

## NHS ENGLAND – BOARD PAPER

Paper: PB.30.11.2017/04

**Title:**

NHS planning for 2018/19

**Lead Directors:**

National Directors

**Purpose of Paper:**

To set out the results and implications of the 2018/19 Budget, and next steps.

**The Board is invited to:**

- Note the welcome Budget increase for 2018/19.
- Endorse the actions suggested to moderate budget pressures for next year.
- Agree the principles that should guide our discussion with Government and our partners between now and March 2018 about priorities and trade-offs for the year ahead.

## NHS Planning for 2018/19

1. It is the government that rightly decides on the level of NHS funding. We help frame for government and the public the resultant options and choices facing the NHS.
2. Following public consultation, government then crystallises its service priorities in the annual NHS Mandate. Once government has made these decisions, NHS England's responsibility is to seek to ensure the best possible Health Service within that funding level.
3. Current legislation also says that, within this national framework, the legal default for most NHS priority-setting rests with local GP-led clinical commissioning groups. Parliament has decided that they should control more than two thirds of the NHS' budget across England.

### The Budget settlement for 2018/19

4. The 22nd November Budget delivered an extra £1.6 billion of NHS revenue and £354 million of public capital for next year.
5. Real terms NHS revenue growth for 2018/19 will therefore be 1.9% (versus growth of 2.0% this year, and 3.1% in 2016/17). Factoring in England's growing and aging patient population, age-weighted NHS revenue growth per person becomes 0.9% in 2018/19 and -0.4% in 2019/20.
6. This extra revenue is welcome, and clearly improves the NHS' prospects for next year. However - as previously reported - it is less than the 2018/19 figure that NHS England originally requested at the time of the Five Year Forward View funding settlement (SR15). The Appendix provides some of the context.

### Implications

7. To moderate these budget pressures to the greatest extent possible, there are a set of actions we should continue to drive hard.
8. NHS productivity has been growing at 1.7% each year, far faster than productivity growth in the wider UK economy. We do however still have opportunities for further efficiency. The 'Next Steps on the NHS Five Year Forward View' published in March set out the NHS' 10 Point Efficiency Plan, which we are making good progress against. We are taking action to manage the cost of medicines and the medicines supply chain, and today's Board meeting will consider rigorous new guidelines to eliminate low value prescribing. Trusts are making good progress cutting agency staff costs, and NHS Improvement is working to ensure trust procurement and other savings are embedded more widely. We will redouble efforts to drive further efficiency.

9. Evidence suggests that the Five Year Forward View care integration agenda, joining up GP, community and hospital care, is taking root, and moderating demand growth. Those parts of the country covered by 'vanguards' and our new care models are seeing much slower per capita emergency hospitalisation growth, of between one third and two thirds less than the rest of the country. Eight new accountable care systems have been identified, who are leading the transition to population health funding and integrated care delivery. Action by CCGs has produced an unprecedented absolute reduction in the number of elective GP referrals to hospital this year, compared with a medium term annual growth rate of 3-4%. So in deciding on a fund allocation mechanism for the additional Budget cash in 2018/19 we will seek to ensure that we support and accelerate this care redesign, through ACS and STPs, rather than reverting to traditional organisational silos and funding pipelines.
10. The NHS' administrative costs are some of the lowest in the industrialised world - costing 2p of each NHS pound here compared with 5p in Germany and 6p in France. We do believe that as we move away from fragmented competition and towards integrated care, there are opportunities for more running cost reductions between national and local bodies across the NHS. Primary legislation would be needed to fully combine NHS England and Monitor/NHS Improvement (and external legal advice is that without that, NHS England and Monitor cannot have a joint board, single chair or single chief executive). The law also says that every part of England must be covered by a CCG. However our aim is to go as far as possible to combine and align our shared work, and we will use the time between now and March to consider with NHSI the shape of this work programme, with a view to freeing up significantly more management cost savings across the national bodies, trusts, CCGs and CSUs than are currently earmarked for reinvestment in patient care through to 2020.
11. However even with these actions, our previous assessment is that with its 2018/19 budget the NHS will likely not be able to do everything being expected of it. This will therefore require realism and some difficult judgements about priorities, as discussed in the sections below.

