

Comprehensive Spending Review 2020: Submission from NHS Providers

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 £87bn of annual expenditure and employing more than one million staff.

KEY POINTS

- **The role of the health and care system has never been more critical in supporting people to remain well and live full, economically independent lives – and in directly tackling COVID-19 and its impact.** The pandemic has had a profound impact on the UK economy leaving the country in recession and facing rising unemployment. We understand that difficult choices about public spending will need to be made however funding a sustainable and effective health and care system remains critical to protect wellbeing and as a means to bolster local economies and communities.
- **The health and care system is facing longstanding pressures which pre-date the pandemic and have arisen from a lack of sufficient investment to meet growing demand for services and to recruit and retain staff in sufficient numbers.** The government has also made a number of manifesto commitments around nursing numbers and new hospitals which require additional funding.
- **COVID-19 also has long lasting implications for both revenue and capital funding requirements across the health and care sector.** These include:
 - the recruitment, retention and remuneration of more staff;
 - the cost of implementing infection prevention and control (IPC) measures including purchasing Personal Protective Equipment (PPE), cohorting COVID and non COVID patients and establishing an effective testing service nationally and locally through NHS Test and Trace;
 - investment in digital technology;
 - funding capacity to respond to unmet, pent up and new demand from the lockdown period including a fully funded programme to recover activity on elective care, and meeting rising and changing demand for mental health, ambulance and community services
- **Achieving the aims set out in the NHS Long Term Plan (LTP), delivering on NHS manifesto commitments and meeting the costs of COVID-19 will either require a significant increase in the current financial envelope or a reprioritisation of the “ask” of the NHS.** The worthy aspirations of the NHS Long Term Plan (LTP) were always ambitious and dependent on social care reform and other central funding being forthcoming. The addition of new manifesto commitments and the costs of the pandemic mean a reprioritisation in consultation with the health and care sector is now vital. The CSR will be a pivotal moment in determining what can be delivered within a realistic timeframe and within the funding envelope available.
- **The pandemic has also shone a harsh light on the need for urgent reform to place social care on a sustainable footing and to reverse years of under investment in public health.**

Context

Prior to the pandemic, NHS trusts were grappling with rapidly growing demand for healthcare and over 100,000 workforce vacancies in the trust sector. Despite treating record numbers of patients, trusts were recording their lowest results against national performance standards in elective surgery and emergency care in over a decade and community, mental health and ambulance services were similarly facing increasing demand, limited

investment and workforce constraints. A key reason for this deterioration in performance is that the longest and deepest funding squeeze in NHS history between 2010 and 2018 meant that the NHS has been unable to grow capacity to keep pace with growing demand, placing it on the backfoot despite the settlement to increase funding agreed in 2019 in support of the LTP.

In parallel to the pressures on the health service, the challenges in social care have been well documented with the National Audit Office reporting that between 2010-11 and 2016-17, local authority spending on adult social care services reduced by 3.3% in real terms¹ and central funding for public health fell significantly.²

In this context, the aspirations of the LTP were always stretching, and dependent on variables including the reform of social care, and appropriate multi year settlements for capital, and education and training. Since the development of the LTP, the government has made a number of additional manifesto commitments including recruitment of 50,000 additional nurses and the creation of 40 new hospitals which require additional funding. Most significantly, the service continues to face unprecedented challenges from COVID-19. The government's injection of additional funding³ for trusts, and the wider NHS at the height of the first peak was both essential and welcome. However, the pandemic, and the requirements of restoring services in the context of COVID-19 have inevitably created new costs and constraints for trusts which the CSR will need to address.

A revenue settlement to deliver key priorities and meet the costs of COVID-19

COVID-19 has had a profound impact on the wider economy, with the UK seeing its first recession in over a decade and rising rates of unemployment. We welcome the extra funding provided by the government to address COVID-19 pressures in the NHS and the lifting of the 1% efficiency expectation but are concerned that the current funding will be insufficient to address sustained and unpredictable pressures on NHS revenue spending created by the pandemic which translates into significant changes to how services are delivered for the foreseeable future.

