/efficiency18-1f-pages.pdf>

- Despite the welcome settlement in 2018, the real-terms increase of an average 3.4% per year for five years to support the long term plan, is still lower than the NHS long-run funding average and is not sufficient to meet increasing demand. Performance against the constitutional standards is at an all time low, alongside rising demand for mental health, community and ambulance services.
- Workforce challenges are the number one concern facing trust boards. With over 100,000 vacancies across the sector, the pressures placed on committed NHS staff are unsustainable. The NHS needs a clear framework and funding settlement to address supply, recruitment and retention, education and training and appropriate pay, terms and conditions, including pensions.
- Repeated raids on the NHS capital budget have left a maintenance backlog of nearly £6.5bn 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, transparent process by which trusts can access capital. Some services including mental health have suffered a historical under funding and require additional investment
- In addition, adult social care services are now facing a funding gap of £3.6bn by 2025⁴ with growing gaps in workforce capacity due to low pay, unattractive working conditions and lack of job security and the funding shortfall for public health services needs to be addressed urgently.
- The forthcoming comprehensive spending review will provide a welcome opportunity to review the medium term needs of the health and care sector and to debate the funding required to meet public need and expectations of the health service. However, the following pressing issues require urgent attention and resolution within the budget for 2020/21:
 - Ensuring the 2020/21 capital budget increases to reflect the additional £1bn allocated in 2019/20 to ensure trusts do not have to cut back spending on increasingly safety critical issues with buildings and equipment. This should be accompanied by a commitment to a minimum four year capital settlement in the forthcoming comprehensive spending review including recognition of the investment needed for mental health, community and ambulance services.
 - An explicit extra revenue commitment for the NHS to support the first year of implementing the People Plan, in the expectation that a non ring-fenced, multi-year revenue settlement will be forthcoming in the spending review which takes into account of the funding required to deliver the combined aspirations and commitments within both the people plan and the long term plan.
 - A definitive solution to the NHS pensions problem applicable to all staff including managers and clinicians. This solution must look to resolve this issue definitively and fairly, including amending the taper and addressing the impact of the annual allowance for all staff moving into senior roles or through pay increments.
 - Urgent additional revenue for social care for the next financial year while a longer-term solution is explored on a cross party basis and in consultation with the public

⁴ <https://www.local.gov.uk/about/news/councils-set-government-ten-week-deadline-publish-much-delayed-social-care-green-paper>

- Appropriate investment in public health.

Funding to deliver the long term plan

We are conscious that in 2018, the NHS received a favourable financial settlement relative to other public services. However, the revenue funding settlement announced in 2018 is a real-terms increase of an average 3.4% per year for five years, lower than the than the average increase of 4% across the period between the establishment of the NHS in 1948 and 2010.

Alongside the day-to-day- operational challenges facing trusts, repeated raids on the NHS capital budget have left a maintenance backlog of nearly £6.5bn 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. 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. Meanwhile, cuts to social care and local authority funding have had a real impact on the pressures felt by NHS services.

Finally, 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, trusts would benefit from greater prioritisation to enable the sector to deliver a realistic 'ask' within the resources available. Trust leaders remain concerned that the funding promises will not be sufficient to meet rising demand for care and to invest in transforming services to deliver the integrated, personalised care for the public envisaged in the long term plan.

A context of rapidly rising demand

The combination of constrained finances and over 100,000 vacancies across the NHS workforce (and more across primary care and social care) mean trusts across the country remain under considerable strain as they seek to absorb additional demands for care and respond to increasing acuity. This mismatch between demand and the available resources is putting the NHS delivery model under demonstrable strain, evident in the fact that trusts and the wider health and care sector, can no longer deliver the constitutional standards around access to care. The latest monthly figures from NHS England and NHS Improvement show that in December 2019, A&E performance dropped to 79.8% against the four hour standard, down from 81.4% the previous month – the worst figures since records began. The monthly statistics also showed that the elective care waiting list is 4.42 million, and cancer saw all three main standards missed for the fifth time in 2019.

Although the constitutional standards are one of the most publicly visible measures by which the NHS is held to account, it is clear that demand for services is rising across all services:

- Emergency admissions increased by 6% from 2017/18 to 2018/19, resulting in an additional 352,530 hospital stays on the previous year.⁵ .
- The number of new referrals into NHS funded secondary mental health, learning disabilities and autism services during October 2019 was 352,995. This is an increase of 13.3% (41,506) compared to the average number of new referrals per month between October 2018 and September 2019.⁶ .
- The number of people on the waiting list for diagnostic tests has grown by 14% from November 2017 to November 2019.⁷. Due to the lack of capital investment in new diagnostic equipment/scanners and severe work shortages in particular specialisms such as endoscopists and radiographers the waiting list has grown but also had a knock on effect on other standards including the timeliness of cancer diagnoses.
- Demand for ambulance services is rising, with 5% more patients transported to hospital over the first five weeks of this winter than the same period two years ago.⁸ .
- The use of the NHS 111 services has grown significantly. Between December 2015 and December 2019 the number of calls answered increased by 29%.⁹.
- Our members tell us their local community provision was not able to meet the current demand for adult community services.¹⁰.

