SHELFORD GROUP REPRESENTATION FOR THE 2016 AUTUMN STATEMENT

About the Shelford Group

1. The Shelford Group represents ten of the leading NHS multi-specialty academic healthcare centres in England.

   - Cambridge University Hospitals NHS Foundation Trust
   - Central Manchester University Hospitals NHS Foundation Trust
   - Guy's and St Thomas' NHS Foundation Trust
   - Imperial College Healthcare NHS Trust
   - King's College London Hospital NHS Foundation Trust
   - Newcastle-upon-Tyne Hospitals NHS Foundation Trust
   - Oxford University Hospitals NHS Foundation Trust
   - Sheffield Teaching Hospitals NHS Foundation Trust
   - University College London Hospitals NHS Foundation Trust
   - University Hospitals Birmingham NHS Foundation Trust

2. We have a track record over many years of delivering excellent patient care, clinical research and education. As a group, we aim to demonstrate system-wide leadership for the benefit of patients and the prosperity of our country.

3. In aggregate, we provide high quality health services worth nearly £10bn p.a., which is equivalent to 10% of the whole NHS England budget and over 13% of all NHS providers. We treat many millions of patients each year across the full spectrum of clinical specialities. Our member trusts saw over 1.6 million Accident and Emergency attendances last year.

4. We are national and international hubs of research, education and innovation, providing some of the most complex and specialised healthcare in the world. About one third of our aggregate income is for specialised services and we provide nearly one quarter of all specialised services commissioned by NHS England. Our organisations are Biomedical Research Centres, in partnership with our universities, and our membership includes the top four BRCs in the country. We account for over two thirds of National Institute for Health Research funding for BRCs.

5. We are also major public employers in our cities and regions, with over 100,000 NHS staff, including 15,000 doctors and dentists, and 40,000 nurses, midwives and health visitors.

6. Our ten Chief Executives have over 150 years of CEO experience between them. We are not external commentators. We are public servants at the heart of the NHS and we are deeply committed to its sustainability.

Health and social care context

7. The NHS and UK life sciences are amongst of our most globally competitive sectors. We believe they should be appropriately funded and feature prominently in the Government's forthcoming industrial strategy. However, the Autumn Statement will be published at a time when the NHS, and our partners in social care, are facing an unprecedented level of financial challenge. We are most

concerned about the potential impact on our ambition to provide high quality patient care and scientific excellence.

8. The question that is pivotal to the current challenges and the future sustainability of the NHS is what proportion of the nation's resources should be spent on health and social care, when set against other competing priorities. We include health and social care together because we do not believe that their sustainability should be detached; indeed the state of social care is one of the biggest risks to the NHS.[1] Whilst this is a question to which there is not a clear 'right answer', there is a growing weight of evidence to show that current and projected levels of spending are the wrong answer for our population's health and care needs, assuming that we aim still to provide a high quality, comprehensive and largely free-to-use health service.

9. In common with all developed countries, the costs of health and social care in the UK are rising inexorably due to long term trends. The population is ageing and suffering more chronic disease caused by unhealthy lifestyles. Scientific advances are pushing the boundaries of medicine and well-informed patients understandably expect access to the latest medicines and therapies, as soon as their efficacy is demonstrated, however costly this may be to the public purse.

10. The near term imperative for the Government to reduce the nation's structural deficit has put pressure on public spending. In that context, the NHS was comparatively well supported in the last Spending Review. Nevertheless, the NHS is having its lowest funding increases for a sustained period in its history.[2] Several factors are putting severe pressure on the funding settlement:

    i. Demand continues to grow rapidly ahead of income for emergency care and across virtually all other parts of the health sector.[3]

    ii. Social care has faced significant cuts in spending and is supporting fewer people and only the highest levels of need, sending delayed transfers of care from hospital to record highs.[4]

    iii. The underlying aggregate deficit of NHS providers was considerably higher than expected (up to £3.7bn) at the time of the settlement, so much of the extra funding was simply plugging underlying gaps.

    iv. Central budgets, such as for public health, training and education, have been cut.

    v. There are still more cost pressures being put into the system from newly approved medicines and clinical strategies.

    vi. The £22bn of efficiency savings required by 2020/21 seem unrealistic in the time available.

