Parliamentary briefing on health service announcements

NHS in transition: Key questions

What are some key questions as a new phase of reforms is announced for the NHS?

- What is being published?
- What is the scale of the financial challenge the NHS faces?
- How well is the NHS responding to the savings challenge?
- Are these savings sustainable?
- What is the impact of the financial squeeze on the quality of services?
- Will greater integration of health and social care take the pressure off the NHS?
- Has the reorganisation resulting from the implementation of the 2012 Health and Social Care Act made things worse?
- Who is now responsible for the NHS?

The coming weeks will see the release of the Government's full response to the Francis Inquiry into Mid Staffordshire hospital, and a set of related announcements which will make this an especially important period for parliamentary scrutiny of policy on the NHS. This briefing is designed to provide background for parliamentarians, and to outline key questions on the response to Francis, and the related announcements that have either taken place or are expected in the near future. Its purpose is to inform parliamentarians of the wider context facing the NHS, by drawing on the evidence from our research, and to enable parliamentarians to ask informed questions about what the collective impact of these multiple initiatives might be, particularly from the perspective of local NHS organisations.

The Nuffield Trust is an authoritative and independent source of evidence-based research and policy analysis to improve health care in the UK. Our independence and expertise mean we are well placed to be a source of expert and impartial analysis for parliamentarians, the media and others. We monitor the quality of care, track the flow of public funds into and within the NHS, and evaluate the costs and benefits of new initiatives in the NHS. We also analyse and monitor the implementation of the NHS reforms in England. More details on our work can be found on our website.

There is a profusion of reports and initiatives coming from central NHS bodies, including the Department of Health, NHS England, the CQC and Monitor, which relate to a broad range of NHS activities. Some of these publications are the consequence of action taken in response to the publication of the Francis Inquiry while others represent the output of new structures set up as part of the 2012 Health and Social Care Act.

Major Upcoming Reports and Announcements in the NHS

Bureaucracy and Regulatory Review (NHS Confederation). Week of November 11th. This report commissioned by the Secretary of State will examine the burden which demands for data collection place on NHS bodies, and how this could be reduced without losing valuable information. More detail here.

Transforming Urgent and Emergency Services in England (NHS England). Week of November 11th. This will look into issues including the pressure facing A&E, and the consistency of services over the course of the week. More detail here.

State of Care (CQC). Expected on November 21st. This will give an overview of the quality of care that the CQC's new inspection regime has found in health and social care.

Full Response to the Francis Inquiry (Department of Health)**.** Expected on November 19th. This will lay out in full Government plans to improve quality in the NHS, drawing on the reports above as well as earlier reports including the Keogh review of hospital mortality, and the Clwyd/Hart review of complaints.

Vulnerable Older People's Plan (Department of Health). December. This will lay out a strategy to improve care for frail elderly people, who are at the heart of concerns about quality of care and joint working between different organisations. It will be important in informing the new direction of the updated Mandate published on November 12th. More detail here.

Taken as a whole, these reports and initiatives raise legitimate questions about the state of quality in the NHS and point to the areas which need improvement. They also indicate that the health service is moving away from the decentralised model outlined in the Health and Social Care Act, as the Government tries to exercise more control to drive focus on these key areas. Ongoing Nuffield Trust fieldwork has highlighted that many people in the NHS feel that the volume of central instruction can be overwhelming, and parliamentarians should look closely at whether the balance between central and local accountability is right.

Our experts will be responding to many of the upcoming reports and announcements, including the Government's full response to the Francis inquiry. We would be happy to discuss these issues further with you and can be contacted via Mark Dayan in the press and public affairs office at mark.dayan@nuffieldtrust.org.uk, or 0207 462 0538.

What is the scale of the financial challenge the NHS faces?

