SHELFORD GROUP SUBMISSION TO THE HOUSE OF LORDS SELECT COMMITTEE ON THE LONG TERM SUSTAINABILITY OF THE NATIONAL HEALTH SERVICE

Introduction

1. The Shelford Group represents ten of the leading NHS multi-specialty academic healthcare centres in England (see membership at Appendix A).[1] 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, and to play a significant role in ensuring the sustainability of the NHS.

2. Our group welcomes wholeheartedly the decision of the House of Lords to establish a committee on the long term sustainability of the NHS. It is perhaps the most cherished of our public services, yet the scale of the challenge ahead is unprecedented. It has come through difficult times in the past, thanks to its importance to national society and the resilience and innovation of its many staff. These enduring qualities give us optimism for the long term future.

3. We find ourselves more pessimistic, however, about the medium term outlook, largely because of the daunting financial challenge and its potential impact on our ambition to provide high quality care. This merits a major national debate, which should be open, honest and informed by the best available evidence, in order to chart a path to long term sustainability.

4. Our organisations are core stakeholders for this inquiry, as large NHS providers delivering services worth in aggregate nearly £10bn per annum, which is around 10% of the total NHS England budget and over 13% of the NHS provider sector. Our trusts, with their relevant universities, are all Biomedical Research Centres, accounting for two thirds of National Institute for Health Research funding nationally.[2] Our ten Chief Executives have over 150 years of CEO experience between them. We are not external commentators. We are at the heart of the NHS and we are deeply committed to its long term future.

5. Mindful of the guidance, we have kept our submission as concise as we felt possible, given the breadth of the subject. We have focused on the long term issues, but cited some near term examples where they provide relevant context. For brevity, we have not answered all of the questions posed, but we are very willing to elaborate on our submission and would welcome the opportunity to present evidence in person as well as in writing.

Resources

6. 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 NHS sustainability.[3] 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.

7. 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.

8. The near term imperative for the government to reduce the nation's structural deficit has meant that the NHS is having the lowest funding increases for a sustained period in its history,[4] even though it has been comparatively well supported and has fared better than other parts of the public sector, including our partners in social care who have faced swingeing cuts. Nevertheless, the demands on health services continue to grow across virtually all parts of the sector.[5] 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.[6] [7] [8] [9] [10] [11]

9. We see this playing out nationally with the NHS provider sector finishing 2015/16 with an aggregate deficit of £2.45bn, almost three times greater than the previous year. The underlying position is likely to have been at least £1bn worse, with overall system balance only achieved by a series of non-recurrent measures.[12] Among them were transfers from capital to revenue that represent under-investment in infrastructure and store up problems for the future in order to shore up the bottom line in the short term. In tandem, there has been a steady decline across the board in operational performance against targets.

10. We also 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.

11. Year-on-year real terms reductions in payment for activity have meant that we are at risk of normalising an NHS financial regime where even high performing organisations can only survive on bail outs. This 'dependency culture' will undo the good work of the last decade to promote fair funding and financial discipline in the NHS. It has a corrosive impact on the prevailing clinical management model when Clinical Directors cannot reconcile the provision of high quality care with a balanced budget for their clinical service.

12. As health economies come under severe financial pressure, and in the absence of national consistency about what can be restricted, we see Clinical Commissioning Groups making difficult and *ad hoc* rationing decisions.[13] [14] 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.

13. There are of course opportunities to realise operational efficiencies, such as those helpfully identified by Lord Carter, which we must pursue vigorously.[15] 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, even if the Carter recommendations could save £5bn, there would still remain a substantial gap to the £22bn of efficiency savings required by 2020, and no credible plan for achieving them to that timeframe. By international comparisons the NHS is already relatively efficient and effective overall, achieving strong outcomes relative to investment.[16] Health service leaders are also mindful that any significant service changes designed to realise savings could potentially conclude, after formal

consultation, in the period before the next General Election, which has often caused changes to stall in the past.

14. Should the country increase funding for health and social care therefore?

15. If we have to accept either more public funding or lower levels of service in this vital British institution, this should be the subject of an open and honest discussion with the government and the public, informed by the best available evidence.