NHS frontline care has also been severely impacted by budget cuts in other areas of public expenditure in recent years, on which it is dependent to operate effectively. This is most notable in public health and social care, although demand for healthcare affected by cuts to broader public services, including housing and policing. Care Quality Commission (CQC) recently commented on the 'integration' lottery 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 2007.¹¹.

Lack of capacity is also having an impact on performance. In acute hospitals there has been 10% reduction in available hospital beds since 2010 – a reduction of 14,500 beds.¹² This has resulted in hospitals running at very high bed occupancy levels, reaching 95% over winter 2018/19.¹³ and again in 2019/20.¹⁴ This has a significant impact on a hospitals' ability to respond to seasonal spikes in demand. Availability of mental health inpatient beds is also a concern, which often results in people receiving their care out of the local

⁵ <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/>

⁶ <https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/>

⁷ <https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/monthly-diagnostics-data-2019-20/>

⁸ <https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/>

⁹ <https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/>

¹⁰ <https://nhsproviders.org/state-of-the-provider-sector-05-18>

¹¹ <https://www.kingsfund.org.uk/publications/public-satisfaction-nhs-social-care-2018>

¹² <https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/>

¹³ <https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/>

¹⁴ <https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/>

area, with a negative impact on the patient and their family. This is also a costly solution: in October 2019 the NHS spent over £11.1m on 720 out of area placements.¹⁵

Workforce challenges

There are currently over 105,000 vacancies in the provider sector alone¹⁶, a number which is predicted to grow in the coming years if urgent and significant policy reform is not introduced.¹⁷ These challenges are similarly felt in social care and primary care, with vacancies in adult social care currently around 110,000¹⁸ and the number of GPs falling by 1.6%.¹⁹ The difficulties providers face in recruiting and retaining sufficient staff numbers is significant and now seen by trust leaders as a core driver of the mismatch between growing demand and their capacity to respond.

Ensuring the right staffing levels with the right skill mix is crucial to maintaining safe and effective care. Two thirds of nurses say they cannot do their job properly due to understaffing.²⁰ Data from the NHS staff survey and recent workforce statistics paint a worrying and unsustainable picture of significant pressures on staff satisfaction compounded by rates of pay as well as staffing levels, poor morale, work-related stress and poor work/life balance. 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%, and 28% of respondents reported bullying by a patient, service user, family member or other member of the public. Three in 10 staff (30%) said they often thought about leaving their organisation.²¹

The interim NHS people plan was published in June 2019 to support delivery of the long term plan, as well as setting out actions supporting the workforce.²² The plan recognises the severity of the service's workforce challenge and helpfully acknowledges that, alongside better planning and increased funding, the NHS needs to look at culture and behaviours, with the government, arm's length bodies and the frontline all having a key part to play. While the interim people plan, alongside announcements from the government about increasing nursing and GP numbers, is a welcome step forwards, a detailed framework and clear funding settlement are still needed in order to address a number of issues:

¹⁵ <https://digital.nhs.uk/data-and-information/publications/statistical/out-of-area-placements-in-mental-health-services/october-2019>

¹⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/february-2015---september-2019-provisional-experimental-statistics>

¹⁷ NHS Improvement, *Performance of the NHS provider sector for the quarter ended 31 December 2018* (March 2019), https://improvement.nhs.uk/documents/4942/Performance_of_the_NHS_provider_sector_for_the_quarter_ended_31_Dec_2018.pdf

¹⁸ <https://www.kingsfund.org.uk/publications/articles/brexit-implications-health-social-care>

¹⁹ <https://www.health.org.uk/news-and-comment/news/nhs-staff-shortages-put-long-term-vision-for-primary-and-community-care-at-risk>

²⁰ <https://www.unison.org.uk/content/uploads/2017/04/Rationotrationing.pdf>

²¹ <http://www.nhsstaffsurveyresults.com/>

²² https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

NHS Pensions

The impact of annual allowance and lifetime allowance pensions tax charges on clinical capacity in the NHS is well documented, with evidence of large numbers of consultants reducing their hours or the number of additional sessions they are willing to do²³, creating a significant knock on effect on the effective running of NHS services.