Although the NHS has been given small real terms increases in its budget since 2010 (unlike most other government departments), the rising trend in demand for services and the cost of health inputs means that the NHS has been faced with a large gap between what it needs to deliver and the resources available to it. In 2009, this gap was estimated to be equivalent to £20 billion between 2010 and 2015 and meant that the NHS is expected to 'save' about 4% of its budget each year.

Recent research by the Nuffield Trust suggests the NHS will need to make savings of this magnitude until 2020 if budgets remain tight and demands on the NHS continue to grow on their historical trend. Savings on this scale, for this amount of time, are unprecedented in the history of the NHS.

How well is the NHS responding to the savings challenge?

Overall, the NHS has met, if not exceeded its financial targets for the first two years of financial austerity, under spending its budget by £2.1bn in both 2011/12 and 2012/13. This money has been returned to the Treasury.

However, targets have largely been met through real terms pay cuts and reductions in the "tariff" price paid to hospitals for procedures. NHS England has said that there is a limit to how much more can be saved here without risks to quality of care. Meanwhile, there is already evidence of growing financial problems at the level of local organisations, such as hospitals and mental health trusts. These are clustered in particular areas, for example outer London and the West Midlands.

The 60 acute hospital trusts which do not yet have "foundation" status (giving them greater independence) tend to be worse off financially. Nearly half of these trusts are forecasting a deficit this year. Originally it was intended that all trusts would be Foundation Trusts (FTs) by 2014/15. This now seems impossible. Monitor, the organisation in charge of approving trusts for FT status, requires trusts to demonstrate their financial health by achieving a 5% profit before tax and depreciation are taken into account. However, 42% of non-FTs are below this level and the underlying trend is downwards. Many FTs, especially smaller hospitals, also fall below this level, and FTs overall are also seeing these earnings fall year on year. Larger numbers of hospital trusts will start to experience severe financial difficulty if these patterns continue.

Our submission to the Health Select Committee's inquiry on public expenditure contains more detail. With respect to commissioning, the most recent report from NHS England suggests that although commissioning as a whole is still forecast to make a small surplus in 2013/14, 24 CCGs are now forecasting an in-year deficit.

The strategies used to generate savings within hospitals include centrally driven initiatives (notably freezing pay for most categories of NHS staff and reducing the national fixed prices paid to hospitals for episodes of treatment) alongside locally agreed 'cost improvement plans', which might incorporate a range of tactics, from streamlining administrative costs to finding cheaper ways to deliver clinical services.

Are these savings sustainable?

It is critically important that any savings made by the NHS are sustainable over the long term. For savings to be considered fully 'sustainable', a number of conditions need to be met. NHS bodies should not be overly dependent on meeting the financial targets set through one-off actions (for example, the sale of premises that can only be sold once), or non-recurrent injections of cash (for example, emergency funding from outside sources). Freezing NHS pay has proved successful in the short run, but may have a negative impact on staff morale and on the ability of the NHS to recruit staff if wages in the private sector begin to recover in the future.

More substantively, sustainability implies a shift in the investment and distribution of services. People need to be supported to stay healthy for as long as possible, which implies that there should be adequate investment in general practice and other "primary care", and in "community care" where people are taken care of in their own homes. When treatment is needed, it needs to be the most cost-effective possible, regardless of where it takes place. The most costly care – typically hospital based care – should ideally be used only when necessary, and non-hospital based alternatives should be encouraged, provided that they can help patients for less cost.

A sustainable response to the financial squeeze, therefore, is likely to require some changes in the number and type of services available locally – tilting the system away from traditional acute hospitals towards primary and community based care.

It is not clear that such changes are yet taking place on a large scale. A study by the Nuffield Trust into PCT spending between 2009/10 and 2011/12 found that the hospital sector is continuing to increase, albeit more slowly, while spending on GP services had declined by 1.2% over the same period. There has been a large and sustained increase in spending on 'community services', although it is not clear what this comprises as data collected on community services is poor.

Overall, we agree with the conclusions reached by the National Audit Office and the Health Select Committee in their analysis of spending up to 2012/13: we have yet to see evidence of a substantial shift of resources away from the hospital sector. We explore the possible reasons for this below.