## **Considerations to guide decisions**

12. The Board is invited to consider and endorse the following considerations (by no means comprehensive) as we work with DH and the NHS over the next four months to finalise plans for 2018/19. These are underpinned by our commitment to patient and public involvement, to reducing inequalities, and to improving the quality of NHS care for everyone.
  - A. *Deal with current levels of unfunded care (deficits) that need funding going in to next year.*
13. CCGs are funding around £500m more patient care this year than they have been allowed to budget for, after the holdback of a £560 million commissioning underspend. However patients will continue to need these services next year, so they will in practice have to be funded from the £560 million. The aggregate 2018/19 provider trust 'control total'

that the Department of Health agrees with NHS Improvement will therefore constitute an offset on the additional £1.6bn of NHS purchasing power available to support Mandate priorities, unless DH has some other mechanism for financing it.

*B. Set realistic activity plans for growth in emergency care*

14. Action is now successfully being taken to moderate demand growth in those parts of the emergency care pathway where better alternative services can help. A&E attendance growth this year has been less than a third of its historic growth rate. Non-elective admissions growth at around 2.3% is in line with expected trend, and non-elective bed-day growth is far lower than that. Evidence suggests that the clinical threshold for emergency admission has risen by 10% over the past five years, meaning that patients who five years ago would have been admitted to hospital as an emergency are now being looked after at home. With no obvious respite in the pressures on social care, and with transformation funding for NHS 'vanguards' ceases from April 2018, it will be important to set realistic plans for the growing level of emergency activity that hospitals and ambulance services will need to respond to next year.

*C. Seek to protect planned investment in mental health, cancer, and primary care.*

15. Given the scale of unmet need in mental health, the importance of cancer services, and the intense service pressures in primary care – the foundation on which the rest of the NHS rests – we believe it would be unacceptable if these services were used as the 'balancing item' relative to other services. We should seek to ensure that the National Mental Health Investment Standard and the service expansions promised in the Mental Health Taskforce and the GP Forward View continue to be delivered.

*D. Be realistic about what can be expected from the remaining available funds.*

16. Our nurses, doctors, and other frontline staff routinely 'go the extra mile' for their patients. It would however be unfair to set unattainable goals which staff would then be criticised for not meeting. In part this therefore means more scrutiny of unfunded new expectations that are loaded onto the NHS. For example, new advisory NICE guidelines can only expect to be implemented locally across the NHS if in future they are accompanied by a clear and agreed affordability and workforce assessment at the time they are drawn up. Similarly, short waits for routine non-urgent elective care matter, and we should do all we can to increase elective activity volumes next year. However even with some increased volume, and even assuming this year's unprecedented elective demand management success continues, our current forecast is that - without offsetting reductions in other areas of care - NHS constitution waiting times standards, in the round, will not be fully funded and met next year.

*E. Ensure that where government sets pay rises above the currently budgeted 1% cap these are separately funded.*

