Message

From: Matt Hancock [matt.hancock@digital.dhsc.gov.uk]
Sent: 19/08/2019 22:34:42
To: Price, Natasha [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=2ff9661092c5453aa67b231e819b9653-NPrice4]
CC: Njoku-Goodwin, Jamie [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=ec863ed599ba4b8cb9648820f43f01d6-JNGoodwin]; Nixon, Allan [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=c6ea443c96dd451d8e9d809026705b05-Anixo]
Subject: Re: TO CLEAR: Spending Review - Letter to CX

Here's my proposed letter - let David W make proposed changes as he sees fit. On the annexes, I'm content EXCEPT the counterfactual on HEE - it includes the baseline adjustment, which is totally unacceptable. Please put in OUR baseline - and then, as I've said many times before, simply REFUSE to engage on any other baseline.

If I see another baseline that accepts the £540m cut I will lose my marbles.

M

Secretary of State for Health and Social Care

XX August

Chancellor, HM Treasury

Dear Sajid

SPENDING ROUND 2019

1. Thank you for your letter dated 8 August 2019 and clarification of the process for the upcoming Spending Round (SR). I wrote to the previous Chancellor in June setting out my Department's position and have since further developed my objectives, and I want to take the opportunity to set out their full alignment with the Prime Minister's domestic priorities.

2. First and foremost, I am committed to supporting the Government's primary agenda to leave the European Union by 31 October. I am requesting the £50m received in 19/20 is rolled-forward into 20/21; we will require at least this amount to cover the ongoing impacts of current activities, for instance the potential maintenance of medicines and medical products stockpiles,

and the costs of winding down these programmes as necessary. Any step up in expectation will require further additional funding. In a no deal scenario in particular, my department will need to discuss with you further financing arrangements.

3. Turning to our domestic agenda, the record increase in funding to the NHS and the publication of its *Long Term Plan (LTP)* in January clearly demonstrated our commitment to the health service. Recent announcements have shown this remains the Prime Minister's first domestic priority. We must build on this at the SR and complete our commitment to the remaining parts of the NHS not included in the LTP agreement. This includes the **education and training of our NHS workforce**, the vital **capital infrastructure** that supports the plan, and the cutting-edge **digital technology** necessary to continue to improve services.

4. The lack of multi-year budget certainty on these areas has proved a barrier to joined-up planning across the health system. **As such, we must agree a multi-year settlement for these budgets which matches the ambition and scale of the NHS England settlement.** Clarity now will allow the NHS to get on with implementing the plan in full, and not allow easy excuses for failure.

5. Before considering these specific areas further, there is a mistake that needs to be rectified. **HMT's paperwork implies an imposed £540m cut in the Departmental baseline.** Such a cut which would affect budgets for training, public health, digital technology, vaccine programmes, life sciences, and genomics, and **is clearly untenable** - we need to be growing support for all these areas. So we will be starting discussions from the actual baseline, not a £540m cut.

Education and training of the NHS workforce

6. It is essential that we provide clarity on NHS training budgets. In the letter I received from the Prime Minister's on XX August, he asks that we "develop our world class workforce through training and support". Indeed, in his letter to Permanent Secretaries on 6 August, he lists the NHS as his first domestic priority, requesting that "*The extra funding for the NHS agreed last June must reach the frontline without delay. We must act to deliver real, measurable improvements in people's everyday interactions with the NHS, particularly focusing on GP, doctor and nursing recruitment.*"

7. The most impactful action we can take is to grow the Health Education England (HEE) budget. **It should grow in line with the NHSE settlement, at 3.4% annual real terms growth, over the same period to 2023/24.** This would allow proper planning to deliver the Long Term Plan, and have a material impact to improve medium-term workforce supply. It would also be the clearest and most visible way to grow the future NHS workforce, allowing us to:

- Deliver existing commitments where costs are not covered within the baseline, including GP, medical school and nursing and midwifery placement expansions;
- Reduce pay pressures - and agency costs - by increasing supply.
- Fund unavoidable pay pressures: HEE funding for placement tariffs and salary support requires adjustment for inflation;
- Invest in better leadership training - including training for better management including financial management.

9. Providing certainty via a multi-year, generous HEE settlement is the most important step the Government can take to allow the NHS to tackle supply problems, and ensure that support is

felt directly by those on the frontline. Without this, my fear is the LTP will get into its second year without meaningful underpinning workforce planning.

