

# Health policy under the coalition government

A mid-term assessment

Editors

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The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

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# Acronyms and abbreviations

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A&E	accident and emergency
AQP	any qualified provider
BMJ	<i>British Medical Journal</i>
<i>C difficile</i>	<i>Clostridium difficile</i>
COF	Commissioning Outcomes Framework
COPD	chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVD	cardiovascular disease
<i>E coli</i>	<i>Escherichia coli</i>
HCAI	health care acquired infection
HPA	Health Protection Agency
IAPT	Improving Access to Psychological Therapies
MHRA	Medicines and Healthcare products Regulatory Agency
MRSA	methicillin-resistant <i>Staphylococcus aureus</i>
MSSA	methicillin-sensitive <i>Staphylococcus aureus</i>
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
OECD	Organisation for Economic Co-operation and Development
PCT	primary care trust
PHOF	Public Health Outcomes Framework
PiP	Poly Implant Prothèse
PROMs	patient-reported outcome measures
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
SHA	strategic health authority
SMR	standardised mortality ratio
TIA	transient ischaemic attack

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# Summary of key messages

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## Access

- Waiting times for hospital services generally remain steady. Median waits for most hospital services at the end of 2011 were very close to the levels recorded in 2009. However, the number of patients waiting longer than the four-hour target for treatment in accident and emergency (A&E) departments rose by 19 per cent from 2010/11 to 2011/12 (quarter 2) (Department of Health 2011q).
- Patients' overall rating of access and waiting in the survey of inpatients declined slightly, from 84.2 (2009/10) to 83.8 (2011/12) (a score of 80 is equivalent to a rating of 'very good'). The results from the outpatient survey improved slightly from 73.3 (2009/10) to 74.9 (2011/12) (Department of Health 2012p).
- The number of dentists carrying out NHS work has continued to rise, by 7.4 per cent, from 21,343 in 2008/9 to 22,920 in 2011/12 (Information Centre 2012d). Public satisfaction with dental services rose five percentage points to 56 per cent in 2011 (National Centre for Social Research 2012).
- By the end of February 2012, more than 12,500 patients had accessed additional cancer drugs through the Cancer Drugs Fund set up in 2011 (Department of Health 2012y).
- The majority of people with depression or anxiety (around two-thirds) still wait more than six months from referral to treatment, with one in five waiting more than a year and one in ten waiting more than two years (Mind 2010).

## Patient safety

- Rates of methicillin-resistant *Staphylococcus aureus* (MRSA) infections have fallen by 25 per cent and *Clostridium difficile* (*C difficile*) by 17 per cent between 2011 and 2012 (quarter 4) (Department of Health 2012bb).
- The number of reported safety incidents rose by 26 per cent from September 2009 to December 2011, but under-reporting remains a major concern, particularly in general practice (National Reporting and Learning System 2012).
- Patients admitted to hospital as a medical emergency at weekends are more likely to die in hospital than those admitted during the week (Dr Foster Intelligence 2011; CHKS 2012). If the weekend mortality rate were the same as the weekday rate, there would be at least 500 fewer deaths a year in London alone (NHS London 2011).
- Claims of clinical negligence have been rising – from 8,655 in 2010/11 to 9,143 in 2011/12. Since 2006/7, the value of payments made in respect of clinical negligence has doubled (NHS Litigation Agency 2012).
- Fourteen per cent of NHS hospitals inspected between April 2010 and July 2011 did not meet Care Quality Commission standards relating to safe management of medicine (CQC 2011c).

## Promoting health

- The proportion of obese adults has continued to rise, from 24 per cent of the adult population in 2007 to 26 per cent in 2010. Estimates suggest that this could rise to over 40 per cent by 2035 (Wang *et al* 2011).
- Smoking rates have declined from 21 per cent of the adult population in 2007 to 20 per cent in 2010 (Information Centre 2012g).
- Alcohol consumption has stabilised and started to fall. The percentage of men exceeding the recommended units per week has declined from 31 per cent in 2006 to 26 per cent in 2010, and in women from 20 per cent to 17 per cent over the same period (Information Centre 2012e).
- The number of deaths from liver disease – 37 per cent of which are accounted for by alcoholic liver disease – rose from 9,231 in 2001 to 11,575 in 2009 (National End of Life Care Programme 2012).
- Life expectancy has been increasing, although women can still expect to live two years longer than men, on average, at age 65 (Office for National Statistics 2012).

## Managing long-term conditions

- About 15 million people in England have at least one long-term condition. Between 2006/7 and 2010/11, the number of people with diabetes increased by 25 per cent and the number with chronic kidney disease by 45 per cent (Department of Health 2012j).
- Emergency admissions among people with long-term conditions that could have been managed in primary care cost the NHS £1.42 billion annually – a figure that could be reduced by 8–18 per cent through investment in primary and community-based services (Tian *et al* 2012).
- There was a fall in the number of emergency bed days by 13 per cent between 2003/4 and 2007/8 but between then and 2009/10 it rose again, by 7 per cent (The King's Fund analysis of Hospital Episode Statistics).
- Every year 24,000 people with diabetes die from avoidable causes related to their condition. £170 million could be saved each year through better understanding and management (National Audit Office 2012b).

## Clinical effectiveness

- There was a decline in mortality amenable to health care of 34.7 per cent between 1997/8 and 2006/7 but the United Kingdom still has the highest rate of 16 Organisation for Economic Co-operation and Development (OECD) countries with the exception of the United States (Nolte and McKee 2011).
- Cancer mortality has fallen by 19 per cent since 2000, but the United Kingdom's cervical cancer five-year relative survival rate for 2004–09 (58.8 per cent) still compares poorly with the OECD average (66.4 per cent). The same is true for breast cancer (81.3 per cent versus 83.5 per cent) and lung cancer (52.6 per cent versus 59.5 per cent) (OECD 2011).
- Mortality due to cardiovascular disease has fallen by 43 per cent from 2000 to 2010. The NHS Atlas of Variations in Healthcare (NHS Right Care 2011) shows significant geographical variations in access to and treatment of cardiovascular disease.

