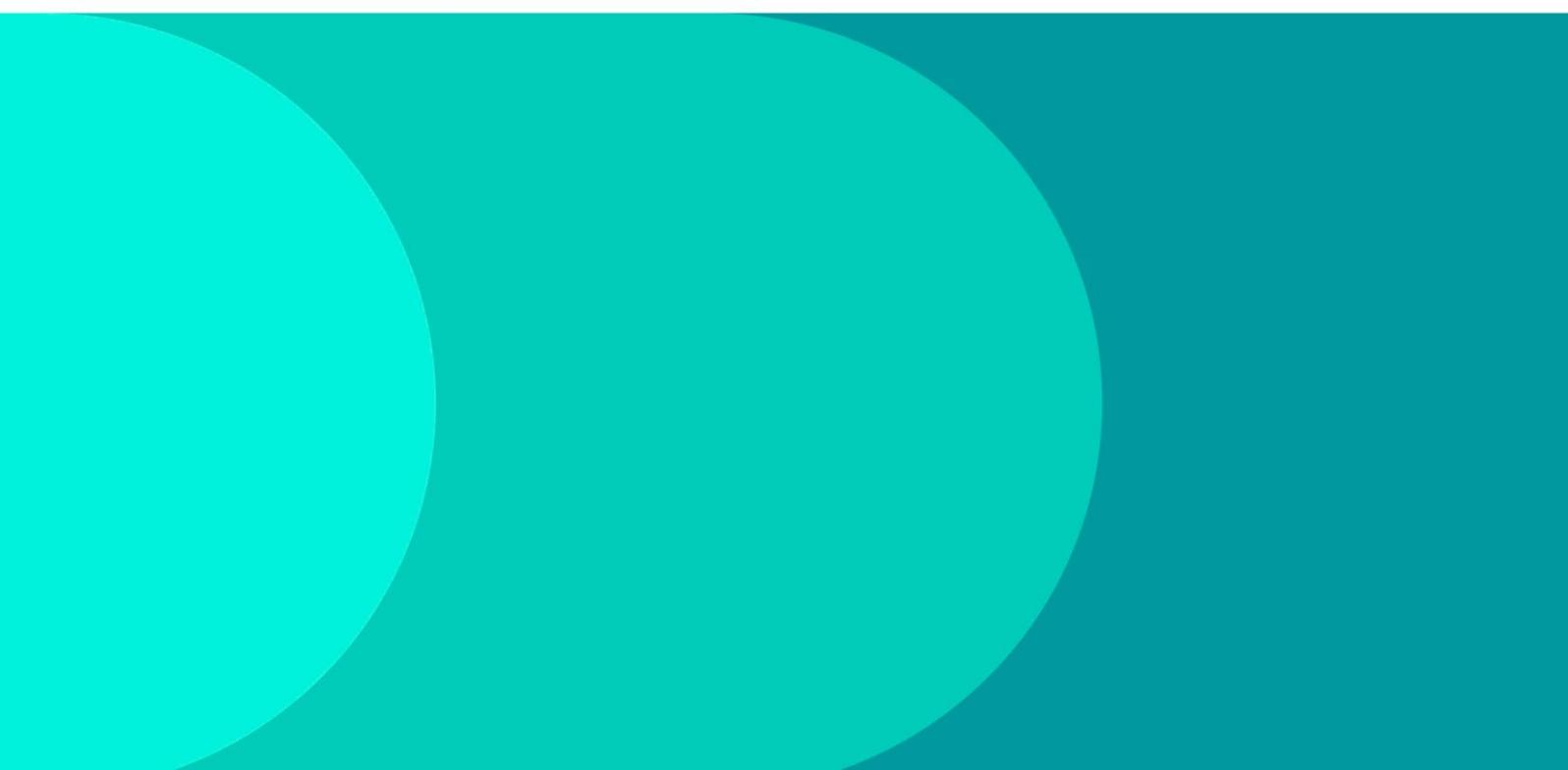


Representation to the Spending Review 2021

September 2021



About

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

Executive summary and key asks

The COVID-19 pandemic is arguably the biggest challenge the NHS has ever faced, with unprecedented demand and pressure on the system resulting in worsening health inequalities, performance against targets and funding shortfalls. Over 5.6 million people are now on treatment waiting lists, including 1.6 million for mental health services, and the efficiency targets from the NHS Long Term Plan (LTP) remain unmet in the previous two years. To recover from the pandemic, the NHS must transform what care it delivers and how it is delivered. That means now is the moment to scale up recent innovations in digital care and patient experience and embed integration to improve patient outcomes and reduce inequalities as intended by the health and care bill.

As the membership body representing health leaders across the NHS, we ask that the government supports the NHS to meet this challenge by:

- **finishing the service funding task started by the September funding announcement** – we need *at least* £10 billion in service funding next year to cover ongoing COVID-19 costs (£4.6 billion), recover care backlogs (£4-£5 billion), and make appropriate allowance for lost efficiency savings, with inflation and demand adjusted settlements to 2024/25
- **creating a multi-year capital funding settlement for the entire NHS** – to reduce the backlog, ensure the safety of the NHS estate, embed positive pandemic-era changes and truly make inroads to reducing inequalities by transforming models of care, the Department of Health and Social Care (DHSC) capital departmental expenditure limit (CDEL) budget should rise to at least £10.3 billion in 2024/25. This funding will also help drive the NHS towards the UK's net zero target