10. To ensure immediate impact is felt by our frontline staff, **we should supplement the core HEE settlement with funding to address immediate workforce supply problems**. I am convinced that an additional £250m per annum for financial support for nursing students, and a further £150m per annum for staff CPD, would have immediate impact on staff morale and behaviour. Table 1 in the Annex sets out my full proposal.

Infrastructure and capital investment

11. It is vital that we invest in a much smarter way in health infrastructure to correct the historic underinvestment of capital in health and social care sectors, which harms productivity and ultimately costs the NHS more.

12. We have a number of pressing problems and opportunities. As we know from discussions last month, NHS capital is not currently strategically managed.
    a. There is a significant backlog of maintenance costs which are impacting on NHS productivity. For example our failure to invest in enough diagnostic and digital equipment means far less is done automatically and far more done by hand than it should.
    b. Some Trusts can make capital expenditure on our balance sheet without our sign off, while others can't. The result is that the overall Capital programme is piecemeal and not strategic.
    c. We do not have a long term approach to capital budgets. Hospital building programmes take years to develop, and so as well as not being strategic, any significant scheme automatically runs beyond the capital budget horizon.

13. This system is not good for anyone. I am therefore developing proposals for the Health Infrastructure Plan (HIP), a strategic approach to health infrastructure, to replace the piecemeal current approach.

14. I would then expect the first trance of HIP projects to be funded in a multi-year health capital settlement. The second trance of HIP projects - HIP2 - would be developed now for a future capital settlement. Future potential projects would be brought forward in future HIP rounds, each covering a five year period.

15. As part of this plan, and to prevent to sort of overspend we could not avoid this year, we will introduce a new capital regime that provides control and oversight of strategic capital, as well as giving the NHS clarity on funding sources, and improving incentives for operational capex at the local level. These reforms will require a multi-year capital structure and settlement.

16. NHSE's ask stands at £4.2bn extra capital per year by 23/24. This would bring NHS capital in line with other major developed economies and include investing in:

- Our HIP programme of planned strategic health investment;
- Tackling poor quality estate and backlog maintenance;
- Supporting the Government's commitment to cancer diagnosis and screening through investment in MRI and CT scanners and other equipment;
- Improving mental health services through reforming inpatient environments such reduced mix sex accommodation and dormitory style wards;
- Improving patient access by enhancing Primary Care Networks.

14. We also risk criticism if related non-NHS capital budgets are not similarly funded. The recent £250m AI announcement was warmly welcomed as an early signal of the new administration's commitment to properly fund our core R&D and life sciences programmes.

15. In any scenario, I ask that we **rebalance funding for research and development, to ensure health gets its fair share of overall UKRI investment**. At the last SR, health R&D spending growth was flat against an overall growing national pot for R&D - despite the value of the life sciences to the eocnomy. NIHR funding will need to grow significantly to meet our ambition to be the world's most innovative economy and raise total R&D investment to 2.4% of GDP by 2027. A rebalancing of allocations to give health its fair share would mean an additional £160m in 20/21, rising to £470m in 23/24.

16. On balance, to meet the Prime Minister's priorities I propose a DHSC CDEL envelope of £14bn per year by 23/24. Table 2 in the Annex sets out our full proposal.

Digital technology

17. Part of the proposed capital investment is for digital technology in social care and in the NHS. Technology spend is critical for greater productivity and efficiency, for improved quality and care outcomes, and for major opportunities in the life sciences sector. And yet in recent years, it has been low compared to other sectors: technology spend accounted for 1.7% of DHSC's budget in 2017/18 (£2.1bn of £126.9bn), compared to around 4% in other advanced health systems - and for example 7.2% in the financial sector.

18. To take advantage of digital technology and drive deployment throughout the NHS and social care, I launched NHSX in July 2019 as a joint unit between the Department for Health and Social Care and NHS England. A major investment in this area would send a clear message that we are serious about **improving public service infrastructure and making it fit for the digital future.** Proposals will tackle the biggest frustrations of patients and clinicians and support the LTP commitments, including longitudinal health and care record platforms and cyber security. Proposals such as the data curation fund would demonstrate the UK's willingness to capitalise on its unique health data assets and unlock a potential £10bn asset.

19. My officials have set out how our proposals break down between capital and revenue **over four years to 23/24**. This is separate and complementary to the NHS's own spend on digital. A multi-year settlement is the most cost-efficient way to realise these benefits; a one-year budget would increase delivery challenges, risk, and may increase overall costs, with real-life consequences for patients. Table 3 in the Annex sets out my full proposal.

