NHS Providers' submission to the Public Accounts Committee's inquiries on:
NHS Financial management and sustainability,
Capital Expenditure in the NHS

15 May 2020

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.

Key messages

- Trust leaders welcomed the decision to pause the financial system in the face of COVID-19, giving providers across the NHS much needed flexibility and space to focus their efforts on coping with the virus. Trusts will need financial support to cope with complex challenges presented by COVID-19, and its knock-on effects.
- However, the measures introduced to tackle COVID-19 are temporary, and it is not yet clear how trusts will return to normal financial arrangements. The five-year funding settlement introduced from 2019/20 brought annual real terms funding growth up to 3.4%: while enough to keep pace with growth in demand, it falls short of what is needed to recover performance and transform services within the health service.
- COVID-19 is having a major impact in all sectors of the health service. While the effect on acute hospitals is widely understood, mental health, community and ambulance services have also faced significant challenges, having to rapidly adapt how they treat patients. All sectors face long term changes to how they operate, and this will have implications for the sustainability of services, trusts and systems.
- The government's recent announcements on NHS capital are welcome, but capital budgets are not yet at the level needed by the NHS to be sustainable in the long term. The pandemic has shone a light on the current underinvestment in buildings and infrastructure and highlighted the clear need to transform estates and tackle backlog maintenance.
- We welcome the NAO's findings on capital. We believe that that securing a multi-year capital settlement, aligning the capital budget with comparable economies, and establishing an efficient and effective mechanism for prioritising, accessing and spending NHS capital based on need are needed to support the NHS Long Term Plan (LTP).
- The pandemic has temporarily halted progress on service-wide efforts to improve and return to a sustainable financial position, adding a new layer of operational priorities, each with accompanying cost commitments. This includes retaining surge capacity, continuing to treat large numbers of people suffering from coronavirus, and support testing and vaccination programmes. NHSEI have stated that the LTP would require an improved capital settlement to drive transformation, expand capacity and improve efficiency. As the earliest such a settlement could begin is now 2021/22 (the middle year of the LTP period), we believe it will

be necessary to revisit how the LTP's goals of a rapid return to financial sustainability align with this new context.

Financial management in the context of the DHSC's response to COVID-19

1. On 17 March, NHS England and Improvement (NHSEI) suspended the normal operation of financial and contracting arrangements for NHS trusts and foundation trusts.[1] The well-established national tariff payment system, contracting processes, and national incentive schemes such as commissioning for quality and innovation (CQUIN) and the financial recovery fund (FRF), were all halted and replaced with block payments based on historic costs, with excess costs funded centrally. Trusts were told not to let financial constraints stand in the way of taking necessary action to tackle COVID-19, on the understanding that all reasonable costs would be centrally funded. These temporary arrangements have been put in place until 31 July 2020.

2. In their letter of 29 April, NHSEI's chief executive and chief operating officer set out arrangements for a gradual resumption of normal activity, as the NHS entered the second phase of its response to COVID-19.[2] While measures have been set out to ensure the provision, as far as possible, of services such as urgent and routine care, cancer services, heart attack and stroke, it is not yet clear how the NHS will transition back to normal financial operations.

3. Pausing the operation of the current financial system was generally welcomed by the provider sector as it gave trusts the space to focus their efforts on changing their services to prioritise treating patients suffering with COVID-19. However, it will be important to ensure these arrangements are temporary: paying trusts on block for a prolonged period would undermine efficiency and cost containment. Mental health trusts have only recently moved away from block payments and we believe that maintaining this would be a retrograde step.

4. Although the first peak of the pandemic's impact has now passed, the provider sector faces the major challenge of continuing to respond to COVID-19 while resuming normal activity and making inroads into the large backlog of cases and pent up demand that have built up over the past two to three months. This period will last for many months and will require very careful management both from the national NHS leadership and at trust level. Ideally, the temporary block arrangements will be replaced by an appropriate set of financial directions and incentives that support trusts to deliver the resumption of normal activity alongside the ongoing response to COVID-19.

