REFORM

Progress on NHS reform

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#NHSreform

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Executive summary

The *Five Year Forward View* is a compelling vision for reform. By changing the way services operate, NHS England aims to deliver better care with less resource. It estimates that the NHS must become 2-3 per cent more productive each year to close the funding gap by the end of the decade. This report collects available evidence on the progress towards those ambitions over this Parliament.

In a number of areas the NHS has made improvements. After a decade of unprecedented increases in funding, the health service has managed under the pressure of flat budgets and rising demand. Patient satisfaction is at an all-time high. The NHS has become more efficient. Patient choice has been extended to primary care, mental health services and community care. The first hospital has been put into special administration and the failure regime extended to primary care. There has been the first new entrant into the provider market (Hinchingbrooke). The Integration Pioneers and the Better Care Fund represent real steps forward in the integration agenda. Transparency on data and outcomes has greatly increased.

However the balance of evidence suggests a less positive picture. Savings have been made through short term efficiencies and not sustainable reform to services. When looking across the NHS, there has been disappointing progress towards a more sustainable workforce, a more integrated health service, greater capacity in out of hospital care, greater use of alternatives to A&E, and greater competition and patient choice.

NHS reform: Progress report

	Reform objective	Progress
Slow progress	Reduction in hospital beds	Beds reduced by 5.2 per cent 2010-11 to 2014-15, but at a slower rate than during the previous decade.
Mixed picture	Failure regime	In place but insecure. Little evidence the new system is turning around struggling providers or acting as a disincentive to fail.
	A smaller workforce	Reductions in staff numbers between 2010 and 2012 were offset by staff increases of 2.2 per cent between 2012 and 2014.
	Competition	Spending on non-NHS providers has risen but from a low base, from 8.5 in 2010-11 to 9.1 per cent in 2013-14.
	Efficiency	The NHS has become more efficient through short term savings, but not transformational change. This has left a funding gap of up to £22 billion by 2020.
Stalled or in reverse	Patient choice	No improvement in patient awareness of choice. Number of patients offered choice shows signs of decline.
	Innovation in how care is delivered	Rising use of alternatives to A&E stalled over the last five years.
	Coordination of care	Number of days lost to delayed transfers from acute care has risen by almost two thirds.
	A more flexible workforce	New flexibilities rejected in 2012.
	Local flexibility	Number of organisations at national and regional level more than doubled.
	Investment in out of hospital care	General and acute services receives 45.5 per cent of all care purchased, rising by £4.7 billion since 2009-10.

This lack of progress is affecting NHS performance against key measures. Visits to A&E departments and emergency admissions have grown considerably over the last five years; A&E waiting times have reached a decade high; and hospital bed occupancy is high and rising.

The NHS is also showing increasing signs of financial distress. Hospital deficits are expected to total more than £800 million in 2014-15, with 62 per cent of acute hospitals already in the red. By the time of the Autumn Statement in 2014 the health service was in need of an additional £2 billion in funding compared to the 2010 settlement.

There is now widespread recognition that the NHS must reform further and faster than ever before. As Simon Stevens has argued, "We are at a pivotal moment. Either we move to something different or we begin to see services run into the sand." The next Government must do better to accelerate NHS reform.

1
Measures of health reform

The need for health reform is now widely acknowledged and there is growing consensus around the direction of travel. The *Five Year Forward View* has put forward the NHS' plan to address the financial, demographic and quality challenges it faces. It estimates that the NHS must become 2-3 per cent more productive each year to close the funding gap by the end of the decade.[1] The ambition is to raise efficiency and manage demand through:

- New, more integrated models of care.[2]
- A "radical upgrade" in prevention and public health. This will mean harnessing patients and communities as a source of "renewable energy" in their own care.[3]
- And innovation in care delivery and the workforce.[4]

Reaching this "better future" for the health service will require root and branch reform to the way care is currently delivered:

- Greater coordination between primary, secondary, mental health and social care.[5]
- Raising the efficiency of struggling providers ("catch up") and improving efficiency across the board ("frontier shift").[6]
- The redesign of services to shift care from hospitals to other settings.[7] As a result of this redesign and efforts to moderate future demand, this will mean fewer hospital beds.[8]
- Greater choice for patients over where and how they receive care.[9]

Reform argues that achieving this goal of a high quality, high value NHS will also require:

- Competition to drive efficiency and to give patients choice between a number of high quality providers.[10]
- Costing half the budget, a sustainable NHS cannot be achieved without a sustainable workforce. This must mean a smaller and more flexible workforce, matched to patient demands.[11]

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1 On the basis of £8 billion in additional funding.

2 "The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need… There is now quite wide consensus on the direction we will be taking: increasingly we need to manage systems – networks of care – not just organisations; out-of-hospital care needs to become a much larger part of what the NHS does; services need to be integrated around the patient." NHS England (2014), *Five Year Forward View*.

3 "Sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and underdeveloped advocacy and action on the broader influencers of health and wellbeing. As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments… The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health." NHS England (2014), *Five Year Forward View*.

4 "We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will improve the NHS' ability to undertake research and apply innovation – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch." NHS England (2014), *Five Year Forward View*.

5 "The NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care." NHS England (2014), *Five Year Forward View*.

6 "Our ambition, however, would be for the NHS to achieve 2 per cent net efficiency gains each year for the rest of the decade – possibly increasing to 3 per cent over time….It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector)…" NHS England (2014), *Five Year Forward View*.

7 "Out of hospital care needs to become a much larger part of what the NHS does." NHS England (2014), *Five Year Forward View*.

8 "It would require … moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years." NHS England (2014), *Five Year Forward View*.

9 "We will make good on the NHS' longstanding promise to give patients choice over where or how they receive care." NHS England (2014), *Five Year Forward View*.

10 Cawston, T. et al (2012), *Healthy Competition*, *Reform*.

11 Cawston, T. et al (2012), *Doctors and nurses*, *Reform*.

The *Five Year Forward View* also sets out that for this change to be effective and lasting, it must be nationally enabled but ultimately locally led. This “meaningful local flexibility” would create an NHS less subject to national control and solutions.

This paper aims to assess progress over the course of the Parliament in achieving sustainable reform to NHS services against these measures of progress.

2
Health reform in a cold climate

Table 1: NHS funding this Parliament, £billion, 2013-14 prices
Source: HM Treasury (2014), *Public Expenditure Statistical Analyses 2014.*

	2010-11	2011-12	2012-13	2013-14	2014-15
Department of Health, total DEL	105.6	105.7	107.0	109.7	110.6

The 2010 Spending Review announced that the NHS budget would be ring-fenced following a decade of unprecedented growth in funding. The Spending Review also detailed specific items of expenditure including an annual cancer drugs fund, a ring-fenced public health budget and continued funding for priority hospital schemes.[12] The allocation was made on the premise that as healthcare costs continued to grow, the NHS would achieve efficiencies of £20 billion by 2014-15. The NHS was not to be "immune" to the challenges facing the public finances, "but far from being reason to abandon reform, it demands that we accelerate it."[13]

NHS spending has as a result grown on average 1.2 per cent a year from 2010-11 to 2015-16. This compares to an average increase of 6.3 per cent each year in the previous decade. However, this represents relative protection. The average department by contrast (excluding the Department of Health) has seen its budget cut by 15.3 per cent over the course of the Parliament.[14]

"NHS spending has grown on average 1.2 per cent a year from 2010-11 to 2015-16. This compares to an average increase of 6.3 per cent each year in the previous decade."

The 2010 Spending Review recognised the importance of social care "to keep people healthy and independent" and announced additional resources for local authorities to maintain access and fund new services. The social services grant would increase and the NHS would provide additional funds to support the care system. In the 2013 Spending Review the Better Care Fund allocated further funds to be transferred from the health service to social care. Nonetheless, social care spending has decreased by 26 per cent between 2010 and 2014.[15]

12 HM Treasury (2010), *Spending Review.*
13 Department of Health (2010), *Equity and Excellence: Liberating the NHS.*
14 Adam, S. et al. (2015), *The IFS Green Budget,* The Institute for Fiscal Studies.
15 Local Government Association (2014), *Adult social care funding: 2014 state of the nation report.*

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Current status

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Investing in out of hospital care

Table 2: Spending on health services 2009-10 to 2012-13 as percentage of total spend
Sources: Department of Health (2009-13), *Annual Reports and Accounts.*

Area of spending	2009-10	2010-11	2011-12	2012-13
Primary health care	24.8%	24.4%	24.2%	23.4%
Secondary health care	74.9%	75.5%	75.5%	76.4%
General and acute	44.2%	44.4%	45.0%	45.5%
Community health services	9.5%	9.6%	10.2%	10.6%
Mental illness	9.6%	9.6%	9.6%	9.6%
Learning difficulties	3.0%	2.9%	1.6%	1.5%
Maternity	2.9%	2.9%	2.9%	2.8%
Accident and emergency	2.4%	2.5%	2.6%	2.7%
Other	3.3%	3.5%	3.5%	3.6%

Note: Data on funding for hospital services, mental health and community services has not yet been published for 2013-14.

