


Health and social care priorities for the Government: 2015–2020

Policy Briefing
June 2015

The start of the new Parliament provides the opportunity for political and health leaders to develop a long-term plan that puts the NHS and social care system on a sustainable footing. As part of our role to deliver evidence to support better health policy, the Nuffield Trust has produced this briefing, which outlines 10 key health and social care priorities for the new Government. It outlines the challenges we believe are critical to the longer-term success of the health and social care system, and which the new administration will need to prioritise. The briefing draws on our published and forthcoming research, expert opinion and insights from key figures in the health and social care system, including through our quarterly leaders' surveys. It follows a series of briefings we published in the run up to the 2015 general election.

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| | |
|-----------------------|----|
| Key points | 2 |
| ① Introduction | 3 |
| ② Funding and finance | 4 |
| ③ Quality of care | 9 |
| ④ New models of care | 13 |
| ⑤ Workforce | 15 |
| ⑥ Conclusion | 18 |
| References | 19 |

Key points

- **PRIORITY 1:** Address the funding crisis facing the NHS by:
 - developing a plan to enable NHS hospital trusts to achieve financial balance over the next two to three years
 - committing to bringing in the £8 billion minimum of extra funding smoothly over the course of the Parliament
 - demonstrating that this will be sufficient to support the transformation of services and to deliver on pledges such as moving to a ‘seven-day’ NHS
 - publishing the assumptions underlying the £22 billion of required efficiency savings.
- **PRIORITY 2:** Commit to a fundamental review of health and social care funding that involves all major political parties.
- **PRIORITY 3:** Review the problems in the management and culture of the NHS and work across organisations to set in place an action plan to tackle them.
- **PRIORITY 4:** Review the effectiveness of performance targets in the NHS, starting with the four-hour A&E target.
- **PRIORITY 5:** Tackle the imbalance experienced by those accessing mental health compared to physical health services.
- **PRIORITY 6:** Set out a credible and funded plan for improving people’s health and wellbeing through effective prevention of ill health.
- **PRIORITY 7:** Ensure that initiatives aiming to transform health and social care are adequately supported and evaluated, given time to succeed (or fail), and can be adopted in other areas.
- **PRIORITY 8:** Support and encourage the development of new care models in general practice and wider primary care.
- **PRIORITY 9:** Reconnect with the core NHS workforce in order that they are engaged and empowered.
- **PRIORITY 10:** Help the NHS implement successful workforce development and planning that realigns ways of working with the needs of patients.

1

Introduction

David Cameron's new Government takes office at a crucial time for the NHS and social care. The health service in England is embarking upon a major programme of change in order to meet the needs of a growing and ageing population. The *Five Year Forward View* (NHS England and others, 2014) describes how care needs to be transformed and sets out a range of new models with opportunities to use various innovations to achieve this.

Yet the new Government takes on a health and care system under significant pressure, with NHS finances at a tipping point and social care struggling from the effects of significant cuts. According to NHS England, meeting the health needs of the population will leave the NHS with a shortfall of £30 billion by 2020. The funding gap for adult social care over the same time period is estimated to be £4.3 billion (Local Government Association and ADASS, 2014).

Recent Nuffield Trust analysis suggested that a further 17,000 hospital beds would be needed over the next seven years unless more can be done to improve efficiency and enhance out-of-hospital care (Smith and others, 2014). Waiting times – often seen as the barometer of the health of the system – are lengthening in many areas.

How the Government chooses to navigate this complex territory over the early years of this Parliament will therefore have a lasting impact upon the long-term performance and sustainability of England's health and social care services.

This briefing outlines the Nuffield Trust's perspective on the priority areas for the new Government, drawing on our published and forthcoming research, expert opinion, and insights from key figures in the health and social care system, including through our quarterly leaders' surveys (Nuffield Trust, 2014a).

The briefing focuses on the NHS in England, given that health is a devolved matter. However, the Nuffield Trust has a strong track record in analysing the funding and performance of the four health systems of the UK. Further information on this can be found at <http://www.nuffieldtrust.org.uk/our-work/uk-international-comparisons>.