- Average compliance across nine key indicators measured by the Sentinel Stroke Audit has continued to rise, from 60 per cent in 2006 to 73 per cent in 2008 and 83 per cent in 2010 (Royal College of Physicians 2012).
- The male suicide rate in England increased slightly in 2008 following the financial crisis, by around 8 per cent between 2007 and 2008, but then dropped back by 4 per cent between 2008 and 2010 (Information Centre 2012c).

## Patient experience

- Patient experience of NHS adult inpatient services showed no change overall between 2009/10 and 2011/12, and the overall score for patient experience in outpatients increased slightly from 78.8 to 79.2 over the same period (a score of 80 is equivalent to a rating of 'very good') (Department of Health 2012p).
- One-fifth of NHS acute hospitals inspected by the Care Quality Commission in 2011 did not meet essential standards in nutrition and dignity for older people (Care Quality Commission 2011a).
- A number of major reports have highlighted serious failures in the quality of care received by vulnerable patients in hospitals and in long-stay residential settings (Francis 2010; BBC Panorama 2011; Care Quality Commission 2011a; Patients Association 2011).
- The number of breaches of mixed-sex accommodation guidance has fallen by over 96 per cent in 16 months (Department of Health 2012ff).
- The number of written complaints to hospitals and community services rose by 23 per cent between 2007/8 and 2011/12, from 87,080 to 107,259 (Information Centre 2012b). The government views complaints as an important part of feedback available to providers (Department of Health 2010a).
- There has been a decrease in the proportion of respondents saying that they were offered a choice of hospital for their first appointment, from 32 per cent in 2010 to 29 per cent in 2011 (Care Quality Commission 2011b).

## Equity

- The gap in life expectancy at birth between Spearhead areas (the fifth-worst in terms of health and deprivation) and England as whole has risen – by 0.1 years for men and 0.2 years for women since 1999–2001 (figures accurate up to 2008–10 (Department of Health 2011j)).
- The infant mortality target set by the previous government (a 10 per cent reduction) has been surpassed, with a 25 per cent reduction in relative inequalities between infant mortality rates of manual socio-economic groups and the England average (Bambra 2012).
- Inequalities in mental health remain stark. The gap in life expectancy between those with a severe and enduring mental health problem and those without is 10–15 years on average (Chang *et al* 2011).
- There are unwarranted differences in health care utilisation that reflect local inequalities in access to services. For example, when treating patients with type 2 diabetes, there is a seven-fold variation between the 2.5 per cent top and bottom primary care trusts (PCTs) in their adherence to 18 core indicators of good care (NHS Right Care 2011).

## Efficiency

- Overall, the NHS ended both 2010 and 2011 in surplus – part of a continuing central policy to generate surpluses to carry over into succeeding years in order to cover transitional costs associated with the government’s reforms.
- There were £4.3 billion of productivity gains in 2010/11 (Audit Commission 2011). For 2011/12, the Department of Health reported that the QIPP scheme had generated £5.8 billion of savings (Department of Health 2012ff).
- Twelve acute or ambulance trusts are performing below par in respect of finance: six of them, all in London, have been placed in the most serious category (Department of Health 2012g). Meanwhile, 15 foundation trusts (out of a total of 144) finished 2011/12 in deficit, and Monitor judged at least four to be not viable in their current form.
- At national level, the government has achieved substantial real-terms reductions in the cost of staff, but the NHS pay bill has continued to rise through the impact of increments.
- Since March 2010, the number of NHS managers has reduced by around 8,000 to 35,555 – a drop of around 18 per cent (Appleby *et al* 2012).
- There were significant reductions in the average length of stay for primary hip replacement in England between 2003/4 and 2009/10, but the variance in length of stay has not changed (NHS Right Care 2010).



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# Introduction

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Ahead of the last general election, we undertook a major review of the performance of the NHS from 1997 to 2010 – *A High-Performing NHS? A review of progress 1997–2010* (The King’s Fund 2010) – and set out the key issues that we identified that the incoming government would need to address. *A High-Performing NHS?* had two main messages. First, performance was improving although there was more to do in some areas. Second, government policies were focused on driving performance through target setting and performance management.

The report highlighted a number of priorities for this government, including:

- tackling the unwarranted variations in access, use of services and quality of care that exist even in areas where there are national guidelines
- ensuring that patient experiences have a real impact on the quality of care locally
- making sure there is adequate investment in, and energy devoted to, tackling the preventable causes of ill health
- providing better support and care for those living with chronic conditions.

This report looks at the policies introduced by the coalition government elected in May 2010 and assesses whether they will address the current and emerging performance issues and what further action is needed. We are now halfway through the current parliament. So, how is the NHS performing?

The past two and a half years have seen a number of significant changes, and these provide the context for this report.

- The government has introduced major reforms to the NHS, as set out in *Liberating the NHS* (2010a) and implemented through the Health and Social Care Act 2012. These have resulted in far-reaching organisational change.
- The NHS budget has been squeezed following a decision in the spending review (HM Treasury 2010) to give the NHS zero real-terms growth. The NHS is now in the second year of the Quality, Innovation, Productivity and Prevention (QIPP) programme, which aims to achieve productivity savings worth £20 billion over four years by 2015.
- Cuts in local government spending have seen reductions in spending on social services in the order of £1.89 billion over the past two years. Of the £622 million allocated to the NHS to promote joint working, over 45 per cent (£284 million) is being used to offset cuts to services and help meet demographic pressures (Association of Directors of Adult Social Services 2012).

We hope this report will make timely reading for the new ministerial team at the Department of Health as well as leaders across the NHS. If they are looking for issues on which to focus energy and action, they need look no further.

## About this report

*A High-Performing NHS?* structured its assessment around eight dimensions of care, drawn from evidence about what makes an effective health care system. On the whole, this follow-up report is structured around the same dimensions and key findings measured against the criteria (*see* the box opposite). However, it separates out two issues that were examined as one dimension in the original review: long-term conditions and health promotion. It also considers in more detail how far the NHS supports people with long-term conditions to have a good quality of life – partly reflecting the objectives of domain 2 of the NHS Outcomes Framework (Department of Health 2011n).

The report does not seek to update the section on accountability because the structures governing the NHS are still undergoing significant change.

