The HFMA's response to the Comprehensive Spending Review (CSR) 2020

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

Summary

This submission is based on the views of our members and draws on HFMA publications and research. Our key points are:

- a five-year settlement for both health and social care, including all parts of the Department of Health and Social Care (DHSC) budget is needed to allow for proper planning. A longer settlement for capital would be ideal
- health and social care must be treated as a whole at local as well as national level. In the longer term, this may mean legislative change to remove barriers but in the short term, equality of funding would ensure that both parts of the system are treated equitably
- the flow of funds from Parliamentary Vote to the patient or service user is overly complex – the system needs to be simplified and focused on value
- service delivery in a Covid-19 world is more complicated and will be at a reduced capacity while demand for health and social care services will continue to rise. Any financial settlement needs to take this into account

- workforce is a critical issue for health and social care providers – the wider consequences of any changes to policies in areas such as immigration, employment and taxation that affect the health and care workforce need to be identified and fully understood.

Detailed response

Long standing financial pressures

The financial pressures facing the NHS in England are well documented. The reasons for the pressures are many and complex and include:

- increasing demand for healthcare
- an aging population
- unhealthy lifestyles leading to an increase in prevalence of long-term conditions such as diabetes
- the need to address health inequalities
- the impact of austerity on the wider public sector particularly local government
- an increasing range of available treatments
- workforce shortages
- the impact of policies such as the annual allowance pension tax and apprenticeship levy
- the unintended consequences of changes to the financial system such as marginal rate for emergency work and the sustainability and transformation fund (STF)
- ongoing efficiency requirements in the tariff.

This is a long-term issue as highlighted by the Public Accounts Committee in June 2020[1]:

'We have reported on the financial and service sustainability of NHS bodies every year since 2011, and have consistently highlighted a range of challenges faced by the NHS, including rising demand, lack of capital investment, tackling trust deficits and workforce issues.'

The spending review must recognise that the NHS is wider than just the organisations within the NHS England and NHS Improvement structure. The NHS also includes arms-length bodies such as Health Education England and NHS Digital, where national funding levels can have a direct impact on the ability of local NHS organisations to deliver effective patient care.

For social care, the financial pressures have been greater as, prior to the pandemic, local authorities were impacted by austerity to a much greater extent than the NHS. For example, the Association of Directors of Adult Social Services (ADASS) reported in 2019 that there had been a reduction of £7bn in social care funding since 2010[2] . This year, its annual survey revealed that only 4% of directors were fully confident that their adult social care budget would be sufficient to meet their statutory duties in 2020/21[3]. Even before Covid-19, the Local Government Association forecast that local authorities would face an £8bn funding gap by 2025[4] and more recent analysis suggests that the pandemic will leave councils facing a £7.4bn Covid-19 funding gap[5].

However, we understand that it is unlikely that the spending review will meet the funding gaps for either the NHS or local government as the UK faces economic recession. It is therefore important that careful consideration is given to where investment will have the biggest impact, rather than directing it at the most popular area for media reports. System wide changes are needed to the way

[1] Public Accounts Committee, *NHS capital expenditure and financial management*, June 2020
[2] ADASS, *Key messages - ADASS budget survey 2019*, June 2019
[3] ADASS, *ADASS budget survey report 2020*, June 2020
[4] Local Government Association, *Councils can*, August 2020
[5] Local Government Association, *LGA analysis: COVID-19 council funding gap widens to £7.4 billion*, July 2020

that health and social care is managed and provided. This will, in part, require legislative change if systems, integrated care systems (ICSs) or sustainability and transformation partnerships (STPs), are to become the basis for financial management going forward. The pandemic has had a positive impact on integrated working relationships, but our members are concerned that these working relationships will be damaged when financial constraints are reintroduced as statutory duties at an organisational level will trump system-wide objectives that have no statutory basis.

Joined up, system working

While health and social care are joined up at government departmental level, the local experience is a much more separate approach with different regimes and statutory requirements in health and social care. It is well documented that this can make collaboration difficult.

The Covid-19 pandemic has improved local relationships for many, but also highlighted the disparity in available support and access to supplies and equipment, with extra difficulties in procuring personal protective equipment (PPE) and accessing testing for social care and care home staff. Integrated working between health and social care at a local system level needs to be an equal partnership that considers the impact of decisions on all parties.

The health and care system should be treated as a whole even though they legally are separate and each have their own expertise. Equal partnerships need to be supported by resources that enable both parties to contribute, be they financial resources or other assets such as workforce or estates. The continued underfunding of social care means that true system working cannot be achieved for the benefit of those who rely on the health and care system.