2

Funding and finance

Priority 1: Address the funding crisis facing the NHS by:

- developing a plan to enable NHS hospital trusts to achieve financial balance over the next two to three years
- committing to bringing in the £8 billion minimum of extra funding smoothly over the course of the Parliament
- demonstrating that it will be sufficient to support the transformation of services and to deliver on pledges such as moving to a ‘seven-day’ NHS
- publishing the assumptions underlying the £22 billion of required efficiency savings.

The immediate funding crisis

The current 2015/16 financial year is a cause for concern for all NHS organisations. A large and increasing number of hospital trusts are in deficit: in July 2014, the Nuffield Trust warned that hospital finances were weak and declining (Lafond and others, 2014), and figures just released by the health care regulators Monitor and the Trust Development Authority highlight a total deficit across NHS and Foundation Trusts of over £800 million in the last financial year (Monitor, 2015; NHS Trust Development Authority, 2015). NHS Providers, a membership association for public provider trusts, has predicted a collective deficit of over £2 billion across all NHS trusts by the end of the 2015/16 financial year (Hopson, 2015). Forthcoming research from the Nuffield Trust will suggest that there are many hospital trusts at risk of failure, but that there is an inadequate failure regime in place to manage this.

Clinical commissioning groups (CCGs) – the organisations responsible for planning and paying for local health care – are also under strain. Nuffield Trust analysis showed that almost one in ten CCGs ended 2013/14 in deficit (Lafond

and others, 2014), and there are signs that this number will increase in this financial year. As our recent briefing suggested, this could lead to financially distressed CCGs attempting to ration access to care – something that will be unpopular with the public and politicians alike (Edwards and others, 2015). In addition, services directly commissioned by NHS England were overspent by £347 million in 2013/14, driven by a growth in specialised services which are provided in relatively few hospitals (NHS England, 2014).

Financial strain is also evident in general practice, which has seen real-terms cuts in recent years, as have community and mental health services, and adult social care (Dayan and others, 2014). The coalition Government promised a further £1.6 billion for the NHS in England for 2015/16, with £250 million earmarked to improve and upgrade GP services. But it is unlikely that this will address the financial shortfall that is predicted by organisations such as NHS Providers.

Rather than forcing some provider trusts to resort to drastic measures to achieve financial balance by the end of the 2015/16 financial year, we would support a more managed transition to achieving financial balance over the next two to three financial years.