Sustainability: Financial performance of providers

5. Real terms increases in funding to trusts since 2010 have fallen short of the long run historical average of 4%. As a result, the provider sector has reported a net aggregate deficit in each year since 2013/14. Although trusts have consistently delivered efficiency savings worth around 3.5% of annual turnover, and despite the imposition of control totals and financial incentives for improved performance, these deficits have persisted due to the gap between the resource available and the costs of providing services.

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[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/second-phase-of-nhs-response-to-covid-19-letter-to-chief-execs-29-april-2020.pdf

6. At a trust level, this resulted in a deficit in roughly half of all trusts, overwhelmingly in the acute sector where growth in admissions has been consistently underestimated and, through the prices paid for emergency care, underfunded. Meanwhile, performance against operational standards has significantly deteriorated and unmet need has grown in the community and mental health sectors. In the mental health sector finances are becoming increasingly strained, with latest data showing the sector was forecast to finish 2019/20 short of its surplus target for the first time.

7. Many trusts and health systems cannot, for structural reasons, bring their costs down to a level that would be covered in full by the national tariff payment system. The reasons are complex, but may include:

    - Isolated care settings serving isolated populations that cannot be closed or consolidated;
    - The costs of contracts, such as cleaning or catering, are higher as economies of scale are unattainable;
    - Gaps in clinical rotas leading to a reliance on expensive locum and agency staff due to recruitment and retention issues;
    - Sub-optimal activity levels leading to proportionately higher overheads and therefore higher unit costs for each episode of care;
    - Difficulties in attracting trainee doctors because of the lack of financial incentives that support relocation;
    - A case mix that tends to run at a loss under the tariff, that is weighted towards essential services such as emergency and maternity care, with relatively little elective or specialist work.
    - Doctors spending some of their working travelling, meaning senior medical time is used less productively.

    These issues have not historically been sufficiently reflected in payments to trusts.

Sustainability in 2019/20

8. The five-year funding settlement introduced from 2019/20 brought funding growth up to 3.4%, enough to keep pace with growth in demand but short of the 5% identified by the Institute for Fiscal Studies and the Health Foundation needed to recover performance and transform services. The impact of this improved settlement is not yet known as year-end data for 2019/20 is not currently available. However, month 10 data published by NHSEI shows a year end forecast provider deficit of over £800m: £500m more than planned and little improvement on 2018/19 once one-off factors are taken into account.

9. The reasons for this are likely to be complex, but will include:

    - Increases in funding only being enough to keep pace with rising demand for care;
    - Resource available not reflecting the built-in costs of running services in some health economies;
    - Spending on agency nurses and doctors to fill vacancies and rota gaps;
    - Years of under-investment in infrastructure making it difficult for some trusts to achieve a transformational improvement in efficiency.

10. It is also the case that the introduction of control totals since 2016 has encouraged a focus on in-year, single-organisational cost containment, ahead of allocative efficiencies such as

looking at how to improve working across a local health and care system can improve efficiency. It is also highly likely that from mid-January onwards trusts will have begun incurring costs related to preparing for coronavirus.

11. NHSEI have reported the number of providers behind plan at month 10 was 63 in 2019/20: a substantial fall from 111 a year earlier.[3] This suggests that, while the new financial settlement is sufficient for an increasing number of trusts to hit their financial targets, there is a significant minority– roughly a quarter of the provider sector – which cannot be sustainable in the financial system that existed before COVID-19 measures took effect, and whose financial difficulties are continuing to worsen.

Debt

12. Years of deficits left many trusts reliant on central support to guarantee cashflow. This was provided by the DHSC via a system of interest-bearing loans which left trusts unable to deliver a surplus with debts that they could not hope to repay: over 100 trusts owed, on average, around £100m each. We welcomed the National Audit Office's acknowledgement that this regime was not working.

13. Since then, the government has announced the conversion of £13.4bn of debt to public dividend capital (PDC).[4] This is a welcome measure although we would like to see more detail on how it will work in practice – including the charges attached to the PDC – at the appropriate time.

14. However, the issue will only be fixed when the underlying financial problems affecting indebted trusts are addressed: for many trusts affected, the debt was a by-product of a more general unsustainability. Their costs must be properly understood, recognised, and appropriately funded.