The barriers presented by the different legislative and regulatory regimes of NHS bodies and local authorities must be recognised and addressed. For example, in our response to the Public Accounts 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. We therefore welcome the recent proposal to reform the VAT refund rules[6].

More broadly, NHS bodies should be encouraged and enabled to act as anchor organisations in their communities. As a significant employer in many areas, the NHS can support local suppliers and provide employment for the population that they serve. NHS bodies also have a key role to play in addressing the wider determinants of health that the Covid-19 pandemic has laid bare. However, it is vital that there is wider engagement across the public sector with areas such as housing and criminal justice to address some of the underlying socio-economic reasons before they impact on health. With the recent widespread support for the NHS, increasing funding would be a popular move. However, unless all parts of the system are adequately funded, there will be little benefit for the NHS as the overall health and wellbeing of the population will decline and demand will increase further. The Marmot review[7] in 2010 made a series of recommendations about how inequity in health outcomes could be addressed and these continue to be relevant in 2020, having been starkly highlighted by the Covid-19 pandemic.

Funding for the future

Investment is needed to change the way that the NHS and social care operate, and to create the ability for the two sectors to work in a joined-up manner as equal partners. This is essential for the long-term sustainability of both the NHS and social care. Both sectors can and should be supported by significantly greater investment in the population health and prevention agenda and addressing wider inequalities which impact on demand for services. A healthier and happier population have less

[6] HM Treasury, *VAT and the public sector: reform to VAT refund rules*, August 2020
[7] Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, *Fair society, healthy lives: the Marmot review*, February 2010

need of recourse to public services. There should be as much focus on good health as good healthcare.

The *NHS long term plan*[8] set out the intention that *'the NHS and our partners will be moving to create integrated care systems everywhere by April 2021, building on the progress already made. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with local authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and long-term plan implementation.'* This requires investment across both health and social care and must be supported by addressing the differing regulatory regimes, as described above. NHS England and NHS Improvement have recommended[9] that *'an NHS Bill should be introduced in the next session of Parliament. Its purpose should be to free up different parts of the NHS to work together and with partners more easily. Once enacted, it would speed implementation of the 10- year NHS long-term plan.'* This continues to be important to the future development and sustainability of an effective health and care system.

In order to meet the ambitions of the NHS long term plan, there will also need to be investment in our workforce – both to retain and increase numbers of staff but also to train (or re-train) existing staff to meet changing demand.

The NHS workforce has received an outpouring of appreciation and support from the public during the course of the pandemic, but this does not change the fact that the workforce is under strain. The recent NHS people plan[10] is welcome. However, as the system resets, the workforce issues of before will return and may even be exacerbated by changes in demand and a necessity to change ways of working. Anecdotal evidence suggests that the exposure to new areas of work, and the cross skilling that has occurred, has had a positive effect for many and could support staff retention through enabling people to move more easily within the NHS. The recent NHS people plan suggests that the pandemic has also created a surge of people wanting to join the NHS, but this must be supported by appropriate investment in training and staff feeling valued and supported.

Both the national appreciation and the positive effect of new ways of working need to be harnessed to enable health and social care provided to recruit, train, and appropriately reward the staff that are so desperately needed. Pay rises are always welcome but consideration needs to be given to the other rewards that working brings by making the health and social care sector a great place to work.

The impact of Brexit on the recruitment and retention of overseas staff, is unknown. Currently, around 153,000 staff are from overseas, with 65,000 from EU countries[11]. These staff form an essential part of the NHS workforce and must be considered as post Brexit policies around immigration and employment are developed.

It is also important that the consequences of taxation and other policies are considered, several recent initiatives have had unintended consequences on the NHS workforce:

- the introduction of the apprenticeship levy has resulted in a cost pressure for many NHS bodies, especially in these early stages, as there are not enough apprenticeship courses available for NHS staff to join
- the amendments to the off-payroll requirements (known as IR35) in the public sector, but not the private sector, made the NHS a less attractive place to work in the short-term, particularly in the area of information technology. This may be resolved when these changes are applied to the private sector from April 2021

[8] NHS, *The NHS long term plan,* January 2019
[9] NHS, *The NHS's recommendations to Government and Parliament for an NHS Bill*, September 2019
[10] NHS, *We are the NHS: people plan 2020/21 – action for us all,* July 2020
[11] House of Commons library, *NHS staff from overseas: statistics*, July 2019

- the introduction of the tapered annual allowance for pension savings that resulted in senior clinical staff reducing their hours or taking early retirement as the tax implications mean that it is not worth them working. The changes to the thresholds made in the March 2020 Budget should largely resolve this issue going forward but the impact over the past two to three years will be felt for some years to come.

