NHS Confederation

NHS Confederation Spring Budget representation 2024

1. Halfway through winter the NHS is still amid an unprecedented industrial dispute now entering its second year. The impact will last for years to come, but we know that it has already resulted in more than 1.3m planned procedures being cancelled since the strikes began (not including harder-to-count impacts in areas such as community care). As a result, the elective backlog has grown to 7.6m.
2. Most finance leaders tell the NHS Confederation that they are not confident that their local systems will achieve their financial targets this year. Health Foundation analysis shows that while the Autumn Statement's planned funding meant cash increases for the NHS, NHS England's revenue budget of £161bn in 2023/24 is £3.5bn less than 2022/23 in real terms (a 2.1 per cent decrease). It's no surprise that many ICSs will struggle to meet their financial plans, especially after the Government didn't provide the sector with enough funding to cover the extra costs resulting from industrial action and other cost pressures. We are hearing increasing concerns from some of our members that they are likely to start the new financial year in a worst underlying financial position. These concerns are echoed by our members in Wales and Northern Ireland.
3. The NHS is not just a cost. Analysis we published in October 2022 shows that every £1 invested in the NHS, returns £4 in Gross Value Added (GVA) for the economy. We should stop seeing the NHS as a drain of public resources and instead as a key driver of economic activity and employment.
4. With that in mind, health leaders have set out five priorities for both political parties this election year: 1. Put the NHS on a more sustainable footing, with no top-down structural reform in England for the next parliament. 2. Increase NHS capital spending across the UK and reform how the capital regime operates. 3. Commit to fund and deliver the NHS Long Term Workforce Plan for England, alongside an equivalent plan for social care. 4. Provide more care closer to home by enabling local health systems to proportionately increase investment upstream into primary care and community based services, mental health and social care. 5. Deliver a cross-departmental strategy for national health given that most policy that impacts people's health is made outside the NHS.
5. Two of these priorities are immediately relevant for the Spring Budget. Firstly, we want the Government to commit to a significant increase in capital funding. The recent RAAC issue in schools, as well as in health settings, highlights the parlous state of much of the UK's public capital infrastructure. It's no surprise given the lack of investment and it's a problem that stretches across multiple governments.
6. The NHS is a case in point: the UK has consistently spent less on capital investment than its OECD peers for more than a decade and a half. This was compounded between 2014/15 and 2018/19 when the capital budget was raided to pay for holes in the revenue budget. We are now paying for that lack of foresight and investment.