The pensions taxation issue must be seen within a wider context of low morale, high and stressful workloads, and growing pressure on staff wellbeing. This issue has revealed how heavily services rely on the additional discretionary efforts of staff, who regularly work beyond their hours to keep services running. The situation has been exacerbated by the already fragile morale of the workforce, and there is a growing sense that recent concerns over pensions taxation have acted as the 'final straw' for many in the NHS, triggering decisions to leave the workforce, reduce hours or draw back from career progression. This underlines the importance of addressing wider workforce challenges and taking a holistic and longer term approach to managing these issues.

Despite efforts by the government and NHS England and Improvement, the current pensions solutions available do not have the full confidence of clinicians, and trust boards do not expect them to restore capacity in frontline services.

We remain very concerned both about the effectiveness of the proposals on the table to mitigate the impact for clinicians, and about the impact of the current pension arrangements for leaders and managers within the NHS. While some trusts have implemented local flexibilities and made them available to all staff affected by tax bills regardless of role, we note that both of the recently announced 2019/20 tax reimbursements through Scheme Pays and national-level flexibilities are currently only available to clinicians.

NHS Providers has long been calling for a comprehensive solution to the issue that takes into account all NHS staff. There is a real risk of divisiveness and a further impact on staff morale if a comprehensive solution is not agreed. As such, we believe there is a need to restore the incentive for doctors to work extra shifts, but also to present a fair offer for all staff affected by these punitive taxes. This has to include both a change to the taper and address the impact of annual allowance for all staff moving into senior roles or through pay increments. A lasting solution to the pension problem must also include a commitment to review flexibilities for lower paid staff who can struggle to afford high contribution rates.

These concerns were confirmed by the findings of our survey²⁴ of all executive directors of the 223 trusts within the provider sector. Trusts told us of the significant impact of annual allowance taxation on managers, on morale within the NHS and the consequent impact on services and frontline care. We believe that the artificial distinction between the value of clinical and non-clinical staff created by the

²³ <https://www.bma.org.uk/features/payingtowork/>

²⁴ <https://nhsproviders.org/an-unnecessary-divide>

pensions issue is counter to the culture of equity in the NHS. Our survey showed that there is a clear and compelling need to implement a solution to address the issues created by annual allowance taxation for all staff affected. There is an opportunity to intervene and strengthen the resilience of the workforce through implementing measures to address workload, burnout and wellbeing, and ensure staff feel valued and motivated.

Education and training

There needs to be significant investment in a future spending review to expand clinical education and training budgets. A reduction in these budgets in recent years, and general issues over workforce capacity, has meant underinvestment in skills development. Health Education England, which manages the NHS's work force and training budget, has seen their funding as a percentage of the overall Department of Health and Social Care (DHSC) budget fall year on year since 2013/14, from 4.32bn in 2013/14.²⁵ to £4.02bn in 2017/18.²⁶ The King's Fund, The Nuffield Trust, and The Health Foundation have together modelled a £250m uplift in investment as necessary for workforce development funding by 2023/24.²⁷ The takeup of nurse training placements has decreased significantly since the removal of the bursary and – while there may be no direct correlation – it is clear that a review of financial incentives and support for clinical training places is essential.

Training in new technologies is vital to ensure the workforce has the skills and confidence to deploy them in the delivery of day-to-day care across the health system. This will be achieved through funding training programmes and continued professional development, as well as cultural changes, such as sabbaticals and secondment and creating a culture of learning and development.

Making the NHS a great place to work

78% of respondents to the 2019 NHS staff survey reported feel under unrealistic time pressures some or all of the time in their jobs²⁸. The interim people plan set out one of its aims as making the NHS a great place to work and is correct in stating that “the culture of the NHS is being negatively impacted by the fact that our people are overstretched”²⁹. While we await publication of the NHS people plan trusts are already innovating to seek to improve health, wellbeing and work-life balance. Examples include trusts:

- employing a staff support chaplain to provide free pastoral care and counselling to those affected by stress, anxiety or depression
- collaborating with the local council to offer free housing to 24 junior doctors
- introducing flexible working schemes, including an option for some staff to take on term-time only working

²⁵ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327682/HEE_accounts_2013-14.pdf

²⁶ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/815969/hee-annual-report-2018-to-2019-web-accessible.pdf

²⁷ <https://www.kingsfund.org.uk/sites/default/files/2018-11/The%20health%20care%20workforce%20in%20England.pdf>

²⁸ <https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2019/>

²⁹ https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

- providing other additional benefits, such as annual leave on staff birthdays.