What is the impact of the financial squeeze on the quality of services?

Analysis of a range of existing indicators of health care performance and quality by the Nuffield Trust and the Health Foundation for a new research programme – QualityWatch – shows that the quality of many aspects of NHS services is holding up. In terms of hospital care, waiting times for inpatient and outpatient care have remained low, rates of hospital acquired infections have continued to fall, and most patients continue to report a positive experience of care.

However, there are some signs that the system is coming under pressure, particularly in relation to the health needs of older patients. There is more demand for hospital A&E services, which led to more people waiting for more than the recommended four hour period in 2013. Our research has also shown a 26% rise in the overall rate of emergency admissions for conditions which are potentially avoidable – conditions such as asthma and pneumonia – between 2001 and 2013. Rates continued to rise between 2010/11 and 2012/13.

The 27 conditions which fall into this category account for a fifth of total emergency admissions, and rates have been growing amongst the older (over 65) age group. It is not clear what is driving this increase, but poor access to preventive services (from primary, community and social care services) is likely to be an important factor.

Although many indicators of quality for the NHS as a whole demonstrate that access and quality are not declining, there is evidence of serious problems at individual trusts. Quality of care at 14 trusts was reviewed in detail by Sir Bruce Keogh. Identifying and rectifying such failings through a tighter process of regulation is now the focus of the new Chief Inspector of hospitals (and other chief inspectors for general practice and social care), part of a rejuvenated and more rigorous regulation process by the CQC, which will also oversee a new process of public ratings of hospitals.

In our review of ratings, commissioned by the Secretary of State for Health, we argued that ratings have the potential to improve care, but there are pitfalls if they are implemented badly, for example distracting management effort within hospitals and distorting effort on what is measured, at the expense of aspects of care which are harder to measure. These concerns still stand and it is important to underline that regulation and ratings alone cannot drive out poor practice in the NHS.

It will be vital for the government to understand how well the multiple bodies which now have a role in monitoring quality are working together. Poor communication and muddled accountability was identified as a particular problem by Robert Francis QC in his report on Mid Staffordshire NHS Foundation Trust. Many of the bodies that existed at the time have changed substantially or been abolished (such as Strategic Health Authorities). In our response to the Francis Inquiry we pointed out that there was a risk that same confusion might have been replicated in the reformed NHS, and our concerns remain.

Will greater integration of health and social care take the pressure off the NHS?

Although the financial squeeze on the NHS could translate into pressure on the quality of (and access to) services for all age groups, there are concerns that services used by the growing number of people surviving into old age with chronic conditions will come under the most intense pressure, particularly emergency admissions for conditions where better primary and community services could avoid the need for an individual to go to hospital. These conditions include diabetes, chronic heart conditions and chronic obstructive pulmonary disease.

Improving the coordination of care for patients who have several conditions has been a policy objective for many years, and the coalition government has made better joined-up working between different parts of the NHS and social care a priority. In addition to giving the NHS a legal duty to "integrate" services in the 2012 act, the government is rolling out a programme of Pioneers (recently announced). It has also set up the Integration Transformation Fund (ITF) which from 2015 will enable the transfer of £3.8 billion, drawn mostly from the NHS budget, to joint projects involving the NHS and local authorities.

The logic underlying these projects is that investment in better coordination between (and within) health and social care services will take the pressure off the NHS, particularly attendance at A&E departments and emergency admissions to hospitals

The evidence underpinning this assumption is ambivalent. The Nuffield Trust has conducted over 30 evaluations of community based interventions designed to reduce hospital admissions through greater integration of services. In a recent overview of those evaluations we found that the vast majority have not reduced admissions (although there may have been other benefits, such as improved patient experience). The one exception was investment in end of life care delivered by

Marie Curie. Although some of these initiatives could prove successful over the longer term, policy-makers consistently underestimate the time and leadership skills needed.