The NHS is currently two years into a five-year funding settlement covering the core NHS revenue budget. This settlement granted an average annual real terms funding increase of 3.4% on the NHS England budget, but did not address the required funding for capital, public health or education and training. While this was a welcome increase compared to other public services at the time, it is at the lower end of what the NHS needs to keep up with annual increases in demand and is significantly less than the 5% the Institute for Fiscal Studies and the Health Foundation said the NHS would need to recover and transform services.⁴ Frontline leaders have raised concerns that the annual average uplift of 3.4% will not be enough to fund the aims set out in the LTP and that it also fails to make up for lost capacity growth between 2010 and 2018. In our view, the improvement envisaged in the LTP - in terms of financial performance, access to care and transformation - was therefore always highly ambitious given the resource available.

Rising demand and the impact of COVID-19

For some time, demand has been outstripping capacity in the NHS provider sector, putting patient care, and staff wellbeing, under strain. This is evident across all services provided by trusts, and the wider health and care sector, and has been exacerbated by the pandemic. Investment in additional permanent capacity in the system is essential to ensure the NHS is sustainable and resilient:

¹ <https://www.nao.org.uk/wp-content/uploads/2018/07/Adult-social-care-at-a-glance.pdf>

² <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health>

³ <https://www.gov.uk/government/news/chancellor-provides-over-14-billion-for-our-nhs-and-vital-public-services>

⁴ <https://www.ifs.org.uk/publications/12994>

- Before the pandemic, despite treating record numbers of patients, trusts were recording their lowest levels of performance against national waiting time standards for elective care and emergency care and routinely missing key national targets for cancer care. The national policy decision to pause elective care during the first peak of the pandemic means that acute trusts are facing unmet and pent up demand from this period particularly for elective services. We believe that a fully funded programme to recover elective activity should be a major priority. This will require sufficient diagnostic capacity as well as additional surgical time. Improving diagnostic capacity, maintaining cancer care and tackling the backlog in elective care are major priorities for the NHS. Despite best efforts by NHS England and trusts to create alternative pathways for urgent and emergency care, acute and ambulance trusts already report demand returning to the levels seen prior to March 2020. Further investment in diagnostics and acute and general beds are required.
- Prior to COVID-19, mental health trusts were reporting growing demand for inpatient care, leading to out-of-area placements and delayed transfers of care. Under-investment in key mental health services for children and young people and for learning disabled people, as well as in community mental health services has been well documented. The emergence of the virus has added yet further pressure on the mental health sector and trusts are reporting significant additional demand for services from those affected by the economic, social and psychological factors associated with COVID-19, as well as from health and care staff coping with the consequences of having to provide frontline COVID-19 care in extremely difficult circumstances. There are also signs that the demand to address those suffering with severe and enduring mental health conditions is on the rise. There remains a need to address the historic inequity in the funding and commissioning of mental health services, to tackle the significant levels of unmet need and rising demand and to provide sufficient capital investment to provide safe and effective care.
- Community service providers have been under increasing strain in recent years with demand growing due to demographic changes, particularly in relation to an ageing population. COVID-19 is likely to change the shape of demand for community providers, which will play a vital role in providing rehabilitation for those recovering from the virus and in supporting timely discharge for patients ready to leave hospital settings. In line with the NHS Providers/NHS Confederation submission on behalf of the Community Network, it is clear that we need national investment to expand capacity in the community, a new national investment standard for community health services similar to the approach in mental health to ensure funding reaches the frontline, capital to drive transformation and appropriate funding to place local authorities on a stable footing.
- Ambulance trusts have similarly been under immense pressure in recent years, particularly during the busy winter period where high volumes of people require care at the scene or transfer to hospital and other settings. Although demand for ambulance services fell during the first wave of the pandemic, trusts are now reporting that demand is once again increasing.

Productivity and efficiencies

While the LTP assumed annual efficiency gains of 1.1%, this was rightly removed from funding assumptions by NHS England and NHS Improvement (NHSE/I) at the beginning of 2020/21. Trusts will always strive to make best possible use of resources however COVID-19 is expected to create long lasting impacts on trusts' productivity given the requirements of IPC (time to don and doff PPE, the need to cohort COVID and non COVID patients onsite and time taken deep cleaning equipment and vehicles for example) and in this changed context, the existing LTP funding will unfortunately not go as far as first assumed⁵. While there will be efficiencies brought about by changes to how services are run in response to COVID-19 (for example greater use of digital technologies), trust leaders tell us it is difficult at this early stage to place a clear financial value on them.

