What will we cover?

- Funding & finances
- Regulation
- Workforce
- Five Year Forward View & Devolution
What is the current mood music?

**MAINTAIN FOCUS ON SHORT TERM**
- Positive outcome on spending review frontloaded 2016/17 funding
- Positive plan for providers emerging for 2016/17 planning and tariff – the Mackey influence
- Need to maintain financial and operational grip including 15/16

**BUT ALSO LOOK TO THE HORIZON**
- After stabilising, must get to grips with long term productivity and sustainability challenges
- Devolution & New care models starting to gather pace
- Increasing focus on systems as the unit of planning and strategic change
## Recent developments

<table>
<thead>
<tr>
<th>Sustained widespread financial distress despite agency caps: -£1.6bn by Q2</th>
<th>Jim Mackey appointed to NHS Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending review results &amp; positive, Mackey led, plan / tariff for 2016/17</td>
<td>Industrial action by Junior Doctors called off</td>
</tr>
<tr>
<td>CQC state of care and new strategy consultation</td>
<td>Next, acute care collaborative, vanguards launched</td>
</tr>
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</table>
What will we cover?

Funding & finances

- Regulation
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The 2015 Spending Review

**Social Care**
- £6.1bn cut to local government grant by 2019/20
- Offset by 2% social care precept for adult social care, but will not close the gap even at full whack
- Better care fund £1.5bn increase from local government side by 2019/20
- Preparing for Dilnot by 2020/21

**Health – NHS England £100 billion and DH £15 billion**
- Extra £8bn funding for NHS England £100bn, with £3.8bn frontloaded in 2016/17
- 25% cut to DH £15bn, impact on HEE and capital
- 2017/18: nurse training from bursaries to loans and training number caps removed; provider opportunity
- £600m extra mental health funding from increases
- Tech funding lower than expected
- Public health 3.9% real terms reduction
- £2bn of land sales needed to balance books
- £23.5 bn of savings needed to meet demand / cost
The phasing of the extra £8bn?

Front-loaded early slug to balance the books, especially frontloaded to 16/17

Some funding hypothecated e.g. drugs, mental health

Capital stands still

Conditionality on plans

Front-loaded early slug to balance the books, especially frontloaded to 16/17

Slower, undeliverable looking, growth in middle of the cycle

Late slug for 7DS and paperless NHS

Funding to:

+ £1.5bn

2016-17

2017-18

2018-19

2019-20

2020-21

8.4

5.3

5.8

6.7
Does it pass the Stevens five tests?

A. Front-loaded investment for service transformation (but now going on deficit recovery)

B. New asks consistent with phasing of funding (not yet visible)

D. Realistic but broad set of efficiencies

D. Protection for social care services

E. Make good on the public health opportunity
And how does it measure up more broadly?

COMES OUT WELL AGAINST
• Constraints of deficit reduction
• Cuts to other departmental budgets
• Expectations before the review

COMES OUT LESS WELL AGAINST
• OBR’s extra back of sofa £27bn
• NHS history (1.5% vs 3.6% p.a.)
• What the NHS needs
• GDP spend per head

Spending has actually fallen since 2010 if adjusted for an ageing population

Source: Nuffield Trust
What we expect from 2016/17 funding / tariff

Briefing given to CEOs last week

**Funding**

- 5 year allocations (3 year firm, 2 outer years indicative) for CCGs
- Place-based with primary, CCG and specialised commissioned services published
- £5.4bn increase 2016/17 split between:
  - Mainstreamed extra funding for CCGs
  - Central new policy initiatives
  - Conditional stabilisation / transition (aka provider deficit reduction) & transformation funding. More detail to come and some tricky issues to manage
- Any 15/16 deficit over £1.8bn has to be recovered from 16/17.

**Tariff**

- +1.1% net adjustment (2% efficiency factor and 3.1% inflation uplift)
- Inflation uplift designed to recognise full cost of additional pension contributions
- Delay HRG4+, pause specialised marginal rate, but phase in new top-ups
- Retain MRET @70% & move all trusts to ETO prices

- A positive, some way above expectations, Jim Mackey influenced, result for 2016/17
- Buying a year to sort out serious long term efficiency savings and sustainability plans
  - But this only makes a previously impossible 2016/17 look very challenging
2016/17 planning (more on 18 Dec)

The planning principles
- Support locally driven change
- Transcend organisational boundaries
- Look beyond one year

The focus
- Manage money and emergency care in the short term
- Create conditions for transformation
- Agree shared objectives across larger units of planning

Sustainability & Transformation plans
(July 2016)
- Place based & Multi-year: how your system will be sustainable by 2020
- Governance structures & shared vision needed
- Close the 3 FYFV gaps
- Open book planning
- Self-assess capacity and capability to deliver
Expected must do’s and further improvement priorities

Too many competing priorities: create very small core we have to get right. A likely further small core of things to improve over next three years.