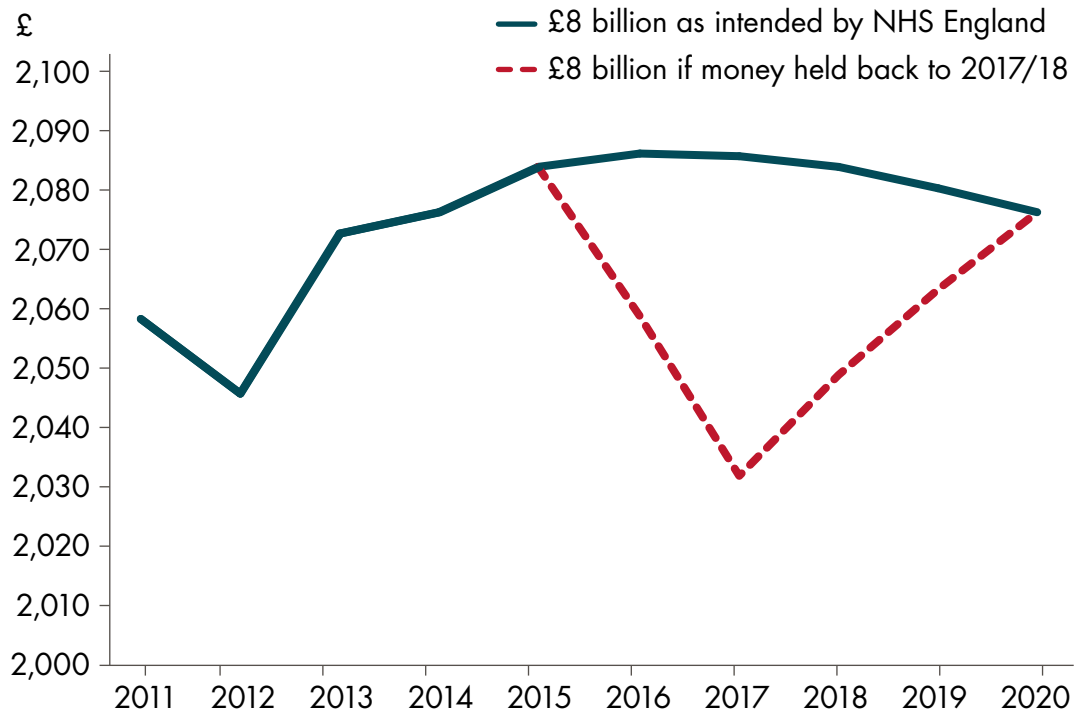
Phasing of the £8 billion extra funding

Looking further ahead, we welcome the Conservative Party’s manifesto pledge to provide real-terms increases in the NHS budget of at least £8 billion by 2020, but it is not clear when any of this additional funding will kick in (see Figure 1).

It is vital both from a sustainability and efficiency point of view that the Government commits to bringing in the extra funding smoothly over the course of the Parliament rather than back-loading it

NHS England has said that above-inflation increases should come in smoothly over the course of this Parliament. Any delay would leave the NHS unable to hold health spending flat in the early years of the Parliament, taking into account the age and size of the population (Dayan, 2015). This could lead to growing waiting lists and deteriorating services.

Figure 1: Projected annual NHS spending per age-adjusted person



Source: HM Treasury Public Expenditure Statistical Analyses (2014); Nuffield Trust analysis of cost curves provided by NHS England

A sudden increase in funds towards the end of the Parliament could also cause problems. History tells us that the NHS does not respond well to sudden increases in funding (National Audit Office, 2010), something demonstrated, for example, by the rapid pay inflation that occurred following the large injection of money in the early 2000s.

It is therefore vital both from a sustainability and efficiency point of view that the Government commits to bringing in the extra funding smoothly over the course of the Parliament rather than back-loading it.

Paying for additional drugs and services

This additional funding may now have to stretch a long way. The Conservative manifesto – backed up by a speech from the Prime Minister following the election on 18 May – set out ambitions for a seven-day NHS in both the acute sector and in general practice. This is the right goal: there is a higher risk of mortality in hospitals at weekends. A 24-hour, seven-day service will help to

improve the flow of patients through hospital. Extended opening hours in a larger number of GP surgeries is also a welcome aspiration.

Implementing a seven-day NHS will mean significant changes to the way services are run, it will require a critical mass of specialist staff to be recruited, and it may mean closures or mergers of local services

But the Government should be under no illusions about the scale of the challenge of implementing a seven-day NHS. It will mean significant changes to the way services are run across the country, and it will also require recruiting a critical mass of specialist staff. It may also mean closures or mergers of local services, such as emergency surgery or maternity units.

Furthermore, it will not be cheap. Recent estimates from the Healthcare Financial Management Association (HFMA) suggest that seven-day working in hospitals could cost between 1.5 and 2 per cent of a hospital trust’s annual income (HFMA and NHS England, 2013).

There are also likely to be other calls upon the additional funding, including new and expensive drugs. The high cost of sofosbuvir, a new and powerful hepatitis C drug, will pose a dilemma for NHS England, who are already under scrutiny for decisions about funding drugs for rare conditions (Lintern, 2015). The division of power between NHS England and the Department of Health may distance the Secretary of State from this decision but will not prevent pressure on the Government to fund new drugs from being exerted.

There is also the question of how the new care models identified in the *Five Year Forward View* can take shape while providers are so hamstrung by stretched resources. It is likely that the Government will need to identify a transformation fund to enable providers to ‘double run’ services for a period of time and adapt their care models. However, it is unclear whether the £8 billion will stretch to this.

Efficiency savings

Finally, the flipside of the £8 billion pledged for the NHS is that it depends on the health service achieving productivity gains of £22 billion by 2020. There is little detail from NHS England or from the Government about how

the service will deliver these or what proportion will release savings in terms of cash. NHS England Chief Executive Simon Stevens said on 18 May that this will be provided by his organisation in June (Health Service Journal, 2015) – this will be an important piece of analysis.