"Meeting the changing needs of an ageing population requires greater investment in primary, community and more preventative services."

Meeting the changing needs of an ageing population requires greater investment in primary, community and more preventative services. The *Five Year Forward View* set out that "one of the most important changes will be to expand and strengthen primary and out of hospital care."[16] Instead hospital services continue to receive the largest proportion of funding (see Table 2). In 2012-13 general and acute services received £41.8 billion, equivalent to 45.5 per cent of all care purchased. This represents a real terms increase of £4.7 billion since 2009-10. Between 2009-10 and 2012-13, funding for all main components of secondary care, including those in mental and community health, increased at an average rate of 2 per cent.

Spending on primary care, mental illness and learning disability services has either reduced or increased much slower. Spending on GP services fell at an average rate of 1.3 per cent in real terms from 2009-10 to 2013-14.[17] Even when support in primary care is taken into account, only 13 per cent of the NHS budget goes on treating mental health conditions despite mental illness accounting for a quarter of the total burden of disease.[18] Local authorities were found to spend on average less than £40 million annually on preventative mental health.[19]

16 NHS England (2014), *Five Year Forward View*.
17 Lafond, S. (2015), *Current NHS spending in England,* The Health Foundation.
18 NHS England (2014), *Five Year Forward View*; The Centre for Economic Performance (2012), *How mental illness loses out in the NHS*, London School of Economics.
19 Mind (2014), "Mind reveals 'unacceptably low' spending on public mental health", accessed February 2015 , http://www.mind.org.uk/news-campaigns/news/mind-reveals-unacceptably-low-spending-on-public-mental-health/#.VRBZGo6sVql.

Service change

Table 3: Overnight beds in England, 1990 to 2015
Source: NHS England (2015), *Bed Availability and Occupancy Data – Overnight.*

	1990-1 to 1994-5	1995-6 to 1999-00	2000-1 to 2004-5	2005-6 to 2009-10	2010-11 to 2014-15
Total reduction in beds	43,667	19,846	5,125	16,975	7,412
Per cent change	17.1%	9.6%	2.8%	9.7%	5.2%

Note: 2010-11 to 2014-15 excludes Q4 2014-15 due to lack of data.

“While there has been a 5.2 per cent reduction in the number of beds this Parliament, the pace of change has been slower than in recent decades.”

Hospitals are at the core of the health and care system, yet successive studies have demonstrated that between 15 and 40 per cent of patients admitted to hospital or A&E could be cared for in another setting.[20] A key measure of how far and fast services are changing is therefore the number of hospital beds. By ensuring patients get the “right care, at the right time, in the right setting from the right caregiver”, the Nuffield Trust has estimated that this could avoid the need for another 17,000 hospital beds over the next five years, equivalent to 34 extra 500 bedded hospitals.[21]

Over the last 20 years the total number of beds in the NHS has fallen by a third, with the greatest reductions taking place in mental health services and geriatric care. While there has been a 5.2 per cent reduction in the number of beds this Parliament, the pace of change has been slower than in recent decades (see Table 3).

The limited progress in reducing the hospital estate is a consequence of some of the Coalition’s policies. Following the General Election, the Department of Health imposed a moratorium on all hospital closures and cancelled the long term reconfiguration of hospital services in London.[22] The Secretary of State outlined four new tests for future reconfiguration.[23] While the vast majority of proposed changes would meet these tests and the moratorium was soon lifted, opposition to proposed changes by local MPs and councils has continued.[24]

20 The College of Emergency Medicine (2013), *The drive for quality – How to achieve safe, sustainable care for our Emergency Departments?*; Bosanquet, N. et al. (2010), *Fewer hospitals, more competition, Reform*.
21 Smith, P. et al (2014), *NHS hospitals under pressure: trends in acute activity up to 2022, The Nuffield Trust*.
22 BBC Online (2010), “NHS London chairman quits over government policy change”, 26 May.
23 The four tests which existing and future reconfiguration proposals had to demonstrate were: support from GP commissioners; strengthened public and patient engagement; clarity on the clinical evidence base; consistency with current and prospective patient choice. Department of Health (2010), “Health Secretary outlines vision for locally led NHS service changes”, Press release, 21 May.
24 BBC Online (2013), “Chris Grayling MP’s fear for Epsom and St Helier hospitals”, 1 May; *Manchester Evening News* (2013), “A&E at the birthplace of NHS downgraded”, 25 January; Health Service Journal (2013), “Judge blocks review of reconfiguration scheme,” 11 October; *Health Service Journal* (2014), “Second challenge to Mid Staffs downgrade,” 30 May.

Alternatives to A&E

Table 4: A&E attendance by Department Type
Source: NHS England (2015), *Quarterly A&E England time series 2004-05 onwards*.

Year	Type 1 Departments – Major A&E	Type 2 Departments – Single Speciality	Type 3 Departments – Other A&E/Minor Injury Units
2005-06	72.3%	3.5%	24.3%
2006-07	71.9%	3.3%	24.8%
2007-08	70.2%	3.4%	26.3%
2008-09	68.5%	3.5%	27.9%
2009-10	66.4%	3.2%	30.4%
2010-11	65.2%	3.1%	31.8%
2011-12	65.2%	3.0%	31.8%
2012-13	65.6%	2.9%	31.6%
2013-14	65.3%	2.9%	31.9%
2014-15	65.4%	2.8%	31.8%
Change 2005-6 to 2009-10	-5.9%	-0.2%	+6.1%
Change 2010-11 to 2014-15	+0.2%	-0.3%	+0.0%

Note: 2014-15 as of Q3. Percentages may not tally due to rounding.

"As demand has risen and efforts to shift patients elsewhere have stalled, there were an additional 250,000 major A&E attendances in the last three months of 2014 compared to the same period in 2010."

A significant number of patients attending A&E could be treated elsewhere. 40 per cent of patients attending A&E require no treatment.[25] One million visits each year are thought to be avoidable, while a survey commissioned by HealthWatch England found that nearly a fifth of people admitted to using A&E for a non-emergency issue.[26] There have therefore been a number of efforts in recent years to divert patients away from A&E to more clinically appropriate and cost-effective alternatives. NHS England has laid out plans to redesign urgent and emergency care services "to integrate between A&E departments, GP out of hours services, urgent care centres, NHS 111, and ambulance services" and make sure "patients get the right care, at the right time, in the right place."[27]

In the previous decade progress was made, with the proportion of patients using major A&E units falling by 5.9 per cent between 2005-6 and 2009-10 (see Table 4). This Parliament progress has stalled, instead rising by 0.2 per cent. The proportion of patients using urgent care alternatives, such as walk in centres, has remained unchanged this Parliament after rising by 6.1 per cent in the previous 5 years. As demand has risen and efforts to shift patients elsewhere have stalled, there were an additional 250,000 major A&E attendances in the last three months of 2014 compared to the same period in 2010.[28]

There is growing evidence that suggests the NHS is not providing the high quality, accessible alternatives to A&E or out of hospital care that is needed. As the Care Quality Commission has recognised, there is a widespread variation in the quality of primary care.[29] Access to GPs during normal hours is becoming more difficult, with 16 per cent of

25 NHS England (2013), *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England.*
26 HealthWatch (2014), "Nearly a fifth confess to knowingly using A&E for non-emergencies", 4 March.
27 NHS England (2014), *Five Year Forward View.*
28 NHS England (2014), *A&E quarterly activity statistics, NHS and independent sector organisations in England, 2014-15 Quarter 2.*
29 Care Quality Commission (2014), *The State of Health Care and Adult Social Care in England 2013/14.*

patients in 2013-14 having to wait a week or more for an appointment, up from 13 per cent in 2011-12 (see Table 5). This has a direct impact on A&E. Recent evidence suggests one in ten people unable to get a GP appointment went to A&E in 2013, equivalent to six million A&E attendances.[30]

Table 5: Accessibility of general practice, 2011-12 to 2013-14
Source: NHS England (2011-2014), *GP patient survey.*

	2011-12	2012-13	2013-14
Not easy to get through on phone	18	22	24
Fairly or very dissatisfied with opening hours	7	8	10
Appointment 1 week or more later	13	15	16
Couldn't get an appointment at all	9	10	11
Waited more than 15 minutes in surgery	8	10	12

"More than a third of walk in centres have either been closed or had their service reduced or modified since 2010."

