Supplementary written evidence submitted by NHS Providers (CSR0095)

1. This paper outlines a number of new developments which may have a bearing on the Health Select Committee’s inquiry on the impact of the Comprehensive Spending Review for health and social care. It sets out further information on three areas:
   a. The current financial performance for the NHS provider sector;
   b. Lord Carter’s review of NHS operational productivity;
   c. Our assessment of the extent to which national policy commitments are funded by the spending review settlement.

a. Current financial performance for the NHS provider sector

2. The financial performance of the NHS provider sector is under considerable pressure. The net deficit over the first three quarters of this financial year was £2.26bn, and on current trajectory could increase to £2.8bn by the end of March. There are currently 179 providers in deficit, 75% of the sector and 95% of all hospital trusts.

3. These figures should not come as a surprise; the sector has been forecast a +£2bn deficit position this financial year for the past 18 months. There has been some further deterioration against the planned financial positions as a result of:
   I. Ongoing necessitated high use of contract and agency staff (on which £2.7bn has been spent so far this year);
   II. Significant impact of delayed transfers of care as a result of a lack of capacity in social and community care;
   III. Under-delivery of planned levels of savings as easy to release savings were largely delivered in the last parliament; and
   IV. A level of efficiency requirement in the national tariff (reducing the prices paid for services), which NHS Improvement’s Chief Executive has described as “unachievable”

4. Providers have been asked to take exceptional measures to improve their financial position in 2015/16. This may mean that on paper the deficit position reported at the end of the financial year is reduced from the £2.8bn currently forecast. However, many of the measures – such as capital to revenue switches and balance sheet adjustments – will do little to change the underlying financial position of providers, and therefore providers are likely to be entering the 2016/17 financial year with an actual deficit over £3bn.

5. The NHS has received a £3.8bn real terms increase in its budget for 2016/17, in part to address the size and scale of provider sector deficits. The NHS only received an upfront settlement in exchange for a commitment to return the sector quickly to balance. The committee may find it useful to scrutinise proposals to support the provider sector back in to balance for 2016/17.

6. Despite the additional investment in the NHS next year, combined with provider access to a sustainability and transformation fund and a more realistic efficiency requirement of 2% (as opposed to 4% as it has been in recent years) in the national tariff, substantial efforts will be required by providers to close the underlying deficit during 2016/17.

7. This is why financial targets ("control totals") have been introduced for every NHS trust and foundation trust next year, to set a maximum deficit position or minimum surplus they must deliver next year. We estimate that around two thirds of providers have accepted their control total but most will have done so with conditions or with a heavy warning around the level of risk that is being run given the level of efficiency and savings being asked for in some cases.

8. There has been a high degree of nervousness among NHS provider boards at signing up too definitively to the control totals at this point when so much still remains to be agreed; two such outstanding variables are:
   a. clinical commissioning group and specialised services contracts;
   b. availability of capital spend for maintaining existing estates and equipment, such as wards and diagnostic equipment.

9. In exchange for agreeing, and meeting, a control total, most providers\(^2\) have been offered a share of the £1.8bn of the new sustainability and transformation fund, which NHS England has set up to support the provider sector to return to balance in the short term. In the medium term, it is intended that this fund be used transform local services in line with the Five Year Forward View.

10. The release of this funding in 2016/17 is contingent on providers meeting their control total, and agreeing a trajectory for improving performance against quality and access standards, such as the 62 day referral to treatment time for cancer patients.

11. This something-for-something approach is understandable, but the committee may wish to assure itself that this plan is realistic and deliverable for getting the sector back to a surplus position by the end of 2016/17. Current issues are:
   I. Every control total provided an additional 2.5% efficiency target on providers’ 2015/16 financial forecast, which has translated to increased savings requirements providers must make next year.
   II. For some trusts, their savings plans will need to increase to between 4 and 6% of their total income, compared to a current average of around 3%.
   III. Although the majority of providers have accepted their 2016/17 control total, our recent survey of provider Finance Directors suggests that around 60% are not confident they could meet their target, suggesting that a majority of trusts are concerned about how deliverable it is.
   IV. An improvement in financial position will also be contingent on providers complying with capital restrictions on how much they are able to spend on

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\(^2\) Only trusts providing emergency services received a share of the sustainability fund.
maintaining or upgrading estates and facilities. Although restricting the use of capital in the short term might be understandable, the implications of continuing to ask providers to delay capital expenditure need to be carefully appraised.

V. The provider sector returning to balance next year is in part reliant on the success of recently announced controls on agency staff spend. Although there is early evidence of the impact this is having on reducing the number of shifts carried out by agency staff off agreed frameworks, we believe that further strong mechanisms might be required to ensure savings are realisable and recurrent.

b. Lord Carter’s review in to NHS operational productivity

12. Since the deadline for written evidence to the committee’s inquiry, Lord Carter’s review in to NHS operational productivity has now reported. This report is a key pillar of the government’s plan to close the £23.5bn funding gap by 2020. We are still waiting for detail from the national bodies and system leaders about how their plan to close the funding gap translates to different parts of the NHS, and what the relative share of the savings will be for the provider sector, compared to commissioners and other organisations.

13. The Carter review confirms that eliminating unwarranted variation could generate £5bn of efficiency savings by 2020, and that acute providers have in principle agreed to £3bn of this. However, it is clear that the savings identified in this review only make up a small proportion - less than a quarter - of the £23.5bn of savings required by the NHS in this parliament. Further savings might be identified from variation within community, mental health, ambulance, primary care and specialist acute services, but work has not yet started with these sectors.