£22 billion: total productivity savings required in the NHS by 2020

The NHS knows it must stretch every pound further. But achieving productivity on the scale implied by the *Five Year Forward View* would be unprecedented. The majority of the £20 billion efficiency savings delivered as part of the ‘Nicholson Challenge’ during the 2010–15 parliament came from a combination of pay restraint, cuts to central budgets, cuts to the payment tariff, and the abolition of some regional and local tiers of management following the Health and Social Care Act 2012 (Appleby and others, 2014). But it is unclear how much more can be extracted from these approaches.

Priority 2: Commit to a fundamental review of health and social care funding that involves all major political parties.

The lack of any discussion on social care funding throughout the election campaign was an omission from all parties, despite social care for older adults experiencing a 16 per cent cut in funding since 2010 (Holder, 2014).

Although the 2014 Care Act has brought some much-needed clarity and consistency to social care entitlements, it will not end the rationing of social care, eliminate the fragmentation of health and social care, or change the illogical and unfair variations in access to NHS-funded continuing care.

The Conservative Party’s wider plans for continued fiscal consolidation imply further cuts to local authority budgets, which will inevitably put great pressure on social care – usually a local authority’s largest area of expenditure – and will have unknown knock-on effects for health care.

Finding an equitable and efficient solution to funding social care has been an unresolved public policy question that has troubled governments of all political persuasions for decades. We therefore recommend the Government commits to a fundamental review of health and social care funding involving all major parties.

3

Quality of care

Our QualityWatch programme with the Health Foundation examines over 300 indicators of care quality and produces a series of in-depth reports to provide an overview of how the quality of patient care is changing. In October 2014 we published an annual statement that suggested deteriorating performance in waiting times, mental health services and staff wellbeing (QualityWatch, 2014). Furthermore, when compared against other international health systems, the UK continues to lag behind other countries on outcomes for a number of key conditions. The coalition Government placed a welcome emphasis on quality and safety in the second half of the last Parliament, but we remain concerned that many performance indicators are pointing in the wrong direction.

Priority 3: Review the problems in the management and culture of the NHS and work across organisations to set in place an action plan to tackle these problems.

The last Parliament had a welcome focus on improved quality and safety following the multiple failings at the Mid Staffordshire NHS Foundation Trust and the report by Sir Robert Francis QC published in February 2013. Nuffield Trust analysis published one year later explored how hospitals had responded to the Francis Report. We found that many of the report's themes, such as the importance of openness, adequate staffing levels and patient-centred culture, had resonated with hospital leaders. However, financial pressures, a complex regulatory environment and a top-down, punitive management culture threatened progress (Thorlby and others, 2014).

More recently, we spoke to a small sample of senior staff (including chief executives) at hospital trusts, as well as commissioners, NHS England and the Trust Development Authority, to examine their views on how performance is managed in the urgent care system. Responses indicated that there was duplication of effort occurring among the various regulators overseeing system performance, which led to a significant amount of frontline management time expended on collecting information, responding to requests, linking with other

bodies, understanding multiple perspectives and encouraging collaboration between organisations (Edwards, 2015).

The coalition Government made some progress in identifying the management culture of the NHS as a particular problem. Don Berwick’s review into patient safety set out an important statement of what needed to happen (National Advisory Group on the Safety of Patients in England, 2013), and by commissioning Sir Stuart Rose to examine NHS management, the Department of Health appeared to be on the right track. However, it is regrettable that publication of the Rose Review has been delayed, and that there has been little concrete action to address the culture problems identified by Don Berwick.

This is a complex area and further evidence may be necessary to prompt action, so we recommend that the Government takes a twin approach to this issue. First, it should initiate a review into the management and regulatory culture in the NHS to explore the reasons for the top-down behaviours identified in our analysis and suggest ways to better balance autonomy for providers with the need to hold them to account. Second, it should bring organisations together across sectors, from regulators to hospitals, and involve patient groups to develop an action plan for improving the culture in the NHS.

Priority 4: Review the effectiveness of performance targets in the NHS, starting with the four-hour A&E target.