Together with NHS Improvement and the Faculty of Medical Leadership and Management we have developed eight high-impact actions which have been recommended by doctors to improve their working environment and morale, and which can be implemented quickly³⁰. However, there is still a huge amount to be done to address staff retention in trusts.

Recruitment and increasing supply

The primary short-term solution to increasing supply would be to ensure immigration policy enables the health and social care sectors to recruit sufficient staff from the EEA and internationally. As well as adopting a positive approach to recruiting health and care staff within the UK immigration rules, a level of coordinated support from the national level would help those trusts who have been less successful or historically active in recruiting from abroad. It would also be helpful for any government to consider an offer of financial support for both trusts and prospective new staff who face a number of cost barriers to migration. We are encouraged to see the migration advisory committee recommend the protection of international recruitment of healthcare staff through the alignment of salary thresholds to national NHS pay scales. It is clear the NHS will need to steadily increase recruitment from overseas in the next five years and beyond to address the 100,000 plus vacancies in trusts and meet its manifesto commitment to add 50,000 nurses to the workforce. However, there are no practical proposals to ensure ongoing and increased recruitment of migrant workers into social care, which is absolutely critical to support the sustainability of care services across the country.

The government needs to work with trusts, universities and unions to ensure the planned 25% increase in nursing student places are filled, as well as fast-tracking development and regulation of new roles and remove trusts' barriers to apprenticeships funding. Removing return to work barriers would also be a positive step forward. More flexibility in re-training and appraisal for experienced staff would benefit both experienced nurses and hospital consultants, while changes to pension rules and other incentives should be considered to encourage early retirees back into practice. Alongside these local initiatives, it is clear that the NHS as a whole needs to do more to improve the recruitment offer to a new generation of staff, to encourage more young people to take up training opportunities in the NHS and provide more flexible and appealing career pathways to new entrants to the workforce. Recruitment issues must also be examined closely across sectors, as there are particular challenges in attracting specialist nurses into community and mental health settings and in attracting all professions and grades of staff to work in rural or remote areas.

Pay, terms and conditions

Staff must be appropriately and fairly rewarded in order to support recruitment and retention and help create a motivated workforce. The NHS is dependent on the efforts of clinical and non-clinical staff who frequently go above and beyond the call of duty as they respond to increasing service demand.

³⁰ <https://improvement.nhs.uk/uploads/documents/NHS-8-high-impacts-A4v5Bm.pdf>

Although the latest Agenda for Change (AfC) agreement was welcome, NHS pay has experienced a prolonged period of restraint and has not kept pace with the wider economy and inflation.³¹ In addition to a resolution to the pensions crisis set out above, this regression needs to be addressed in any subsequent pay deal for AfC staff, with a continued emphasis on improving remuneration for those in lower pay bands. It is essential that any pay deal is fully funded and trusts receive central funding to ensure that NHS staff paid via local authority funded contracts are not left out of any pay rises that the wider NHS workforce receive, and that this group of staff providing essential community based services are not treated as 'second class NHS citizens'.

On medical staff pay, the recent junior doctor contract agreement and 2% uplift is welcome and it is important that similar multiyear deals are reached for SAS and consultant doctors in the near future.

Finally, clarity is needed on DHSC's approach to a new 'very senior manager' pay framework, with an acknowledgement of how any changes could affect the large number of vacancies and high rate of turnover in trust management.

Apprenticeship levy

Apprenticeships are recognised as an important route to building a committed workforce and increasing supply. However, in its current form, the apprenticeship levy has proved inflexible and confusing for employers in all sectors. The current available funding for a trust to train a nurse apprentice is £27,000. Additional costs, calculated by subtracting training costs from the total cost of the apprenticeship per annum, amount to £34,000 and have to be covered by the employer.³² In particular, the Nursing and Midwifery Council requires nurses to spend part of their time in on-the-job training, but they have supernumerary status and cannot be counted in overall staffing levels. In order to make nursing degree apprenticeships affordable while maintaining and increasing numbers of places filled, additional funding would be required to cover some or all of the costs of employing a nursing degree apprentice. Trusts are undoubtedly eager to employ more apprentices but cost barriers – particularly in higher level nursing apprenticeships – must be addressed, and a supply pipeline created before this policy expectation can be fulfilled.