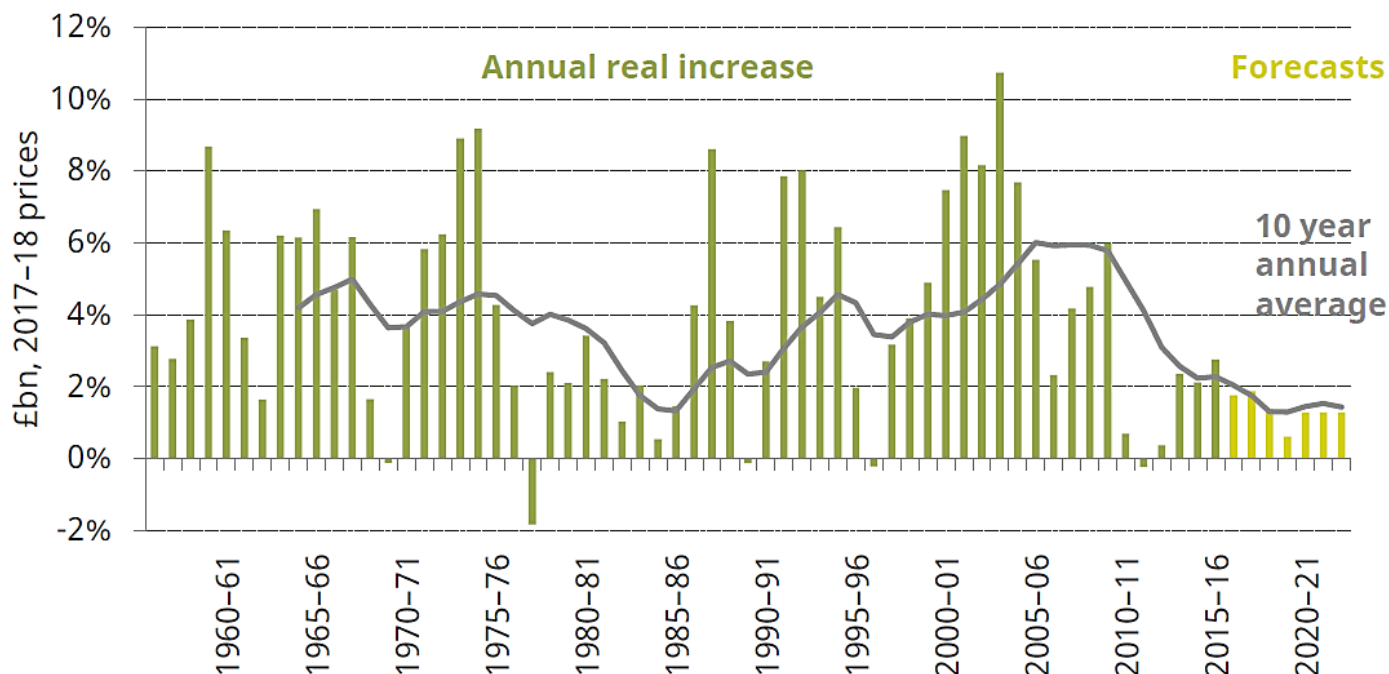
17. It is very welcome that this principle has now been accepted by the Government for the Agenda for Change NHS staff groups. The approach for doctors (including GPs and their practice staff) is still to be determined.

## **Process and timelines**

18. We believe it is important that these judgements and priorities are set transparently and clearly. In doing so, and working alongside DH and NHSI, we will engage with patients groups, the public, and frontline NHS leaders and staff.
19. We will next provide a public update at our Board meeting on 8th February 2018. This will set out where discussion has got to on 2018/19 priorities, informed by the required DH public consultation on the NHS mandate.
20. Then as required by statute, at our public board meeting on 29th March 2018 we will agree the NHS England priorities and operating plan for 2018/19.

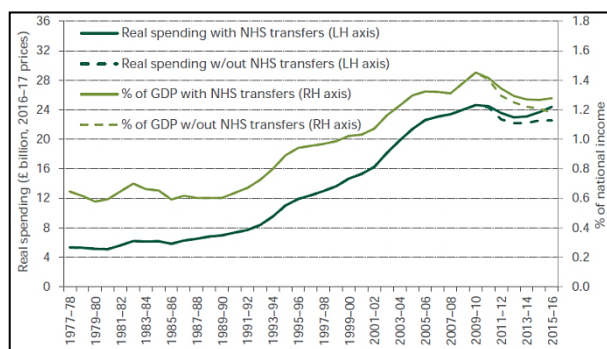
## APPENDIX

**Figure 1: IFS: NHS funding growth**



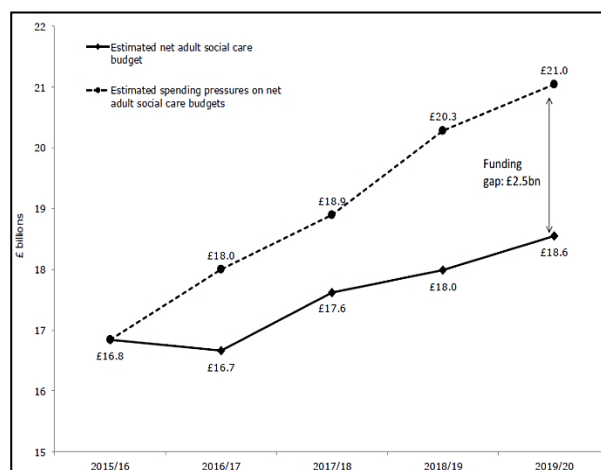
**Source:** Institute for Fiscal Studies' calculations using Office of Health Economics, HMT PESA 2017, Autumn Budget 2017, OBR Nov 2017 EFO.