Targets in health care can be an effective way to manage performance if used sparingly, and for a few carefully chosen areas. They have been used successfully in the past to help identify failing systems, but they should never be used as a sole arbiter of care quality.

As demand for NHS services continues to rise, there is a risk that the emphasis placed on certain high-profile targets will detract from the quality of patient care, as regulators and politicians become preoccupied with seeking assurance from staff. This is very obviously the case at present with the four-hour A&E target.

Recent analysis published by the Nuffield Trust looked at how all 156 hospital trusts in England performed against six national targets over the course of the last Parliament (Dorning and Blunt, 2015). On the A&E target, we found that even hospitals in the top ten per cent for performance breached the four-hour target

in the third quarter of 2014/15. This indicates that problems are systemic rather than confined to a handful of poor performers.

There is an argument for taking a longer-term and broader view of A&E department performance. As politicians and regulators have focused disproportionately on this one measure of performance, it now looms over every other measure of how well patients with urgent needs are being cared for (Blunt and others, 2015). The new Government should revisit earlier plans explored by the coalition Government in 2010/11 to relegate the four-hour target in importance and explore ways of putting it on a more equal footing with other critical indicators, like trolley waits or time to treatment.

Priority 5: Tackle the imbalance experienced by those accessing mental health compared to physical health services.

It is clear that mental health services are under severe pressure. Our QualityWatch analysis found that inpatient services for mental health are becoming harder to access for both children and adults, with people experiencing mental ill health waiting almost twice as long for a consultation as people with physical ailments, and being a fifth less likely to have their first outpatient appointment within 18 weeks. In addition to growing waiting times for mental health services, there is also cause for concern regarding the physical health of people, the quality and availability of child and adolescent mental health services, and mental health support for people in acute and primary care.

The Conservative Party's manifesto commitment to enforce minimum standards of access and waiting times for mental health services is a good start, but the focus should not be on these issues in isolation. We urge the Government to explore ways to boost mental health services across the board, and use the NHS Mandate to drive up quality.

Priority 6: Set out a credible and funded plan for improving people's health and wellbeing through effective prevention of ill health.

The *Five Year Forward View* placed a considerable amount of emphasis on the importance of preventing ill health by using the NHS to encourage healthier lifestyles for patients (and its own staff) and by fully involving communities and the voluntary sector to transform public attitudes to wellbeing.

By contrast, the Conservative Party's **manifesto** was light on detail about its commitment to prevention. Given the multiple and immediate financial pressures facing curative services in the NHS and the likely future cuts to local authorities (who are responsible for public health), there is a real risk that the *Five Year Forward View's* vision for prevention will not be achieved. But unless sustained investment goes into prevention, many of the assumptions behind the long-term financial viability of the NHS (including whether £8 billion will be enough) are at risk.

It is vital that the Government sets out a credible plan for keeping more people healthy for longer. Compared with many other countries, the UK could do more to incentivise employers to take more active steps to improve the wellbeing of employees and their families. Policies should be explored to provide incentives and sanctions to encourage this.

4

New models of care

Priority 7: Ensure that initiatives aiming to transform health and social care are adequately supported and evaluated, given time to succeed (or fail), and can be adopted in other areas.

There are a range of projects under way to trial new ways of working across health and social care, from NHS England’s 29 ‘vanguards’ to the devolution experiment in Manchester and the Government’s Better Care Fund. It is right that the NHS should be embarking upon this kind of change at a local level, with the transition driven by local clinicians and managers working closely with patients, rather than being imposed from the centre.

Politicians must avoid the temptation to draw premature conclusions from the schemes, and we urge them instead to give these projects time to develop and adapt. Some may fail but this must not be seen as a failure of the entire approach

There is no shortage of ideas about how to design and manage better services, but the NHS lacks a consistent approach to effectively monitoring innovation and there is a shortage of reliable evidence regarding which of the ideas makes progress towards the desired outcomes. The Nuffield Trust has considerable expertise in examining information to evaluate health and social care projects and to help spread best practice. Our experience suggests that planning and implementing large-scale service changes takes time, requires strong working relationships and will not necessarily save money. The 29 vanguard projects established under NHS England’s *Five Year Forward View* are at a very early stage of development. Politicians must avoid the temptation to draw premature conclusions from the schemes, and we urge them instead to give these projects time to develop and adapt. Some projects may fail but this must not be seen as a failure of the entire approach. It is important that robust learning from the pilots is generated and disseminated to different parts of the health service so that they too can benefit from the experiences of the vanguards.