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- **addressing workforce issues such as lack of a multiyear funding settlement, pension issues, unfunded pay uplift and unclear future commissioning arrangements** – to reduce the elective backlog and meet increasing demand, the workforce must increase by around a fifth by 2024/25; this means increasing Health Education England’s budget to £5.5 billion by 2024/25.
 - **allowing primary care to lead in helping people wait well** – as we move to integrated care systems, the role of primary care will be more important than ever in driving better patient outcomes; however, leaders need more funding to deliver vital services – the current five-year funding settlement was agreed before COVID-19 and so does not consider the significant additional costs the pandemic has brought
 - **making discharge-to-assess funding permanent so community providers can help reduce inequalities and address long COVID** – lifting local authority and public health budgets will mean that community providers do not have to absorb the recent unfunded Agenda for Pay uplift costs unfairly and, further, for community care providers to play their key role in reducing the backlog, they must be included in wider medium-to-long-term plans
 - **helping mental health providers address the increased mental ill health of the population** – mental health services will need between £1.6–£3.6 billion, an annual average of £410–£900 million per year until 2023/24 (depending on demand) over and above existing funding to deal with this surge in people seeking support; however, in the absence of a new specific allocation in the spending review, mental health providers risk being left out of the recent funding announcement
 - **equipping public health and social care to work effectively with the NHS and integrate care** – a successful health and care system needs a well-funded social care and public health system, yet both have been neglected in recent years, creating greater demand for NHS services as a result; both need more funding, with local authority funding vital for a successful public health system.

More than ever, the past 18 months show the NHS to be a significant economic force, an ‘anchor institution’ that can level up the country, which positively impacts on people’s wellbeing, providing employment and boosting local economies. With adequate funding they will be able to do so even more effectively. As large employers, purchasers, and capital asset holders, NHS organisations are well positioned to use their spending power

and resources to address the adverse social, economic, and environmental factors that widen inequalities and contribute to poor health outcomes.

Finally, while the Spending Review relates to England, COVID-19 again demonstrates the importance and interconnectedness of the UK's health and care system. As such, the spending announcements must consider not only the Barnett consequential and the additional funding provided to devolved administrations, but the strategic and collective needs of the entire UK in fighting inequalities, population health and chronic health issues.

Throughout the submission, we draw heavily on the economic modelling undertaken by the Health Foundation's REAL Centre.

Part 1: the NHS needs a better funding settlement to recover from COVID-19

Key asks: The September funding announcement falls short of what the NHS needs over the coming three years. We need at *least* £10 billion in service funding next year to cover ongoing COVID-19 costs (£4.6 billion), recover care backlogs (£4-5 billion), and make appropriate allowance for lost efficiency savings, with equivalent rises to 2024/25.

In addition to day-to-day funding, capital investment is key to continue to deliver high-quality, safe health services as well as meet longer-term goals to integrate care as set out in the health and social care bill. The DHSC CDEL budget should rise to £10.3 billion in 2024/25 and complement a multiyear strategic plan for all parts of the NHS.

1.1. COVID-19 has arguably been the greatest challenge to ever confront the NHS. In almost an instant, the pandemic transformed the NHS, forcing health leaders to adapt to new ways of working, re-prioritise and introduce a test and trace system, while postponing many thousands of routine procedures and pushing millions more interactions online. It is a testament to the remarkable work of everyone within the NHS that the country has survived several severe waves.

1.2. But even in 2019, the NHS was underfunded and understaffed. Per capita health spending had barely increased in the decade previous, despite the increasing demands of an ageing population. Social care funding had fared even worse.

1.3. This spending review must help the NHS recover and continue to manage both the direct and indirect costs of COVID-19. The pandemic's effects on the NHS are two-fold. Firstly, it introduced a range of new costs, such as test and trace, PPE, vaccination and long COVID.

1.4. Secondly, COVID-19 increases the costs of providing normal NHS services and meeting the targets of the LTP. The pandemic both reduces the service's productivity and increases the backlog for both physical health and mental health services, and COVID-19 exacerbates issues such as mental ill-health, an underfunded public health system and workforce supply.

2. The September funding announcement isn't enough for the next three years

2.1. While health leaders welcomed the certainty provided by the 2018 multi-year funding settlement, analysis showed it was below the historical average, below what was needed to meet the goals of the LTP and left many crucial questions – sufficient funding for capital, public health, workforce, and a policy solution for social care – unanswered. Waiting lists were also creeping up, compounded by staffing shortages of at least 100,000 which restricted the entire service's ability to provide care.¹ The 2018 settlement was based on historically unrealistic assumptions for both activity and productivity growth² and, put simply, was not enough. Nuffield Trust analysis estimates the NHS will spend £5 billion more in *non-COVID-19* patient care in 2021/22 than anticipated when the 2018 funding settlement was agreed.³

2.2. Our estimate, based on surveying our members, is that the NHS England 2022/23 budget for secondary care needs to increase by around £10 billion – or approximately £4 billion more than has been announced – compared to the 2018 NHS settlement to cover ongoing COVID-19 costs (£4.6 billion), recover care backlogs (£4-5 billion), and make appropriate allowance for lost efficiency

¹NHS Digital (2021), NHS Vacancy Statistics England April 2015 – March 2021 Experimental Statistics <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---march-2021>

² Nuffield Trust (2021), Checking the NHS's Reality, <https://www.nuffieldtrust.org.uk/news-item/checking-the-nhs-s-reality>

³ Ibid.

savings.⁴ These estimates are broadly in line with those made by both the Institute for Fiscal Studies and the Health Foundation.⁵ The government's recent funding announcement is welcome, but only the start of what we need as it excludes investment in primary care or capital (discussed in further detail below).