**Figure 2: IFS: Social care funding**



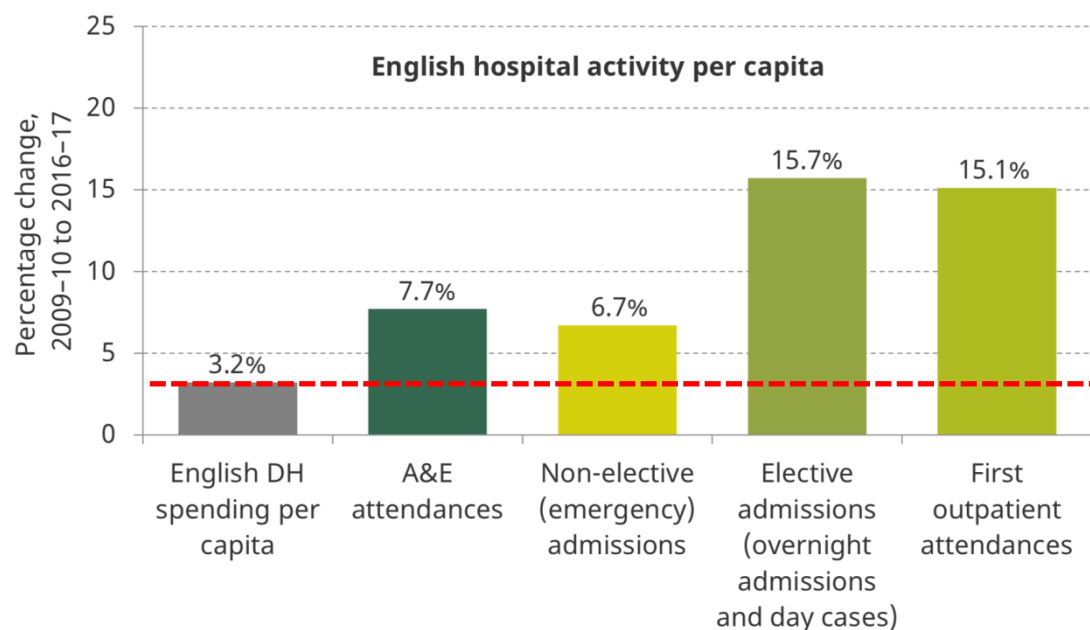
**Note:** Public social care spending is defined as net expenditure on social care by local authorities, plus NHS transfers to local authorities to fund social care from 2010-11 onwards. It excludes any NHS spending on social care other than the transfers for local authorities (e.g. continuing health care arrangements, nurses in care homes etc.). They assume that the learning disability and health reform grant (which prior to 2011-12 was part of the NHS budget and is included in this figure) grew at the same rate as the rest of social care spending.

**Source:** DCLG local government budget data (2015-16), DCLG local government out-turn data (2014-15), CIPFA financial and general actuals (2007-08 to 2013-14) and adjusted CIPFA financial and general estimates (1977-78 to 2006-07).