7. This isn't just in acute hospitals. In primary care, over one fifth of the near 9,000 general practice and primary care premises in England are not fit for purpose. Primary care leaders are calling on the government to set aside additional investment to support the building and modernisation of new and expanded clinics to treat patients in the community, as well as for improved IT and management support for staff.
8. Meanwhile, mental health services have some of the oldest buildings across the NHS estates, with 15 percent of mental health and learning disability sites built pre-1945 - older than the NHS itself – compared to 9 percent of acute sector sites. The cost of addressing the high-risk maintenance backlog across mental health and learning disability sites has almost trebled from £16.2 million in 2019/20 to £48.3 million in 2021/22. Despite this, of over 50 bids from mental health trusts for the government's New Hospitals Programme only two were successful.
9. Capital investment is the key to NHS productivity. We recently set out the case for a large increase in the NHS capital budget to allow for the necessary large increase in productivity called for by both our increasingly complex and aging society and the NHS workforce plan. Capital funding needs to increase to at least £14.1bn annually, a £6.4bn increase from the current level of £7.7bn. This is vital if we are to increase productivity and reduce waiting lists. Ensuring investment in capital in the NHS will boost productivity, support the NHS to get through its care backlogs and ensure patients can access the best possible treatment and support.
10. For example, Maidstone and Tunbridge Wells NHS Trust has invested in an electronic bed management system to manage patient flow across two acute hospitals, an 80-bed community hospital, and two hospices. As a result, capacity, including community placements, is coordinated centrally. For example, the trust can redirect incoming ambulances between hospitals to minimise handover delays and waiting times. The logistics and allocations teams are based in one room, with clinical support on hand and a range of dashboards on large screens. This enables real-time, comprehensive data to be discussed live, supporting the prioritisation of activity and a joined-up approach. The new digital system has successfully improved productivity and patient care by: a. reducing A&E bed allocation time by 86 per cent. b. reducing the time between confirmed to discharge and actual discharge by 64 per cent. c. freed up an average of 15 additional beds per day since going live, saving £2.1 million per year. d. released 2,300 hours of ward staff each month, equating to an estimate of £620,000 of savings per year.
11. In addition, NHS leaders continue to describe the capital allocation process as opaque, overly bureaucratic, and too slow to approve business cases. Members have told us that they have been allocated funding and have planned a project based on this, but given inflation, by the time the money is received they are able to get less for the funding and are unable to complete their planned works. We would like to see these allocation processes addressed in the review. Therefore, the NHS Confederation is also calling for the NHS Capital review that was recommended in the Hewitt Review and promised by government to be carried out as soon as possible.
12. 12. Secondly, the Government needs to fully support the NHS Workforce Plan with a clear long term funding commitment. NHS leaders welcomed the publication of the NHS Long-Term Workforce Plan. We must now see that the measures are fully funded this coming financial year.
13. The NHS currently has 100,000 vacancies which is impacting productivity, patient experience and staff morale. To take one example, the permanent GP workforce is 2,000 less than where it should be and the target to recruit an additional 6,000 GPs will not be met.
14. Industrial action has exacerbated this pressure, with NHS England estimating that up to July 2023 (the last time such figures were available) industrial action had already cost the NHS £1.1bn, and there have been several more costly rounds of strikes since. This why we are urging the BMA and government to set aside their respective pre-conditions and resume talks. At the same time, the government must ensure that

providers working in the NHS but not on Agenda for Change pay – such as in community or primary care – are given enough money to pay their staff the equivalent increase.

15. One important route to better NHS productivity lies with digitisation. Digitisation can help to improve productivity in the NHS, but there is a severe digital and data skills shortage in the NHS workforce which is impacting its ability to fully develop, deliver, and scale the full ambition of digital transformation required to realise real productivity gains. As recommended by the recent Hewitt review, the NHS needs to urgently invest in, develop, train and recruit more specialists in fields at both the system and provider level. It cannot do this without sufficient HM Treasury funding and support.
16. The Government should complete the Long-Term Workforce Plan with a social care equivalent. We know that the social care workforce faces even bigger challenges than we see in health and that without an equivalent plan for social care, the full benefits of the NHS plan will not be realised. Hence, NHS leaders want to see a plan for the social care workforce that mirrors the NHS Long-Term Workforce Plan and last year we wrote to the Prime Minister asking for his support to do so with HM Treasury's backing.
17. While not specific just to this Budget, we support a cross-government approach that creates the conditions for everyone to enjoy the best possible health, to increase the number of years people live in good health and to reduce the unacceptable inequalities in health outcomes that we see across the country. The Budget therefore allows the opportunity for HMT and the Government to take a first principle look at how each government policy contributes to better health.
18. We know 80 per cent of people's health needs are influenced by factors outside the NHS, and those communities with the highest levels of deprivation and that face the biggest challenges are most adversely impacted by lack of access to support in these areas. Therefore, Treasury should mandate that every Government department should include health equity impact assessments for any new policy and/or programmes, assessed by a cross-government health committee to ensure that health is considered across Whitehall.
19. We welcomed the recent major conditions strategy case for change and strategic framework given its focus on multimorbidity, prevention and improving outcomes. However, this must now be backed up by funding for all the necessary departments. To start, the public health grant must be increased back to a level sufficient to meet demand following more than a 25 per cent decrease over the past eight years and delivered far earlier each financial year.
20. Finally, payment and tariff systems enable health care leaders to best allocate money to reduce health inequalities, the Confederation will shortly publish member led research setting out how we might further improve the payment system in conjunction with Government.

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