Public Health Grant

20. I strongly advocate this should continue to **remain ring-fenced** until adequate agreement around Business Rate Retention can be reached across Government. This is also important given the context of the recent Prevention Green Paper, the focus on prevention in the LTP, and the Prime Minister's objective of prioritising essential frontline health services, which over half of the grant funds directly.

21. **The grant should grow in real terms, which is a further £58m in 20/21.** In a one-year SR this means no major change to current arrangements. However, in addition we must fund costs to local authorities resulting from the Agenda for Change pay deal. This is a significant pressure which would have material impact on frontline staff and services if not covered. I also propose we provide additional funding to cover the HIV Pre-exposure Prophylaxis (PrEP) national roll out through sexual health clinics. Recent trials have been successful at preventing and lowering HIV infection rates and this is a priority of the Government Equality Office. Table 4 in the Annex sets out my proposal for the Public Health Grant.

Adult Social Care and Local Government

22. As set out in my joint letter with the Communities Secretary, I welcome and fully support the ambition of the Prime Minister to fix the issues in adult social care. This must start by stabilising the current system. **Local government requires at least an additional £1.7bn funding for adult social care next year.** This is just to keep up with demand and cost pressures, to stabilise the market, and to fulfil commitments to those deprived of their liberty and ensuring people with learning disabilities and/or autism are in the most appropriate care setting for their needs.

23. **We should also start addressing wider system issues now,** ahead of the whole-scale transformation. An additional [c.£100m] of DHSC DEL will be needed to make meaningful progress and lay ground for future reform. This includes:

- Investment to develop the social care workforce, including expanding the mental health social work graduate programme and CPD for social workers;
- A new Prevention and Productivity Fund to target support at the most innovative councils to help them go further and sharing learning to embed best practice more effectively.

24. I am confident that this package will stabilise the system and meet the June 2018 commitment for social care to apply no additional pressure to the NHS.

DHSC central budgets and ALBs (excl. HEE & NHSE)

25. Departmental central budgets have experienced large cuts in recent years. As your officials will be aware from the rigorous savings exercise we conducted with them ahead of 2019/20, these budgets are already extremely tight and there is nowhere further to go here for savings. Because of the nature of much of Deaprtmental expenditure on preventative measures, the falling Departmental spend since SR15. Has led to rising costs elsewhere.

26. Furthermore, our latest prudent estimates suggest a total pressure in 20/21 in the region of [**£410m**]. The main causes of this are growing pressures on our large central programmes including Reciprocal Healthcare, Vaccines and the DHSC contribution to the Home Office's Emergency Services Network programme [£Xm increase over 19-20], pressures on our ALBs [£Xm] and central Admin [£Xm]. This does not include the new demands to our DHSC DEL captured above. It also does not include new opportunities that I also would like to support, such as a new National Suicide Prevention campaign, and an extended Childhood Obesity programme.

27. Nevertheless, in any large system, savings can always be found. I propose we look hard again to see where we can reprioritise. However, this will not close the gap. Given the one-year exercise, I do not believe there is scope to explore the fundamental reforms that would be necessary to release material spending reductions, such as tightening the scope of statutory

programmes. However, if Government agreed to bring forward the proposed increase to the Immigration Health Surcharge (in line with the actual cost of the care that non-EEA migrants receive and the 2017 Manifesto commitment), my Department estimates **this would generate an additional £210m of income** per year. I support bringing this measure in at the earliest opportunity.

28. To touch on our international support, I am committed to ensuring our Official Development Assistance (ODA) programmes boost our health diplomacy and support the Government's commitment to spend 0.7% of GNI on overseas aid. To continue this global leadership, we require a top up to funding in 20/21, the detail of which is set out in our return.

[concluding remarks]**ANNEX**

Table 1: Proposed HEE programme budget to 23/24

£m, nominal	19-20	20-21	21-22	22-23	23-24
19-20 opening HEE programme budget (DHSC Grant-in-Aid only)	4,010				
Less Leadership Academy baseline transfer to NHSI	-49				
3.4% annual real terms uplift from adjusted 19-20 baseline = Proposed core HEE programme budget	3,961	4,171	4,396	4,635	4,888
Counterfactual - reduction in 20-21 (-£147m) under SR15 trajectory, then flat cash	n/a	3,814	3,814	3,814	3,814
THEREFORE, HMT funding required to deliver core HEE programme uplift		**357**	**583**	**821**	**1,074**
PLUS CPD		149	152	155	158
PLUS targeted extension of Learning Support Fund (DHSC-held)		252	257	262	267
TOTAL NHS EDUCATION AND TRAINING FUNDING UPLIFT REQUESTED		**758**	**991**	**1,238**	**1,499**

