1 Summary

1.1. The Shelford Group warmly welcomes the additional £10bn investment in the NHS and the frontloading of this funding for 2016/17 in the 2015 Spending Review. We recognise and acknowledge the budget constrains within which the NHS must operate, and are keen to work with the wider system to deliver efficiencies and service transformation, with high-quality patient care and outcomes kept front and foremost.

1.2. Moreover, the moves towards working on a population basis to develop place-based strategic and transformation plans provides the opportunity to examine the demand for primary care, social care and mental health services. As such, we should, over time, be able to better predict overall demand and be certain of the financial benefits of shifting care to non-acute settings. Combined with the introduction of multi-year tariffs and planning, this sets the precedence to bring about greater stability and certainty in the healthcare sector as a whole.

1.3. However, it is important to note that the complexity of putting those plans together involving a much wider range of stakeholders, with at times differing objectives, does not feature in the planning guidance. The emphasis on coherence and the strength of the vision will be easier to achieve in smaller co-terminus footprints, rather than more diverse range of stakeholders. The Sustainability and Transformation Funds may therefore be at risk of resolving local challenges at the disadvantage of regional and national initiatives, such as those for specialised services. Providers of specialised services, such as our members, will need to work closely with NHS England to resolve this.

1.4. There are a number of concerns we would also stress with regards to the long-term sustainability of the healthcare system, particularly as the Spending Review years two and three funding increases are notably low. The Q2 2015/16 data showed the provider sector in £1.6bn aggregate deficit, and 95% of acute providers in deficit. This suggests the overall balance of risks is not being shared equally across the NHS and whilst the frontloading of investment for 2016/17 will address provider deficits in the short term, there are wider demographic and demand challenges, new cost pressures and the removal of funding from other central budgets which will impact on provider budgets over the Spending Review period.

1.5. In addition, the Shelford Group would caution that both the £22bn efficiency target by 2020-21 and the deadline to integrate health and social care by 2020 remain ambitious, particularly if healthcare providers are focused on service transformation and reconfiguration to reduce costs between 2016-17 and 2020-21.

1.6. With regards to the work being led by Lord Carter, whilst savings can certainly be made through this approach and we are fully supportive of the initiative, the basis and methodology being applied is open to challenge. We are keen to work with Lord Carter and his team, and help improve the measures and build the model hospital. At the same time, we will look at the areas of savings opportunities flagged to explore if more can be achieved than we are already planning.

2 Meeting new cost pressures

2.1 There are concerns around whether the frontloading of the Spending Review funding will be sufficient to address deficits in the system, meet forecasted demand, and deliver new cost pressures, such as pay awards, Clinical Negligence Scheme for Trusts (CNST), and pensions and employers NI changes.
2.2 Moreover, new commitments for primary, community and acute services outlined in the Spending Review documents, notably seven-day services, service transformation, shorter waiting times etc., will further stretch the newly-allocated resources, particularly if target efficiencies prove unrealistic. It is vital that the NHS keeps patient safety and outcomes at the centre of what we do, rather than compromising patient care when delivering new commitments.

2.3 It remains a concern that no additional funding is being provided to develop seven-day services, as there is a significant risk of spreading existing resources more thinly, and thereby reducing quality from the current service. Rather than promising the same service every day, the NHS should be prioritising the areas where people are sickest and therefore in most need, and ensuring that those are properly staffed and resourced whenever they are required, operating at appropriate levels of efficiency.

2.4 With regards to specialised services in particular, the pool of staff and technological resource is necessarily smaller than more general services where it might be more appropriate to run a more evenly-spread seven-day service.

3 **Sustainability and Transformation Fund**

3.1 The recent offer of Sustainability and Transformation Fund allocations, set against control targets for 2016/17, has raised the particular challenge around transparency in setting tariffs, targets and allocations. There is little detail on how these control targets were calculated, leaving the question of what has been factored in, for example donations/impairments and non-recurrent in-year gains.