2.3. Subsequent COVID-19 waves as well as the emergence of more destructive variants of concern could be disastrous for NHS productivity, and the government's September announcement allows little wiggle room for COVID-19-related surges. The Health Foundation has modelled the productivity shocks should we suffer further wave(s) of COVID-19. Every 1 per cent hit to productivity arising from, for example, infection prevention and control measures, would require around £1.5 billion per year (2021/22-2024/25). A 10 per cent hit would require £13-16 billion over this period.⁶

3. Reducing the backlog will require more than just short-term funding

3.1. Not least among COVID-19's effects is its impact on the elective waiting list backlog. During 2020/21, 5.3 million less elective treatment pathways were completed compared to 2019/20,⁷ a pathway is completed when definitive treatment starts, a patient declines treatment or a clinical decision is made that treatment is not needed. This has contributed to the highest waiting list on record, with over 5.6 million people waiting for treatment as of July 2021.⁸ This waiting list is only set to increase as a 'hidden waiting list' of 7 million or more people, who stayed away from services during the pandemic, are expected to join the official queue in the coming year.⁹ Our own analysis shows 5.9 million fewer referral-to-treatment pathways were started in 2020 compared to 2019.¹⁰

⁴ NHS Confederation and NHS Providers (2021), A Reckoning: the Continuing Cost of COVID-19, <https://www.nhsconfed.org/sites/default/files/2021-09/A-reckoning-continuing-cost-of-COVID-19.pdf>

⁵ Institute for Fiscal Studies (2021), Pressures on the NHS, <https://ifs.org.uk/uploads/Green-Budget-2021-Pressures-on-the-NHS.pdf>

⁶ Health Foundation REAL Centre (2021), Health and Social Care Funding to 2024/25, <https://www.health.org.uk/publications/reports/health-and-social-care-funding-to-2024-25>

⁷ NHS Confederation analysis of NHS England (2021), Consultant-led Referral to Treatment Waiting Times Data 2021-22, <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22/>

⁸ Ibid.

⁹ Institute for Fiscal Studies (2021), Could NHS Waiting Lists Really Reach 13 Million? <https://ifs.org.uk/publications/15557>

¹⁰ NHS Confederation analysis.

3.2. The waiting list is not just in acute care. It is estimated that 1.6 million people are currently on waiting lists for secondary mental health services, including approximately 800,000 adults and 450,000 children and young people, while 380,000 people are waiting for NHS psychological therapies services (known as IAPT services).¹¹ NHS England and NHS Improvement calculate that 8 million people would benefit from support for their mental health, but do not meet the current thresholds for care. This includes 1 million adults with severe mental illness, up to an additional 1 million children and young people, and approximately 6 million people for IAPT services.¹²

3.3. Reducing the elective backlog will take sustained investment over many years and a commitment from the government. History is instructive here. While the situations are different, the experience of clearing waiting lists in the 2000s provides guidance. It took seven years and a significant increase in health funding to meet the targets set in 2000.

3.4. Finally, reducing the elective backlog must consider all parts of the health and social care system – not just in acute hospital settings. Mental health, primary and community providers form an eco-system that helps patients wait well before elective treatment. Ambulance services, for instance, play a critical role in supporting communities and working across the entirety of the NHS. They have a unique role in connecting with all parts of the NHS, as well as other emergency services, and can play a big role in helping transform the way that patients interact with the health service.

4. We need a multi-year strategic capital plan

4.1. The recent government funding announcement relies on increased productivity over the next four years. The NHS can't meet the elective backlog goals, implement the new health and care bill, scale up innovative practice or make the system fairer for all without a strategic capital plan. Research shows that capital constraints hamper NHS trusts' ability to successfully deliver care, that the state of the built environment affects patient outcomes, and that staff are more productive

¹¹ The Guardian (29 August 2021), Strain on Mental Health Care Leaves 8m People Without Help, say NHS Leaders, <https://www.theguardian.com/society/2021/aug/29/strain-on-mental-health-care-leaves-8m-people-without-help-say-nhs-leaders>

¹² Ibid.

when they have the right up-to-date equipment to efficiently treat patients.¹³ Despite this, the total maintenance backlog cost rose to over £9billion pre-pandemic.¹⁴

4.2. This reflects a longer-term neglect of capital funding, with UK health capital investment consistently lower than rich world averages,¹⁵ and a decade where the capital budget was consistently raided to pay for an underfunded service.¹⁶ NHS Confederation members across the NHS tell us they struggle to quickly access capital to address the backlog, and that arbitrary CDEs threaten to impede the effective creation of integrated care systems (ICS) or bring waiting list numbers down.