Capital

15. We welcomed the NAO's findings on capital, which closely aligned to our own, set out in our report: *Rebuilding our NHS – why it's time to invest.*[5]

16. We agree with the NAO that:

    - Parts of the NHS estate do not meet the demands of a modern health service;
    - The growth in the maintenance backlog increases the risk of harm to patients;
    - The amount of money available has not kept up with the resource trusts believe they need;
    - Trusts that can access capital are not necessarily those with the greatest need;
    - The long-term capital strategy that the NHS needs has been delayed by political events.

17. In our campaign #RebuildOurNHS, NHS Providers has argued that three fundamental changes are needed to support the NHS LTP:

[3] https://www.england.nhs.uk/wp-content/uploads/2020/03/bm2010-board-financial-performance-report-month-10-v2-draft.pdf
[4] https://www.gov.uk/government/news/nhs-to-benefit-from-13-4-billion-debt-write-off
[5] https://nhsproviders.org/rebuilding-our-nhs

- securing a multiyear capital settlement, ideally lasting ten years and extended annually
- aligning the capital budget with comparable economies, meaning funding available to trusts should roughly double
- establishing an efficient and effective mechanism for prioritising, accessing and spending NHS capital based on need.

18. The most obvious problem facing the NHS relating to capital is that the annual capital budget was far less than the service required for the decade that begin in 2010. In its April 2019 report, *Failing to capitalise: capital spending in the NHS,*[6] the Health Foundation found that capital spending by the DHSC declined, both in real terms and as a proportion of revenue spending between 2010/11 and 2017/18. The portion of the DHSC capital budget available to the provider sector for spending on NHS buildings and equipment was cut by an even greater amount.

19. This was partly brought about by repeated transfers of funding from capital to revenue budgets. The total transferred out of the capital budget between 2014/15 and 2018/19 was £4.46bn.

20. At the same time as this prolonged squeeze on capital resources, the main source for large scale health building projects – the private finance initiative (PFI) – fell into disuse without being replaced. PFI used to provide an extra £1bn of infrastructure investment a year at its peak. As a consequence, very few new or large-scale NHS facilities have been built over the past decade.

The impact of underinvestment

21. The impact of many years of underinvestment in facilities is now obvious to patients, demoralising for staff and of concern to NHS leaders. NHS leaders are clear about the impact of inadequate access to capital on frontline services. When we surveyed them last year:[7]

    - 94% of trust leaders said restricted funding posed a high or medium risk to patient experience
    - 82% said there is a high or medium risk to patient safety. Constrained capital funding is stopping trusts from improving how they run.
    - 97% reported high or medium risks to transformation programmes
    - 95% saying there was a high or medium risk to productivity and efficiency initiatives.

22. There is a particular need for capital investment within the mental health sector. Under-investment in the mental health estate is having a real impact on trusts' ability to ensure a safe environment for patients. Mental health trust leaders are concerned that lack of capital investment places their patients at increased risk and has left them unable to respond to concerns raised by the Care Quality Commission, such as removing fixed ligature points and replacing dormitory wards.

23. The coronavirus pandemic has highlighted many of the problems trusts have been struggling with relating to under investment in facilities: there is an overall lack of acute beds, with many sites running at or close to capacity all year round, unable to easily absorb spikes in demand. There will be further demand on capacity as the NHS copes with the resumption of

[6] https://reader.health.org.uk/failing-to-capitalise
[7] https://nhsproviders.org/media/689131/capital-20-report-pages.pdf

services, while keeping physical space aside to deal with possible future waves of the virus. The NHS lacked sufficient ventilators at the beginning of the outbreak – the NHS generally suffers from under-provision of essential equipment. Finally, the oxygen supply systems that support ventilators were found in many places to be unable to deal with the level of need for oxygen.

Renewed commitments to investment

24. From summer 2019, the government signalled a change in approach, recognising the need to begin investing in NHS infrastructure once more. This was seen in the 2019 Spending Round, which provided an additional £1bn for the capital departmental expenditure limit (CDEL) for 2019/20, the publication of the Health Infrastructure Plan, which committed to building or rebuilding 40 hospitals, overwhelmingly in the acute sector, and the 2020 Budget, which again increased the CDEL by more than £1bn.

