HFMA response
August 2019

HFMA evidence to the Health and Social Care Committee's implementing the NHS long term plan inquiry

Who we are

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For the past 60 years, it has provided independent and objective advice to its members and the wider healthcare community. We are a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through our local and national networks. We also analyse and respond to national policy and aim to exert influence in shaping the wider healthcare agenda. We have a particular interest in promoting the highest professional standards in financial management and governance and are keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

Summary

This submission is based on the views of our members and draws on recent HFMA publications and research.

Key points:

- our members have consistently identified capital and workforce as areas of significant concern
- the Prime Minister's recent announcement in relation to capital is very welcome, it will go some way to resolving a critical issue in 2019/20. However, for the *NHS long-term plan* (the Plan) to succeed, additional capital funding is needed to ensure that the NHS estate is fit for purpose as well as to invest in system transformation and digital solutions
- the system for managing capital funding and expenditure in the NHS is no longer fit for purpose and needs to be reformed so that all funding can be used efficiently and effectively

- as well as additional funding, the success of the Plan is dependent on the holistic development of policy which will allow the NHS, local authorities and other parties to work on an integrated basis to deliver the best value care for patients at the right time in the right place.

Detailed response

1. The HFMA and its members support the vision of the Plan and the intention to create a sustainable NHS, fit for the future. Recent announcements of additional funding are a welcome boost for a healthcare system struggling to meet demand within the current funding envelope.
2. It will be challenging to meet the ambitions of the Plan to deliver provider sector balance by 2020/21. Achieving financial performance targets will be dependent on the adequate funding of critical enablers, such as the four areas identified by the Health and Social Care Committee in this inquiry.
3. To meet the long-term challenges facing the NHS, it is important to have some certainty over funding. We welcome the additional capital funding recently announced by the Prime Minister but are concerned that the one-year Spending Review introduces uncertainty that will delay the implementation of the Plan.

NHS capital

4. Capital has been an issue for our members for several years and is a key concern raised at many of our committee meetings. Members concerns fall into three categories:
    - the capital departmental expenditure limit (CDEL)
    - availability of funding
    - the complexity of the system for managing capital.

Capital departmental expenditure limit (CDEL)

5. The CDEL is the limiting factor on capital investment in the NHS. The total amount of capital expenditure incurred as defined by HM Treasury[1] cannot exceed the CDEL even if NHS bodies can access funding for capital projects[2].
6. Between 2014/15 and 2016/17, the CDEL decreased year on year. In 2017/18 and 2018/19 that trend was reversed, but the CDEL is still not sufficient. NHS providers were asked in May 2019 to review their capital programmes to find projects which could be deferred as their current plans would have resulted in a breach of CDEL by the end of 2019/20. In order to avoid the possible breach, providers were asked to reduce their locally agreed plans by up to 20%, this led to increased concerns regarding patient safety.
7. In 2017, the Naylor review[3] concluded that £10bn was required for NHS capital investment. Subsequently, NHS bodies reported increasing levels of backlog maintenance - to £6bn in 2018[4] - and the Health Foundation has concluded[5] that to be in line with the OECD average the 2019/20 CDEL needs to be increased by £3.5bn (37%) raising to £4.1bn by 2023/24.

Availability of funding

8. The CDEL is the critical barrier to investment in NHS capital projects, although until this year many NHS bodies did not have sufficient cash to fund capital projects without borrowing or

[1] HMRC, *Consolidated budgeting guidance 2019 to 2020*, 2019
[2] HFMA and CIPFA, *Capital collaborations between the NHS and local authorities*, June 2017
[3] Sir Robert Naylor, *NHS property and estates : why the NHS estate matters to patients,* March 2017
[4] NHS Digital, *Estates Returns Information Collection, England, 2017-18*, October 2018
[5] Health Foundation, *Failing to capitalise,* April 2019

seeking permission from the Department of Health and Social Care (DHSC). The exception were those foundation trusts with internally generated cash balances.

9. The Prime Minister's announcement on 4 August 2019 of an increase to CDEL has removed the need to reduce capital programmes by up to 20% in 2019/20 and is welcomed by our members. At recent meetings, members have reported that the lack of CDEL has meant that safety work and replacement of equipment has had to be slowed down, transformational plans have been put on hold and investment in digital solutions have been deferred.