11. A number of independent analyses have found that there is a significant and growing mismatch between what the NHS and social care is expected to deliver and the amount of funding available.[5] [6] [7] [8] [9] [10] As a result, there has been a steady decline across the board in organisations' financial positions and in operational performance against targets.

12. We see this situation manifested locally in our organisations and health economies. The Shelford Group trusts have normally operated in surplus or balance, whilst meeting all major performance targets. In 2015/16, in common with most of the provider sector, many of our trusts registered a deficit, some for the first time. When a small minority of organisations are in deficit habitually, they

may be considered to be the problem, but when the vast majority are in deficit, some for the first time in their history, the problem is systemic underfunding relative to demand.

13. History suggests that financial and operational pressures will only rise as we go into the traditionally difficult winter period. As things stand, it seems inevitable that the financial pressures we face now and in the future will impact on the quality of care for patients, whether through lower than recommended staffing levels on wards, longer waiting times for emergency and elective care, or restricted availability of medicines and therapies.

14. There are of course opportunities to realise operational efficiencies, such as those helpfully identified by Lord Carter, which we must pursue vigorously.[11] Indeed our group is working on a collaborative procurement programme to save £200m over five years by harnessing our purchasing power and clinical expertise to inform product selection. However, there will still remain a substantial gap to the £22bn of efficiency savings required by 2020/21. By international comparisons the NHS is already relatively efficient and effective overall, achieving strong outcomes relative to investment.[12]

Recommendations for policy

15. Within that context, we make the following ten recommendations for fiscal policy in relation to the NHS, life sciences and social care.

i. A national debate about funding levels for health and social care

If we have to accept either more funding or lower levels of service for the NHS and social care, this should be the subject of a major national debate, which should be open, honest and informed by the best available evidence. This should weigh what patients and users want to access against what taxpayers are willing to pay. It must consider health and social care together, as they are critically interdependent, and should address the crisis of funding for social care.

ii. Independent and expert recommendations on funding levels

In order to inform that national debate about the relative value which the public places on health and social care, there should be an independent and expert assessment of the international and domestic evidence on funding levels. There are several examples where the Government has set up independent experts to make, recommend or scrutinise significant financial decisions, such as the Office of Budget Responsibility. An independent expert committee could be established to keep under review the best available evidence and to publish recommendations on levels of spending and efficiency on health and social care, at least on an advisory basis.

iii. A moratorium on new, discretionary cost pressures

Some major cost pressures, such as rising demand for emergency care, appear intractable. However, we recommend a moratorium on any new cost pressures, such as new policies or standards, without equal or greater savings by reducing costs elsewhere. Any new objectives should be properly costed to ensure they are affordable, as well as deliverable. Efficiency requirements for NHS providers are already well above realistic expectations, so further efficiencies cannot be used as a balancing figure to cover new cost pressures.

iv. Investment in infrastructure

Long term sustainability requires appropriate investment in infrastructure, including clinical and research facilities, equipment and information technology. Current spending plans under-estimate the need for capital investment across the board, which has been exacerbated by the need to transfer capital to revenue.[13] This could be addressed by a strategic and ambitious approach to selling parts of the existing NHS estate, where the buildings are crumbling but the land is valuable, and reinvesting in state-of-the-art infrastructure with better clinical and academic coadjacencies than we have now.[14] We also strongly support Simon Stevens's call for a new NHS infrastructure fund.[15]

v. Developing new models of care

We support a thrust of policy that incentivises hospitals and other health services to focus on keeping people healthy and out of hospital, where possible and clinically appropriate. The *NHS Five Year Forward View* and NHS England's new care models programme offer real promise.[16] [17] We aim to help build the evidence base for the various models, which must become more rigorous. However, fundamental redesign of complex health systems will take time and there should be a realistic assessment of return on investment over several years.

vi. Aligning responsibility for planning with accountability for delivery

There must also be clearer alignment between responsibility for service planning and accountability for delivery. There is much that is positive in Sustainability and Transformation Plans (STPs) and we welcome the principle of multi-year planning. However, STPs are not well aligned to the current framework of accountability that was set up in the Health and Social Care Act of 2012 and previous legislation. In the not-too-distant future, there should be a realignment between how health services are managed and the governing framework of accountability.