While pooling health and social care budgets – as Manchester is about to do and Better Care Fund areas have already done – might be the right thing to do in principle, we are wary of linking it to quick financial savings. Such approaches might create opportunities for financial savings over the longer term, but such savings are far from guaranteed, and bringing together the budgets of two services will not reverse the long-term funding problems of social care. An additional concern is that the money currently available for research, education and training (around £5 billion in total) will be siphoned off to front-line services.

Priority 8: Support and encourage the development of new care models in general practice and wider primary care.

Developing new ways of working and building new models of care around the needs of patients is important in all areas. However, transforming the care that patients and the public receive outside of hospital needs to be a particular priority. Shifting care out of hospitals into the community has been a long-running policy goal but, despite the rhetoric, there has been little progress and funding for out-of-hospital care. Funding for general practice in particular has lagged behind the hospital sector.

To achieve this there will need to be a step change in services offered through GP surgeries and community care. However, with general practice facing a looming workforce crunch caused by a potential shortfall in GP numbers, real financial pressures and a growing primary care workload, there is a clear need to embrace change. Scaled-up general practice, better use of existing skills such as pharmacists or practice nurses, and developing innovative working arrangements with other health or social care providers in the area should all be pursued.

As with the other care models being explored, it will be important to strike the right balance between allowing new GP organisations the freedom to experiment and test new ways of working without undermining accountability to the taxpayer. Politicians should also be mindful of the need to evaluate such projects to understand what works – trialling different approaches and disseminating the learning from them, rather than applying a ‘one size fits all’ model, will be crucial to the future of general practice.

5

Workforce

Over 1.4 million people work in the NHS in England and a further 1.5 million work in the social care sector. Together they account for one in ten of the working population. Staff are therefore the health and social care system's most valuable resource, yet we enter the new Parliament with significant workforce challenges ahead: many staff in health and social care feel undervalued, the NHS is struggling to attract and retain high-quality leaders, and there is a misalignment between existing ways of working and the needs of patients.

Priority 9: Reconnect with the core NHS workforce in order that they are engaged and empowered.

The effect of five years of pay restraint, growing demand for health care services and increasing complexity of patient need has left the NHS workforce feeling undervalued. Many NHS organisations are struggling to recruit and retain clinical staff and staffing costs are being inflated by the use of agency and locum staff. Significant gaps are also forecast in some staff groups such as GPs, while an oversupply is forecast in others such as pharmacists. One in ten training places in general practice is unfilled (Dayan and others, 2014) and, at board level, one third of hospital trusts have reported vacancies (Janjua, 2014).

In the hospital sector, public sector pay policies have combined with a drive to increase staffing levels brought about by the Francis Inquiry to result in a growing reliance on temporary or agency staffing, particularly in nursing. Recent Nuffield Trust analysis described a 20 per cent growth in spending on temporary staff in one year (Lafond and others, 2014). NHS and Foundation Trust spending on contract and agency staff increased by £800 million in the last financial year (Monitor, 2015; NHS Trust Development Authority, 2015).

There has also been a rise in staff stress. Analysis of the NHS Staff Survey for our QualityWatch programme demonstrated that the proportion of NHS staff reporting stress-related illness rose by a tenth, from 28 per cent in 2008 to 38 per cent in 2013, reversing a declining trend prior to 2008 (QualityWatch, 2014).

NHS England figures suggest that workload and staff shortages may contribute to the problem: the 2014 NHS Staff Survey reported that 44 per cent of respondents felt that they were unable to manage conflicting demands on their time and 47 per cent said that there were not enough staff to enable them to do their job properly.