Each section includes the following information:

- a snapshot of current performance since the publication of *A High-Performing NHS?*, highlighting where new data is available. The data is used to highlight any emerging issues that may need to be addressed, rather than to assess government policy
- a description of the key policies introduced by the current government. In some cases, continuity with the previous government's policies is noteworthy, while in others policies have been dropped or changed. This report is necessarily selective, so not every policy change has been included
- an assessment of these policies, including whether they address the key issues and whether they are likely to be sufficient to tackle the scale of the challenge
- suggestions for future priorities – for example, are there emerging performance issues that need to be addressed or issues that are being overlooked?

Many of the organisational changes introduced by the Health and Social Care Act 2012 are still in the process of being implemented. Many of the new bodies do not take up their responsibilities until April 2013 and so evidence is not yet available on how these reforms have impacted on performance.

There is also a lag in the release of data on which to judge the performance of the NHS. In many of the areas that we examine, the most recent data available are for 2010/11, the first year of tighter budgets. So while the report offers the most up-to-date assessment of performance, it is very early days. Any impact on performance of the reforms and funding pressures are not yet likely to be apparent.

In the final sections we consider what the analysis reveals about the government's approach to driving performance improvements in the NHS. We conclude with a section that looks to the future and the prospects for the NHS.

### Criteria for a high-performing health system

- 1. Access** A high-performing health system ensures that people have access to a comprehensive range of services in a timely and convenient manner.
- 2. Patient safety** A high-performing health system minimises the risk of accidental injury or death due to medical care or medical error.
- 3. Promoting health** A high-performing health system supports individuals to make positive decisions about their own health and acts to maximise its positive impact on the broader determinants of people's health.
- 4. Managing long-term conditions** A high-performing health system supports individuals with long-term conditions to manage them effectively and achieve a high quality of life.
- 5. Clinical effectiveness** A high-performing health system delivers services to improve health outcomes in terms of successful treatment, the relief of pain and suffering, and restoration of functions.
- 6. Patient experience** A high-performing health system delivers a positive patient experience. This includes giving patients choices and involving them in decisions about their care, providing the information they need, and treating them with dignity and respect.
- 7. Equity** A high-performing health system is equitably funded, allocates resources fairly, ensures that services meet the population's needs for health care, and contributes to reducing health inequalities.
- 8. Efficiency** A high-performing health system uses the available resources to maximum effect. This requires productivity in the delivery of care, supported by economy in the purchase of the goods and services that a health service needs to deliver care.
- 9. Accountability** A high-performing health system can demonstrate that it is achieving high standards of care, taking into account the views of those who it serves, and has in place effective systems to remedy poor performance.

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# 1 Access

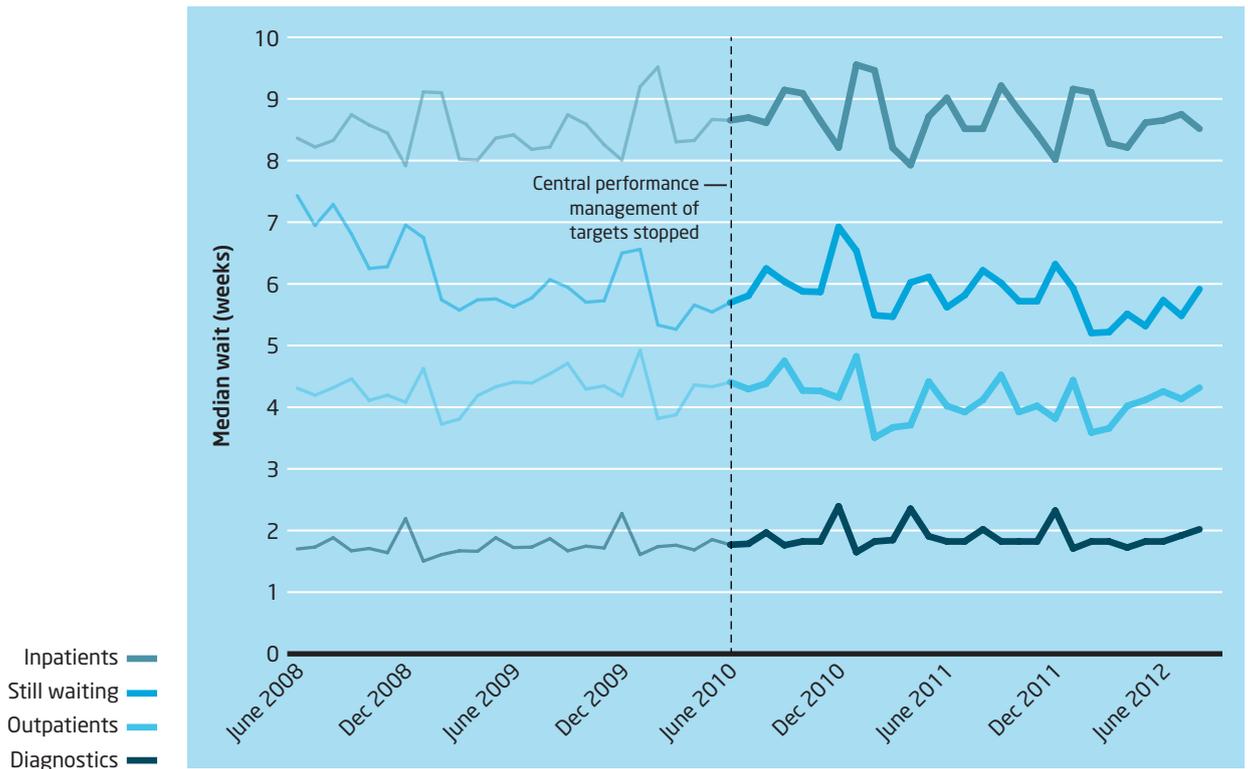
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*Criterion 1: A high-performing health system ensures that people have access to a comprehensive range of services in a timely and convenient manner.*