Another potentially limiting factor is the intense financial pressure facing local authorities which fund adult social care, such as care homes and support workers at home. Funding for local government has been reduced by 14 per cent in real terms between 2011/12 and 2014/15, and in 2013 the Government announced a further 10 per cent reduction for 2015/16. This has resulted in local government having to reduce the eligibility for, and generosity of, social care packages for older people. It is not clear whether the additional NHS funding will enable a transformational change, or simply plug some of the big financial gaps in local authority social care funding.

Although data is shared between the NHS and social services locally, the scope to link patient and user records and histories is limited. This means it is often impossible to tell whether an admission is the result of poor quality care in social services, primary acre or community care or some combination of the three.

Has the reorganisation resulting from the implementation of the 2012 Health and Social Care Act made things worse?

Since 2011/12 the NHS has implemented a complex and wide ranging reform programme which has created over two hundred new local commissioning groups, Health and Wellbeing Boards at local authorities, and several new central bodies, including NHS England, Public Health England and HealthWatch. There has been an expansion to Monitor's remit, as the economic regulator for the NHS.

There is as yet no systematic evaluation of the impact of the new system, many parts of which only began formally operating in April 2013. Our work on the factors that enable success in previous models of commissioning (PCTs) and the evolution of new models of general practice have shown that it is vital that organisations have good quality leadership that is given adequate time and space to develop.

The Nuffield Trust has published a report on the early development of Clinical Commissioning Groups (CCGs), one of the key elements of the NHS reforms that was intended to drive change through greater involvement of GPs in the spending of NHS resources. Our research, based on case studies of six CCGs in the run up to going 'live' in April 2013, found that the authorization process was very demanding, but that there was broad support for the principle of clinical commissioning amongst GPs. There was, however, considerable uncertainty about how the relationship between CCGs and NHS England would develop, and some respondents were concerned that a 'top down' mentality would reappear, which the reforms were designed to reverse.

Viewed from the perspective of local NHS organisations, whether providers or commissioners, the scope for autonomous development and service redesign is at risk from the complexity of the new system and the scale of the initiatives and guidance coming from the centre.

The understandable concerns emanating from the Francis report have led to new plans or guidance being drawn up for the care of vulnerable older people in all care settings. This has included a much more intensive process of quality inspection led by the CQC, and initiatives affecting the opening hours of GPs, urgent care, action on dementia and hospital safety, the details of which are expected soon.

These overlay a growing body of guidance from Monitor governing the behaviour of providers and commissioners in relation to procurement and competition, which potentially affects decisions about new GP-led initiatives to provide more services through to clinical networks and hospital mergers.

Who is now responsible for the NHS?

A decade ago, the Chief Executive of the NHS was responsible for its day-to-day running, while the Secretary of State for Health provided political accountability to Parliament and taxpayers. While this system was heavily centralized and allowed for considerable political interference, it had the virtues of simplicity and a line of responsibility for success or failure. Following the recent reorganisation, accountability for the NHS has become less simple.

Responsibility is now shared between NHS England and its Local Area Teams, the Care Quality Commission (CQC), Monitor, The Trust Development Authority, Public Health England, and the Secretary of State at the Department of Health. Meanwhile, local authorities are now in charge of public health, while the Competition Commission makes many important decisions about how and whether NHS trusts can merge and work together.

This means that high-level guidance and policy often comes from several different bodies. For example, both the Department of Health and NHS England are currently working on strategies for primary care. At a local level, meanwhile, multiple bodies often need to work together to examine and reform failing trusts.

The Nuffield Trust has argued that taxpayers and patients have a right to know who to hold accountable for money spent and care provided on their behalf. In public and in the press, the Chief Executive of NHS England is often seen as the chief executive of the health service as a whole, and is held to account for success of failure. In reality, he is in charge of just one of six key central bodies: an important question is whether he actually has the power to affect the outcomes for which he is held responsible.

evidence for
better health care

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