Capital expenditure

Capital covers all money used to invest in goods and services that will be used for more than one year, such as buildings, equipment, vehicles and IT. Capital spending in the NHS is a fraction of the size of the revenue budget: the highest DHSC capital budget (known as the capital departmental expenditure limit – CDEL) a proportion of the revenue budget in the past decade is 5%, in 2010/11. The UK also spends a

³¹ For example, the Health Foundation found that between 2008/09 and 2015/16 the basic pay of NHS staff fell by 6% in real terms. Health Foundation, *In short supply: Pay policy and nurse numbers* (April 2017)
https://www.health.org.uk/sites/default/files/Workforce%20pressure%20points%202017%20FINAL_0.pdf

³² Oral evidence to the Education Committee for its *Nursing apprenticeships inquiry* (June 2018),
<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/education-committee/nursing-apprenticeships/oral/84628.html>

significantly smaller proportion of GDP on health infrastructure than other countries: 0.27% compared with an OECD average of 0.5%, and 0.6% in many comparable economies³³.

The long term plan set out a vision for an NHS built around preventative and technologically-enabled models of care³⁴. Delivery of this ambition will require building and investment in new facilities, repair and upgrade of the existing estate and investment in enhanced digital capabilities and diagnostic equipment. This in turn will create a more efficient and productive provider sector, which is able to keep pace with the expected rising need for care in the years ahead. In order to achieve this, the NHS needs a substantial capital settlement to eradicate the backlog, enable routine maintenance and invest in service transformation.

Investment in facilities and up to date technology is essential in keeping any health system safe, and adapting to meet the changing needs of the population served. There has been significant underinvestment in NHS capital for many years. The core NHS revenue budget – covering ongoing day-to-day running such as salaries, heating, lighting, services, medicines and supplies – has risen at least in line with inflation every year since 2010. However, there has been no such protection for capital budgets, with £4.46bn of capital funding diverted to keep day-to-day NHS spending in balance since 2014/15. This has created a £6.5bn maintenance backlog, £3bn of which is deemed ‘high risk’ or ‘significant’³⁵. In August 2019, the prime minister announced £1.8bn of additional capital spending power, including £850m of new funding for 20 hospitals to upgrade outdated facilities and equipment. While this is welcomed by trust leaders, it needs to be seen as a first down payment ahead of a consistent, longer term approach to capital funding. The £1.8bn will not sufficiently bring down the backlog, let alone enable the transformation of NHS technology and infrastructure required.

Ensuring there is sufficient capital funding is vital in several ways:

- **Safety.** Poorly maintained facilities put patients, staff and any members of the public at risk. This manifests in a variety of ways, including:
 - poorly maintained water supplies leading to legionella outbreaks
 - unresolved fire risks from unsafe cladding
 - broken guttering falling from a roof into a public carpark
 - lifts needed to transfer critically ill patients around a hospital not working
 - easily accessible ligature points and flat roofs pose a risk to people in mental health crisis.
- **Supporting good performance.** Trusts need appropriate facilities to be able to treat ever-increasing volumes of patients and service users needing NHS care. The long term plan makes a number of commitments to improve care for major health conditions, including cancer, cardiovascular disease and diabetes. The NHS also needs to work towards recovering performance against constitutional standards.

³³ <https://www.health.org.uk/sites/default/files/upload/publications/2019/Failing-to-capitalise.pdf>

³⁴ <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf>

³⁵ All trusts are required to carry out a risk assessment of their maintenance backlog and rank them into 4 categories; low, moderate, significant, high

- **Efficiency and productivity.** Investment in equipment and buildings can enable trusts to adopt more efficient ways of working, which make better use of clinicians' time and free them up for more patient facing activities. In a recent survey of trust leaders, 39% said that lack of access to capital was a barrier to making efficiency gains.³⁶
- **Transformation.** Trusts are keen to adopt the most up to date and best models of care but this requires investment. For example, large strategic reconfigurations such as the consolidation of trauma or stroke services to improve outcomes may involve building works to provide new facilities or repurpose old ones. Smaller reconfigurations, such as the consolidation of services within a multi-site trust, also require investment. Adopting technologically-enabled forms of care, such as the use of remote monitoring of patients or e-consultations can only happen with investment. Meanwhile, a shift to a preventative model with more care delivered in the community and away from hospitals may require the expansion or modernisation of community facilities.
- **Supporting the workforce.** Better working conditions for staff can improve recruitment and retention in the trust sector. Outdated technology and uncomfortable working environments wastes time and demotivates and frustrates staff. Clinicians, nurses, managers, social care workers and healthcare scientists are all more likely to want to work within organisations that are digitally advanced and investing in innovation.