As the UK faces economic recession, any announcements to the taxation regime intended to stimulate economic growth must be tested for unintended consequences for the public sector.

The CSR 2020 is the opportunity to provide some much-needed certainty about future funding for the public sector. It is not possible to plan for transformation when the funding for the following financial year is unknown. While the five-year settlement for the NHS announced in June 2018 was welcome, the funding covered only part of the health and social care system. A system as large as the health and social care system, as well as the interconnected wider public sector services, cannot be transformed overnight so plans need to be put in place now for the whole system covering at least the next five years with known, adequate funding that takes account of the Covid-19 pandemic. Ideally, capital settlements will be made for the next 10 years to allow for longer term planning.

Funding flows

The system by which the money announced in any Budget or Spending Review reaches the patient is complex and, at each stage, there are different constraints and criteria that have to be met:

- the flow of funds from HM Treasury to the Department of Health and Social Care (DHSC) is determined by Parliamentary vote-on-account and then managed under the consolidated budget guidance that requires expenditure to be contained within departmental expenditure limits (DEL) – both revenue (RDEL) and capital (CDEL)
- funds flow from the DHSC via NHS England (NHSE) to clinical commissioning groups (CCGs) in accordance with the NHS Mandate and allocation process – this expenditure also has to be contained within RDEL and CDEL
- the providers receive their income in accordance with contracts agreed with CCGs – prior to 2020/21 these were largely based on national tariffs (for acute trusts) published by NHS Improvement. In 2020/21 due to the Covid-19 pandemic, these have been on a block basis moving, in the second half of the year, to a blend of block and activity-based contracts.
- NHS providers are able to incur deficits, in effect, spend more than they receive in income, but this usually results in a need to borrow cash to pay staff and suppliers.

As the pandemic has resulted in a pause to business as usual, this is the time to look at improving the mechanisms for system based funding of the NHS to remove inconsistencies, unintended consequences and focus on getting the most value for the patient from each pound spent. The simplification of the NHS finance regime during the pandemic has shown how financial flows can support, or block, system working. As the NHS, and wider public sector, develop plans for 2021/22 onwards, the lessons learnt from temporary changes to governance and working arrangements must be incorporated into the future financial regime.

Delivering services in a Covid-19 world

Prior to Covid-19, the NHS was in a difficult financial situation. Any settlement in the Covid-19 world needs to consider the fact that all health and social care services will have to be delivered differently for the foreseeable future:

- social distancing requirements and unknown Covid-19 status for new patients is likely to increase the overall staff numbers needed
- these same issues will reduce the capacity of NHS buildings as more space is needed to deliver the same services
- the changes to service delivery through the use of technology, such as on-line and telephone consultations, has been astounding but future investment will be required to understand the long-term impact of this method of delivery on both providers and patients/ service users. The

short-term solutions delivered at pace during the initial crisis may require investment to be stable enough to be used in the long term

- while changes have been made to service delivery, the capacity of the health and social care sector will be reduced as a result of the requirements for social distancing and increased cleaning – however, demand for healthcare services will continue to rise. In the short-term demand will be higher as it will include those services that were deferred during phases 1 and 2 of the NHS' response to the pandemic. In the longer term, all evidence points towards increasing demand as the population lives longer with more complex co-morbidities
- additional services created to deal with the pandemic need to be maintained at the same time as restarting all other healthcare provision. This is not possible within the current financial, and workforce, constraints. Some of these services were existing ambitions in the *NHS long term plan* but have been accelerated to cope with Covid-19, however the identified funding has not been brought forward to support them recurrently
- critical care staff ratios need to be reviewed and, possibly, maintained to deal with future cases of the virus
- personal protective equipment (PPE) will be needed in all areas of health and social care delivery for the foreseeable future
- necessary changes to services provided in acute trusts will have an impact on community services and social care. The reduced capacity of acute trusts will mean that more patients have to be treated in the community and are likely to have more complex needs than community services would normally deal with. In addition, patients are likely to be discharged form hospital quicker requiring greater support, for a longer time, by community health services and social care
- the consequences for those who are recovering from Covid-19 are still not fully understood - there may be a need for increased specialist rehabilitation and support in the community
- there will also be consequences for mental health and ambulance providers. Mental health providers are anticipating an upsurge in demand and ambulance providers are facing significant challenges to manage Covid-19 issues
- we need to ensure that we continue to improve the focus on population health especially reducing health inequalities in our most deprived communities – no one should feel left behind.

If you would like to discuss any of our comments in more detail please contact Emma Knowles, director of policy and research, emma.knowles@hfma.org.uk