## How is the NHS performing?

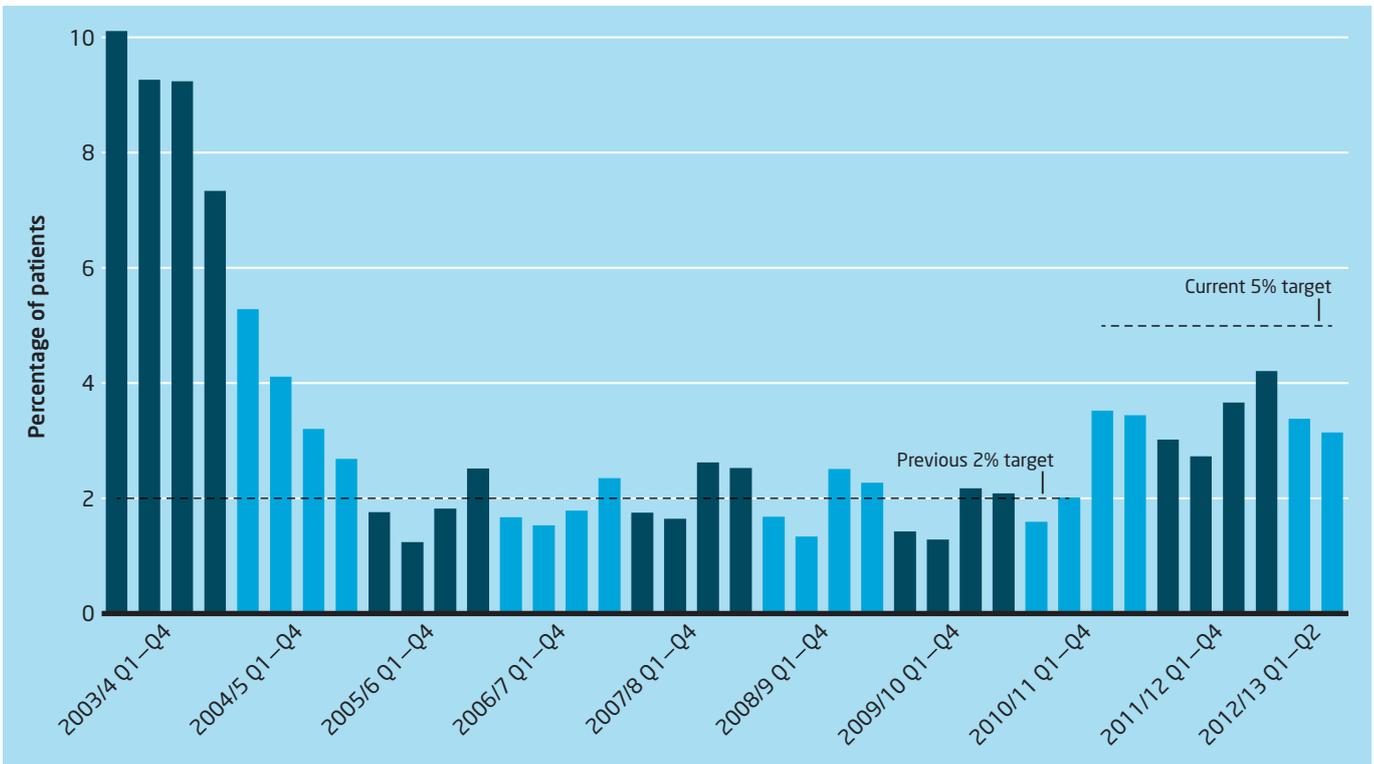
- Despite the pressures on the NHS budget, waiting times for hospital services generally remain steady. This partly reflects the continuing close attention that the Department of Health pays to waiting times as an important performance measure for the NHS (Appleby *et al* 2012).
- Median waits for hospital services at the end of 2011, including inpatients, outpatients and diagnostics, were very close to the levels recorded in 2009 (*see* Figure 1 opposite). Cancer waits have also remained steady.
- Waiting times for treatment in accident and emergency (A&E) departments have risen, with the number of patients waiting longer than the four-hour target for treatment in A&E departments rising by 19 per cent from 2010/11 to 2011/12 (quarter 2) (Department of Health 2012ff) (*see* Figure 2 opposite). This is largely due to a change in the target, from 98 per cent of patients waiting less than four hours in A&E to 95 per cent (Department of Health 2010h). Although the number of longer waits has risen at a national level, it remains within the new target – although locally, by the first quarter of 2012/13, 35 trusts were in breach of this target (Appleby *et al* 2012). There remains no systematic information on waiting times for access to services such as physiotherapy and other community-based services not covered by the 18-week target.
- Patients are asked their views on access and waiting. A number of questions are combined to calculate an overall score on this dimension (where a score of 80 is equivalent to a rating of ‘very good’). The scores in the inpatient survey declined slightly, from 84.2 (2009/10) to 83.8 (2011/12), and the outpatient survey results improved slightly, from 73.3 (2009/10) to 74.9 (2011/12) (Department of Health 2012r).
- The targets set by the previous government to see a GP within 48 hours and a nurse within 24 hours are no longer monitored. Due to changes to the questionnaire design and survey frequency, 2011/12 results are not comparable to those in previous years. In 2011/12, nearly one in 10 respondents was unable to get an appointment, and a further 12 per cent had to call back closer to or on the day. Half of patients who got an appointment were able to see or speak to a GP or nurse on the same day or next working day. Only 6 per cent wanted an appointment a week or more later, yet as many as 13 per cent had to wait this long (*see* Figure 3, p 6).