14. Eliminating variation within the acute sector will only possible if the least efficient providers are able to catch up to the most efficient providers. However, the variation in productivity between acute hospitals has changed little between 2009/10 and 2014/15, suggesting that efficiencies dependent on organisations catching up to the best performers are hard to unlock.

15. This is a view confirmed in Lord Carter’s final report, which suggests that although hospitals can do more to improve productivity, much greater support will be required at a national and whole-system level if we are to realise these savings:

I. System leadership is required to address shared health and social care issue of delayed transfers of care, which is having a significant impact on the NHS achieving efficiency savings.

II. Further efficiencies might only be unlocked through changing the way hospitals deliver their clinical services, necessitating reconfiguration within and between organisations – this will require concerted national and political support.

3 Health Foundation publication
III. A single reporting framework needs to be created which pulls together all clinical quality and resource performance data, in turn reducing and rationalising the significant reporting burden currently placed on providers.

16. Lord Carter’s review also recommends the introduction of targets on hospitals to ensure they are managing their resources appropriately, including spending no more than 6% on corporate and administration costs by 2020 and having a maximum of 35% of non-clinical floor space at a site. Caution should be exercised over the introduction of hard targets in this area – the Carter review has buy-in from the provider sector for its emphasis on benchmarking, shared learning and collaboration, rather than top-down grip and regulation. Unlocking efficiencies needs to be a shared agenda between local and national organisations, rather than an initiative imposed on local organisations.

17. With these developments in mind, the committee may wish to explore with representatives of the government and national bodies:
   I. When NHS national bodies and system leaders are going share their plan for meeting the savings required in this parliament, given the Carter review can only meet £5bn out of the £23.5bn efficiency challenge.
   II. Whether the savings plans will be developed in collaboration with NHS frontline organisations.
   III. How the requirement to lower administration and corporate costs be reconciled with the resources and leadership required to meet the unprecedented challenges providers are facing.
   IV. Whether providers will be able to put in place sufficient non-clinical capacity and resource to turn finances around, meet increased demand and activity pressures, and rapid, large scale service transformation across local systems. Many of our members tell us that they have already reduced middle manager capacity in response to savings required in the last parliament.

18. Since the publication of the spending review, detail is starting to emerge over which policy commitments will be funded as part of the £8.4bn real term investment in the NHS – we have outlined our assessment of these commitments in the below table.

19. The committee may wish to ask for further detail from the government and national bodies about how funding for these policy priorities match to the additional investment. As the situation currently stands, we question whether the spending review settlement meets all national policy commitments and priorities in full.
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<th>Policy commitments and priorities</th>
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| Increased investment in commissioning allocations for local clinical commissioning groups (CCG), primary care and specialised commissioning allocations | • An additional £10bn (in cash terms) will be allocated to commissioning budgets over the between 2016/17 to 2020/21⁴.  
• This translates to a:  
  o 2.7% average annual increase to CCG budgets  
  o 5.2% average annual increase in specialised commissioning budgets  
  o 4.6% increase in primary care budgets⁵. |
| Implementing the recommendations from the mental health task force⁶ | • The government has committed £1bn out of the spending review settlement for health to implement recommendations from the mental health taskforce, published in February 2016.  
• It is not clear whether this is:  
  o A real or cash term increase in funding for mental health  
  o A recurrent or cumulative allocation  
  o To be funded through CCG allocations or the sustainability and transformation fund.  
• It would also be helpful to understand whether this includes or is in addition to:  
  o £600m funding for mental health originally announced in the Autumn Statement for 2015/16  
  o £1.25bn previously announced for perinatal, and children and young people’s mental health over five years. |
| Supporting sustainability and transformation | • NHS England has announced the creation of a £14bn sustainability and transformation fund. £2.1bn will be available in 2016/17, rising to £4.3bn in 2020/21.⁷  
• In 2016/17, the majority of this fund (£1.8bn) will be used to support sustainability in the provider sector, helping providers back to financial balance. In future years, it is envisaged that a greater proportion of the fund will be used to support transformation, but this is contingent on NHS finances stabilising in 2016/17 and 2017/18⁸. |
| Investing in improving | • The government has committed £4.2bn to NHS technology, |

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⁵ NHS Providers analysis of NHS England Board paper (December 2015).  
| **Technology in the NHS** | including £1.8bn to create a paperless NHS and £1bn on cyber security.\(^9\)  
- It is not clear whether any of this will be funded through the sustainability and transformation fund or commissioning budgets. |
| **Improving Maternity Services** | The government has not yet committed funding to meet the recommendations outlined in the national maternity review\(^{10}\), published in February 2016.  
- The cost implications identified in the report’s recommendations would necessitate an additional investment of around £10m in maternity services over the course of this parliament. |
| **Implementing Recommendations of the Cancer Taskforce** | The government has committed to fund in part the recommendations from the cancer taskforce\(^{11}\), published in 2015: £300m a year will be invested to support recommendations on earlier GP diagnosis for cancer, including investment in additional staff and diagnostic capacity by 2020.  
- It is unclear whether the other recommendations from the taskforce (worth an additional £700m) will be implemented in full, and how the £300m will be made available to frontline providers. |
| **Delivering Seven Day Services** | From a recent evidence session with the Public Accounts Committee, there is uncertainty over how much the spending review settlement provides sufficient funding for a comprehensive seven day service across primary and secondary care by 2020\(^{12}\).  
- Previous studies have suggested that implementing seven day services would increase provider costs by 1.5%-2%\(^{13}\). |

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