25. While this change in direction is welcome, capital budgets are not yet at the level the NHS needs them to be sustained at long term, and the service does not yet have a system or strategy for ensuring the money available reaches where it is needed. This is particularly stark in mental health trusts.

The broken allocations system

26. The NAO cited NHS Providers' view that "the capital bidding, prioritisation, allocation and approvals process, is broken and in need of rapid reform."[8] In short there has been, for many years, a mismatch between access to investment and need. Trusts with the biggest estates challenges have been disproportionately unlikely to be able to access funding. Trusts with entrenched deficits have not been able to generate funds to reinvest in their facilities – a problem exacerbated by the regime of sustainability funding, which has rewarded trusts that stay on plan and penalised those unable to.

27. Because the overall amount of capital that can be spent is limited by the national CDEL, financially secure providers have built up their cash reserves in recent years, even as the cost of bringing deteriorating assets back to a suitable working condition has risen. In 2018/19, provider cash balances were £5.8bn, while the backlog of maintenance work was valued at £6.5bn. Trusts in surplus had on average smaller backlogs, and were able to spend more to keep their facilities in good working order.

28. Capital has been provided centrally to fund systemwide service transformation or support discrete areas of investment such as improvements to the ambulance fleet or new diagnostic equipment. However, these allocations, while welcome for those that are awarded funding, are still problematic: as the resource available does not cover the overall requirement, some trusts in need of funding still miss out. Allocations criteria have not been transparent, meaning decisions can appear arbitrary. Finally, decisions about what to spend the money on are set at the centre, rather than reflecting trusts' own spending priorities.

29. When we surveyed trusts about capital last year, respondents were broadly very critical of centrally-run processes for accessing capital. They said approval and applications processes were laborious, lacked clarity, and took too long. Too often, the release of funding late in the year made it hard to spend the money available before year end.

[8] https://www.nao.org.uk/wp-content/uploads/2020/02/Review-of-capital-expenditure-in-the-NHS.pdf

30. In some years, the combination of strict centrally imposed capital limits on the provider sector, normal slippage of capital schemes during the year, and slow signoff processes meant that trusts finished the year spending less than their national aggregate allocation on capital, despite there being an increasingly urgent need to invest.

Suggestions for an improved capital allocations system

31. The chief executive of NHS England, Sir Simon Stevens, told the health and social care committee in October 2019 that the current sign-off process had acted as an implicit rationing system which prevented the service from spending more than its CDEL allocation. The health and social care secretary Matt Hancock agreed, adding: "The truth is that the Department, in many cases, did not have the national budget and therefore did not approve things because they did not fit within our envelope."[9]

32. The primary solution to this problem is therefore not to design a better way of rationing insufficient resource: it is to first ensure there is enough headroom in the CDEL for the service's capital needs to be met.

33. There needs to be enough revenue available to enable any well-run provider to make a surplus that they can invest in capital in future years, and a system to tackle legacy structural financial challenges. CDEL should then be high enough to enable those surpluses to be reinvested when needed. It is reasonable to expect that the total budget available to the health service will be enough to cover both its revenue and capital costs.

34. A key principle should be that wherever possible capital spending decisions should be devolved to the level where service accountability sits. To avoid rationing, the national capital spending limit must be high enough with sufficient revenue to fund most investment from trust surpluses. As the service moves back towards normal day to day operation, the link between good management and capital investment will give trusts a positive incentive to perform well financially, and has the added benefit of clinical engagement: the promise of improved facilities can help engage clinicians in redesigns which will make a trust more efficient.

35. Central funding will be needed to fund large-scale projects, such as rebuilds, that cannot be paid for from surpluses. It may also be necessary for national level action to deal with entrenched problems, such as the maintenance backlog.

36. It is reasonable that capital decisions affecting more than one provider within a sustainability and transformation partnership (STP) or integrated care system (ICS), are taken collectively by trusts at a system level. Trusts may also choose to delegate decision making or capital planning to their systems.