Must Do’s

- Money – eliminate provider deficits and return to surplus
  - Reduce agency staff spend
  - Serious efficiency savings plans incorporating Carter and estates savings
  - Explicit 16/17 control total to manage to, Xmas holidays
- Deliver constitutional performance standards
  - Agree performance recovery trajectories on A&E standard
- Develop any required service redesign proposals to do difficult work in first half of parliament

Improvement wins

- Cancer: deliver Task Force recommendations; recover lost momentum
- Mental health: deliver Task Force recommendations
- Prevention especially obesity, diabetes
- Seven Day Services
  - Availability of hospital consultants and diagnostics at weekend
  - Urgent and emergency care out of hospital
  - GP access at weekends

2016/17: deliver must do’s and make incremental progress on improvements
We also need some proper system alignment as well...

We now need to ensure that every CCG in the South West is using all appropriate contractual sanctions available to incentivise providers to focus on delivery of access standards.

....I expect any fines levied are neither waived nor “reinvested” into the same provider, except in highly exceptional and fully justified circumstances...

Where fines are levied the CCG is at liberty to spend this money with alternative providers to improve the delivery of the standard at a population level (for example in the Independent Sector in the case of RTT) or to use it to visibly improve your overall financial position in meeting Business Rules and delivering or improving on your Control Total.
What will we cover?

- Funding & finances
- Regulation
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How do you think the overall regulatory framework of the NHS is currently working?

- **Very well**: 29%
- **Fairly well**: 28%
- **Neither well nor poorly**: 6%
- **Fairly poorly**: 38%
- **Very poorly**: 6%

(n = 69)

To what extent do you think the regulators have coordinated their activity effectively over the last 12 months?*

- **Very effectively**: 28%
- **Fairly effectively**: 19%
- **Neither effectively or ineffectively**: 44%
- **Fairly ineffectively**: 9%
- **Very ineffectively**: 12%

2014 2015

Has the regulatory burden experienced by your organisation increased, stayed the same, or decreased over the last 12 months?

- **Decreased**: 13%
- **Stayed the same**: 22%
- **Increased**: 87%

(n = 70)

- **44%** of respondents feel the regulatory framework is working poorly and nearly **90%** say regulatory burden has increased.

- Regulatory environment has become much more complex over the last 12 months as:
  - Regulators balance supportive approach with formal regulatory duties
  - Roles of regulators becoming increasingly blurred
  - Increasing burden from requests for data and information from regulators, commissioners and NHS England

- Benefits to be gained by streamlining the overall regime, reducing the number of regulators and ensuring policy priorities are consistent. Some hope that over last year, regulators have made more effort to coordinate activity
Overall approach: what we need

Moving from setting an impossible task and intervening when providers fall short to....

....Supporting providers to deliver an achievable task

Right unit of regulation: single institution or whole system?

Balance challenge / intervention and support and be deeply conscious of all costs being incurred

Don’t blur Board accountability
CQC approach evolving

- Consulting on strategy in light of FYFV e.g. more risk-based
- Use of resources assessment still developing. Our workshop supported provider input into the process.
- Developing approach to ‘quality in a place’ inspection under Prof Steve Field
- Alignment with NHS Improvement and the new ‘Independent Patient Safety Investigation Service’
- Significant changes to fees to offset reduction in grant-in-aid funding
- Peter Wyman Chair Designate (Yeovil DGH FT)
  - Focus on outcomes not process
  - Recognition of system challenges and pressures on providers
  - Self-awareness of implications of CQC inspections and approach
NHS Improvement

• Jim Mackey already having a significant impact

• One board by Jan 2016

• Objectives
  • Maximise number of good & outstanding CQC ratings
  • Get sector into financial balance

• Keep TDA regional model and align with NHS England local teams
FT pipeline: NHS Providers view

- Binary idea of FT / aspirant escalator where all reach top to deadline now dead

- A number of trusts will not become FTs – alternative solutions needed

- Twin pillars of FT’dom - appropriate autonomy and local accountability - as relevant today as ever

- FT authorisation process simulates valuable transformations whatever the external environment

- FT status appropriate for a colder climate and doesn’t prevent / inhibit move to new care models

- Expect announcement relatively soon: we believe everyone towards top of escalator should be supported to reach top as quickly as possible
What will we cover?