⁵ https://www.nuffieldtrust.org.uk/files/2020-06/1591362811_nuffield-trust-here-to-stay-how-the-nhs-will-have-to-learn-to-live-with-coronavirus.pdf

Furthermore, the inability of trusts to deliver their 2020/21 cost improvement programmes due to COVID-19 will have a knock-on impact on the overall NHS cost base in future years.

Both the prioritisation of the LTP ambitions, and its associated funding package must be revisited in light of the pandemic as the NHS continues to face rising and changing demand for care, and additional pressures due to COVID-19. We believe that a reprioritisation in consultation with the health and care sector is now required to ensure the “ask” of the NHS is matched with appropriate resource.

A People Plan backed by a multi year funding package

Making the 'People Promise' a reality

The NHS People Plan published at the end of July advocates an inclusive culture and a commitment to the NHS frontline workforce of compassionate working conditions including flexible working. Local employers will not require additional funding to deliver many of these commitments, however it is clear that the pressures placed on staff within the NHS due to severely constrained resources directly impact on morale, stress, staff sickness and productivity and arguably, bullying and harassment. The NHS entered the COVID-19 pandemic with over 100,000 workforce vacancies. Staff were exhausted after coping with year-round levels of 'winter' demand prior to the pandemic and are now facing a further winter season. In a survey conducted by NHS Providers in June, 9 out of 10 trust leaders (93%) were concerned about staff wellbeing, stress and burnout following the pandemic.

Investing in education, training and recruitment

In this context investment in recruitment and retention is paramount. Yet the Health Education England (HEE) budget has been tightly restrained in recent years and was £1 billion less (£4.3 billion) in real terms in 2018/19 than it was in 2013/14 despite year-on-year growth in the number of staff working in the NHS and in funding for frontline services. While the Chancellor announced a 3.4% real terms rise for the HEE budget from 2019/20 to 2020/21, the overall figure is reported to be less than in 2018/19.⁶ We also remain concerned about the lack of central funding for “Continuing Professional Development” (CPD) which was reduced from £205 million in 2015 to £83 million in 2017, and only partially restored since then.

A series of recent one off announcements have been made on funding for healthcare education and training including: an additional £10 million to fund extra clinical placements, £172 million to support nursing apprenticeships, additional money for learning disability services, the partial restoration of the nursing bursary and lifting the cap on medical school training places this year, with additional places funded by the government. While any additional funding is welcome, the NHS requires greater certainty over long term investment in education and training with a multi year settlement to support a significant boost to recruitment and improvement in retention both to reduce the current level of vacancies and meet future demand. In May, a report by IPPR found that one in five health and care staff were more likely to leave their jobs as a result of working through COVID-19. NHSE/I has called for a phased restoration of CPD funding over the next four to five years but the government needs to address professional development funding more quickly: at a minimum, accepting the recommendation of the Nuffield Trust, King's Fund and Health Foundation to raise central funding for CPD to £250 million by 2023/24.⁷

⁶ <https://www.hsj.co.uk/finance-and-efficiency/governments-new-training-funding-not-enough/7025867.article>

⁷ <https://www.kingsfund.org.uk/sites/default/files/2019-03/closing-the-gap-health-care-workforce-full-report.pdf>

In addition, we understand that to meet the Conservative Party's manifesto commitment of 50,000 additional nurses, a 41% increase in international recruitment will be required⁸. We welcomed the recent announcement of a 'health and care visa', which – while doing little to support the care sector to recruit migrant social care professionals under the new immigration system – will help to reduce the costs of international recruitment into the NHS, both for eligible individual migrants, and for trusts and other employing organisations. We believe that the manifesto commitment to deliver the 50,000 extra nurses will be difficult to deliver without giving the NHS greater certainty over education and training budgets via a stable multi-year settlement rather than annual changes which we have recently seen. The commitment to a multi year core NHS England revenue settlement needs to be replicated in the approach to education and training spending.

Pay, terms and conditions which recognise and reflect the contribution made by NHS and care staff

Uplifts to staff pay are currently funded through the five-year settlement for the NHS, announced in 2018. NHS England have noted that the settlement assumes annual pay increases of around 2% and has indicated that increases over and above this would compromise the delivery of other long term plan priorities unless additional funding is provided by government. The majority of NHS staff are coming to the end of a three-year Agenda for Change pay deal in March 2021; a decision will soon need to be taken on whether staff are offered another multi-year pay deal or a one-year pay settlement through the normal annual pay review process. Fair pay and recognition are essential elements of the NHS's offer to staff. This sits alongside a longstanding need to resolve various issues with NHS pensions to create a system which works equitably for all staff.