3.2 Moreover, there is a lack of communication around what other conditions are expected to be linked to the Sustainability and Transformation Fund at present, whilst trusts are expected to accept the control target and other unclear conditions within a tight timescale of them being allocated. There has been an improvement in engagement when the national tariff was being calculated for 2016/17, for example, greater understanding of the impact of the proposed tariff effects led to the delay in HRG version 4+ implementation.

3.3 The 2016/17 planning guidance indicates that income allocated to providers through the Sustainability and Transformation Fund will be allocated on a quarterly basis retrospectively. This may mean that the day-to-day cash management becomes very difficult for many acute NHS providers, who require this funding to break even.

3.4 The Shelford Group strongly advocates greater transparency in such processes and early engagement with the provider sector to agree tariffs, targets and allocations that are fair and achievable throughout the health and care system.

4 **Workforce**

4.1 The Spending Review document references record levels of employment (1.3) and the lowest levels of unemployment in seven years (1.5). It goes on to state that real earnings are expected to grow by 3.9% per annum by 2020 (1.6); at the same time, public sector maximum pay awards will be 1% for the next four years (1.291). Over this time, disparity between private and public sector will result in potentially significant difficulties in public sector recruitment and retention.
4.2 We would recommend reviewing the public sector maximum pay awards, particularly in light of challenges around nurse shortages and the need to ensure safe staffing across health and social care services.

4.3 With regards to Health Education England (HEE) and the removal of the ring-fence for education and training funding, approximately 70% of HEE expenditure is with providers of NHS services, and therefore any reduction in funding will impact on them.

4.4 There are particular concerns around the implications of the reduction in HEE’s budget on training of additional staff and the transformation of the workforce, which is key to underpinning the delivery of a transformed NHS. There is a risk that a significant number of valuable and innovative initiatives that Local Education and Training Boards have driven to date across the development of the existing workforce and, importantly, across health and social care will cease if funding is withdrawn. These initiatives are vital to better support integrated care and need to be driven at both undergraduate and postgraduate training levels.

4.5 In addition, there remain concerns around the impact of the removal of the current bursary and fee arrangements for undergraduate nursing, midwifery, allied health professionals and other clinical groups on both future workforce planning and future non-medical workforce supply. This is particularly pertinent when it comes to training placements, which we understand will continue to be funded by HEE; it is important that quality of placements is not compromised by quantity. Furthermore, there was no consultation in advance of this proposal, which brings potential risk to future workforce capacity at a time when nursing, in particular, is experiencing very significant shortages. We would therefore urge greater clarity on these proposals and a full impact assessment so that stability can be achieved for our future workforce. We look forward to feeding back through the upcoming consultation process on this significant policy change.

5 Public health and prevention

5.1 As local authorities continue to experience reduced funding, the removal of the public health ring-fence could see a significant drop in local authority public health spend, alongside a cut in Public Health England’s budget, at the exact time when the NHS needs to be investing in prevention as a key way to reduce and manage the ever-increasing demand on acute services. This would appear to be inconsistent with the Five Year Forward View’s emphasis on public health.

6 Social care

6.1 There has been increasing discussion about the inter-relationship between health and social care in cash terms by the NHS and recognition that a stronger financial settlement for social care is required in order to manage growing demand on the NHS. It is widely accepted that reducing budgets in one part of the system will have an impact on other areas within the system.

6.2 However, we are concerned that the settlement offered to local authorities in relation to social care funding does not offer a sustainable financial footing for the sector. For example, the 2% Council Tax precept announced in the Spending Review will introduce greater variation in access and quality across the country. Moreover, there is currently downward pressure on what councils can pay and an upward pressure on home providers on costs, for example through the National Living Wage and maintaining CQC registration.

6.3 There is therefore potential for a negative impact on acute/community providers, both in terms of admissions and discharges. Slower hospital flow and a higher proportion of medical/social
patients mean that tertiary capacity could be increasingly restricted, which will impact on elective work and performance targets.

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