In recent years there has been rising concern about poor and varied access to out of hours care. With only 57 per cent of patients aware of how to contact out-of-hours GP services, there is significant public confusion.[31] While there has been some recognition that community pharmacists could also act as an alternative source of health advice, patients remain unaware of their expanded role.[32] More than a third of walk in centres have either been closed or had their service reduced or modified since 2010.[33] As Monitor's review of walk in centres concluded, patients continue to "default to A&E" as they are forced to turn to the only available, rather than most appropriate, service.[34]

Online and telephone triage services have been operating in the NHS for over a decade and aim to take pressure off primary care and acute services. NHS Direct had a marginal impact on services, receiving 4 million calls in 2012-13, with 35 per cent requiring referral to urgent or emergency care.[35] In 2014 NHS 111 received 12.4 million calls, however the majority were directed to a GP (50 per cent) or to A&E (15 per cent, or 1.9 million attendances).[36] According to the President of the College of Emergency Medicine, this contributed to A&E pressure in early 2015. Dr Clifford Mann told the Health Select Committee, "Of the 450,000 extra attendances in the last year, 220,000 were advised by NHS 111 to come to the emergency department, and for another 220,000 an ambulance was dispatched to them by NHS 111. If you put those figures together, you have more than 95 per cent of the rise in type 1 attendances."[37]

30 *The Times* (2015), "6m go to A&E after failing to see their GP", 9 December.
31 Ipsos MORI (2013), *The GP Patient Survey: Summary Report*.
32 NHS England (2013), *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England.*
33 Monitor (2014), *Walk-in centre review: final report and recommendations.*
34 Ibid.
35 NHS Direct National Health Service Trust (2013), *Annual Report & Accounts 2012/13*.
36 Blunt, I. et al. (2015), *What's behind the A&E 'crisis'?*, The Nuffield Trust.
37 Health Select Committee (2015), "Oral evidence: Accident and emergency services", 14 January.

Choice and competition

Table 6: Spending on independent providers, 2013 prices

Source: Department of Health (2010-14), *Annual Report and Accounts*; Monitor (2006-14), *NHS Foundation Trusts: Consolidated Accounts*; BBC News Online (2014), "A third of NHS contracts awarded to private firms – report", 10 December.

	2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	2012-13	2013-14
Total expenditure on healthcare from non-NHS bodies £ million	5,471	6,582	7,292	8,157	8,982	9,203	9,657	10,018
Non-NHS bodies as % of total expenditure	6.8%	7.4%	7.7%	7.9%	8.5%	8.7%	9.0%	9.1%
Private providers as % total expenditure	2.8%	3.4%	3.9%	4.4%	4.9%	5.3%	5.5%	6.1%

"Although spending on non-NHS bodies has risen, it remains a small proportion of total spending."

In 2010 the NHS White Paper laid out reforms to encourage greater diversity of providers and ensure "competition stimulates innovation and improvements, and increases productivity within a social market".[38] The Department of Health stated an ambition to create "the largest and most vibrant social enterprise sector in the world".[39]

The reality has been very different. Although spending on non-NHS bodies has risen, it remains a small proportion of total spending at 9.1 per cent; that spent on the private sector is just 6.1 per cent (see Table 6). Much of the increase is attributable to rises in non-NHS providers in community health services, instigated by reforms under the previous government, and diversity of provision within mental health. Between 2011-12 and 2012-13, expenditure on non-NHS providers in these sectors grew 34 per cent and 15 per cent respectively.[40] Meanwhile the increases in spending on non-NHS providers of acute care has slowed. While spending on acute care by non-NHS providers (including ISTCs and other private providers) rose on average by 6.7 per cent each year from 2010-11 to 2012-13, in 2012-13 increased expenditure on non-NHS providers halted, with PCTs spending £14 million less in real terms compared with 2011-12.[41]

Rather than opening up healthcare to new entrants, there has been only one private sector takeover this Parliament. Monitor has identified factors such as an unstable commissioning environment and limited data as continued barriers to entry.[42] The Office of Health Economics found that private providers face a cost disadvantage equivalent of 12 to 15 per cent of total costs compared to NHS providers.[43]

38 Department of Health (2010), *Equity and Excellence: Liberating the NHS*.
39 Ibid.
40 Nuffield Trust (2014), *Into the red? The state of the NHS' finances: an analysis of NHS expenditure between 2010 and 2014.*
41 Ibid.
42 Monitor (2013), *A fair playing field for the benefit of NHS patients.*
43 Office of Health Economics (2012), *Competition in the NHS.*

There remains widespread hesitation within the NHS when it comes to the role of competition. A survey of CCGs in 2012 found that only 50 per cent were planning to make greater use of competition and 30 per cent identified competition as a barrier to change.[44] Analysis by the *British Medical Journal* found that only 6 per cent of contracts were subject to competitive tender in 2013-14.[45] According to one survey, 42 per cent of CCGs did not open any new services to any qualified provider in 2013-14 and 60 per cent had no plan to do so in 2014-15.[46] While a third of contracts in England have been tendered to private sector providers since April 2013, this represents just 5 per cent of the total value of all contracts.[47]

"The number of patients recalling being offered such a choice has declined this Parliament from 49 per cent in 2010 to 38 per cent in 2014."

Part of this hesitation is the result of the regulatory framework around competition. There are concerns that competition law is too lengthy and costly a process, with Sir David Nicholson arguing the NHS is "bogged down in a morass of competition law" that is not working to improve quality for patients.[48] The Dalton Review identified that the perception of competition and legislative issues can cause organisations to become "overly risk averse."[49] Looking forward, The King's Fund has warned that uncertainty among commissioners and providers regarding how competition rules operate in practice could hinder the development of new models of care.[50]

Patient choice

Surveys consistently show patients value choice and control in their health and care. The *Five Year Forward View* pledged to "make good on the NHS' longstanding promise to give patients choice over where or how they receive care." The Coalition ambition to ensure "no decision about me, without me" has seen the expansion of patient choice in secondary, primary, maternity and mental health care this Parliament.

Yet despite the extension of the right to choice, many patients remain unaware of their right.[51] While the number of patients aware they had a choice of hospitals for their first outpatient appointment had risen from 29 per cent in 2006 to 50 per cent in 2010, this has now stalled at 51 per cent in 2014.[52, 53] Moreover the number of patients recalling being offered such a choice has declined this Parliament from 49 per cent in 2010 to 38 per cent in 2014.[54] Outpatient appointments made through the electronic booking system "Choose and Book" fell from 54 per cent at the start of the Parliament to 53 per cent in 2014, though the impact of the expected transfer to an e-referral system is difficult to quantify.[55] There is considerable variation in use across the country, from 87 per cent in Devon and Cornwall down to 17 per cent in Surrey and Sussex.[56]

Efforts to increase choice in community services appears to have made similarly little progress. A review by Monitor revealed 90 per cent of patients did not recall being offered a choice of hearing care provider and fewer than one in four patients were aware that choice was available. The regulator found GPs were often unaware of the ability for patients to choose provider, had limited knowledge of the options available or felt confident in making the choice on behalf of the patient.[57]

44 *Health Service Journal* (2013), "Interest in franchise model has 'waned dramatically'", 18 February.
45 Iaobucci, G. (2014), "A third of NHS contracts awarded since health act have gone to private sector, BMJ investigation shows", *British Medical Journal*, 10 December.
46 *Health Service Journal* (2014), "Exclusive: CCG interest in 'any qualified provider' scheme dwindles", 11 September.
47 Ibid.
48 Health Select Committee (2013), *2013 accountability hearing with Monitor.*
49 Dalton, D. (2014), *Examining new options and opportunities for providers of NHS care.*
50 Ham, C. and Murray, R. (2015), *Implementing the NHS five year forward view: aligning policies with the plan,* The King's Fund.
51 Monitor (2014), *Investigation into the commissioning of elective services in Blackpool and Fylde and Wyre: Final report*.
52 Department of Health (2010), *Report on the National Patient Choice Survey – February 2010 England.*
53 NHS England (2014), "Patient choice: survey reveals more needs to be done", Press release, August 7.
54 Ibid.
55 NHS England (2014), *Choose and book utilisation reports (2010 – 2014).* Author's calculation.
56 NHS England (2015), *Choose and book utilisation report: 25 January 2015.*
57 Monitor (2014), *NHS adult hearing services in England: exploring how choice is working for patients.*

> **"In the wake of significant opposition to the Health and Social Care Bill in 2011-12, there has been a marked retreat from competition and choice as levers for driving improvement in services."**

The retreat from competition and choice

At the start of this Parliament, the Coalition set out to place competition and choice at the heart of health reform to improve the quality, efficiency and responsiveness of services to patients. In the wake of significant opposition to the Health and Social Care Bill in 2011-12, there has been a marked retreat from competition and choice as levers for driving improvement in services:

- In 2011, Ministers and Number 10 began to attack competition when "it undermined the NHS."[58]
- In April 2011, the definition of a new entrant was changed from "Any Willing Provider" to "Any Qualified Provider". The subsequent Any Qualified Provider framework was dramatically downscaled to a limited number of community and health services.[59]
- In February 2012, Sir David Nicholson claimed "there will be no question of introducing price competition", and the Bill was amended to remove any possible reference to allowing providers to compete on price.[60]
- Clauses in the Bill banned any policy that would increase the market share of private providers, changed Monitor's role so increasing competition was no longer an objective and removed its power to require existing providers open up their facilities to new providers.[61]
- The *Five Year Forward View*, published in October 2014, made no mention of competition or the role of the private sector.[62]
- In an interview with the *British Medical Journal* in November 2014, Simon Stevens said "The figure quoted is that 94p of £1 of care is delivered by NHS providers. For some things, patient choice is going to create some permeability there, but that's not going to be the central driver of change or improvement…My firm prediction is that the vast majority of care will continue to be provided by NHS providers."[63]
- In November 2014, the Health Secretary Jeremy Hunt argued "there are natural monopolies in healthcare, where patient choice is never going to drive change," and questioned whether "the market will ever be able to deliver" integrated out of hospital care.[64]

58 Speaking to the House of Commons to announce a pause in the passage of the Health and Social Care Bill in April 2011, Andrew Lansley said that "People want to know that private companies cannot cherry-pick NHS activity, undermining existing NHS providers, and that competition must be fair. Under Labour, the private sector got a preferential deal, with £250 million paid for operations that never happened. We have to stop that"; HM Government (2011), *Working together for a stronger NHS*.
59 Health Service Journal (2011), "'Any qualified provider' guidance to slow market expansion", 14 April.
60 Department of Health (2011), "Equity and Excellence: Liberating the NHS – managing the transition", Letter, dated 17 February 2011.
61 Department of Health (2011), *Government response to the NHS Future Forum report*.
62 NHS England (2014), *Five Year Forward View*.
63 Iacobucci, G. (2014), "Simon Stevens: the man charged with saving the NHS," *British Medical Journal*, 18 November.
64 *Health Service Journal* (2014), "Exclusive: Patient choice is not key to improving performance, says Hunt", 26 November.

Workforce

Table 7: NHS Headcount, England
Source: HSCIC (2015), *NHS Staff 2010-14 Overview.*

	2010	2011	2012	2013	2014	Headcount change	% change
All doctors	141,326	143,836	146,075	147,807	150,273	8,947	6.3%
Total qualified nursing staff	375,950	372,277	369,868	371,777	377,191	1,241	0.3%
Total qualified scientific, therapeutic & technical staff	151,607	152,216	153,472	154,109	155,960	4,353	2.9%
Qualified ambulance staff	18,450	18,687	18,645	18,734	18,673	223	1.2%
Support to clinical staff	356,410	347,064	343,927	348,999	360,402	3,992	1.1%
NHS infrastructure support	233,342	219,624	215,071	211,185	212,123	-21,219	-9.1%
Other GP practice staff	112,985	110,593	113,832	114,223	115,520	2,535	2.2%
Other non-medical staff or unknown classification	356	266	237	220	209	-147	-41.3%
Total headcount	**1,387,191**	**1,361,533**	**1,358,295**	**1,364,165**	**1,387,692**	**501**	**0.0%**

Note: Headcount totals are unlikely to equal the sum of components due to some staff working in more than one role.

"Between 2011-12 and 2012-13, the wage bill for these staff grew 19.5 per cent – the largest source of increased expenditure for NHS trusts and foundation trusts."

Over the last decade the growth in the NHS workforce was the largest in the public sector. Between 2000 and 2010 total headcount increased by over 300,000, almost a third.[65] Staff costs are estimated to account for two thirds of NHS providers' total expenditure. The Government acknowledged at the start of the Parliament that containing the costs of healthcare meant the size of the NHS workforce would have to decline. As the 2010 White Paper put it, "as a result of the record debt, the NHS will employ fewer staff at the end of this Parliament; although rebalanced towards clinical staffing and front-line support rather than excessive administration. This is a hard truth which any government would have to recognise."

The first half of the Parliament saw some progress. By 2012, NHS headcount had fallen by 2.1 per cent, with considerable reductions in the number of managers and clinical support staff (see Table 7). However the pace of change slowed towards the end of this period, and by 2013 the downward trend reversed altogether. In the wake of the Francis Inquiry, new NICE guidance on safe staffing ratios and a requirement to publish ward staffing levels, providers started hiring again. From 2012 to 2014 total headcount grew 2.2 per cent, while the number of support staff increased 3.3 per cent in 2014 alone.

In addition, as the NHS struggled to recruit permanent staff, spending on temporary staff rose sharply. Between 2011-12 and 2012-13, the wage bill for these staff grew 19.5 per cent – the largest source of increased expenditure for NHS trusts and foundation trusts.[66] Spending on temporary staff as a share of total staff spending rose from 8 per cent to 10 per cent from

65 Bassett, D. et al. (2011), *Reformers and wreckers*, *Reform.*
66 Lafond, S. et al. (2014), *Into the red? The state of the NHS' finances,* Nuffield Trust.

2010-11 to 2013-14.[67] This trend has continued into 2014-15, with foundation trust expenditure on contract and agency staff in Q1 double the amount planned.[68]

The right workforce

While the workforce as a whole has grown rapidly since 2000, NHS England has warned that "these increases have not fully reflected changing patterns of demand."[69] Shifting care out of hospitals will require a rebalancing of the workforce as well as services, yet the vast majority of clinical professionals continue to work in acute hospitals, with hospital consultants increasing around three times faster than GPs.[70] Traditional community nursing roles such as district nurses and health visitors are in long term decline. Similarly, difficulties in recruiting staff to mental health and learning disabilities fails to correspond with the pattern of patient demand. In primary care, there is a shortage of GPs and an oversupply of pharmacists yet thus far limited attempts to expand the role of community pharmacies and pharmacists in other care settings. Across the workforce, while patients with multiple conditions require a generalist clinical approach, there is a growing trend towards a more specialised workforce.[71]

A flexible workforce

"The NHS has continued to rely on national pay restraint and national pay bargaining to control workforce costs."

Pay, terms and conditions have also not been reformed. The NHS White Paper stated that "pay decisions should be led by healthcare employers rather than imposed by government." A survey of NHS HR directors found that 95 per cent favoured further changes to pay, terms and conditions.[72] However the NHS has continued to rely on national pay restraint and national pay bargaining to control workforce costs. Early in the Parliament, a consortium of 20 employers from the South West announced plans to reform pay and conditions and reduce costs. Progress collapsed when the Chancellor announced in 2012 regional pay would not proceed.[73]

This Parliament pay costs have been contained through national freezes and caps. As the Institute for Fiscal Studies (IFS) has noted, this will prove difficult to sustain as wages recover across the economy.[74] The OECD recently concluded more could be done to address the "excessive remuneration" for staff such as general practitioners.[75] The Department of Health has recognised the need for "the modernisation of national pay frameworks" to ensure "there is a better balance between pay, performance and productivity, rather than time served."[76] The shift towards seven day working is likely to require further changes to medical contracts and pay in the next Parliament.[77]

67 Lafond, S. (2015), *Current NHS spending in England*, The Health Foundation.
68 Monitor (2014), *Performance of the foundation trust sector: 3 months ended 30 June 2014.*
69 NHS England (2014), *Five Year Forward View.*
70 Ibid.
71 Bohmer, R. and Imison, C. (2013), *NHS and social care workforce: meeting our needs now and in the future?,* The King's Fund
72 *Health Service Journal* (2013), "HR Directors Barometer: Workforce chiefs seek further cuts to pay, terms and conditions", 30 May.
73 BBC News Online (2012), "NHS regional pay plan halt welcomed in South West", December 5.
74 Adam, S. et al. (2015), *The IFS Green Budget*, The Institute for Fiscal Studies.
75 OECD (2015), *OECD Economic Surveys, United Kingdom February 2015.*
76 Department of Health (2014), *NHS Pay Review Body Review for 2014 - Written evidence from the Health Department for England – September 2013.*
77 *Health Service Journal* (2015), "Exclusive: NHS Employers reveals plans to overhaul contracts", 13 January; *The Guardian* (2015), "NHS staff 'unsocial hours' payments under threat", 9 January.