**Figure 1** Median waiting times in weeks

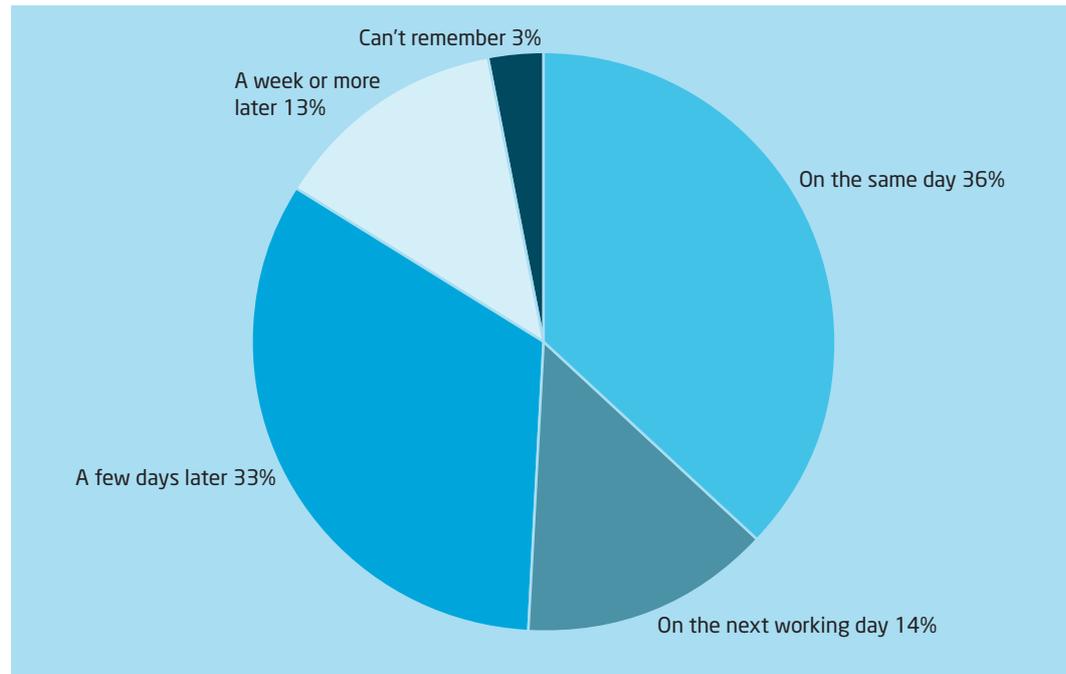


Sources: Department of Health 2012d and Department of Health 2012l

**Figure 2** Percentage of patients waiting longer than four hours in accident and emergency



Data source: Department of Health 2012gg

**Figure 3** Length of wait to see or speak to a GP or nurse

Source: Department of Health 2012z

- The number of dentists carrying out NHS work has continued to rise, by 7.4 per cent, – from 21,343 in 2008/9 to 22,920 in 2011/12 – although the increase in 2011/12 was very much smaller than in previous years (Information Centre 2012d). The number of patients treated by NHS dental services reached 29.6 million in the 24-month period until June 2012. This is an increase on the baseline figure of 28.2 million before the introduction of the new dental contract in 2006 (Information Centre 2012d). The number of courses of treatment provided under the NHS also rose during this period.

It is these improvements in access that almost certainly account for the increased public satisfaction with dental services over the past few years (a 5 per cent rise to 56 per cent in 2011) – a trend not reflected in other NHS services (National Centre for Social Research 2012).

- In some parts of the country, primary care trusts have introduced measures to limit access to elective care – some through the introduction of referral management schemes, some through introducing explicit thresholds, and others through blanket restrictions (Co-operation and Competition Panel 2011). Nevertheless, in May 2012 the total number of planned admissions was at a record level. The total fell back in June, but a similar decline occurred for the same month in previous years (Information Centre 2012c).
- By the end of February 2012, more than 12,500 patients had accessed additional cancer drugs through the Cancer Drugs Fund, set up in 2011, with funding of £200 million each year from 2011–14 (Department of Health 2012y).
- In response to recent concerns around out-of-hours services, in 2010 the Department of Health published a report making a number of recommendations for improving standards (Department of Health 2010c), but a subsequent report from the Primary Care Foundation (Clay 2012) found that performance was improving and that the vast majority of users had easy and rapid access to these services. Seventy-one per cent of patients surveyed in 2011 said the overall experience of their out-of-hours GP service was good (Department of Health 2012z).

- The previous government's drive to improve access to psychological therapies has continued under the current government. However, a survey by Mind found that around two-thirds of people with depression or anxiety still wait more than six months from referral to treatment, with one in five waiting more than a year and one in 10 waiting more than two years (Mind 2010). These results are corroborated by data from Improving Access to Psychological Therapies (IAPT) – the programme established to make such services widely available – showing that the majority of IAPT service users had been depressed or anxious for more than six months before their treatment began (Clark 2011).

Our previous report, *A High-Performing NHS?* (The King's Fund 2010), noted that there was a risk that the gains that had been made with regard to waiting times might be lost in the new financial climate. It also suggested that the economic situation might lead to greater local variation in access to new drugs – particularly if (as the new government intended) localities were given greater scope for exercising choice over their use of resources.

## What policies has the current government introduced?

The government's first White Paper (Department of Health 2010a) affirmed its commitment to the principle that health care should be (largely) free at the point of access. It made specific commitments to improve access to new drugs, through a new pricing regime, and to reducing inequalities in access to health care through the NHS Commissioning Board mandate. The Department of Health's mandate to the NHS Commissioning Board (Department of Health 2012aa) refers to the Board's duties to reduce unjustifiable inequalities in access to services, the quality of care received, and the outcomes from that care. The mandate sets a specific objective to maintain levels of performance in access to care and improve on them where possible.

Soon after the 2010 election, the government announced that it would be abolishing national targets, and the White Paper made it clear that it would also abolish the machinery by which they had been enforced. However, the 18-week target for access to hospital treatment remained in force, as it had been embedded in the NHS Constitution, as did the targets for access to cancer care. In reality, waiting times targets remain too, with the Department of Health paying close attention to waiting times as a key performance measure for the NHS. And while the government has relaxed slightly the A&E four-hour wait target, to accommodate clinical concerns, it has introduced a new target to ensure that no more than 8 per cent of people nationally are still waiting more than 18 weeks from their GP referral to starting their first treatment (Department of Health 2011o).

### General practice

In its programme for government (HM Government 2010), the government stated that it would renegotiate the GP contract and incentivise ways of improving access to primary care in disadvantaged areas. However, so far no new measures have been announced to make the distribution more equitable. The Department of Health's mandate to the NHS Commissioning Board states that 'the government expects the principle of ensuring equal access for equal need to be at the hearts of the Board's approach to allocating budgets [to clinical commissioning groups]'. (Department of Health 2012aa)

## Access to drugs and treatments

A number of measures have been taken to improve access to new medicines.

The government has established a Cancer Fund, worth £200 million a year, to provide access to treatments not currently available on the NHS – either because they have not been appraised or because they have been rejected on cost-effectiveness grounds or recommended for only a limited number of patients. This came fully into effect on 1 April 2011, and is intended to bridge the gap until the introduction of a value-based pricing system for new branded drugs in 2014. A report from the Rarer Cancers Foundation found that this initiative had succeeded in extending the range of treatments available on the NHS, but that variations between different parts of the country remained (Rarer Cancers Foundation 2011).