10. The CDEL uplift will need to be carefully managed to ensure that it is allocated equitably between NHS bodies facing varied challenges both operationally and in terms of the capital funding system. The challenges in relation to capital are not the same throughout the provider sector and the impact is also unevenly distributed:
    - some providers simply do not have sufficient cash to cover their running costs let alone capital projects – they are reliant on the centre to fund all of their capital spend
    - some providers have internally generated resources but need to use them to fund private finance initiative (PFI) repayments, finance leases and other contractual commitments meaning that any additional capital work can only be undertaken if central funding is made available
    - other providers, especially those who have benefited from the provider sustainability fund (PSF), have cash but are organisations in financial distress so need approval to enter into capital projects over £15m[6]
    - NHS trusts are required to keep their capital expenditure within a centrally determined capital resource limit (CRL) and to manage their capital expenditure and cash balances so they also remain within the external financing limit (EFL)
    - NHS foundation trusts that are not in financial difficulty have the autonomy to enter into capital projects without approval, where they have sufficient internally generated funds to finance them.
11. This analysis does not consider the capital requirements outside of the provider sector – by primary care providers and DHSC managed schemes. These are equally important to the success of the Plan.

The complexity of the current arrangements

12. Since 2017, our members have become increasingly concerned about their ability to invest in new capital projects as well as maintaining the existing NHS estate. These on-going concerns and our conclusion that the current system is no longer fit for purpose were published in October 2018[7].

13. Recently, we have concluded that:
    - the system is too complicated and, for some NHS bodies[8], centrally managed:
        - bids are required for different pots of money which take resource to produce
        - there is no feedback on why some bids are successful and others are not
        - there is no clear guidance on what makes a successful bid/ business plan
    - there are insufficient funds to meet all the demands for capital projects but no clear understanding of how projects are prioritised

[6] DHSC, *Secretary of State's guidance under section 42A of the National Health Service Act 2006*, April 2014
[7] HFMA, *NHS capital - a system in distress?*, October 2018
[8] NHS foundation trusts that are not classified as 'in financial distress' are restricted only by the levels of funding that they can generate internally so are not centrally managed. NHS trusts and NHS foundation trusts are required to seek approval for schemes above the delegated limit of £15m. Those NHS bodies that are reliant on external funding for their schemes report that they are reliant on the centre (the DHSC) to access any funding. For them, the system is centrally managed.

- the demands on constrained capital resources are varied and many are a high priority – backlog maintenance is a well-documented pressure; transformational projects are critical to achieve the Plan's objectives and technology and digitisation is also a priority.

14. Our members are aware that they need to improve oversight of their capital programmes and to improve forecasting so that capital resources can be better managed within the CDEL.

15. Any future capital settlements should be for a longer period to allow for necessary planning. Ideally, a five-year settlement would be accompanied by changes to the current system for managing capital expenditure. Flexibility could be introduced to allow performance against the CDEL to be measured on a rolling basis rather than it being a fixed annual target. However, we do understand that this would require a fundamental change to the government budgeting and accounting arrangements.

16. Any settlement beyond 2019/20 needs to reflect the requirements of IFRS 16 *Leases*. From 1 April 2020, NHS bodies will no longer be able to enter into operating lease arrangements to maintain their asset base, particularly equipment, without a charge against the CDEL[9]. This change, coupled with the then Chancellor's announcement in the 2018 Budget that there will be no new PFI schemes, effectively closes off the main routes to access assets without an accompanying CDEL impact.

Education and training

17. After capital, workforce is the next critical concern raised by our members – both in terms of the impact that workforce shortages are having on patient care and managing demand, but also the impact on the financial position of their organisations.

18. The Plan is clear that workforce growth has not kept up with need, partly due to increasing demands on the NHS and partly because the NHS has not been a sufficiently flexible and responsive employer. The *Interim NHS people plan*[10] gives an immediate focus for the workforce actions that need to be taken to begin the implementation of the Plan. Sufficient long-term funding for the essential education and training to support this is vital.

19. Many of our members' concerns around workforce stem from the difficulties of managing the consequences of wider policy decisions. For example, the introduction of the apprenticeship levy has resulted in a cost pressure of up to 0.5% of the payroll budget for many NHS bodies. This is because there was insufficient time to enter into apprenticeship contracts or to set up new apprenticeships to fill training needs. Also, the impact of the annual allowance taxation policy on senior clinical staffing levels has been well documented.

20. Any decisions relating to education and training need to be considered within the wider workforce agenda. For example, consideration needs to be given to where staff are going to come from and how they are going to be trained to meet the needs of an integrated health and social care system. At a recent Nuffield Trust workshop on rural district general hospitals, it was clear that one of the solutions to these bodies' staffing issues was to train local people in local settings as they were more likely to want to stay to work at the district general hospital. The same would also be true for staff working in non-acute health and social care settings.

21. The removal of the nursing bursary is also having an impact on the numbers of trainee nurses, particularly on older students who are unable to fund their training.

22. The *Interim NHS people plan* focuses on the actions required to address the future staffing needs for clinical professions. When considering the education and training needs of the NHS, the workforce must be looked at as a much more complex network of both clinical and non-clinical professions. For example, changes in working practice to adopt evolving digital technologies will have a significant impact on how the finance function carries out essential activities to support a financially sustainable NHS.