Workforce and waiting lists

37. Prior to the outbreak of COVID-19, trusts were already under significant pressure. Following the longest and deepest financial squeeze in NHS history, the service had 100,000 workforce vacancies alongside a growing demand for healthcare. Capacity growth was already a long way behind growth in demand, and although trusts were treating record numbers of patients, performance was at its lowest in over a decade for both elective surgery and emergency care. Trusts now face a huge challenge to cope with a significantly increased

[9] Health and social care select committee, 2019

backlog of elective surgery – it has been suggested that the total number on the waiting list could exceed 7 million – while addressing workforce capacity constraints, and a need to safeguard exhausted frontline staff who have coped with winter pressures and the immense pressure of treating COVID-19 patients. NHS Providers would welcome clarity from the government and NHSE/I on how any extra funding to sustainably expand services over the mid- to long-term to meet new demand (e.g. extra mental health demand arising from coronavirus) will work.

Recovery from COVID-19

38. The immediate impact of the COVID-19 pandemic has been a rapid and dramatic change in how health services operate, with consequent major changes for the workforce they employ, the buildings and equipment they use and the mix of services they provide. These factors combined mean that for many trusts their running costs are now significantly different.

39. While the number of patients being treated in NHS facilities with COVID-19 is now falling, it is not the case that trusts will be able to get back to "normal" working. In the medium term, they will need to:

    - Retain surge capacity
    - Continue to treat significant numbers of critically ill COVID-19 patients
    - Treat growing numbers of post-discharge COVID-19 patients
    - Provide an increasing number of outpatient appointments either remotely, or face to face but with social distancing in place
    - Treat an expected surge in people with serious illness who have not seen a doctor due to the pandemic
    - Deal with an expected wave of mental health referrals, some of which will be caused directly by COVID-19 and social distancing
    - Meet the needs of rapidly discharged patients with complex needs in the community
    - Provide care to vulnerable groups who will be shielded for the foreseeable future
    - Perform elective operations where possible.
    - Support mass testing and vaccination programmes

40. Trusts and systems will need financial support to meet this complex new challenge: there must be enough money available to the provider sector and it must be accompanied with a framework that supports appropriate prioritisation, good local decision making and value for money. The health service will also likely need financial support to sustain and normalise the positive service changes that have taken place in response to COVID-19.

The long term plan

41. Before normal operations were paused in March, the financial framework supporting the NHS long term plan was not yet fully in place, and several critical issues were in need of resolution. These were:

    - how to move from outdated payment systems based on activity in the acute sector and block payments for community, mental health and ambulance trusts to one promoting preventative care and population health across a system;
    - how to balance system working with financial governance that legally sits at trust level;

- how an appropriate regulatory support system for unsustainable providers or systems may work;
- how to use the financial recovery fund to support trusts out of deficit.

42. Financial improvement trajectories beginning in 2020/21, which aimed to bring every provider, commissioner and system to a breakeven or surplus position by 2023/24, had not yet been finalised. These trajectories were based on the 2018 revenue settlement, plus a commitment by NHSE/I to an efficiency factor of 1.1% a year. However, the baseline for these trajectories would be set by the outturn in 2019/20. Given the deterioration in financial performance in the provider sector in the latter months of 2019/20, it is not clear that achievable trajectories could be set for every trust and every system without either more money being made available, or a less realistic efficiency factor.

43. The funding settlement covering 2019-24 was a welcome improvement on the previous decade, but the provider sector has always been clear that with an average annual real terms increase of 3.4% a year, it would be difficult to recover lost ground on operational standards, transform services and restore trusts to a sustainable financial footing. The deterioration of financial performance in 2019/20 underlines that fact.

44. The coronavirus pandemic has temporarily halted progress on both fronts, and has added a new layer of operational priorities, each with significant accompanying cost commitments, to the task facing trusts This will complicate the return to sustainability for all trusts and all systems.

45. NHSEI have been explicit that delivering the plan will require a much-improved capital settlement to enable investment in technology, increase capacity, and drive efficiency. We are now in the second year of the five-year long-term plan period: no such settlement has yet been finalised. The earliest a multi-year capital settlement could begin is now 2021/22 – the middle year of the long-term plan period.

46. Because of this, and the necessity of adopting new ways of working to deal with the ongoing challenges of COVID-19 and its knock-on effects, it will be necessary to revisit how the long term plan's goals of a rapid return to financial sustainability align with this new context.