In its programme for government (HM Government 2010), the coalition announced that it would introduce a new system for pricing new pharmaceutical products. Details of the new approach – known as ‘value-based pricing’ – remain sketchy, but the aim is to provide a closer link between the price the NHS pays and the value a drug offers to patients (Department of Health 2011a). This is not yet in place, but when it is, in 2014, it should offer improved access to expensive drugs.

In addition, the 2009 Pharmaceutical Price Regulation Scheme (negotiated under the previous government) introduced patient access schemes, which have reduced the cost to the NHS of some expensive drugs. Twenty-five such schemes had been approved by July 2012.

Drugs recommended by the National Institute for Health and Clinical Excellence (NICE) are legally required to be available to all NHS patients. However, in practice, some local commissioners have not been accepting NICE recommendations – particularly for expensive drugs. This is because although they may satisfy NICE’s cost-effectiveness thresholds, using these more expensive interventions can result in cost-effective treatments being squeezed at local level. The Health and Social Care Information Centre (Information Centre 2012h) estimated that in 2009, out of a selection of 12 medicine groups, usage was lower for three groups than would be expected from the estimated populations who might benefit from them, even though it was higher for eight.

In 2011, the Department of Health document *Innovation, Health and Wealth* (Department of Health 2011i) announced the introduction of a compulsory compliance regime. In January 2012, the Secretary of State confirmed that it would be compulsory for approved drugs to be included in local formularies. In August 2012, the NHS Chief Executive (Department of Health 2012ff) indicated that the requirement set out in *Innovation, Health and Wealth* would be made a standard part of NHS contracts.

Finally, in response to complaints that its clinical and economic appraisals were taking too long, NICE is now beginning its appraisals before drugs are licensed. As a result, the time lag between licensing and approval is now around four months (NICE 2012).

## Will these policies be effective?

Current government policy does not include any measures to tackle the significant local variations in access that remain. A survey carried out by *GP* magazine found that of 101 primary care trusts responding, over 90 per cent were aiming to limit GP referrals, 59 per cent were setting limits to joint and bariatric surgery, and 66 per cent to cataract surgery (Moberly 2012). Research by Coronini-Cronberg *et al* (2012) covering 71 out of 151 primary care trusts found that half were restricting access to cataract surgery – but were using a variety of criteria to define access to treatment. The limits set reflected neither

national guidance nor the evidence base for determining when treatment should be carried out. However, there was extensive variation in treatment rates and thresholds even before these restrictions were introduced.

The latest data for cataract operations showed a decrease of 1.4 per cent between 2009/10 and 2010/11 – the first decrease in year-on-year cataract operations since 2005/6. However, hip operations increased by almost 5 per cent – an increase of more than 4,900 operations – during the same period (Information Centre 2012c).

The previous Secretary of State stated that blanket imposition of treatment thresholds should not be allowed, and sanctions were promised against those who did. However, no specific action has been taken to prevent them or to promote the introduction of evidence-based thresholds.

## What needs to happen next?

Maintaining the historic reduction in waiting times has been a particular achievement for the NHS at a time of organisational upheaval and financial stringency. While *de facto* targets remain – along with, importantly, the supporting managerial and political pressure – the prospect for maintaining waiting times at an all-time low look reasonable. Nevertheless, the continuing financial freeze will exert more pressure on the NHS next year and beyond as it faces increasing demands. And it is the continuing financial parsimony – almost certainly beyond the end of the current spending review – that overshadows the government's attempts to improve access.

As far as drugs and appliances are concerned, the current government is committed to improving access to drugs by getting lower prices for new, high-cost medicines and ensuring that everyone has access to NICE-approved drugs.

Nothing comparable is in sight for access to other NHS services and treatments. Access to elective care is one of the few areas where demand can be controlled, so it is only to be expected that commissioners will seek to limit demand. However, unlike medicines, the government has not announced any measures designed to ensure that such restrictions are applied on a consistent and justifiable basis across the country as a whole.

That may seem more in line with the coalition's philosophy, as set out in its 2010 White Paper *Equity and Excellence* (Department of Health 2010a), that the role of the centre should be reduced, and that of localities expanded. However, the evidence suggests that restrictions on access are being introduced in ways that mean that patients are being denied beneficial and cost-effective treatments (Information Centre 2012h). If this is the case, there is a role for the Secretary of State to intervene, by virtue of his responsibility as set out in the Health and Social Care Act 2012 to ensure the provision of a comprehensive health service.

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## 2 Patient safety

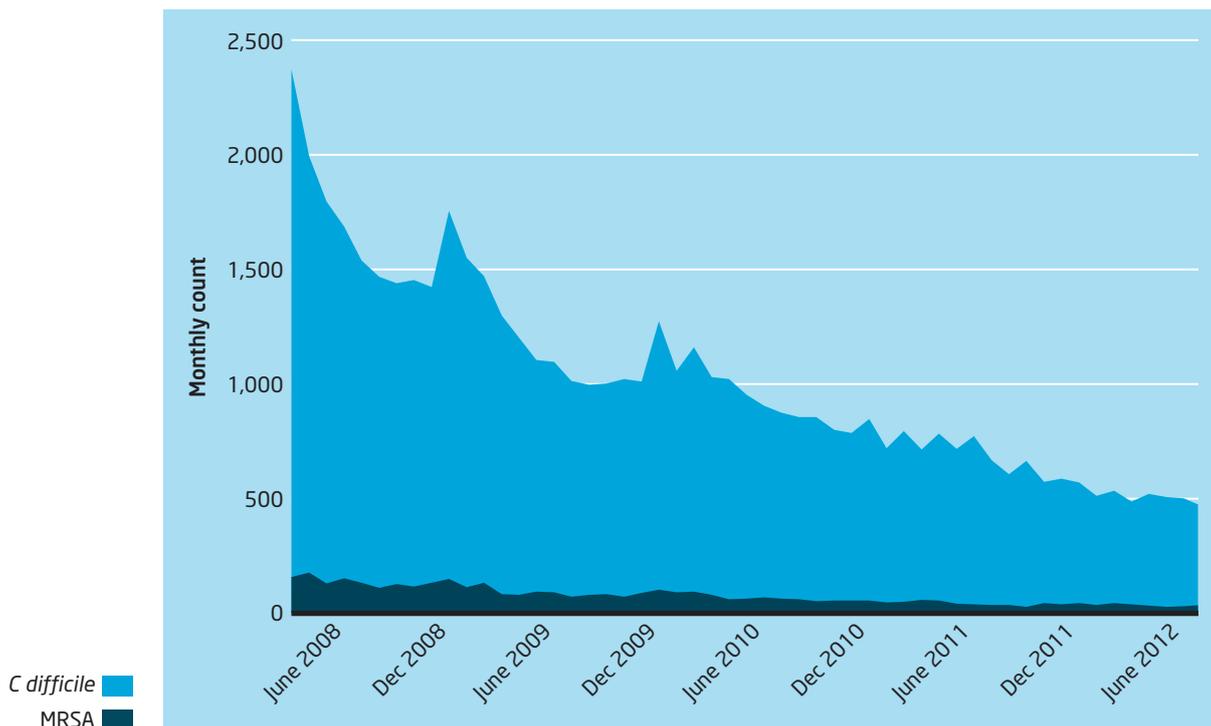
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*Criterion 2: A high-performing health system minimises the risk of accidental injury or death due to medical care or medical error.*