16. As in any publicly funded service, there is an inherent tension between what patients and the public want to access and what taxpayers are prepared to fund. In the current circumstances, that tension is closer than ever to breaking point. Funding has to match ambition. We cannot have a first class health service with second class levels of funding. On one analysis, we ranked 10th of the original EU 15 on health spending as a proportion of GDP, which was behind Greece and about on a par with Slovenia[17]. We recognise that there is feverish academic debate about how to measure health spending as a proportion of GDP,[18] but our real world experience is clear that frontline health services are being squeezed year-on-year, in some cases to the point of unsustainability.

17. To the extent that NHS funding was conflated with the referendum on Britain's membership of the European Union, it was apparent that there was public support for channeling more resources to the NHS. The government has dropped its previous target for the economy to achieve a structural surplus by 2020 and that might afford space for a reappraisal of current spending plans.

18. 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.[19] 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.[20] We would also strongly support Simon Stevens's call for a new NHS infrastructure fund.[21]

19. As well as capital investment, it is of course equally important that there is sufficient revenue to meet demand for services on a recurrent basis. Whilst we do not attempt to define the 'right' amount of expenditure on health and social care, we do believe that there should be a new approach to determining an optimal level of spending. We note that there are several examples where the UK Government has set up independent expert panels or organisations to make, recommend or scrutinise significant financial decisions, such as the Bank of England setting interest rates; the Office of Budget Responsibility providing independent analysis of public finances; and independent review bodies making recommendations on public sector pay.

20. The Government could establish an independent expert committee to keep under review the best available international and domestic evidence and to publish recommendations on optimal levels of spending on health and social care. Accepting that any government of the day will wish to retain executive authority over spending plans, the recommendations could be advisory rather than binding, but would at least make visible 'target' levels of spending. It would also support longer term planning.

21. We note that it has proven entirely possible to set target levels of spending for a sector, as with the North Atlantic Treaty Organisation target for at least 2% of GDP being spent on defence,[22] and with

0.7% of GDP for international aid being enshrined in law.[23] The important caveats are that any such targets for health and social care would need to be kept under review for changes in demography, epidemiology and technology, and that the definition of what counted as health and social care spending would have to be similarly independent to prevent arbitrary redrawing of the boundaries.

22. Where actual spending levels on NHS and social care were to fall below the target level recommended by experts, the NHS would have to cut its cloth accordingly, for instance, by reducing unfunded cost pressures. This could offer a more credible alignment than we have now of what can be achieved for the resources available.

23. For the avoidance of doubt, we are not saying the *only* answer is more money. We have to be realistic about the prospect of additional resources in the current economic circumstances and with many competing claims on national resources. 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.

24. 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.

25. It will always be the role of the government of the day to determine what the country *can afford* to spend on its publicly funded healthcare. That is not necessarily the same as what the country *ought to spend* to meet population health needs within defined service standards. The latter question could be answered with a greater degree of expertise, transparency and independence, at least on an advisory basis. That would make clear the gap between affordability and optimal spending and help to have an open dialogue about trade-offs. It would avert what we fear will be a growing spate of *ad hoc* rationing decisions breaking out unevenly across the country.

Workforce

26. The extremely high regard in which the NHS is held in this country and internationally is a testament to its talented and dedicated workforce. In our organisations, we employ over 100,000 NHS staff, including 15,000 doctors and dentists, 40,000 nurses, midwives and health visitors, and 15,000 scientists and allied health professionals. Each one is a dedicated public servant.

27. It has often been said that the greatest asset of the NHS is its staff. It is also frequently noted that staff are the largest cost in the NHS, representing over two thirds of recurrent spending. Both observations are of course true, but, regrettably, 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.[24]

28. 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 long term sustainability of a highly skilled, motivated and retained workforce. We are increasingly concerned by the difficulty in filling clinical posts.[25] Central cuts to training budgets have left trusts increasingly reliant on agency and overseas staff.

29. It is essential that industrial relations between junior doctors and the Government are repaired and that there is no deterioration with other, equally important staff groups. This is entirely possible with constructive dialogue between the Government, the British Medical Association, NHS Employers and clinical leaders. As a group of large teaching hospitals, Shelford organisations aim to support constructive industrial relations, to act as exemplar employers for clinical training and to provide high quality care consistently.