4.3. A key area where greater capital funding could have an impact is in allowing the NHS to embed recent digital innovations accelerated by the pandemic. Currently, health and care staff use a plethora of legacy IT systems, many of which do not work with other systems across the NHS, subsequently hampering successful digital integration and better patient outcomes. Almost a quarter (22 per cent) of doctors who responded to a survey by the British Medical Association (BMA) in its [vision for NHS IT report](#) said that IT systems at their place of work are not fit for purpose and 56 per cent said it significantly added to their day-to-day workload.¹⁷ As well as this, the [Topol Review](#) found that between 15 per cent and 70 per cent of a clinician's working time is spent on administrative tasks.¹⁸

4.4. Fixing these issues requires both more funding and a joint strategic approach. Government strategies, the [digital strategy](#), the [LTP](#) and [Data Saves Lives](#) set out the government's ambitious aims to modernise NHS data architecture and infrastructure. However, these will struggle without significantly more money, a

¹³ The Health Foundation (2019), Failing to Capitalise, <https://reader.health.org.uk/failing-to-capitalise/key-points>

¹⁴ NHS Digital, Estates Returns Information Collection Summary page and dataset for ERIC 2019/20, <https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2019-20>

¹⁵ NHS England (2019), Long Term Plan – Chapter 6, <https://www.longtermplan.nhs.uk/>

¹⁶ King's Fund (2019), The King's Fund Responds to the Government's Announcement of Additional Capital Funding for NHS Hospitals, <https://www.kingsfund.org.uk/press/press-releases/announcement-additional-capital-funding-nhs>

¹⁷ British Medical Association (2020), NHS Technology, Infrastructure and Data Report, <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/technology/nhs-technology-infrastructure-and-data-report>

¹⁸ Health Education England (2019), The Topol Review, <https://topol.hee.nhs.uk/>

strategic approach to digital capital investment and further investment in staff training.

4.5. Most crucially, fixing IT must be part of a broader, multi-year strategic capital settlement for all the parts of the NHS that includes a plan to fix the maintenance backlog, build new hospitals, reduce inequalities throughout the country, integrate care and embed recent changes to the service to meet ongoing COVID-19 and future patient needs.

4.6. Health leaders describe a fragmented approach across health and care, with several different unconnected strategies that fail to account for the role played by non-secondary care providers, such as primary care and mental health. Ninety-eight per cent of our Primary Care Network members say they need more capital investment to accommodate new roles and deliver effective multi-disciplinary care.¹⁹ Insufficient capital funding hampers the government's plans for both mental health and primary care with the changes to the Mental Health Act and the growth in primary care services respectively. Acute trusts' efforts to treat more patients safely while also treating COVID-19 patients cannot happen without upgrading their estate.

4.7. And yet the government has focused narrowly on new hospitals as part of its Health Infrastructure Plan. While new hospitals are welcome, we need a more ambitious health infrastructure plan focusing on the entirety of the NHS, that is easy to access, that extends over multiple years, and ensures fair access for all. To do this, at the bare minimum, the NHS will need capital funding to increase to £10.3 billion per year by 2024/25.²⁰

¹⁹ PCN Network (2021), Primary Care Networks: Two Years On, NHS Confederation, <https://www.nhsconfed.org/publications/primary-care-networks-two-years>

²⁰ Health Foundation REAL Centre (2021), op cit. <https://www.health.org.uk/publications/reports/health-and-social-care-funding-to-2024-25>

Part 2 - Priorities from health leaders across the NHS

5. Investing in workforce growth and retention: employers' priorities

Key asks: Fully fund a new workforce strategy, that includes specialist roles and lifts Health Education England's (HEE) annual budget to £5.5 billion by 2024/25. Retain funding for increasing workforce supply including apprenticeships and unfreeze the NHS pension scheme to incentivise senior clinicians.

- 5.1.** The NHS workforce has worked tirelessly to fight COVID-19 and protect our communities during the pandemic. As a result, they are understandably exhausted and NHS leaders worry about burnout and the risk of people leaving. Employers are adopting a range of strategies to support staff in the best way possible to ensure we retain our valuable people resource.
- 5.2.** The NHS in England went into the crisis with a shortage of at least 100,000 staff and without a long-term workforce funding settlement. Tackling the elective care backlog and meeting rising demand will mean the NHS workforce will need to grow by almost a fifth by 2024/25.²¹ The Health Foundation estimates this requires HEE's budget to increase to £5.5 billion by 2024/25.²²
- 5.3.** We welcome the recent announcement of the 3 per cent pay uplift for 2020/21. However, this must be fully funded, including where services are funded through public health contracts, as well as any plans to introduce future changes to employer pension scheme contributions as part of the NHS Pension Scheme valuation.
- 5.4.** Employers have three other key priorities. Firstly, the government must continue funding nursing workforce growth and smaller allied professions to address strategic supply and widen participation. The NHS is on track to achieve the 50,000 extra nurses manifesto commitment by 2024. However, we need to sustain the investment in training between 2022 and 2025 for nurses and smaller professions

²¹ Ibid.

²² Ibid.

to meet the growing demand, especially in mental health, learning disability and community settings where we have not seen the growth in numbers that have been achieved in hospital settings.

- 5.5.** We have seen that the employer-led nurse degree apprenticeship route has very low levels of attrition and high levels of retention. It is attractive to the existing workforce for whom we can offer the opportunity to progress into a professional role and achieve their potential. Increasing these roles means more money for employers to cover the significant backfill costs.
- 5.6.** Secondly, we need a strategy for specialist roles. We desperately need more experienced mental health professionals to meet the growing demand for services and provide supervision for more junior staff, including new roles such as the educational mental health practitioner roles. The Centre for Mental Health estimates that two to three times current capacity is needed to meet the expected rise in demand for mental health services.²³ In addition, changes to make the most of Additional Roles Reimbursement Scheme (ARRS) for primary care including proper training, investment in technology and easier access to the pension scheme for non-NHS providers will be necessary.
- 5.7.** Finally, we need changes to the NHS Pension Scheme. Although changes in the 2020 Budget have mitigated the service impact of tax charges for higher earners, uncertainty and resentment persists – particularly for senior clinicians – with a remaining sense of unfairness about the way pension tax rules have operated. There remains a compelling case for reform of the scheme to allow varying percentages of contribution and to reflect the comments made by the Senior Salaries Review Body (SSRB) in their 2021 report.
- 5.8.** In recovering from the effects of the COVID-19 pandemic, employers will need to maximise available capacity of senior clinicians in reducing waiting lists (elective work) and restoring services. The freezing of the Lifetime Allowance at current rates until 2025/26 should be reviewed as it will improve incentives for senior clinicians to provide additional capacity to the NHS and improve retention rates.