### How is the NHS performing?

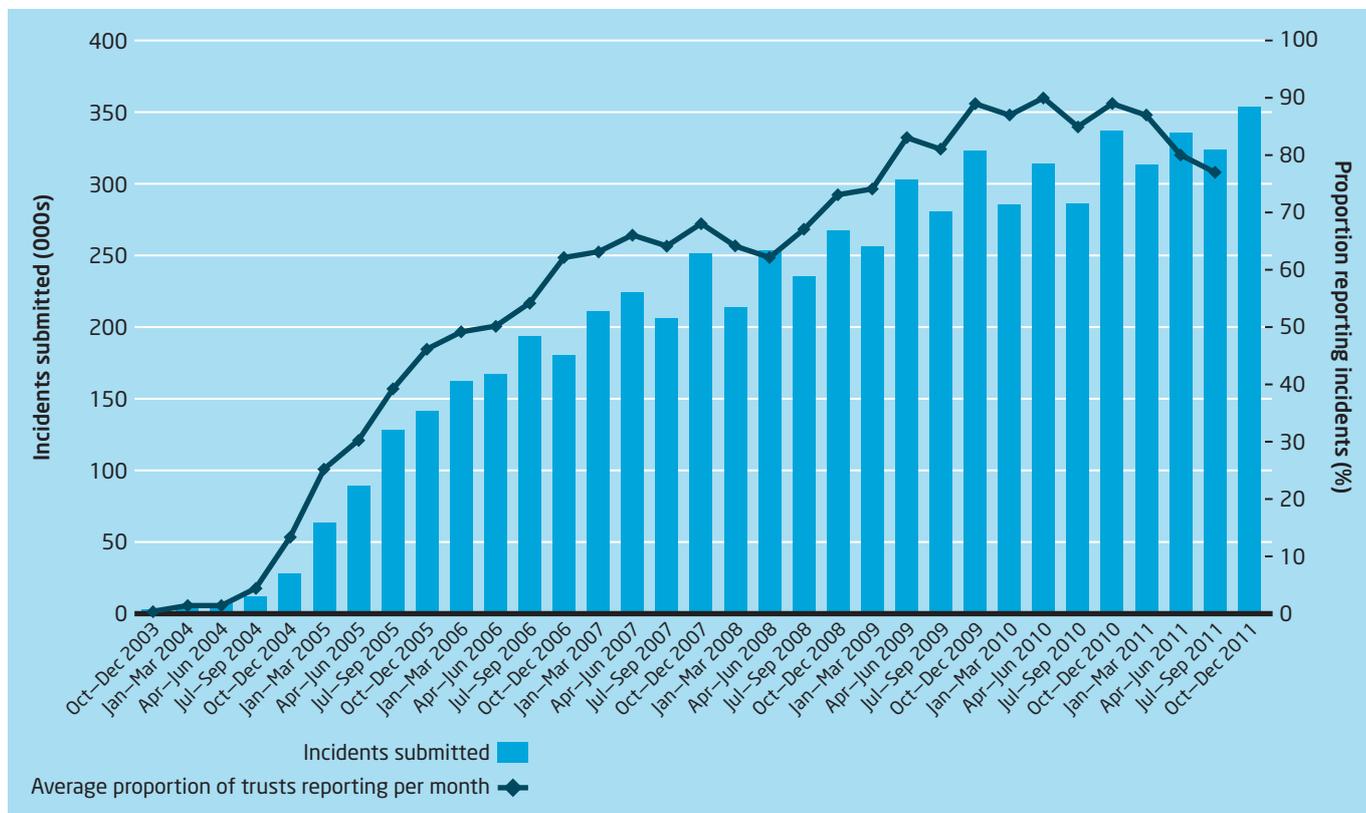
- The previous government introduced challenging targets for reducing infection, supported by national campaigns such as the ‘cleanyourhands’ campaign. Rates of the two most prevalent health care acquired infections (HCAIs) – *Clostridium difficile* (*C difficile*) and methicillin-resistant *Staphylococcus aureus* (MRSA) – fell dramatically, and have continued to fall (see Figure 4 opposite). Rates of MRSA infection have fallen by 25 per cent, and *C difficile* by 17 per cent between 2011 and 2012 (quarter 4) (Department of Health 2012bb).
- However, while levels of MRSA and *C difficile* have decreased, infections caused by other bacteria (notably coliforms, which include *Escherichia coli* (*E coli*) and salmonella) have been increasing (Health Protection Agency 2012a). Coliforms now cause 32.4 per cent of all HCAIs. In a snapshot survey of 103 hospital trusts, 12.4 per cent of the bacteria tested were found to be resistant to the antibiotics most commonly used to treat these infections (Health Protection Agency 2012b).
- The number of reported safety incidents rose by 26 per cent from September 2009 to December 2011 (see Figure 5 opposite). However, under-reporting remains a major concern – particularly in general practice, which generated fewer than 0.5 per cent of all safety incident reports in 2011 (National Reporting and Learning System 2012).
- Patients admitted to hospital as a medical emergency at weekends are more likely to die in hospital than those admitted during the week (Dr Foster Intelligence 2011; CHKS 2012). If the weekend mortality rate were the same as the weekday rate, there would be at least 500 fewer deaths a year in London alone (NHS London 2011).
- Claims of clinical negligence have been rising – from 8,655 claims in 2010/11 to 9,143 in 2011/12 – and since 2006/7 the value of payments made in respect to clinical negligence has doubled (NHS Litigation Agency 2012). The number of complaints made against doctors has also increased, from 7,153 (2010/11) to 8,781 (2011/12) (General Medical Council 2012a), although not all of these complaints relate to safety. These trends could also indicate changing patient expectations and improved access to information.
- Fourteen per cent of NHS hospitals inspected between April 2010 and July 2011 did not meet Care Quality Commission standards relating to safe management of medicine, and 9.9 per cent did not meet standards relating to the safety and suitability of their premises (CQC 2011c).