30. The current resource position is causing a mismatch between *appropriate* staffing levels and *affordable* staffing levels in many parts of the NHS. The Mid Staffordshire scandal should have seared into our collective memory the importance of staffing healthcare services according to what is right and safe for levels of acuity and need, rather than staffing them based on what financially distressed organisations think they can afford.[26] We forget that lesson at our peril. That is why the Shelford Group is continuing to develop a range of evidence-based tools on safe nurse staffing levels for the benefit of NHS organisations.[27]

31. The impact that Brexit will have on the NHS workforce is so far uncertain. There may be welcome opportunities to focus more attention on training our domestic workforce as part of a long term strategy. At the present time, however, 135,000 people from the EU work in health and social care in this country. In our member organisations based in London and the South East, EU staff represent around 10% of our workforce, and they make a significant contribution to organisations right across the country. They are highly skilled and valued members of our teams. We are members of the Cavendish Coalition which calls for swift reassurance for those staff that they will have the right to remain in the UK, advocates a reasonable level of international workforce mobility, and which calls for zero tolerance of discrimination towards staff or patients.[28]

32. An important, but currently neglected, element of the workforce to ensure long term sustainability is leadership. The leaders of our organisations hold themselves and others to the highest standards as stewards of public healthcare and taxpayers' money. However, the resource environment is making it increasingly difficult for leaders throughout the service to succeed. It risks discouraging future generations, including clinical leaders who see the financial strictures as incompatible with high quality care.[29] At present, NHS leadership talent is currently spread too thinly across too many organisations and there is insufficient attention to nurturing a new and more diverse cadre of leaders.[30] We would be delighted to work with other partners to ensure a renewed focus on leadership development in the NHS.

Service delivery and integration

33. We have long known that we need a health system that focuses more on keeping people healthy, as well as treating them when they are sick. Equally important is harnessing the potential of technological innovation to improve the quality and integration of primary and acute care, and to support individuals to manage their own health and care. These related aims remain central to long term sustainability, but have proven stubbornly difficult to achieve at scale, which is partly why hospitals and clinics up and down the country are immersed by a wave of demand.

34. We undoubtedly need more integration of services across the full continuum of care, and between physical and mental health, supported by investment in technology and better sharing of data. Those are key drivers of the innovative devolution settlement for Manchester. But we must be cautious about shifting resources from the NHS to local government, because recent experience has suggested that money gets channeled away from health promotion and social care when councils are under severe financial strain, as in recent years. That is partly why delayed transfers of

care from hospital have risen by 163% in the last five years, placing a huge burden on the NHS, which is a higher cost environment in which to care for these vulnerable people.[31] There are other models, such as the one trialled successfully in Oxford, where the university hospital has taken greater responsibility for the social care needs of its patients, thus reducing delayed transfers of care by 50%.[32]

35. The NHS is still driven substantially by targets, which have both catalysed improvements for patients and led to some unintended consequences. In recent years, the financial and operational pressures on providers have seen a deterioration in performance. For the longer term, it would be preferable for there to be a shift away from top-down targets and to move towards more locally tailored goals, which incentivise health promotion and the reduction of inequalities, and join up services between physical and mental health and between the NHS and social care. However, any targets or objectives should be properly costed to ensure they are deliverable and affordable.

36. 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. In that respect, the *NHS Five Year Forward View* and NHS England's new care models programme offer real promise.[33] [34] A number of our member organisations are experimenting with Primary and Acute Care Systems (also known as Accountable Care Organisations) and Acute Care Collaborations. We agree that there is not a one-size-fits-all solution for every locality. We aim to help build the evidence base for the various options, which is currently at an immature stage of development and must become more rigorous. However, we caution that fundamental redesign of complex health systems will take time and the return on investment might be over several years.

37. Any field needs pioneers and innovators to lead the way. Our organisations have been at the forefront of many of the most prominent health service reforms of recent decades, such as the creation of NHS Trusts, then NHS Foundation Trusts, Academic Health Science Centres and Biomedical Research Centres. A common theme of successful reform is a clear and evidence-based national policy framework, allied with local engagement and innovation. Whilst the organisational forms will change in the future, that theme should endure.

38. However, 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.[35] This may help short term cash control, but will have an uncertain and risky impact on local service provision.

39. 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.[36]

40. In the next phase of organisational change, we believe there must be a return to the principles behind the NHS Foundation Trust movement, namely that leading organisations should be given local freedom to innovate and invest, rather than being tightly managed from Whitehall or arm's-length bodies. 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. That Act promoted a more competitive and market-based approach, which is quite different to the

health economy wide planning of STPs. In the not-too-distant future, there should be a realignment of how health services are managed and the governing framework of accountability.