There is widespread agreement that the current system of capital project identification, prioritisation, allocation and approval is broken and needs rapid and radical reform. No capital budget has been set for the NHS beyond 2020/21 and as a result, when NHS organisations plan for long-term change they are currently doing so without being sure that the funding for the infrastructure to support those changes will be available. Current levels of capital spending are insufficient to meet the NHS' needs and the existing mechanisms for individual trusts to access capital funding do not work. There is no match between trusts' need to replace, update or repair facilities and their ability to do so as allocation of the capital funding is not based on need. Agreements for major new NHS infrastructure projects effectively ceased in 2015, when the private finance initiative (PFI) regime fell out of favour without an alternative being put in its place. There is also a lack of transparency in how decisions over central allocations are made.

We welcome the government's recognition of this important agenda, and the prime minister's recent commitments to provide six hospitals with £2.7bn by 2025 as part of a "new hospital building programme" and £100m in seed funding for a further 21 hospitals. However, we believe the government needs to make significant changes to the current system including;

- Setting a multi-year capital settlement, which will allow the NHS to plan for the long term and transform its services and equipment. Ideally, this would match the ten years of the long term plan and be extended annually.
- The NHS' capital budget needs to be brought into line with comparable economies, meaning funding available to trusts should roughly double. Some of this should be spent on essential maintenance

³⁶ <https://nhsproviders.org/media/518505/efficiency18-1f-pages.pdf>

works. However to rebuild and replace facilities, it will also be necessary to fund a national building programme on a scale comparable with the 1960s hospital plan, and the investment that took place between 1999-2010.

- The NHS needs an efficient and effective mechanism for prioritising, accessing and spending NHS capital based on need. A key principle should be that wherever possible capital spending decisions should be devolved to the level where service accountability sits, and to avoid rationing, the national capital spending limit must be high enough with sufficient revenue to fund most investment from trust surpluses.

Capital expenditure in mental health trusts

The additional capital government has announced to date has been welcome, but entirely acute focused. There remains a need for capital investment within the mental health sector – and within community and ambulance services.

As we highlighted in our briefing, *Mental health funding and investment: a digest of issues*, trusts providing mental health services need capital investment, particularly in order to improve patient safety in mental health settings.³⁷ Yet, NHS mental health providers receive less capital funding than might be expected given the sector's proportion of turnover across the whole of the NHS provider sector.³⁸ Furthermore, only three mental health trusts were allocated funding in the waves of capital investment for trusts announced by the government in September 2019.³⁹

The under-prioritisation of investment in the mental health estate is having a real impact on patients and mental health trust leaders have already expressed their concerns that lack of capital investment places their patients at increased risk.⁴⁰

According to our latest survey of trusts providing mental health services undertaken within the last month, four out of five (81%) trusts estimate their capital needs in 2020/21 to be between £4-20m. A small number of trusts' estimations are significantly higher, with one trust requiring an estimated £100m of capital investment next year, mainly in order to fund significant redesigns of two inpatient services.

Two thirds of trusts (67%) who responded to our survey told us they will not be able to access enough capital funding in 2020/21 to meet their estimated capital needs for the year. For a quarter of trusts (27%), current levels of capital funding in 2020/21 will meet less than 50% of their needs next year. One trust told

³⁷ NHS Providers, Mental health funding and investment: a digest of issues, January 2020

<https://nhsproviders.org/mental-health-funding-and-investment>

³⁸ NHS Improvement, Performance of the NHS provider sector for the year ended 31 March 2019, 2019

https://improvement.nhs.uk/documents/5404/Performance_of_the_NHS_provider_sector_for_the_quarter_4_1819.pdf

³⁹ Department for Health and Social Care, Health infrastructure plan, September 2019

<https://www.gov.uk/government/publications/health-infrastructure-plan>

⁴⁰ NHS Providers, The end of parity of esteem? Patients face increasing risks as NHS funding announcements neglect mental health, October 2019

<https://nhsproviders.org/news-blogs/news/the-end-of-parity-of-esteem-patients-face-increasing-risks-as-nhs-funding-announcements-neglect-mental-health>

us it will not be able to meet any of its capital needs for 2020/21 and has been told it cannot raise private finance even though a bank has indicated it could provide the funding.

Our survey has highlighted that there are a number of trusts that have had CQC enforcement action taken against them due to the condition of their estates or infrastructure, who are not able to meet the capital costs required to address CQC's concerns with the current levels of capital funding available to them. We are particularly concerned by this given CQC take such action in order to protect people from harm and the risk of harm, and to ensure they receive services of an appropriate standard. Two trusts have told us they are unable to meet over 70% of the capital costs required to address CQC's concerns.

There is a significant amount of variation in the level of capital investment trusts need over the next 5 to 10 years. Two thirds of trusts (69%) responding to our survey estimate they need between £50m and £150million over the next 5 to 10 years. The lowest estimated figure is just under £16m whilst the highest estimation is just over £500m. Many trusts are not able to meet their estimated capital needs for 2020/21 so we would assume this would be the case for the next 5 to 10 years also. One trust told us that, based on its current predictions, it will only be able to meet approximately 33% of its capital needs over the next five years.