An appropriate balance needs to be found between a meaningful recognition of staff efforts throughout the pandemic, and the agreement of a long-term pay settlement which provides security for the workforce and for trusts as employing organisations. Using the spending review to put down a marker of the government's intention to increase pay could well mitigate the risks of any industrial disputes in the NHS in the coming months and would ensure that increased pay is not directly funded at the expense of other priorities. Any pay settlement must however be carefully calculated to ensure all of the costs associated with an uplift are met by government funding. We are aware that the Agenda for Change deal in 2018 underestimated the implementation costs and did not initially cover all eligible staff – including NHS staff working on contracts commissioned by local authorities. For this reason, the methodology for calculating costs of pay settlements should be co-produced with input from trusts and other employing organisations.

The NHS requires an appropriately funded, co-ordinated approach to supporting staff. Additional national funding should be provided to support local action to support staff wellbeing during the pandemic.

A multi-year settlement is essential to offer trusts clarity over future workforce supply, and available funds to support the training and professional development of current staff beyond the end of this financial year.

The government should announce its intention to increase staff pay and make provision within the spending review to cover the full costs. Funding for Agenda for Change must cover any increase in pay costs which result from a new pay deal including NHS staff who are commissioned via local authorities.

⁸ <https://www.hsj.co.uk/workforce/exclusive-nhs-planning-41pc-increase-in-international-recruitment/7028444.article>

Investing in infrastructure to maintain safety and transform the NHS estate

Tackling years of underinvestment

The 2015 CSR set the Department of Health and Social Care's capital departmental expenditure limit (CDEL) too low to enable trusts to adequately maintain their estate and equipment⁹. Analysis by The Health Foundation demonstrates the proportion of the NHS' budget spent on capital fell from 5% in 2010/11 to 4.2% in 2017/18 – mainly as a result of capital budgets being diverted into revenue to pay for day-to-day running costs. The most recent data from NHS Digital shows that the total cost to eradicate the capital maintenance backlog in 2018/19 was £6.46bn – an 8% increase on the previous year when the cost was £5.96bn. The backlog has risen each year since 2013/14 and is now 60% higher than it was in 2013/14.

The result of the prolonged lack of access to capital can be seen across the NHS. Underinvestment in capital impacts patient safety, operational performance, efficiency, and the service's ability to transform and modernise care. In recent years, there have been too many providers with inadequate buildings, failing equipment and an inability to adopt new technologies to improve care. Within this, the under prioritisation of investment in the mental health estate is having a real impact.¹⁰ Mental health trust leaders have expressed their concerns that lack of capital investment places their patients at increased risk. There are also challenges for community providers which must balance sufficient investment in beds and equipment with facilities for staff covering considerable geographical areas, and for ambulance trusts whose estates are often complex with smaller ambulance stations often decades old and in extreme cases stations, too small to accommodate modern, larger ambulances.

Looking forwards

There has recently been growing recognition of the need to invest in NHS infrastructure with welcome increases in the 2019 Spending Round and 2020 budget, which together have increased provider capital limits by more than £2bn and enabled some essential improvement works to take place. Commitments to upgrade and rebuild hospitals, to eradicate mental health dormitory wards and expand emergency departments show that investing in the NHS is prudent, necessary, and will help boost local economies by employing people locally and using local companies to carry out improvements.

However, although the Health Infrastructure Plan (HIP) of September 2019 set out plans to build or rebuild 40 hospitals, a much more ambitious building programme will be needed to replace all outdated buildings currently being used to deliver NHS services across the provider sector. The HIP is modest in ambition when compared with the 1960s hospital plan, and the PFI programme of the 2000s.

The NHS long term plan, which accompanied the 2018 revenue settlement, made clear that a new capital settlement will be needed, to realise efficiency gains, to transform and upgrade existing facilities, enhance digital capabilities and expand diagnostic capacity. A proper capital settlement will also help trusts to invest in sustainable estates to support the NHS' zero carbon ambitions.