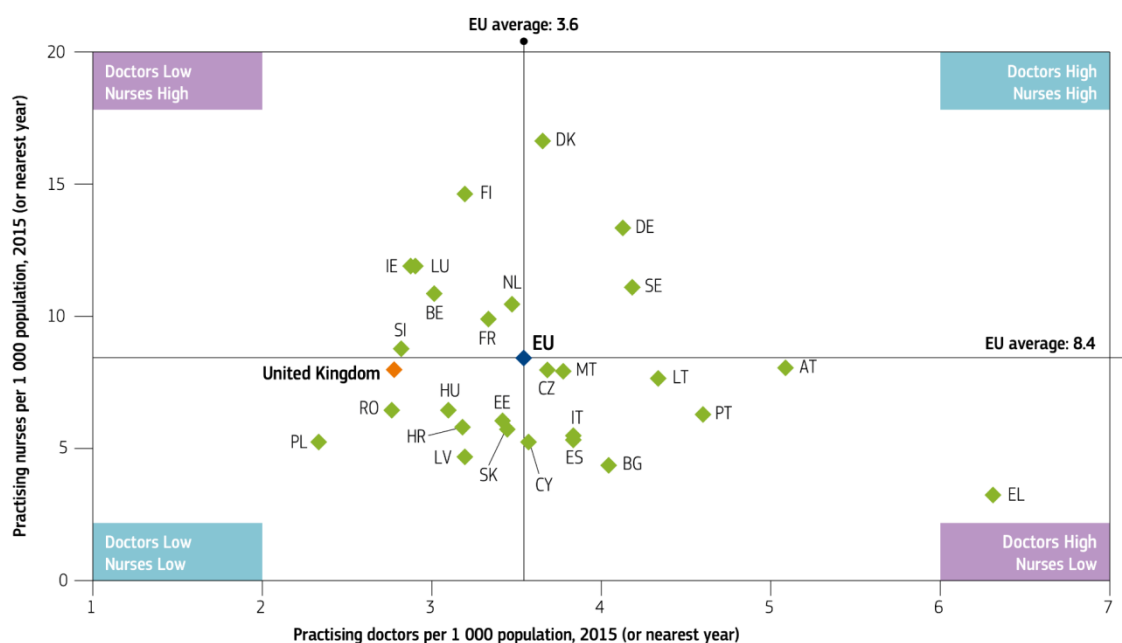
**Source:** Health Foundation analysis based on multiple sources. **Notes:** Gap between estimated net public spending on adult social care and funding pressures (2017/18 prices). Cost pressures include updated estimates for the cost of the National Living Wage, sleep-ins pay (both back-pay, and future costs), and updated assessments of social care demand. The estimated budget assumes social care spending maintains its share of local authority core funding, after subtracting new funding from the social care precept and improved Better Care Fund.

**Figure 3: NHS productivity: the IFS view**



**Source:** Institute for Fiscal Studies

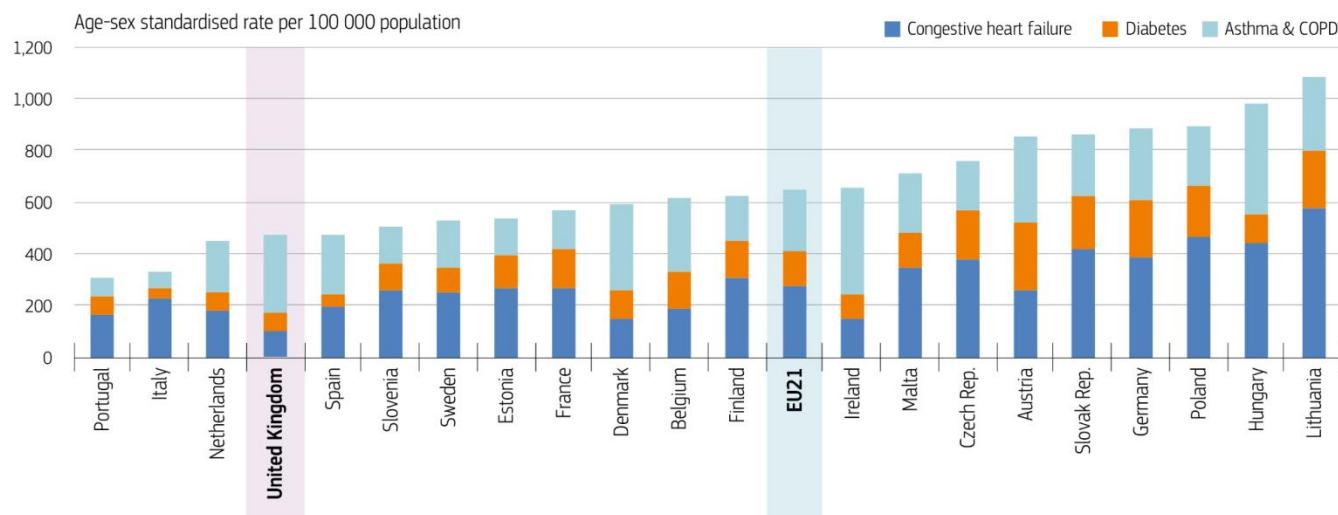
**Figure 4: OECD: Doctors and nurses per person in the United Kingdom than the EU average**



**Note:** In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

**Source:** Eurostat Database.

**Figure 5: OECD: The NHS now delivers low avoidable hospitalisation rates**



**Note:** Rates are not adjusted for health care needs or risk factors.

**Source:** OECD Health Statistics 2017 (data refer to 2015).