Efficiency

Table 8: QIPP savings
Source: The Health Foundation (2015), *Current NHS spending in England.*

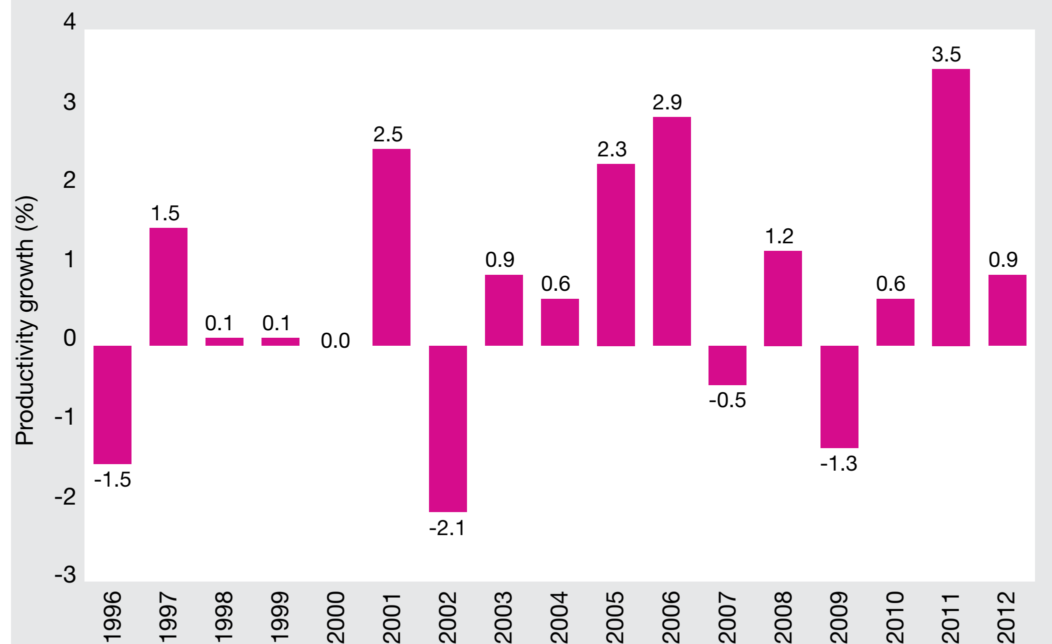
Year	Saving £bn, cash terms	Saving £bn, 2014-15 prices
2011-12	5.8	6.1
2012-13	5.0	5.2
2013-14	4.3	4.4
2014-15 (forecast)	4.8	4.8
Total	19.9	20.5

"Since 2009 it has been widely recognised that NHS spending is failing to keep pace with rising demand."

Since 2009 it has been widely recognised that NHS spending is failing to keep pace with rising demand.[78] To address this gap, in 2009 Sir David Nicholson tasked the NHS with delivering £15-20 billion of efficiencies by 2014-15, savings to be reinvested in front line care.[79]

Judged against this original target, the NHS is on track (see Table 8).[80] However, as John Appleby of the King's Fund has noted, while this headline target has been achieved, the NHS has not become sufficiently more efficient to meet the future twin pressures of rising demand and cost.[81] Annual UK healthcare productivity growth improved from an average of +0.6 per cent in 1995-2009 to +1.6 per cent in 2010-12 (see Figure 1).[82] Nonetheless, these gains fall short of 4 per cent annual productivity growth the King's Fund and the IFS estimated the NHS needed to achieve to close the gap between funding and need.[83] As a result, the NHS required £2 billion in additional funding in the 2014 Autumn Statement, of which £1.5 billion went towards front line services.

Figure 1: UK healthcare annual change in productivity, 1996-2012
Source: ONS (2015), *Public service productivity estimates: Healthcare*, 2012.



78 Appleby, J. et al (2009), *How cold will it be? Prospects for NHS funding: 2011-17*, The King's Fund
79 *The Daily Telegraph* (2009), "NHS chief tells trusts to make £20bn savings", 13 June.
80 Lafond, S. (2015), *Current NHS spending in England,* The Health Foundation.
81 Appleby, J. (2015), "UK NHS: Less money (but more bangs per buck)?", British Medical Journal, 10 March.
82 ONS (2015), Public service productivity estimates: Healthcare, 2012.
83 McKinsey & Company (2009), Achieving world class productivity in the NHS 2009/10 – 2013/14: detailing the size of the opportunity.

As the scale of the funding gap became clear, in 2013 NHS England extended their estimate of the productivity improvements required:

> "Our analysis shows that if we continue with the current model of care and expected funding levels, we could have a funding gap of £30 billion between 2013-14 and 2020-21, which will continue to grow and grow quickly if action isn't taken. This is on top of the £20 billion of efficiency savings already being met. This gap cannot be solved from the public purse but by freeing up NHS services and staff from old style practices and buildings."[84]

On leaving his post in 2014, Sir David Nicholson concluded that, even with the efficiencies achieved on his watch, "The NHS in its current form is unsustainable."[85]

"There has been an over reliance on the one off effects of cost savings rather than transformational change to the way services operate."

The wrong savings

Moreover the level of savings has fallen over the course of the Parliament (see Table 8). This is the result of over reliance on the one off effects of cost savings rather than transformational change to the way services operate. Reductions to the tariff and a national pay freeze were responsible for 44 and 16 per cent respectively of the first two years of QIPP savings (see Table 9). Providers have already begun to push back against tariff squeezes while wage restraint will be increasingly difficult to sustain as real wages recover in the next Parliament.[86]

Table 9: QIPP savings by method

Source: Health Select Committee (2013), *Public expenditure on health and care services*.

QIPP saving method	2011-12 (£m)	2012-13 (£m)	Per cent of Year 1-2 savings
Tariff efficiency	2,400	2,400	44.2%
Pay restraint	850	850	15.7%
Administration costs	7171	163	8.1%
Demand management	675	200	8.1%
Prescribing	417	472	8.2%
Primary care, dental and ophthalmic costs	255	194	4.1%
Other	501	757	11.6%
Total	**5,815**	**5,036**	

By contrast sustainable reform to services has barely begun, according to the Health Select Committee.[87] In their review of NHS hospital efficiency savings, the Audit Commission found "there had been no significant change in the way that trusts operate."[88] A recent study found the average acute provider to be 10 per cent less efficient than the most efficient provider in the sector. If the average provider became as efficient as the 60th percentile provider, further efficiency gains of between 0.9 per cent and 1.2 per cent a year could be achieved.[89]

84 NHS England (2013). "The NHS belongs to the people: a call to action," Press release.
85 *The Guardian* (2014), "NHS chief David Nicholson offers tough medicine as he stands down" 12 March.
86 Dowler, C. (2015), "Hospital objections scupper controversial 2015-16 pricing plans", *Health Service Journal,* 29 January. Adam, S. et al. (2015), *The IFS Green Budget*, The Institute for Fiscal Studies.
87 Health Select Committee (2014), *Public expenditure on health and social care.*
88 The Audit Commission (2012), *NHS financial year 2011/12.*
89 Lafond, S. (2015), *Current NHS spending in England*, The Health Foundation.

"Evidence suggests that, on current trend, the NHS will struggle to sustain productivity improvements in future years."

Reports by Monitor and the Trust Development Authority show that trusts are finding it increasingly difficult to identify and realise savings. Evidence suggests that, on current trend, the NHS will struggle to sustain productivity improvements in future years:

- Hospitals are falling behind on their cost improvement plans, with foundation trusts 20.6 per cent behind forecast savings.[90]
- Hospitals are becoming increasingly reliant on one off savings to realise CIP plans. In 2013-14, the proportion of non-recurrent savings made by foundation trusts increased by 30 per cent.[91]
- In 2013-14 commissioners only achieved 2 per cent savings, compared to the 4 per cent needed, with the largest shortfall coming under the "transformational" heading.[92]
- The proportion of CCG finance directors concerned about delivering their QIPP plans increased by over 10 per cent in the last 6 months alone.[93]
- 53 per cent of NHS Trust finance directors feel concerned about achieving their cost improvement plans for the year.[94]

90 The King's Fund (2014), *Quarterly Monitoring Report October 2014*.
91 Monitor (2014), *Performance of the foundation trust sector: 9 months ended 31 December 2014.*
92 Lafond, S. et al. (2014), *Into the red? The state of the NHS' finances,* Nuffield Trust.
93 Healthcare Financial Management Association (2014), *NHS Financial Temperature Check.*
94 The King's Fund (2014), *Quarterly Monitoring Report.*

Dealing with failure

The Coalition inherited a large hospital estate with many failing providers in urgent need of change and committed to end “bail-outs for organisations which overspend public budgets”. [95] Turning around struggling health economies and matching the performance of the least efficient providers with the best (“catch up”) is a key part of NHS England’s strategy to raise productivity.[96] The introduction of a failure regime was designed to both provide the incentives for leaders to manage their finances effectively and provide a mechanism to restore those providers which fail to return to good financial health.

This Parliament providers have been put under unprecedented financial and clinical pressure with the tariff heavily reduced and standards of quality, safety and staffing put under renewed scrutiny. A growing number of providers have been pushed to the brink as a result:

“In the first three-quarters of 2014-15 the Department of Health spent £841 million on bailouts, already exceeding its 2013-14 total.”