²³ O'Shea N (2021), COVID-19 and the Nation's Mental Health, Centre for Mental Health, https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMentalHealth_COVID_MH_Forecasting4_May21.pdf

6. Help mental health services cope with increased pandemic demand

Key asks: Increase funding for mental health to reflect demand caused by the pandemic, which could mean services need an extra £900 million per year by 2024/25 over and above existing funding. Continue funding mental health practitioner roles as part of the HEE workforce settlement.

- 6.1.** The pandemic has significantly increased the demand for mental health services across the UK. The Centre for Mental Health estimates that 10 million people will need new or additional support for their mental health.²⁴ During the pandemic, calls to ambulance control rooms concerning mental health issues increased, with one ambulance trust reporting calls doubling;²⁵ and primary care services reporting a 50 per cent increase in cases involving mental health.²⁶
- 6.2.** The impact on children and young people has been particularly hard. A report from the Royal College of Paediatrics and Child Health found that the number of children and young people in paediatric beds with a mental health need nearly doubled between September 2019 and December 2020.²⁷ Between March 2020 and February 2021, there was a 29 per cent increase in the number of children and young people in contact with mental health services²⁸ and a 104 per cent increase in children and young people completing eating disorder pathways between quarter four in 2019/20 and quarter four in 2020/21.²⁹
- 6.3.** COVID-19 also significantly impacted NHS staff mental health, which has knock on effects on capacity and costs.³⁰ NHS staff absences for mental health reasons increased by around 40 per cent between May/June 2020 and May/June 2021.³¹

²⁴ Ibid.

²⁵ Private conversation with ambulance trust members (2021).

²⁶ Private conversation with PCN Network (2021).

²⁷ Royal College of Paediatrics and Child Health (2021) Impact of COVID-19 on Child Health Services between December 2020 and February 2021, <https://www.rcpch.ac.uk/resources/impact-covid-19-child-health-services-part-2-report>

²⁸ Based on analysis of Mental Health Services Data Set data (2021), <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set>

²⁹ Based on analysis of data from NHS England eating disorder statistics, (2021) <https://www.england.nhs.uk/statistics/statistical-work-areas/cyped-waiting-times/>

³⁰ O'Shea a (2021), op cit.

https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMentalHealth_COVID_MH_Forecasting4_May21.pdf

³¹ Collins A (2021), Leap in Mental Health Absences among NHS Staff, HSJ, 6 August 2021, [Leap in mental health absences among NHS staff | News | Health Service Journal \(hsj.co.uk\)](https://www.hsj.co.uk/news/health/leap-in-mental-health-absences-among-nhs-staff)

The Mental Health Economics Collaborative estimate that a 1 per cent increase in NHS staff absences would cost £476 million per year.³²

6.4. Mental health services will need between £1.6–£3.6 billion, an annual average of £410–£900 million per year until 2023/24, depending on demand, over and above existing funding to deal with a surge in demand.³³ Without extra funding, the system will not be able to successfully implement the Mental Health Act Review, LTP or mental health clinically-led standards – all of which are existing government commitments and are crucial to improving patient care in the longer term. Continued funding for mental health practitioner roles, and social prescribing in primary care, will help early intervention efforts succeed.³⁴

7. Help primary care reach its potential to help patients ‘wait well’

Key asks: Guarantee primary care funding beyond 2024 and continue funding for non-clinical roles. Include primary care providers in the Elective Recovery Fund, recognising their role in managing the growing backlog.

7.1. Primary care is the front door to the NHS: over 90 per cent of patient contact with the NHS happens in general practice.³⁵ They are essential system leaders and partners in improving population health, reducing inequalities, and levelling up the country.

7.2. Therefore, if the health and care system is to improve local population health and reduce inequalities, it is essential that primary care is properly resourced and supported. International studies show that increasing access to primary care

³² O’Shea N (2021), Now or Never: a Systematic Review of Mental Health Care in England, Centre for Mental Health, https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMH_NowOrNever_PDF.pdf

³³ Health Foundation REAL Centre (2021), op cit. <https://www.health.org.uk/publications/reports/health-and-social-care-funding-to-2024-25>

³⁴ PCN Network (2021), Recruiting Mental Health Practitioners through the Additional Roles Reimbursement Scheme (ARRS), <https://www.nhsconfed.org/publications/recruiting-mental-health-practitioners-through-additional-roles-reimbursement-scheme>, NHS Confederation.

³⁵ NHS England (2013), Transforming Primary Care in London, <https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/Call-Action-ACCESSIBLE.pdf>

professionals is one of the most effective ways to improve the health of that population.³⁶

7.3. Primary care is also essential to successfully integrating care. Primary care providers have worked tirelessly to support the COVID-19 response, delivering vaccination programmes, reaching out to underserved communities and making headway against their objective to tackle health inequalities while delivering record numbers of consultations. However, the pressures caused by the pandemic and underlying workforce shortages has meant longer-term ambitions set out in the LTP have been challenging to deliver.