Funding for car parking

In December 2019, the government announced a policy⁴¹ to require trusts to provide free car parking groups to 'frequent hospital visitors and those disproportionately impacted by daily or hourly charges for parking. Currently, there is only non-mandatory guidance, which states that trusts should offer concessions to patient groups including those with disabilities, frequent outpatient attendees, visitors to relatives who have an extended stay in hospitals; carers, and other groups.

The government has said it will work with the NHS and others to ensure that it spreads existing good practice in applying current exemptions, and will identify practical ways for trusts to implement the policy. We are concerned that unless it is funded centrally, this policy will impose a significant additional cost pressure on trusts. In 2017, the government estimated that mandating free car parking for all trusts "would result in some £200m per year being taken from clinical care budgets to make up the shortfall"⁴² – as all car parking profits are currently reinvested in frontline services. At quarter two 2019/20, the most recent available data, trusts were forecasting to deliver a £320m deficit.⁴³ If the costs of this policy were borne by existing budgets, there is a significant risk the NHS would not be able to deliver its long term plan commitment for the provider sector to achieve overall balance in 2020/21.

⁴¹ <https://www.gov.uk/government/news/free-hospital-parking-for-thousands-of-patients-staff-and-carers>

⁴² <https://www.parliament.uk/written-questions-answers-statements/written-question/commons/2017-03-06/66653>

⁴³ <https://www.england.nhs.uk/wp-content/uploads/2017/06/financial-performance-report-q2-2019-20.pdf>

Funding for digital transformation

In order to achieve the core level of digital capability, as required by the long term plan trusts will need to invest in long term digital programmes. The sector therefore requires access to a significant level of digital investment over ideally a ten-year period. This won't be possible if the government and its central bodies continue to channel funding through piecemeal announcements related to specific digital and IT schemes (for example initiatives such as 'axe the fax', or single sign on). This approach makes it difficult for digital leaders to plan long term investment. While extra funding is always welcome, it is trusts themselves who are best placed to decide how to use this funding most appropriately to benefit their patients. For example some will want to invest in AI while others will still need to invest in their basic IT infrastructure.

Funding models for digital increasingly rely on both revenue and capital streams. This is because effective digital/IT provision is often a service rather than a single capital asset. The move to the cloud and licensing models means IT departments are making fewer one off purchases. Developers (a revenue cost pressure) will always be needed for new digital services. Where it is appropriate, negotiating national licensing and commercial agreements with large suppliers is welcome. Trusts acknowledge that utilising the purchasing power of the sector makes sense when procuring digital solutions that will be universally adopted. These negotiations, however, should always be informed by the needs of trusts, along with full and appropriate engagement with trust digital leaders.

While digital transformation represents an opportunity to drive efficiencies, it should also be recognised that digital ways of working can drive up quality and improve safety. Investing in digital technologies should not simply be seen a cost saving exercise.

Social care

The estimated funding gap for adult social care is £1.5bn, set to rise to £3.5bn by 2024/25⁴⁴. The impact of the funding gap in social care is wide reaching and puts significant, avoidable pressure on the NHS. Those who do not receive the support they need to live independently in the community are vulnerable to deterioration in their health conditions, social isolation, and falls. Many hospital admissions could be prevented by effective social care, which is better for patients and enables more efficient use of scarce resources. The social care system also needs sufficient capacity to ensure people can return home as soon as it is appropriate after a stay in hospital. The care home sector needs sufficient funding to remain sustainable and safe.

The prime minister's commitment to fixing "the crisis in social care" is therefore welcome, as is the recent one off increase in funding for social care announced by government. However, we are concerned that social care services require greater financial support for the short term than has been made available. Moreover a long-term solution is long overdue. Any settlement announced in a future spending review

⁴⁴ <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7903#fullreport>

should take into account this funding gap and make a meaningful contribution towards closing it. This should be accompanied by system reform to ensure the system works well for those who need it.

There are a number of options for funding an increase in the adult social care budget, including changes to tax contributions, a social care premium, and changes to the self-funding model. The merits and drawbacks of these have been explored at length across numerous publications over the last five years. The choice of which option to pursue is ultimately a political decision for the government to take. However, the Health for Care coalition, which comprises 15 organisations representing the NHS, has set out a number of principles which any settlement for adult social care should meet:

- eligibility should be based on need and must be widened to make sure that those with unmet or under-met need have access to appropriate care and support
- any settlement should provide secure, long-term funding at a local level to enable the social care system to operate effectively and deliver the outcomes that people want and need, addressing immediate needs from April 2020 as well as putting the sector on a sustainable path for the longer term
- social care funding would need to rise by 3.9% a year to meet the needs of an ageing population and increasing numbers of younger adults living with disabilities, and any additional funds must be accompanied by reform and improved service delivery.