- Between 2006-07 and 2013-14, the Department of Health gave NHS trusts and foundation trusts a total of £1.8 billion in cash support, of which just £160 million has been repaid.[97]
- Since 2008 the Foundation Trust “pipeline” has slowed down with just 18 trusts making the transition this Parliament and only 4 since May 2014. [98] Nearly half of NHS Trusts have been assessed to have no “independent future” by the Trust Development Authority.[99]
- In October 2011, the Department of Health identified 20 Trusts whose “clinical and financial stability is at risk” and announced a package of £1.5 billion to support hospitals facing “onerous” PFI payments.[100]
- The National Audit Office has reported that at least 20 NHS Trusts are not clinically or financially viable in their present form.[101] In 2014 Sir David Dalton, following his review into new organisational models, concluded 20-30 trusts will need to be taken over or run by a franchise.[102]
- In 2013-14 the Department of Health spent £760 million on bailing out trusts in deficit. In the first three-quarters of 2014-15 the Department of Health spent £841 million on bailouts, already exceeding its 2013-14 total.[103]
- A small number of failing hospitals remain responsible for a disproportionate amount of NHS deficits. Of the 41 foundation trusts that ran deficits in 2013-14, 16 made up nearly two thirds of the reported gross deficit value.[104]

95 NHS England (2010), *Equity and Excellence: Liberating the NHS.*
96 NHS England (2014), *Five Year Forward View.*
97 National Audit Office (2014), *The financial sustainability of NHS bodies.*
98 NHS England (2011), *NHS (England) Summarised Accounts 2010 - 2011*; Trust Development Authority (2014), *Annual report and accounts for the period 1 April 2013 – 31 March 2014.* Four trusts have been authorised subsequent to the TDA’s report: Bridgewater Community Healthcare Trust, Derbyshire Community Health Services Trust, Royal United Hospital Bath Trust and St George’s Healthcare Trust.
99 *Health Service Journal* (2013), “Analysed: the state of the FT pipeline”, 25 March.
100 *Health Service Journal* (2011), “Lansley identifies 20 ‘unsustainable’ trusts, 11 October; *The Guardian* (2012), “Hospital trusts offered £1.5 billion emergency fund to pay PFI bills”, 3 February.
101 National Audit Office (2011), *Achievement of foundation trust status by NHS hospital trusts.*
102 *Health Service Journal* (2014), “Exclusive interview: Dalton sets out plan to restart FT pipeline,” 8 December.
103 *Health Service Journal* (2015), “Exclusive: DH bailouts already higher than 2013-14 total”, 13 February.
104 Monitor (2014), *NHS foundation trusts: consolidated accounts 2013/14.*

This Parliament the Government made the landmark decision to put two trusts into special administration for the first time, South London Healthcare NHS Trust in 2012 and Mid Staffordshire NHS Foundation Trust in 2013. However the Trust Development Authority and Monitor are still facing public and political resistance to implementing changes to unviable services. In the case of South London Healthcare, the Secretary of State did not fully accept the recommendation of the administrator to downgrade Lewisham Hospital's A&E due to local opposition. At Mid Staffordshire, the process has once again been threatened with legal challenge and the trust special administrator (TSA) solution requires ongoing central subsidy.[105]

The growing number of providers in financial or clinical difficulty has led to a number of new "pre-failure" supports and sanctions and new organisational models to turnaround struggling providers.[106] However commissioners and providers continue to struggle to ensure these changes are yielding the desired benefits. The King's Fund recently concluded the track record of takeovers and acquisitions delivering good outcomes is "surprisingly negative."[107] Hospitals such as Heart of England NHS Foundation Trust and King's College Hospital NHS Foundation Trust this Parliament have been put under financial strain by the acquisition of underperforming services.[108] Hinchingbrooke NHS Trust, the first NHS organisation to have its management franchised to a private sector operator, ran into similar financial difficulty leading Circle to pull out of the contract in January 2015.

"This Parliament the Government made the landmark decision to put two trusts into special administration for the first time."

While the special measures regime has been found to improve mortality rates the evidence suggests this has been at the expense of financial performance.[109] The 11 original trusts are predicting a collective deficit of almost £140 million in 2014-15. 5 of the 11 trusts expecting to end 2014-15 with deficits between 10 and 12 per cent of their turnover. Those trusts moving out of special measures are doing so through considerable investment in capacity and staff. George Eliot Hospital, one of the first trusts to leave special measures, ended 2013-14 with a deficit of £10.2 million against a plan of £7.9 million, and forecasts a further £12 million deficit for 2014-15.[110]

The evidence therefore suggests that despite greater use of the failure regime, this is not providing the incentives for good financial management intended. As the King's Fund recently concluded, "When caught between an apparently clear conflict between quality of care and financial balance, so far the conflict is being decided in favour of the former."[111] The National Audit Office has argued that far from an "end to bailouts", trusts now assume that the Department of Health will continue to provide cash support.[112] Monitor has recently converted a number of bailouts into loans to try and push financially distressed organisations "to manage their finances better".[113] However while providers are allowed to default without consequences, it seems unlikely this will make a difference on its own.

105 Murray, R. et al.(2014), *Financial failure in the NHS: What causes it and how best to manage it,* The King's Fund.
106 NHS England (2014), *Examining new options and opportunities for providers of NHS care: the Dalton Review.*
107 Murray, R. et al. (2014), *Financial failure in the NHS: What causes it and how best to manage it*, The King's Fund.
108 Ham, C. (2015), *The NHS under the coalition government,* The King's Fund.
109 *Health Service Journal,* "'Hard evidence' special measures worked at Keogh trusts, says researchers'", 8 February.
110 *Health Service Journal,* "Hunt dismisses Keogh trusts' finance struggles", 23 July.
111 Murray, R. et al. (2014), *Financial failure in the NHS: What causes it and how best to manage it,* The King's Fund.
112 National Audit Office (2014), *The financial sustainability of NHS bodies.*
113 *Health Service Journal* (2015), "Exclusive: £188m of bailouts switched to loans in DH clampdown", 12 March.

Coordination of care

Table 10: Total days lost to delayed transfers from acute care
Source: NHS England (2015), *Delayed transfers of care time series*.

Time period	Total days lost to delayed transfers from acute care
2010-11 Q3	177,211
2010-11 Q4	187,031
2011-12 Q1	183,652
2011-12 Q2	190,145
2011-12 Q3	191,363
2011-12 Q4	201,093
2012-13 Q1	200,340
2012-13 Q2	212,025
2012-13 Q3	205,336
2012-13 Q4	215,082
2013-14 Q1	214,369
2013-14 Q2	220,328
2013-14 Q3	222,410
2013-14 Q4	230,020
2014-15 Q1	236,288
2014-15 Q2	270,176
2014-15 Q3	281,435
Change 2010/11-2014/15	**59.0%**

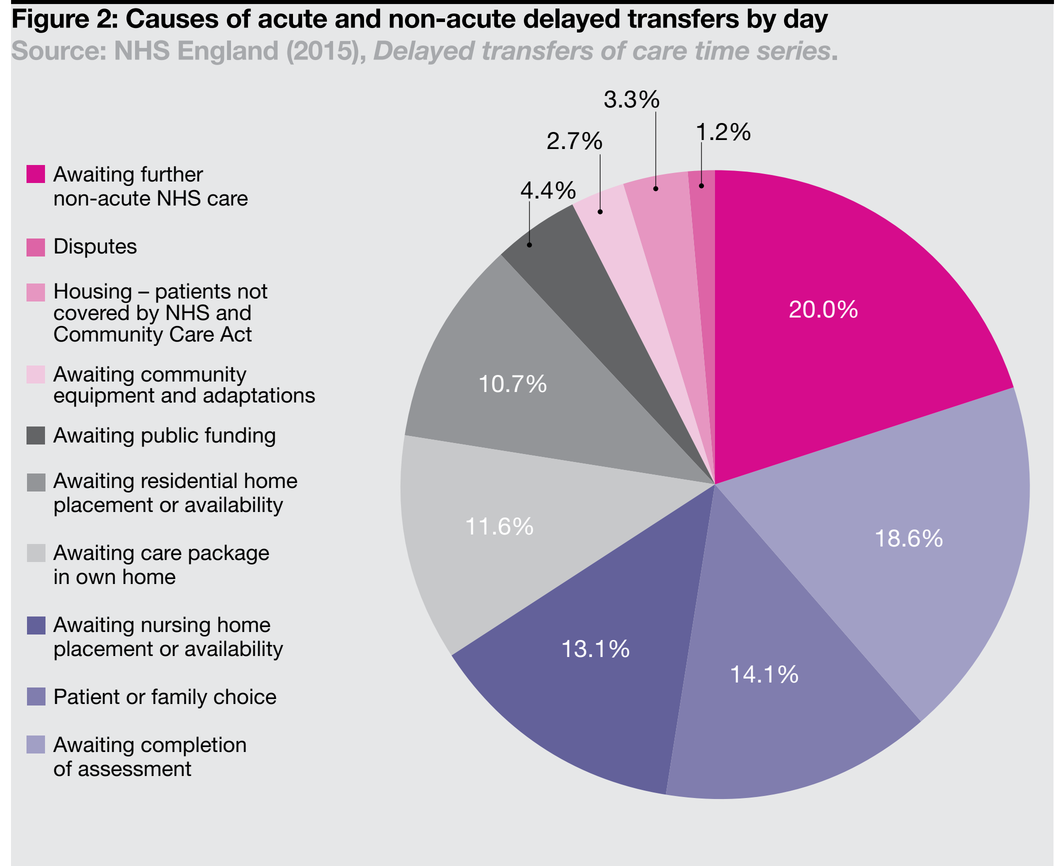
"Days lost to delayed transfers from acute care … were 59 per cent higher in the last three months of 2014 compared to the same period in 2010."