7.4. Primary care networks (PCNs) have in many ways grown and made progress in collaborating with system partners during the pandemic, but challenges remain. In a recent survey of PCN Network members, more than 90 per cent said their workload was greater than expected, with the consistently high workload derailing PCNs' existing and planned work programmes.³⁷

7.5. Primary care will play a key role in reducing the elective backlog, delivering the future vaccination programme, and managing their own increased clinical demand, assisting the many millions who have not sought treatment during the pandemic to 'wait well.'

7.6. Delays in secondary care create further demand in primary care. Despite this, primary care providers have not received money from the Elective Recovery Fund (ERF), the fund established to fund backlog reduction. The government should expand funding for the ERF, ensuring it is sufficient to cover all pay everyone involved in care and ensure funding destination corresponds with where activity takes place.

7.7. Funding for general practice is currently locked until 2024. While welcome, we believe that future guarantees of primary care funding would allow for good long-term planning. This is especially true for PCNs, enabling them to plan for their own

³⁶ L'Esperance V, Sutton M, Schofield P et al (2017), Impact of Primary Care Funding on Secondary Care Utilisation and Patient Outcomes: a Retrospective Cross-Sectional Study of English General Practice, *British Journal of General Practice* 2017; 67 (664): e792-e799. DOI: 10.3399/bjgp17X693101

³⁷ PCN Network (2021), Primary Care Networks: Two Years On, NHS Confederation, <https://www.nhsconfed.org/publications/primary-care-networks-two-years>

organisational development and their populations' health needs, including any role they may take in the long-term project to reduce the secondary care's backlog.

7.8. The future of primary care is also at risk due to the ongoing workforce shortage. The commitment to an additional 6,000 doctors in general practice, while welcomed, will not be met without additional support and investment. A recent Royal College of General Practitioners' survey found that the sector may lose up to 3,500 GPs over the next year, and up to 16,000 over the next five,³⁸ which risks further fueling the workforce crisis and elective backlog. In roles such as social prescribers and 'care navigators', non-clinical staff signpost patients to support and care, offering a holistic approach to people's health and wellbeing. The Spending Review is an opportunity to ensure a long-term commitment to increase and train more of these roles.

8. Community providers can assist with health inequalities and long COVID

Key asks: Strengthen mechanisms to ensure money set aside for community care reaches its intended provider. Enhance community care by making discharge to assess funding permanent. Increase local authority and public health budgets so that community providers do not have to absorb pay uplift costs unfairly. Plus, include community care providers in medium-to-long-term plans to reduce the backlog.

8.1. Community health services have a key strategic role across health and care, delivering vital services to support people in the community. The sector has historically been overlooked for funding and a lack of sustainable investment reduces the sector's ability to innovate and provide resilient and sustainable services.

8.2. NHS England and NHS Improvement committed to primary and community services receiving at least £4.5 billion more money by 2023/24. Despite this commitment, there is concern that this funding isn't reaching community providers and that funding 'flows' make it difficult to follow and measure funding. We need a stronger mechanism to ensure that the investment allocated to community health services reaches community providers.

³⁸ Royal College of General Practitioners (2021), 2021 Tracking Survey, <https://www.rcgp.org.uk/policy/rcgp-ad-hoc-surveys.aspx>

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- 8.3.** COVID-19 has highlighted several further areas where the sector needs funding. Firstly, discharge to assess funding must be made permanent to better serve long-term planning and better patient care.³⁹
- 8.4.** Cuts to local authority budgets have resulted in the local government public health budget being cut by almost 25 per cent per head between 2014/15 and 2018/19. This has two effects. Firstly, community services have had to absorb the risk of these contracts. Community interest companies, who deliver community services, may suffer further from a loss of income. Secondly, local authorities haven't been given money for the recent NHS Agenda for Change (AfC) pay uplift. As a result, community service providers must absorb the pay uplift from their own budgets, which further affects service delivery and may ultimately impact on their ability to maintain services.
- 8.5.** Finally, community health services need to be factored into any plan to clear the care backlog. Community providers have seen a 15 per cent increase in demand for services since last year and there is not sufficient funding to meet this rising demand.⁴⁰
- 8.6.** Community providers are at the forefront of delivering care for long COVID, and many are leading aspects of the COVID-19 vaccination programme. While the future of managing COVID-19-related demands is uncertain, these new pressures will be with us for the foreseeable future, and dedicated resource must be allocated with this in mind. The community sector needs long-term investment in services supporting people with long COVID, alongside a fully resourced and planned vaccination delivery.

³⁹ NHS Confederation and NHS Providers Community Network, Discharge to Assess: the Case for Permanent Funding, [Discharge to assess | NHS Confederation](#)

⁴⁰ NHS England and NHS Improvement data, January 2020.

9. Social care and public health: the building blocks of an effective health system

Key asks: Increase funding above the September announcement to fully account for increases in demand and to lift the pay and working conditions of social care staff. Increase the public health grant to £4.3 billion by 2024/25, bringing the rise in line with September's service funding.

9.1. COVID-19 and the inequal toll it has taken on parts of society highlight two overlapping and often neglected parts of the health and care system.