vii. A more proportionate approach to regulation

As the NHS overall slides into financial deficit, the regulatory diagnosis seems to have been of widespread local failure. The treatment regimen has therefore been to pull the reins ever more tightly from the centre, as exemplified by the so-called 'NHS reset' of July 2016.[18] This may help short term cash control, but will have an uncertain and risky impact on local service provision. Our diagnosis places far more emphasis on systemic underfunding of the NHS and social care relative to demand. That problem will not be cured by more central regulation and inspection of local providers. The reporting burden to various regulators and inspectors has already become so onerous that it is crowding out time and space to innovate. A health system cannot inspect and regulate its way to efficient, high quality care.[19]

viii. Returning pay awards to reasonable levels

The extremely high regard in which the NHS is held in this country and internationally is a testament to its talented and dedicated workforce. The thrust of central policies in recent times has been to treat the workforce more as a cost to be contained for short term cash control, than an asset to be nurtured for our long term investment.[20] The previous Spending Review had already identified a need for £15bn of NHS savings between 2010 and 2015, much of which was achieved through sustained pay restraint that was replicated across the public sector. This may

have been necessary for a period, but its continuation will not support the sustainability of a highly skilled, motivated and retained workforce.

ix. Supporting training and education

Training and education budgets have been reduced year-on-year. We would support them rising at least in line with the headline settlement for the NHS. We welcome the Health Secretary's recent focus on increasing training places for doctors. A similar focus on nursing and other health professions would be equally welcomed. Nevertheless, it will be some years before these training places translate to staff on the wards and we are increasingly concerned about the difficulty in filling clinical staff rotas in the near term. Given the financial and workforce pressures that the NHS faces already, we believe new domestic training places should be additional, rather than replacement for overseas doctors, and should come with commensurate new funding.

x. Priorities for Brexit negotiations

We believe that the NHS and life sciences should be a significant component of the UK's future industrial strategy. There are also some important links between the NHS and the European Union which we believe should be prioritised within the Brexit negotiations, particularly in relation to the workforce and scientific research. We are members of the Cavendish Coalition which calls for swift reassurance for EU staff working in health and social care that they will have the right to remain in the UK, advocates a reasonable level of continuing international workforce mobility, and which calls for zero tolerance of discrimination towards staff or patients.[21] In terms of science, we believe that there will be a continuing need for scientific professional mobility, research collaboration and funding with Europe, as well as other international partners, long into the future.

Conclusion

16. For the avoidance of doubt, we are not saying the *only* answer to the challenges for the NHS and social care is more money. There is significant opportunity to drive efficiency savings, as evidenced by Lord Carter, to standardise good practice at pace and scale and to focus on new models of care that keep people healthy rather than just waiting to treat them when they are sick. We aim to do all of those things as leading organisations with a track record of delivery.

17. However, our experience leads us to the conclusion that with current levels of spending, and stretching but realistic efficiency gains, we cannot afford to deliver the high quality, comprehensive standards of care across the board to which we aspire as providers and which patients have come to expect. This is the reality of where we are now and where we are heading in the future.

18. Some of the challenges and potential solutions are so significant that they can only be addressed with government intervention, hence our policy recommendations in this submission. Equally, we are a central part of the NHS and we see it as our responsibility to lead changes in our own organisations and health systems to help deliver long term sustainability for the NHS to which we are so committed.

Submitted by the Shelford Group on 7 October 2016

End notes

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[5] Health Select Committee, *Impact of the Spending Review on Health and Social* Care (July 2016).
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[10] The Health Foundation, *A Perfect Storm: an impossible climate for NHS providers' finances?* (March 2016).
[11] Lord Carter of Coles, *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations* (February 2016).
[12] The Commonwealth Fund, *Mirror, Mirror on the Wall* (June 2014).
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[20] Lord Carter of Coles, *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations* (February 2016).
[21] The Cavendish Coalition, http://www.nhsemployers.org/your-workforce/need-to-know/brexit-and-the-nhs-eu-workforce/the-cavendish-coalition (7 September 2016).

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