41. We have made clear our commitment to a health service that promotes health and manages illness in lower acuity settings where possible. Nevertheless, as our population ages, and biomedical science advances, we see, and are able to treat, ever more complex conditions and co-morbidities. For example, we are now able to treat HIV successfully as a chronic rather than a terminal condition, so some of our trusts have seen year-on-year growth of 5-10% in treatment costs. Over the last six years, one of our trusts has seen an average 12% year on year increase in kidney transplants, which adds significantly to short term costs, even though it is less expensive than the alternative of long term dialysis. Demographic changes and advances in assisted fertility have increased the demand for, and the costs of, IVF and that has also had an impact on the rising demand for specialised neonatal care. Right across the hospital sector, the cost of medicines has been rising significantly faster than income due to the introduction of new and innovative medicines and the pharmaceutical costs of specialised services.

42. These examples, among many others, demonstrate that the demand for, and cost of, NHS specialised services will accelerate apace. We welcome NHS England's recognition that the specialised commissioning budget will have to increase above headline NHS revenue growth,[37] although we are concerned that the projected increases will still be insufficient to meet fast growing demand.

43. In aggregate, the Shelford Group trusts deliver around a quarter of all specialised services commissioned by NHS England. Those services remain at the cutting edge of global biomedical science. They are a jewel in the crown of the NHS, not to be neglected or underfunded. We welcome the attention this vital area of provision has recently received from the National Audit Office and others,[38] [39] and we will continue to engage with NHS England on the strategy for specialised commissioning. We believe this should result in a significant rationalisation of the number of sites undertaking specialised services, for the sake of quality and efficiency, and this must be based on robust and transparent evidence to command public and professional confidence. There must also be closer network arrangements between specialised sites and their related services.

Science and research

44. As large and highly specialised providers, our organisations are national and international hubs for advanced healthcare, education and research. Five of the world's top ten clinical research universities are partnered with Shelford trusts.[40] In partnership with their universities, our organisations are all Biomedical Research Centres, and are responsible for two-thirds of National Institute for Health Research funding nationally.[41] We also host eight of the NHS Genomic Medicine Centres in England.[42] As one of our globally competitive industries, we believe that the NHS and UK life sciences should feature prominently in the government's forthcoming industrial strategy. This will be of benefit for the sustainability of the NHS and the wider UK economy.

45. The impact that Brexit will have on science and research is unclear. There may be increased opportunities to develop domestic talent and to make new links with non-EU countries. However, we also believe that the continuing need for professional mobility, research collaboration and funding with Europe should be prioritised by the government in the forthcoming Brexit negotiations. In the meantime, we are aware of instances where UK researchers are not being included as Principal Investigators on research applications for EU funding. Until there is a clear alternative strategy, we are concerned this will affect clinical research in our organisations.

46. We should focus more research into ways to address the long term funding challenge. New ways of delivering care will be driven as much by scientific research as redesign of care pathways. Perhaps the most revolutionary change on the horizon is the use of genomics in precision medicine. Genomics will allows us to examine the underlying causes of ill-health and confront diseases before they have even started. This is particularly important in conditions such as diabetes, cancer and cardiovascular disease, where current therapies are effective in 30-60% of patients. By using precision medicine we will be able to tailor treatments and interventions to the individual rather than the average of the patient group. This holds the promise of radically increasing the effectiveness of treatments and eliminating extraneous costs.

47. Personalised medicine requires precision diagnostics to identify underlying conditions and to monitor the early and late effect of interventions. With £8bn a year spent on diagnostic testing and £15bn on medicines, there is clear potential to make savings through precision techniques and targeted interventional technologies.

48. As the largest integrated healthcare system in the world, the NHS is superbly well suited to translate genomic and other scientific breakthroughs quickly and efficiently to a large, diverse population. In seeking to design a health system that first aims to keep people healthy and out of hospital, it is essential that we do not under-invest in our leading centres of medical, educational and scientific excellence, which will design the health interventions of the future and act as centres for innovation and the introduction of new technologies.

Conclusion

49. From the benefit of our experience, we have attempted to lay out fully and frankly the challenges for the NHS as we see them. Sustainability for the long term can only be achieved by action in the short and medium term. Some of the challenges and potential solutions are so significant that they can only be addressed with government intervention. 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.

50. For our last words, we simple quote the first words of the NHS Constitution:

> *'The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.'*[43]

51. Long may it be so.

Submitted by the Shelford Group on 23 September 2016

Appendix A – Shelford Group members

- 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

End notes

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