9.2. The first is social care. Social care services play a crucial role in continuity of care pathways and protecting NHS capacity by keeping people well for longer outside of hospital, and enabling faster, safer discharges home. The last 18 months have exposed deep cracks in the system and have exacerbated structural vulnerabilities, with devastating consequences for social care residents and their families. The introduction of a health and social care levy is a good first step towards a long-term plan for social care, but the challenge is much more than finding a funding mechanism, crucial though that is. In addition, increasing tax on NHS and social care employers through increased national insurance contributions may prove counterproductive.

9.3. Even though the number of people needing care is rising, the UK now spends less on social care than the EU average; social care spending per person fell by 12 per cent between 2010/11 and 2018/19.⁴¹ As a result, an estimated 1.4 million people have an unmet need for social care.⁴² The Department of Health and Social Care estimates that mental health social care services require an additional £1.1 billion per annum to help meet the demand,⁴³ which would help reduce pressures on the NHS and support the eradication of out-of-area placements in mental health. Implementing the Community Mental Health Framework, a cornerstone of mental

⁴¹ The Health Foundation (2020), The Health Foundation's Supplementary Evidence to the Health and Social Care Select Committee Inquiry on Social Care: Funding and Workforce, <https://www.health.org.uk/sites/default/files/2020-07/Health-Foundation-Supplementary-submission-social-care-inquiry.pdf>

⁴² Age UK (2018), New Analysis Shows Number of Older People with Unmet Care Needs Soars to Record High, <https://www.ageuk.org.uk/latest-press/articles/2018/july-2018/new-analysis-shows-number-of-older-people-withunmet-care-needs-soars-to-record-high/>

⁴³ Department of Health and Social Care (2020), Report of the Department of Health and Social Care C19 Task Force, [Social Care Sector COVID-19 Support Taskforce: Mental Health and Wellbeing Advisory Group report and recommendations \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464242/social-care-sector-covid-19-support-taskforce-mental-health-and-wellbeing-advisory-group-report-and-recommendations.pdf)

health commitments, depends on adequate social care funding. It is vital that social care services for working age adults receive their fair share of the additional social care funding.

9.4. Therefore, we are concerned that the funding levels do not go far enough and will fail to deliver a sustainable and equitable social care system for improvement of all areas of social care services, including working age adults as well as our older citizens. Health Foundation estimates that the core adult social care system would still need £9.3 billion extra in 2024/2025 than it does today, with the funds for the cap on care costs *on top of that*.⁴⁴

9.5. It is vital to ensure appropriate access for those who need support, with adequate state funding to improve access and quality of care. We also need to secure a stable provider market providing the right model of care, and a sustainable workforce, properly valued, paid and respected for this vitally important work.

Public health

9.6. The pandemic has demonstrated how inextricably linked wider determinants of health, such as housing, education and employment, determine population health outcomes. Improving physical and mental health and wellbeing, as well as reducing health inequalities, should be a key outcome across all departments of government. Public health funding is essential to tackling health inequalities. But the NHS alone cannot fight health inequalities. Therefore, a shift towards a preventative approach therefore requires tackling the underlying causes of health inequalities, with investment targeted at infrastructure and services which provide sustainable solutions.

9.7. Many local authorities with areas of greater deprivation, which have suffered from years of budget reductions, were disproportionately hit by the pandemic, with

⁴⁴ Anita Charlesworth (2021), Will Johnson's Social Care Tax Gamble Pay Off Politically?, https://www.prospectmagazine.co.uk/politics/will-johnsons-social-care-tax-national-insurance-gamble-pay-off-politically-health-nhs-service?mkt_tok=OTM2LUZSWi03MTkAAAF_ol1XX95X6cDhZUD5Ji6FUNUXBIBYYrZ_nPHwYQKpAnKff-34cr_HNhi2THLUuC9n-nMEVHBEmsjh70tblGkxHJtVtMGYgOmv7OeND0_Zlb8srYw

higher rates of infection and mortality.⁴⁵ The ring-fenced public health funding allocations for 2021/22 saw every local authority in England receive an increase of at least 0.67 per cent in cash terms, however, this does not compensate for the 24 per cent decrease in real terms funding that has been experienced since 2015/16.⁴⁶ Evidence shows that prevention-based interventions are hugely beneficial and cost effective, offering a considerable return on investment. To successfully fight health inequalities, funding for public health grants should match NHS funding and increase to £4.3 billion by 2024/25.⁴⁷

Part 3 - Conclusion: The NHS can lead the economic recovery

10. Investment in the NHS pays dividends

10.1. The UK faces a further period of economic uncertainty as the furlough scheme ends and COVID-19's long economic tail continues to be felt throughout our communities. Thankfully, the NHS doesn't just treat patients, it plays a significant economic role too; as an employer, as a driver and consumer of innovation, as a landowner and anchor institution within places, and as a vital element in raising wellbeing and addressing the challenge of reducing regional inequalities throughout the UK. This civic, economic and social impact of the NHS will be particularly important in delivering on the government's levelling up priority and we would strongly recommend all government departments adopt a health in all policies approach.

10.2. Investment therefore doesn't just drive immediate health outcomes. Instead, health investment drives a virtuous cycle whereby spending on the NHS lifts local economies and drives innovation across the UK. One good example is genomic research. The NHS genomics project is currently sequencing 100,000 genomes

⁴⁵ Marmot et al (2021) – Building Back Fairer in Greater Manchester: Health Equity and Dignified Lives, Institute of Health Equity, <https://www.instituteoftheequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives>

⁴⁶ Ibid.