There is now a consensus around the need to coordinate health and social care more effectively. The *Five Year Forward View* set out the need to "take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."[114] Throughout the Parliament the Health Select Committee has called for more "joined up services".[115] A number of the Integration Pioneers this Parliament have demonstrated the potential benefits for health economies, including significant reductions in hospital admissions, improved patient experience and reduced cost.[116]

A number of studies have indicated that information has been poorly shared across the NHS, there has been a lack of multidisciplinary working, and the NHS continues to revolve around the interests of providers, not patients.[117] This has delivered fragmented care to patients whose needs are holistic, and driven duplication from providers and commissioners. One indicator is the days lost to delayed transfers from acute care, 59 per cent higher in the last three months of 2014 compared to the same period in 2010 (see Table 10). This is owing both to poor coordination within the NHS and between the NHS and social care. Patients waiting for further non-acute NHS care, the completion of an assessment, or a domestic care package account for over half of delays experienced in 2014 (see Figure 2).

114 NHS England (2014), *Five Year Forward View.*
115 Heath Select Committee (2012), "Committee report on Social Care calls for joined up commissioning", Press release, 8 February; Health Select Committee (2014), *Public expenditure on health and social care.*
116 NHS England (2015), *Integrated Care and Support Pioneer Programme, Annual Report 2014*.
117 Ham, C. (2013), *Making integrated care happen at scale and pace*, The King's Fund; Health Select Committee (2013), *Public Expenditure on health and social care*; Goodwin, N. (2013), *Integrated care for patients and populations: Improving outcomes by working together*, The King's Fund.

Figure 2: Causes of acute and non-acute delayed transfers by day
Source: NHS England (2015), *Delayed transfers of care time series*.



"This Parliament has seen new momentum towards more integrated care but no national initiative has delivered the silver bullet."

This Parliament has seen new momentum towards more integrated care but no national initiative has delivered the silver bullet. While the Health and Social Care Act contained a commitment to improve integration, the financial incentives in the system remain skewed towards treating patients in hospitals.[118] The Better Care Fund, established in the 2013 Spending Review, is designed to pool spending between health and care and facilitate joint working between the two. However the National Audit Office has raised concerns, describing the initial planning as "deeply flawed" and arguing that the planned savings – largely delivered through reductions in emergency admissions – may well prove difficult to realise.[119] The first round of Integration Pioneers have realised financial and clinical benefits, but there is recognition that the spread of the pioneers' lessons and models must be greatly accelerated.[120]

118 Health Select Committee (2014), "Oral evidence: Integrated care pioneers, Tuesday 4 November 2014."
119 National Audit Office (2015), *Planning for the Better Care Fund.*
120 Health Select Committee (2014), "Oral evidence: Integrated care pioneers, Tuesday 4 November 2014."

Local vs national

There is growing agreement across the NHS that reform to services must be nationally enabled, but locally led.[121] By simplifying the commissioning structure the Coalition aimed to create a NHS less subject to political control and more answerable to patients. [122] In practice, however, the Health and Social Care Act left accountability divided, and thus diluted, between clinical commissioners, NHS England and local authorities. For providers and patients, the organisational complexity of the NHS has multiplied (see Figure 3).

Figure 3: NHS organisational structure

	NHS 2010	NHS 2015
National	Department of Health Monitor Cooperation and Competition Panel Care Quality Commission	Department of Health NHS England Monitor NHS Trust Development Authority Care Quality Commission Health Education England Public Health England Health Watch
Regional	Strategic Health Authorities (10) Primary Care Trusts (152) Local Involvement Networks (152)	NHS England Regional Offices (4) NHS England Local Offices (26) Clinical Commissioning Groups (212) Local HealthWatch (152) Health and Wellbeing Boards (152) Local Education and Training Boards (13) Clinical Senates (12) Specialised Services Clinical Reference Groups (74) Academic Health Science Networks (15) Commissioning Support Units (15)

"The Health and Social Care Act left accountability divided, and thus diluted, between clinical commissioners, NHS England and local authorities."

As such the grip of the centre has proved tough to release. The White Paper's intention was to remove the Secretary of State from direct management responsibility and shift away from a "command and control" structure.[123] The Future Forum and amendments to the Health and Social Care Act, however, quickly reasserted ministerial accountability, giving the Secretary of State the power to set a mandate for NHS England, and intervene over Monitor and the Care Quality Commission.[124] Reliance on targets and national controls has also continued. In June 2011 David Cameron set out "guarantees you can hold me to and that I will be personally accountable for", including not endangering universal coverage, not breaking up integrated care and keeping waiting times low.[125]

The delivery of healthcare continues to be centralised, with central moratoriums on service redesign, national workforce strategy and political oversight clearly visible in areas such as A&E performance . Regulatory oversight has been strengthened in the wake of high profile incidents of failings of care such as the Francis Inquiry. As hospital finances show increasing signs of deterioration, there is growing reliance on bailouts from the centre (see Table 11). Polling in 2014 found stakeholders reported the Department's grip on the operational management of the NHS was tighter than expected.[126]

121 NHS England (2014), *Five Year Forward View*.
122 HM Government (2010), *The Coalition: Our programme for government*.
123 Department of Health (2010), *Equity and Excellence: Liberating the NHS*.
124 Department of Health (2012), Health and Social Care Act.
125 *The Independent* (2011), "David Cameron sets out NHS reform changes", 7 June.
126 Ipsos Mori (2013), *Department of Health 2013 Stakeholder Research*.

4 Consequences

Rising deficits	29
A&E	30
Waiting times	31
Occupancy	32

Despite its relative protection, the NHS is showing increasing signs of financial distress. The limited progress made in sustainable reform to services has led to additional pressure on providers. Rising hospital deficits, pressure on A&E departments, declining performance against waiting time targets, and rising hospital occupancy are some of the symptoms of this pressure.

Rising deficits

Table 11: Hospital deficits 2010-11 to 2013-14

Sources: Department of Health (2011-14), *Annual Report and Accounts*; Monitor (2011-14), *NHS foundation trust consolidated accounts.*

	2010-11	2011-12	2012-13	2013-14
Proportion of foundation trusts in deficit	14%	15%	14%	27%
Net FT surplus before impairments (£ million)	393	439	487	134
Proportion of NHS trust in deficit	6%	9%	17%	25%
Net NHS trust surplus before impairments (£ million)	95	59	-10	-241
Total proportion of hospitals in deficit	10%	12%	16%	26%
Total net surplus before impairments (£ million)	+488	+498	+477	-107

"Despite its relative protection, the NHS is showing increasing signs of financial distress."

From 2010-11 to 2012-13 the financial position of the hospital sector had remained largely stable. The combination of rising workforce costs, pressure on emergency services and increasing difficulty in delivering efficiencies by 2013-14 had begun to present considerable challenges for providers. As a result, the proportion of trusts and foundation trusts in deficit rose from 16 to 26 per cent between 2012-13 and 2013-14 (see Table 11). 20 NHS trusts and 9 foundation trusts reported deficits of more than £10 million or more than 5 per cent of their income.[127]

The latest financial reports from Monitor and the Trust Development Authority indicate that 2014-15 will see further deterioration. 62 per cent of acute hospitals are in deficit. As of March 2015, deficits were forecast to reach £823 million across trusts and foundation trusts.[128] While NHS England and CCGs finished 2013-14 in net surplus (£813 million), the National Audit Office estimated that 2014-15 could see this fall to deficit.[129] The Trust Development Authority has reported that "early evidence suggests that forecasts for 2015-16 will be more difficult still."[130]

127 National Audit Office (2014), *The financial stability of NHS*.
128 Monitor (2015), *Quarterly report on the performance of the NHS foundation trust sector: 9 months ended 31 December 2014*; NHS Trust Development Authority (2015), *Board Meeting – 19 March 2015: Chief Executive's Report*.
129 National Audit Office (2014), *The financial sustainability of NHS bodies.*
130 NHS Trust Development Authority (2015), *Board Meeting – 19 March 2015: Chief Executive's Report.*

A&E

The absence of reform to the NHS has led to growing pressure on hospital services and particularly A&E. As Professor Keith Willett, National Director for Acute Episodes of Care, has argued "When pressure builds across the health and social care system, the symptoms are usually found in the A&E department."[131]

This is a significant cause for concern for providers. Emergency admissions are a significant and growing burden on providers, costing the NHS £12.5 billion annually.[132] Commissioners have long sought to reduce demand on secondary care, particularly for ambulatory sensitive conditions (those that could have been avoidable).[133] But a reduction in admissions to A&E has not materialised over the last five years (see Table 12). The National Audit Office has raised concerns that the 15 per cent reduction in emergency admissions required to finance the Better Care Fund is likely to prove difficult to achieve.[134]

Table 12: A&E attendance and admission
Source: NHS England (2015), *A&E quarterly activity statistics.*

	Total number of A&E visits	Visits to major A&E departments	Emergency admissions from major A&E departments
2004-5	17,837,180	13,265,820	2,755,952
2005-6	18,759,164	13,553,686	2,891,759
2006-7	18,922,275	13,602,589	2,977,330
2007-8	19,076,831	13,395,275	3,031,806
2008-9	19,588,344	13,426,136	3,206,642
2009-10	20,511,908	13,618,300	3,363,345
2010-11	21,380,985	13,931,715	3,478,743
2011-12	21,481,402	14,013,922	3,585,749
2012-13	21,738,637	14,252,068	3,727,062
2013-14	21,778,657	14,213,148	3,792,806

"Emergency admissions are a significant and growing burden on providers, costing the NHS £12.5 billion annually."