[9] HFMA, *IFRS 16 – leases*, updated August 2019
[10] NHS Improvement, *Interim NHS people plan,* June 2019

Social care

23. Health and social care are inextricably intertwined. We welcome the consideration of social care in this inquiry as we are concerned that there is too much focus on the NHS part of the system, with an expectation that local authorities will engage with this NHS led initiative. Without the involvement of local authorities, the Plan is unlikely to be successful.

24. We have two main concerns about social care. Firstly, the barriers presented by the different legislative and regulatory regimes of NHS bodies and local authorities. For example, in our response to the Committee's inquiry on legislative changes in the NHS we identified that the differing VAT regimes between the sectors present unnecessary cost and administrative pressures when seeking to work collaboratively.

25. Secondly, the impact of austerity on local authorities which has had an impact on the NHS. Policy decisions relating to the NHS or local authorities must be reviewed through the lens of the other to determine whether there are any unintended consequences.

Public health

26. As we move to a more integrated approach to designing, planning and delivering health services, the question of how we allocate finite resources in a way to maximise outcomes becomes increasingly important. The HFMA has recently explored[11] how resources are currently distributed across different parts of the system, the data needed to do this and the current challenges. Adopting a value-based approach to improving population health requires input across public sector organisations. Appropriate funding is required to ensure national direction and local input is sufficient to support culture change; capacity and skills development; and data development for informed decision-making.

27. Public health is the responsibility of both local authorities and NHS bodies. This should be an enabler to closer integration and joint working. However, the differing regimes that the organisations work within mean that it can also be a barrier. For example, smoking has been identified by the Royal College of Physicians (RCP) to be the single largest avoidable cause of death, disability and social inequalities in the UK[12]. However, smoking cessation services are commissioned by local authorities and funded by the public health grant. Local authority smoking cessation budgets have fallen from £128m in 2013/14 to £89m in 2017/18, according to the RCP.

28. The Plan sets out the target for all patients admitted to hospital to be offered tobacco treatment service by 2023/24. However, if the government's vision of a smoke-free society by 2030 is to be realised, sustained funding is going to be required beyond 2024. The 'polluter pays' model discussed in the prevention green paper[13] would fund these services without adding pressure to already restricted public sector budgets.

29. The HFMA has worked with NHS England, NHS Improvement and the RCP on the development of a tariff to allow NHS providers to offer smoking cessation services in hospital[14] and to put in place a mechanism for those services to be commissioned and paid for by CCGs. If integration is to be successful, barriers such as the lack of a tariff need to be identified and removed.

30. The future prevention strategy relies on local authorities having sufficient resources to work with the NHS to address issues such as obesity and smoking, but also to develop the methods by which the population engages with their health; for example supporting the use of personal technology and expanding screening programmes.

31. Prevention traditionally focuses on physical health conditions but addressing the causes of poor mental health is also essential for population wellbeing and the prosperity of the nation. The work of public health in addressing some of the social determinants of mental health, such as addiction

[11] HFMA, *What finance data is required to drive value at a population level,* June 2019
[12] HFMA blog, *Smoking cessation: making a real difference*, February 2019
[13] Cabinet Office and DHSC, *Advancing our health: prevention in the 2020s*, July 2019
[14] HFMA, *Smoking cessation: stubbing it out*, December 2018

and child health, requires appropriate resource to ensure that the most disadvantaged populations can be supported.

The potential impact on the implementation of the Plan of a failure to provide the necessary funding in these areas

32. The Plan sets out the objectives for the whole health and social care system over the next ten years. To succeed, health and social care services need to be delivered on an integrated basis to patients or clients once, by the most appropriate team in the most appropriate setting.

33. This will require a change in working arrangements and in culture. It will also require a change in policy making to ensure that policies are developed on a holistic basis and their longer-term consequences are considered at an early stage.

34. If policy changes continue to be made on a siloed basis then the implementation of the Plan will not be successful. Real change towards a streamlined and integrated system will not be possible.

35. The four areas identified by the Committee are relatively small in value compared to the total health and social care budget, but they are critical to the success of the Plan.

The impact on the wider economy and other public services of investment in this area.

36. Ill health amongst working age people costs the economy around £100 billion each year. Supporting the NHS to effectively deliver the Plan through investment in the four areas identified is essential to address this cost.
37. Investment in prevention, through supporting public health, can have an impact beyond pressure on the NHS and enabling people to work. For example, investment in drug and alcohol services which are currently commissioned by local authorities as part of their public health provision, can have a direct impact on costs incurred in the criminal justice system as well as addressing a common cause for A&E attendances.
38. As one of the largest employers in England, the NHS can directly impact the social determinants of health such as employment for over 1 million people. Investment in education and training therefore provides an additional social, and economic, benefit.

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