Public health and local authority funding

Public health budgets, which pay for essential community services such as sexual health, school nursing and health visiting, are essential to a more prevention-focused health service, but were placed outside the NHS ring fence in 2013. Public health budgets have been reduced by £531m between 2015/16 and 2019/20, with the public health grant from DHSC to councils being cut from a peak of £3.6bn in 2016/17 to £3.1bn in 2019/20⁴⁵. The public health grant for local authorities received a small uplift recently, but this will not go far enough to address the recent under funding of these services or to allow local authorities and their partners to address the wider determinants of health.

This has had a direct impact on NHS staff on agenda for change providing community services, whose roles are funded by local authority contracts, and on the trusts who employ them. It is essential that agenda for change uplifts for local authority funded services are funded centrally to avoid trusts being tasked with finding the additional funding. Trusts and local authorities are often not in a position to renegotiate multi year contracts to make annual, local adjustments for pay in line with a previously unknown and centrally led agenda for change uplift.

However, the long term plan sets out an aim to tackle the top five causes of premature death and has a focus on the action the NHS can take on prevention and health inequalities. In order to achieve these aims, government must urgently address the shortfall local authorities are facing in funding public health services. There is a link between cuts to public health budgets and local support services, and a rise in

⁴⁵ Health Foundation, *Briefing: Taking our health for granted* (October 2018), https://www.health.org.uk/sites/default/files/upload/publications/2018/Taking%20our%20health%20for%20granted_for%20web.pdf

hospital admissions. Investment in public health and prevention is vital if we are to move care closer to home.

Cuts to public health funding also have a specific impact on NHS staff on agenda for change providing community services, whose roles are funded by local authority contracts. It is essential that agenda for change uplifts for local authority funded services are funded centrally to avoid trusts being tasked with finding the additional funding. Trusts and local authorities are often not in a position to renegotiate multi year contracts to make annual, local adjustments for pay in line with a previously unknown and centrally led agenda for change uplift.

Moreover, good health is supported not just by health services and social care, but also by access to green spaces, leisure activities, libraries, education, and accessible public transport. With many local authorities forced to reduce spending and cut services across these areas just to fund their statutory duties in respect of adult social care and social services, much has already been lost in the way of local authorities' financial capability to support a holistic and tailored approach to population health. The spending review should consider population health overall and restore sufficient funding for local authorities to deliver these services.

The recently published prevention green paper provides an opportunity to talk about prevention and public health as a central pillar of a sustainable health and care system. However, to deliver these ambitions the support of wider services is crucial, including public health services commissioned by local authorities. The NHS has a role to play, but the proposals outlined in the prevention green paper do not sufficiently address the wider determinants of health. A precondition to good public health is socio-economic prosperity and equity: individuals and communities being enabled to access the support they need to thrive. We need to see a commitment to this in the spending review.

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In summary

The NHS plays a central role within our society. It supports us to stay well and to live healthy lives, offering treatment and care when we are unwell from cradle to grave. NHS organisations are 'anchor institutions' in local communities acting as the largest employer in the country. The NHS is a source of innovation, pioneering research and an international brand of which we are all proud. For the NHS to realise the ambitions of the long term plan, meet rising and changing demand and continue to support the

government's ambitions of a prosperous society, it will require appropriate, and additional, investment. This includes:

- Ensuring the 2020/21 capital budget increases to reflect the additional £1bn allocated in 2019/20 to ensure trusts do not have to cut back spending on increasingly safety critical issues with buildings and equipment. This should be accompanied by a commitment to a minimum four-year capital settlement in the forthcoming comprehensive spending review including recognition of the investment needed for mental health, community and ambulance services.
- An explicit extra revenue commitment for the NHS to support the first year of implementing the people plan, in the expectation that a non ring fenced, multi year revenue settlement will be forthcoming in the spending review which takes into account of the funding required to deliver the combined aspirations and commitments within both the people plan and the long term plan.
- A definitive solution to the NHS pensions problem applicable to all staff including managers and clinicians. This solution must look to resolve this issue definitively and fairly, including amending the taper and addressing the impact of the annual allowance for all staff moving into senior roles or through pay increments.
- Urgent additional revenue for social care for the next financial year while a longer term solution is explored on a cross party basis and in consultation with the public.
- Appropriate investment in public health.