Table 2: Proposed capital budgets for DHSC and NHS to 23/24

£ nominal	*19-20*	20-21	21-22	22-23	23-24
NHS: Operational	*3,759,000*	4,570,000	4,719,000	4,875,000	5,050,000
NHS: Capital Upgrades		1,166,000	1,536,000	938,000	945,000
NHS: Digital/tech		977,000	1,317,000	1,051,000	1,215,000
NHS: Major hospital schemes		183,000	596,000	1,198,000	1,767,000
NHS: Critical Infrastructure Risk		1,018,000	1,038,000	1,058,000	0
NHS: LTP Delivery		2,793,000	2,106,000	1,795,000	1,624,000
NHS: In-year uplift	*1,000,000*	0	0	0	0
NHS: 20 Hospital Upgrades	*100,000*	205,000	283,000	140,000	126,000

NHS Infrastructure Total	***4,859,000***	***10,912,000***	***11,595,000***	***11,055,000***	***10,727,000***
Announcement: AI and genomics	***250,000***	***78,000***	***83,000***	***89,000***	***0***
Research and Development	*1,158,000*	1,318,237	1,367,517	1,480,800	1,624,728
Genomics	*50,000*	69,000	80,000	109,000	145,000
Disabled Facilities Grant	*505,000*	695,000	700,000	705,000	705,000
Care and Support Specialised Housing	*76,000*	79,400	83,100	87,000	91,200
Public Health England and Science Hub	*121,000*	310,587	135,782	358,802	451,963
Other ALBs	*140,000*	191,000	193,000	195,000	197,000
Central DHSC	*157,000*	180,000	183,000	187,000	191,000
Pan flu	*0*	0	20,000	80,000	60,000
Non-NHS Total	***2,207,000***	***2,843,224***	***2,762,399***	***3,202,602***	***3,465,891***
Total	**7,316,000**	**13,833,224**	**14,440,399**	**14,346,602**	**14,192,891**

Table 3: Additional DHSC RDEL to deliver proposed digital tech programme to 23/24

£m, nominal	20-21	21-22	22-23	23-24
2019/20 baseline Non-NHSE RDEL spend £322m				
Mission 1 reduce burdens on staff	22	17	20	23
Mission 2 give citizens tools to access information and services directly	24	12	8	6
Mission 3 ensure clinical information ca be safely digitally accessed	36	53	10	1
Mission 4 improve patient safety	5	11	7	1
Mission 5 increase NHS productivity	7	14	12	12
Live services	11	0	0	0
Provider digitisation	209	398	284	296
Social care	20	16	14	14
NHSX Admin	20	20	20	20
AI	4	4	5	5
OLS Data Curation	50	100	100	100
Centre of expertise	3	5	5	5
Full fibre	0	1	2	0
Workforce capability	24	24	24	24
Cardiac trailblazer	10	10	10	10
Digital inclusion	5	5	5	5
Org 2	12	0	0	0

Predictive prevention	1	4	4	4
Screening	16	17	11	3
Primary care	0	17	24	29
Total pressure	**479**	**727**	**565**	**558**

Table 4: Proposed Public Health Grant funding in 2020/21

£m, nominal	19-20	20-21
Real terms growth	3,134*	3,192*
Agenda for Change pay pressure	-	80
PrEP	-	11.4
TOTAL PHG available to LAs		**3,283***

**Figures include funding associated with Greater Manchester Business Rates Retention pilots*

Table 5: Proposed ASC funding in 2020/21

£m, nominal	2019/20	2020/21
LGFS		
Baseline	£19,048	
Funding pressures		
Demographic and cost pressures		£874
Correction for provider market underpayment		£479
Resolving Deprivation of Liberty backlog and implementation of Liberty Protection Safeguards		£141
Delivering Transforming Care commitments		£312
Funding requirement before efficiencies	£19,048	£20,842
Theoretical efficiency savings		*£138*
Total LA funding required	**£19,048**	**£20,715**
Additional funding for LAs compared to baseline		**£1,667**
DHSC RDEL pressures		
Social care workforce support – increase on existing levels		£80m
Prevention and Productivity Fund		£20m
TOTAL RDEL		**£100m**