We believe that allowing appropriate flexibility and discretion over capital spending to allow appropriate local prioritisation is vital. There is a concern that a combination of ring-fenced spending to meet the aims set out in the manifesto and spend on technology will leave insufficient funding to meet other priority investment needs.

⁹ <https://www.nao.org.uk/wp-content/uploads/2020/02/Review-of-capital-expenditure-in-the-NHS.pdf>

¹⁰ <https://nhsproviders.org/media/689187/mental-health-services-meeting-the-need-for-capital-investment.pdf>

This spending review is a key opportunity to address prolonged under-investment in estates and facilities across the NHS and it should:

- **Set a multiyear NHS capital funding settlement** – this would allow the NHS to plan for the long term and transform its services and equipment. While the 2019 Health Infrastructure Plan¹¹ commits to “indicative multi-year planning envelopes over a rolling five-year period”, to be confirmed annually, the NHS ideally needs at least ten years of indicative budgets
- **Commit to a capital budget appropriate for a world-leading health service.** The NHS is overdue a capital settlement that will support it in meeting its goals of transforming services, embracing the use of technology, improving access to care and keeping pace with demographic changes. The Health Foundation has found that countries facing similar challenges spend considerably more than the UK, and concluded that a £2.5bn increase in capital spend, using the 2019 Spending Round figures as a baseline, would bring the NHS into line with its peers. This figure should be seen as an absolute minimum.
- **Reform the system for accessing and allocating capital, in consultation with those planning and delivering services.** This mechanism must enable all trusts to invest to improve, expand and transform NHS services. The capital system should be based on the principle of subsidiarity and align accountability for services with the ability to make necessary investments.

Delivering digital transformation

An ambitious programme of digital transformation is vital to the future sustainability of health and care services and tackle years of under investment in the digital capability of the service. Following a welcome and significant injection of government funding, the pandemic has been a catalyst for considerable progress against the ambitions of the LTP for digital transformation primarily through the mainstreaming of virtual outpatient clinics in many trusts, and the requirement for many non-clinical staff to work remotely.

The level of ambition set by the government and national bodies including NHSX is welcome and encouraging¹², but requires substantial additional financial investment to come to fruition. There simply remains a gap between digital ambitions and availability of funding in the sector. The average trust spends around 2% of its total expenditure on digital, but Lord Darzi has suggested this should be closer to 4-5%¹³. For trusts facing in-year financial pressures, it may be difficult to justify investment in long term digital solutions particularly as the benefits can be seen elsewhere in clinical outcomes, safety, patient experience of staff satisfaction.

Many trusts remain reliant on funding from national bodies for aspects of their digital transformation programmes, but in recent years there has been uncertainty over how funding from national bodies is made available for digital programmes with new money often announced for specific programmes that trusts must bid for. This undermines a long term, strategic approach to digital investment and makes it difficult for trusts to invest in core infrastructure. Finally, greater consideration must be given to the revenue costs associated with capital investment. For example, increasingly, trusts are procuring services through managed service contracts which impact revenue costs.

¹¹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835657/health-infrastructure-plan.pdf

¹² *The future of healthcare: our vision for digital, data and technology in health and care* (October 2018): <https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care>

The NHS Long Term Plan (January 2019): <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

NHSX tech vision (February 2020) <https://jointheconversation.scwcsu.nhs.uk/3217/widgets/10570/documents/4079>

¹³ <https://www.ippr.org/files/2018-06/better-health-and-care-for-all-june2018.pdf>

The allocation of central funding for digital programmes should cover a multi year period, consider capital and revenue costs, and be transparent and consistent. Additional funding should be made available for trusts to invest in core infrastructure to achieve the basic level of digitisation - a key ambition of the LTP.

Appropriate investment in prevention and public health

A recent stall in life expectancy¹⁴, and widening of health inequalities, comes in the context of a long period of cuts to central funding for local authorities, including the public health grant, which has reduced local councils' ability to provide services which support the health of people living in deprived communities.

The central government public health grant has been reduced by £531 million between 2015/16 and 2019/20. This has a direct impact on how much local authorities spend on public health - 85% of councils reported reducing their spending on core public health services in 2017/18 and like-for-like spending on public health services was 8% lower in 2017/18 compared to in 2013/14.¹⁵ Local government is operating under severe financial pressure, with councils seeing reductions in their central government grant by 77% between 2015 and 2020. Those councils more reliant on the central government grant have been hit hardest by the cuts and are often areas with higher levels of deprivation and need.¹⁶ With many local authorities forced to reduce spending and cut services simply to fund their statutory duties in respect of adult social care and social services, much has been lost in the way of local authorities' financial capability to support a holistic and tailored approach to population health.