⁴⁷ Health Foundation REAL Centre (2021), op cit. <https://www.health.org.uk/publications/reports/health-and-social-care-funding-to-2024-25>

from NHS patients with rare diseases, and their families, as well as patients with common cancers. The project aims to improve outcomes for patients through scientific discovery, and to help kickstart a UK genomics sector. While still in its infancy at present, the UK market for genome sequencing alone is valued at £0.8 billion.⁴⁸

10.3. Similarly, the UK Life Sciences Vision and UK Innovation Strategy set out the Prime Minister's plan to make the UK a global science superpower.⁴⁹ For the NHS this means a focus on early disease intervention including predictive and monitoring technologies, and genomics and data to help prevent, detect and diagnose, as well as to treat disease early.

10.4. With the NHS is central to the Vision's success and delivery as an innovative partner, sufficient support and investment will be vital. It is committed to driving forward the life sciences sector but cannot do so alone and unsupported. As part of its vision, the government has committed to provide £200 million in funding through the Life Sciences Investment Programme and through the UK-UAE Sovereign Investment Partnership has resulted in an £800 million commitment to investment in the UK life sciences sector. These initiatives, aimed at improving availability of capital, are welcome - but additional NHS-specific funding will be required if we are to fully realise the government's ambitions for the life sciences sector.

11. Building resilience to future external shocks

11.1. The government's 2018 funding settlement, while seemingly generous, relied on unrealistic efficiency savings, even before the pandemic struck. As Nuffield Trust research shows, the NHS was set unrealistic projections for both activity growth and efficiency gains as far back as 2015.⁵⁰ The NHS went into the LTP settlement

⁴⁸ Deloitte Monitor (2015), Genomics in the UK: An Industry Study for the Office of Life Sciences, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464088/BI_S-15-543-genomics-in-the-UK.pdf

⁴⁹ Department for Business, Energy and Industrial Strategy (2021), UK Life Sciences Vision, <https://www.gov.uk/government/publications/life-sciences-vision>; Department for Business, Energy and Industrial Strategy (2021), UK Innovation Strategy: Leading the Future by Creating It, <https://www.gov.uk/government/publications/uk-innovation-strategy-leading-the-future-by-creating-it>

⁵⁰ Gainsbury S (2021), Checking the NHS's Reality: the True State of the Health Service's Finances, Nuffield Trust blog, [Checking the NHS's reality: the true state of the health service's finances | The Nuffield Trust](https://www.nuffieldtrust.org.uk/news-and-views/checking-the-nhs-reality-the-true-state-of-the-health-service-s-finances)

with costs running 2.5 per cent higher than the funding settlement assumed.⁵¹ The 1.1 per cent efficiency target was already a stretch target based on higher-than-average productivity savings in the previous decade or so. Even before COVID-19 began, trusts were on target to miss the first year's target by £2 billion. And because trusts couldn't meet their efficiency goals during the pandemic, the total gap between the LTP plan and reality is now £5 billion.⁵²

11.2. Perhaps most strikingly, COVID-19 shows how financially and operationally ill-prepared the NHS was for a major shock. The NHS lost 11 per cent of its NHS hospital beds in the decade before the pandemic and the number of general and acute beds fell by 8 per cent, despite rising demand.⁵³ Of those beds, more than 90 per cent were continually occupied during winter, leaving very little room for an external shock like COVID-19.⁵⁴ Too few beds can lead to delayed emergency treatment, patients being placed in inappropriate or even dangerous scenarios, and increases in hospital acquired or 'nosocomial' infections.⁵⁵

11.3. Some reduction in bed capacity reflects changes in clinical practice and moving more care out of the hospital. However, occupancy rates above 90 per cent demonstrate a system lacking the ability to deal with surges in demand, and far from the 95 per cent recommended by National Audit Office guidelines. As far back as 2017, the Nuffield Trust warned that the ambition to shift care out of hospitals was overly ambitious, and that hospital bed demand would continue to rise in the absence of increased capacity in the community.⁵⁶ Compounding this, the NHS has been desperately short of clinical staff for years. When COVID-19 hit, the NHS was short of at least 100,000 clinical staff. The Health Foundation estimates a further £1.6 billion in funding to 2024/25 to get occupancy levels to 85 per cent, making the NHS better prepared to deal with demand surges.⁵⁷

⁵¹ Ibid.

⁵² Ibid.

⁵³ King's Fund (2020), NHS Hospital Bed Numbers: Past, Present, Future, <https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers>

⁵⁴ Nuffield Trust (2021), Quality Watch - Hospital Bed Occupancy, <https://www.nuffieldtrust.org.uk/resource/hospital-bed-occupancy#background>

⁵⁵ Ibid.

⁵⁶ Nuffield Trust (2017), Shifting the Balance of Care, <https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-summary-web-final.pdf>

⁵⁷ Health Foundation REAL Centre (2021), op cit. <https://www.health.org.uk/publications/reports/health-and-social-care-funding-to-2024-25>

11.4. COVID-19 provides a rare moment to reconsider how we build resilience into the system. This means investing more than the bare minimum is required to provide services across the NHS, solving the long-term issues of workforce supply, social care and public health, and exploiting the NHS's potential as a driver of economic recovery post-pandemic.

For further information, please contact Jonathan Barron, Senior Policy Advisor – NHS Finances (jonathan.barron@nhsconfed.org)

18 Smith Square
Westminster
London SW1P 3HZ

020 7799 6666
www.nhsconfed.org
@NHSConfed

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