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Agency staffing

- Expected £3.5bn spend on temporary staffing in 2015/16 despite controls from Nov 2015 on:
  - Cap on price per hour of agency shifts
  - Organisation ceilings on temporary staffing spend
  - Reducing use of off-framework agreements

- Controls offer some help e.g. some health economies collaborating to hold the line within the internal market
  - Also recognise further efficiency opportunities possible from rostering, rota’ing, and increased clinical risk appetite for sub-acute patients (Lord Carter work)

- However we cannot
  - Assume supply of staff is elastic with respect to price – REC survey shows only 10% of agency nurses would come back to the NHS as a first preference
  - Assume price controls can solve more fundamental problems with supply and demand
VSM pay

Meeting with SofS – agreed to speed up approvals process

Meeting with DH to review data on level of VSM pay uplift

Guidance issued to trusts and FTs on VSM approvals process and reporting

Continuing to work with DH to unpick true level of VSM pay growth

VSM survey coming out shortly to RemCo Chairs
Need a clearer workforce narrative

Supply
- HEE workforce planning cycle & LETBs
- Move to self-funded nursing places without a training cap
- Shortage occupation list for migration
- Staff staffing council developing new approach to guidance
- Providers playing on the front foot (e.g. Lancashire Teaching & Milton Keynes)

Pay terms and conditions
- Need flexibility for staff (e.g. fit preferences on working patterns), affordability and seven day services
- Consultant contract
- Junior Doctors contract
- AfC

Roles
- Need training and development support for existing and future workforce
- New care models disrupting existing professional boundaries and relationships
- Royal Colleges being more flexible on who does what
- Advance nurse practitioners and physician associates at scale
- Education and training

Leadership
- Talent management
- Pipeline
- Change the operating environment and culture
What will we cover?

- Funding & finances
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Move to New Care Models: Board Thought Process

Running harder in existing model no longer an option

Need to do something different

Assess strategic options: vertical; horizontal; internal pathways

Create and deliver transformation programme

Strategic ferment
<table>
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<td><strong>Enhanced health in care homes</strong></td>
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Devolution

**Appetite is high.**
- By Oct 38 devo bids, of which 12 express interested in health & social care
- Manchester, Cornwall, West Mids, Liverpool and North East publicly interested to date
- NHS England & HMT criteria being developed to assess bids – set of principles rather than prescriptive

**Will need serious enablers**
- Some proposals will have an impact on commissioning architecture
- Regulatory change inc. unit of planning
- Tariffs and budget pooling
- Governance arrangements

**Bill will present menu of options for those interested – ‘but interest has to be real’**
- Integration
- Joint working and delegation
- Full transfer of functions

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We have been building on 20 years of relationships, stability and partnership working

(Greater Manchester strategy director at NHS Providers Annual Conference & Exhibition 2015)
Ten Things We Are Learning from New Care Models & Devolution

1. New, exciting and different things are starting to happen at scale and pace
2. This is more complicated and difficult than we thought
3. It will take longer than we thought: 5 to 10 years, not 3 to 5 years
4. Clear and rapid evidence on ability to improve patient outcomes
5. Little evidence on rapid and significant efficiency savings
6. Work needed on enablers: data; contracting; funding and governance models
7. Amount that needs to change is much larger than anticipated
8. Existing system framework prevents development of new care models
9. Until framework is changed/aligned, consistent adoption unlikely
10. Alignment across entire local health and care economy key but challenging
Moving from deep pessimism to some optimism....

- Recognition that impossible provider task doesn’t work
- Prioritisation of provider deficit recovery
- Spending Review 2016/17 outcome
- Time to develop efficiency and sustainability plans
- Move to New Care Models starting to work in Vanguards
- Taking responsibility for whole system does work
- System moving from regulation to support
- Recognition that more system leadership alignment needed
- Jim Mackey and Ed Smith
### But some major challenges to meet

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<th>A credible plan for the £22bn savings</th>
<th>Credible local system sustainability plans</th>
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<td>Delivering tough choices required for sustainability</td>
<td>String of workforce issues to solve</td>
<td>Can the system leader leopard really change its spots?</td>
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Winter 2015

Delivering tough choices required for sustainability

A credible plan for the £22bn savings

Credible local system sustainability plans

Can the system leader leopard really change its spots?

Sheer size of provider leadership task vs capacity

Coping with 1.5% p.a. funding increase 2010-20
Final thought

There is always a risk that financial pressures will drive rational organisational behaviours that are irrational for the system.

But the cake is only so big, and the crisis is not purely local. So if we don’t collaborate in partnership, in the end, although we might triumph in the short term, we can’t in the long term.

Professor Sir David Fish
MD UCL Partners
Q&A

THANK YOU