An engaged and empowered NHS workforce will be crucial for meeting the multiple challenges ahead for the health service, including the efficiency challenge and the move to seven-day services. However, staff burnout is becoming a significant risk in many settings. Politicians must think carefully about how to reconcile the need to develop and encourage the workforce with the inevitable political desire to maintain ‘grip’ on the NHS when the financial situation continues to deteriorate. We recommend that the Government prioritises reconnecting with the NHS workforce and ensuring staff feel valued in their work. The reliance on agency staffing also needs to be reduced.

Priority 10: Help the NHS implement successful workforce development and planning that realigns ways of working with the needs of patients.

Successful workforce planning should also ensure that we have the right number of staff with the right skills in the right place at the right time. Yet the professional health care workforce has been trained to work in a model based on acute episodes of care at a time when the greatest demands on the health and social care system come from older people with multiple long-term conditions who need care for their mental and physical health, as well as social care needs.

Manifesto pledges to recruit a specific number of doctors or nurses may do more harm than good. Targets may ultimately leave significant workforce gaps and miss opportunities to deploy staff differently

Developing more generalist skills in secondary care, more specialist skills in primary care, and more resources in primary and community care to support the increasingly complex needs of patients would be a way forward. But we have seen precisely the opposite clinical workforce trends.

Between 2004 and 2014 the number of hospital doctors grew by 44 per cent (Health and Social Care Information Centre, 2015) and, while the number of GPs per 100,000 population across England increased from 54 in 1995 to 62 in 2009, it has now declined to 59.5 (Health Education England, 2014). Between 2001 and 2011 the number of community nurses fell by 38 per cent (Royal College of Nursing, 2013).

Cuts in social care mean that this area is facing growing workload pressures too. Poor terms and conditions coupled with demanding yet sensitive tasks make social care a difficult area for retaining staff (Centre for Workforce Intelligence, 2013). In domiciliary care, around 30 per cent of staff leave their jobs each year. By 2025 there could be a shortfall of over 600,000 care workers (Skills for Care, 2014).

But manifesto pledges to recruit a specific number of doctors or nurses may do more harm than good. Targets may ultimately leave significant workforce gaps and miss opportunities to deploy staff differently. Workforce issues vary across the country and require local solutions.

The Government should be reviewing workforce plans and encouraging opportunities to deploy staff in different ways, including changing the skill mix and/or upskilling staff, to address these challenges and improve the quality of care. We recommend the Government sets a clear strategy for training the new workforce and supporting the existing workforce, and makes clear its long-term plans on staff pay.

6

Conclusion

The start of the new Parliament provides the opportunity for political and health leaders to develop a long-term plan that puts the NHS and social care system on a sustainable footing. The *Five Year Forward View* provides the NHS leadership’s own plan and there is much to support in this vision. While it does not provide all the answers, we would urge politicians to work with the grain of the *Forward View* and support the local innovation and experimentation that will follow from the vanguards in particular.

The financial outlook for the NHS – not to mention for social care services – is a significant cause for concern, and, as our QualityWatch programme has shown, we are now seeing worrying signs that historic gains in quality are going into reverse, particularly around waiting times, mental health services and staff wellbeing.

How politicians respond to this challenge will be critical. We have outlined some of the more immediate approaches that we would recommend. However, more generally, we would also encourage further thinking on the mechanisms for creating change that are deployed during this Parliament. The NHS has become fixated with the use of targets, micro-incentives and punitive approaches, which are an attempt to continue to try and manage care services in detail. Directives and requirements enforced by regulation have also been overused.

But the approach to change outlined in the *Forward View* requires more organic and locally tailored approaches. For these approaches to be successful, there will need to be experimentation, risk taking, and time and space for clinical and managerial leaders to do the work. It will require a shift in mind-set away from central control. It will also require an engaged and empowered NHS workforce. Politicians must therefore think carefully about how to reconcile the need to develop and encourage the workforce with the inevitable political desire to maintain ‘grip’ on the NHS when the financial situation continues to deteriorate.

We do not underestimate how difficult this will be for political and health system leaders – especially given the deteriorating financial outlook and the need to maintain standards of quality. However, it is essential that we move to a more empowering, bottom-up approach while at the same time holding health care leaders to account for the care their organisations deliver to patients and service users.

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