COVID-19 has laid bare the impact of the lack of investment in public health over the years, with well-publicised inequalities in the impact of the virus on Black, Asian and minority ethnic communities, amongst others.¹⁷ A lack of resource and overly complex funding mechanisms have led to a fragmented public health infrastructure, and local authorities, having been largely stripped of their public health resources, were not empowered to play their pivotal role in meeting diverse communities' needs during the pandemic. This, coupled with an apparent lack of preparedness for a pandemic including the lack of suitability of the national stockpile of personal protective equipment - exposes a need to review the policy trend of deprioritising public health funding across the breadth of its functions.¹⁸

The dissolution of Public Health England scheduled for the next financial year presents a unique challenge to the public health landscape. Clearly investment in health protection functions is important, given the impact of COVID-19, however we would emphasise the importance of making use of local expertise in addition to a national coordinating role and the continued role for prevention as well as protection. All trusts have a key role to play in supporting prevention and are committed to supporting population health management. Should certain clinically facing public health services be moved into the NHS, there will be a clear need for investment in infrastructure and the workforce to ensure a smooth transition and restore resilience to these services.

Piecemeal injections of funding will not enable proper investment in health protection and disease control or in addressing the wider determinants of health. It is essential that public health funding is restored to pre-austerity levels on a long term basis.

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<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2015to2017>

¹⁵ <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health>

¹⁶ <https://www.ifs.org.uk/research/197>

¹⁷ <https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes>

¹⁸ <https://www.nao.org.uk/press-release/readying-the-nhs-and-adult-social-care-in-england-for-covid-19/>

Urgent reform to place social care on a sustainable footing

The government has provided much needed, short term funding for social care over the winter period. However, the need to engender the necessary cross party and public debate to place the social care system on a sustainable footing has never been more urgent.

Cuts to local authority social care budgets have placed significant, avoidable pressure on the NHS in the context of rising demand for social care fuelled by population changes, including rising numbers of older people and more complex care needs. The social care funding gap is now estimated to range between £2.1bn and £12.2bn by 2023/24.¹⁹ The NHS is directly impacted by local authority budget cuts, through increased demand and delays in discharging patients from hospital to care settings. Some of this increased demand comes as a result of people being unable to access early intervention services provided by local authorities. The suspension of NHS Continuing Healthcare assessments and accompanying financial negotiations during the pandemic greatly reduced demand for hospital beds with a positive effect on timely discharge. Current discharge to assess arrangements should be funded on a permanent basis to ensure people can return home as soon as it is appropriate.

The COVID-19 pandemic has shone a harsh light on the tragic impact of years of delays to social care reform. The high number of excess deaths in care homes (about 26,500 from March to August compared with the 2015-19 average²⁰) provides bleak testimony to the importance of investing in the care system so that it is more resilient in the face of future challenges. The Local Government Association estimates that the funding gap for local authorities will come to £7.4bn in 2020/21 due to COVID-related income losses and increased costs in addition to exacerbating the fragility of the social care provider market.

Short-term funding must be accompanied by steps towards long-term reform to improve access and deliver a sustainable and fair social care system. Failure to do so will leave more people unnecessarily dependent on NHS care, placing extra demand on already stretched services and leading to poorer outcomes for many of the most vulnerable in society.

Conclusion

The CSR is a pivotal moment in determining what the NHS can deliver over the next three years. Trust leaders stand ready to meet the challenge of restoring services and 'living with' COVID-19. However the NHS will need additional funding to meet new costs created by the pandemic on a longer term basis; to recruit and retain staff in sufficient numbers in a positive working environment; and to deliver priorities set out by government in its manifesto and in the LTP. In our view, the pandemic must prompt a reprioritisation in consultation with colleagues at the frontline about what can realistically be delivered within the funding envelope available. We would urge the government and the national NHS bodies to work with the sector to agree key priorities for the duration of the parliament, aligned with the CSR.

¹⁹ <https://www.health.org.uk/news-and-comment/charts-and-infographics/social-care-funding-gap>

²⁰ <https://www.kingsfund.org.uk/publications/deaths-covid-19>