According to weekly situation reports the number of visits to A&E has continued to grow with the NHS handling around 3,500 extra attendances each day compared to five years ago.[135] Moreover the number of emergency admissions from major A&E departments has grown rapidly (see Table 11). Pressure on hospitals led to the creation of the "Winter bailout fund", eventually totalling £700 million.[136]

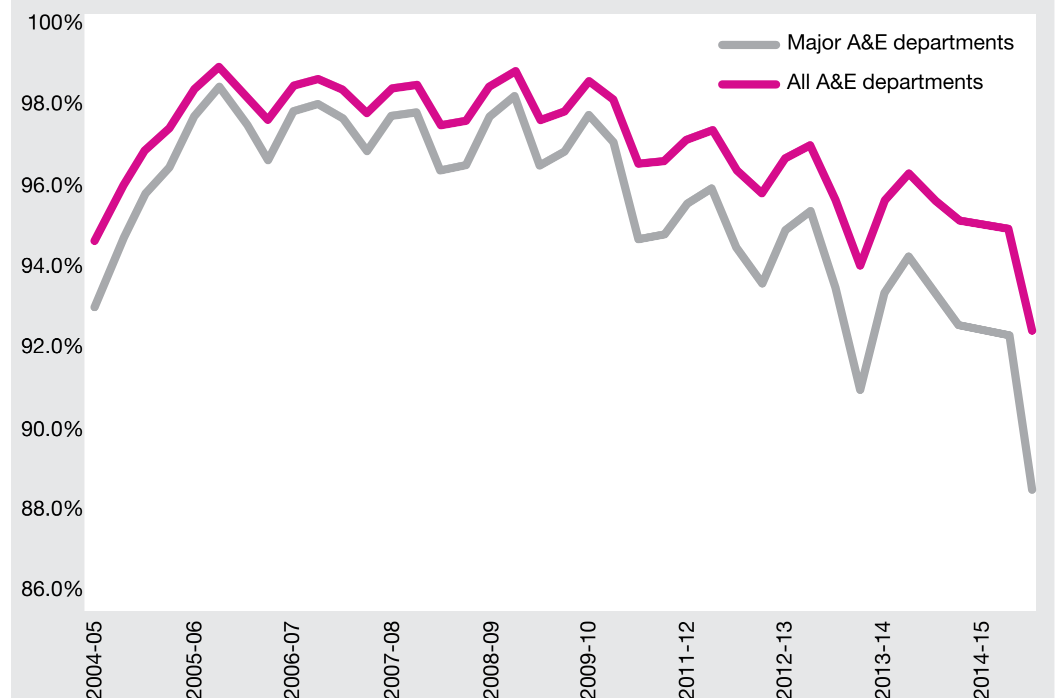
Responding to A&E pressure in early 2013, NHS England published an A&E action plan identifying a number of challenges. These included the rise in visits to A&E, growth in hospitalisations of patients who arrive at A&E, increasing complexity of patient conditions, rising length of stay, absence of effective triage systems, lower thresholds for admissions, poor coordination and absence of alternatives.[137] In early 2015 pressure on A&E services peaked again fuelling widespread public concerns about the quality of NHS services as a number of hospitals declared "special incidents" in search of greater capacity. As Simon Stevens noted in response, while improved planning and temporary additional funding can provide relief for hospitals, the only long-term solution can be "to redesign quite radically what the ways into the health service are."[138]

131 NHS England (2013), "NHS support plan launched to help hospital and A&E departments keep waiting times in check", press release, 9 May.
132 National Audit Office (2013), *Emergency admissions to hospital: managing the demand.*
133 Tian, Y. et al. (2012), "Data briefing: Emergency hospitals admissions for ambulatory care-sensitive conditions", The King's Fund.
134 National Audit Office (2015), *Planning for the Better Care Fund.*
135 NHS England (2014), *Five Year Forward View.*
136 *Health Service Journal* (2014), "Accident and emergency bailout fund increases to £700m", 14 November.
137 NHS England (2013), *NHS England: Improving A&E Performance.*
138 *Financial Times* (2015), "Access to emergency care in need of urgent redesign", January 4.

Waiting times

This Government announced that it would remove many of the activity based performance targets and start to assess healthcare providers on outcomes.[139] The target for A&E services to admit, transfer or discharge a patient who attends A&E within four hours was relaxed from 98 per cent to 95 per cent. Nevertheless, the Prime Minister committed to ensuring the Government would "not lose control of waiting times in A&E."[140]

Figure 4: A&E attendances dealt with under 4 hours
Source: NHS England (2015), *A&E quarterly activity statistics.*



"In Q3 2014-15 nearly half of providers failed to meet their waiting time target, up from 16 per cent in the same period in 2011-12."

Since 2010 there has been a gradual decline in A&E performance which accelerated at the beginning of 2013 and then again at the beginning of 2015. In Q3 2014-15 the proportion of patients who had to wait over four hours reached 7.4 per cent (see Figure 4). Just 83.1 per cent of patients admitted to Type 1 A&Es were processed within four hours in the week immediately before Christmas – the lowest figure since records began in 2004.[141] The NHS missed the 95 per cent waiting time in every week this winter.[142] The number of providers that have breached the A&E target has also increased significantly. In Q3 2014-15 nearly half of providers failed to meet their waiting time target, up from 16 per cent in the same period in 2011-12 (see Table 13).

139 Department of Health (2010), *Equity and Excellence: Liberating the NHS.*
140 Cameron, D. (2011), "Protecting the NHS for tomorrow", 7 June.
141 NHS England (2013), *A&E weekly activity statistics, NHS independent sector organisations in England, week ending 21/12/2014.*
142 BBC News Online (2015), "A&E in England misses target for whole of winter", 13 March.

Table 13: Providers breaching 4 hour waiting time target, all A&E departments
Source: NHS England (2010-15), *A&E activity and emergency admission statistics*.

	Number of providers	Per cent of providers
2011-12 Q1	27	9%
2011-12 Q2	17	6%
2011-12 Q3	43	16%
2011-12 Q4	47	17%
2012-13 Q1	34	13%
2012-13 Q2	14	6%
2012-13 Q3	61	24%
2012-13 Q4	92	37%
2013-14 Q1	61	25%
2013-14 Q2	38	16%
2013-14 Q3	60	25%
2013-14 Q4	65	27%
2014-15 Q1	64	26%
2014-15 Q2	70	28%
2014-15 Q3	121	49%

Occupancy

Table 14: Increase in occupancy rates, all beds
Source: NHS England (2015), *Bed Availability and Occupancy Data – Overnight*.

	Average occupancy	Proportion of trusts with occupancy above 85 per cent	Proportion of trusts with occupancy above 90 per cent
2010-11	85.4%	53.4%	26.0%
2011-12	85.3%	57.5%	26.5%
2012-13	86.1%	62.4%	31.1%
2013-14	86.3%	59.5%	31.4%
2014-15	86.8%	60.9%	35.0%

Note: 2014-15 data excludes Q4, which has not yet been released.

"Average annual occupancy has surpassed 85 per cent in every year this Parliament."

The increase in visits to A&E, combined with the absence of high quality and co-ordinated alternative services, has meant that hospital beds have come under greater pressure. Average annual occupancy has surpassed 85 per cent in every year this Parliament, while the number of trusts with an occupancy rate above 85 per cent has increased from 54 per cent in 2010-11 to 61 per cent in 2014-15 (see Table 14). The number of trusts with occupancy above 90 per cent has also risen rapidly, reaching 35 per cent this year.

Hospitals often aim for occupancy at 85 per cent to allow flexibility and because greater occupancy is thought to have a negative impact on productivity. Experts have warned that patient safety and quality of care can be put at risk by high bed occupancy.[143] It also restricts the ability of hospitals to undertake elective care, important for raising revenue. In 2013-14, revenue generated from elective in-patients by foundation trusts fell £99 million, although this shortfall was balanced by increased volumes of day case and outpatient work.[144]

143 Bagust, A. et al. (1999), "Dynamics of bed use in accommodating emergency admissions: stochastic simulation model", *British Medical Journal*; Dr Foster (2012), Good hospital guide.
144 Monitor (2014), *Performance of the foundation trust sector: year ended 31 March 2014.*

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