**Figure 4** Number of reported cases of *C difficile* and MRSA, April 2008-July 2012



Source: Health Protection Agency: [www.hpa.org.uk](http://www.hpa.org.uk)  
*C difficile*: [www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb\\_C/1254510678961](http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1254510678961)  
 MRSA: [www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb\\_C/1254510675444](http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1254510675444)

**Figure 5** Patient safety events, reported by quarter



Source: National Patient Safety Agency - National Reporting and Learning System, Quarterly Data Summary  
[www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/](http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/)

## Other performance issues

There have been two scandals concerning the regulation of medical devices since 2010. In December 2011, it emerged that the French company Poly Implant Prothèse had been using industrial-grade silicone to make breast implants. Around 47,000 women in the United Kingdom had received these implants (NHS Choices 2012). In February 2012, the *British Medical Journal* (BMJ) and the BBC's Newsnight programme revealed research showing that patients who had received metal-on-metal hip implants were at risk of cobalt and chromium seeping into their tissues, causing local reactions that destroy muscle and bone (BMJ 2012).

Our previous report, *A High-Performing NHS?* (The King's Fund 2010), concluded that new sources of data needed to be explored in order to create a more complete picture of safety, and emphasised the importance of creating a safety culture in providers of NHS care.

## What policies has the current government introduced?

### Changes to national structures

The current government has abolished the National Patient Safety Agency (NPSA) and transferred its functions to the NHS Commissioning Board (Department of Health 2010e). In April 2012, the National Reporting and Learning System (NRLS) was transferred to Imperial College for two years.

The Secretary of State holds the NHS Commissioning Board to account through a mandate based on the NHS Outcomes Framework. The NHS Outcomes Framework includes indicators relating to patient safety (domain 5) (*see* box opposite).

A Commissioning Outcomes Framework (COF) will be used to measure the performance of clinical commissioning groups against the indicators set out in the NHS Outcomes Framework. It has not yet been finalised which safety indicators will be included.

The government has developed an NHS Safety Thermometer, which measures four 'high-volume' patient safety issues once a month. Data is collected by a nurse at point of care. The four areas are:

- pressure ulcers
- falls in care
- urinary infections in patients with a catheter
- treatment for venous thromboembolism.

The inclusion of an NHS Safety Thermometer survey for each month in the relevant quarter's submission triggers payment under the Commissioning for Quality and Innovation (CQUIN) payment programme. The intention is to reward the collection of data 'and not the achievement of any specific quality of care threshold' (Department of Health 2012f, p 7).

In addition, the government has maintained the Never Events Framework, which specifies incidents that must not happen – for example, wrong-site surgery (National Patient Safety Agency 2009) – and has expanded the list of events from 8 to 25 (Department of Health 2011m). Primary care trusts have the right to withhold payment both for the procedure and, where appropriate, for costs incurred in treating the consequences of that 'never event'.

## NHS Outcomes Framework, domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

### Overarching indicators

- 5a Patient safety incidents reported
- 5b Safety incidents involving severe harm or death
- 5c Hospital deaths attributable to problems in care

### Improvement areas

#### *Reducing the incidence of avoidable harm*

- 5.1 Incidence of hospital-related venous thromboembolism
- 5.2 Incidence of health care associated infection: MRSA bacteraemia; *C difficile*
- 5.3 Incidence of newly acquired category 2, 3 and 4 pressure ulcers
- 5.4 Incidence of medication errors causing serious harm

#### *Improving the safety of maternity services*

- 5.5 Admission of full-term babies to neonatal care

#### *Delivering safe care to children in acute settings*

- 5.6 Incidence of harm to children due to 'failure to monitor'

Source: Department of Health (2012cc, p 14).

## Tackling health care associated infections

Mandatory surveillance of key infections was extended from MRSA and *C difficile* to include methicillin-sensitive *Staphylococcus aureus* (MSSA) in January 2011 and *E coli* in June 2011 (Department of Health 2011d). However, while incidences of MRSA and *C difficile* infections are specified as indicators in the NHS Outcomes Framework, MSSA and *E coli* are not.

## Regulating providers

From October 2011 to February 2012, the government undertook a review of the capability of the Care Quality Commission (CQC), which is responsible for ensuring that providers of NHS care meet essential safety and quality standards. The review recommended that the CQC improve its analytical capacity, revise its strategy and develop its internal performance measures (Department of Health 2012r). A House of Commons committee had also concluded that the CQC had 'a long way to go before becoming an effective regulator' (House of Commons Public Accounts Committee 2012).

From December 2012, the General Medical Council will be introducing revalidation for all licensed doctors across the United Kingdom. The process is designed to ensure that doctors are up to date and fit to practise, and will normally be required every five years. It will be based largely on regular appraisals, but as part of their revalidation doctors will also have to gather feedback from patients and colleagues.

## Regulating medical devices

The House of Commons Health Select Committee criticised the Medicines and Healthcare Products Regulatory Agency (MHRA) for not responding quickly enough in the case of the Poly Implant Prothèse (PiP) scandal (House of Commons Health Committee 2012) and for downplaying the problem of metal-on-metal implants (BMJ 2012). There has been one government inquiry into the roles of the Department of Health and the MHRA in the PiP scandal, and Professor Sir Bruce Keogh is leading another review of regulation of the cosmetic surgery industry (Department of Health 2012t).

## Creating a safety culture inside organisations

The latest version of the NHS Constitution (Department of Health 2012n) now incorporates legal protection for whistleblowers. It states that staff should raise concerns about safety or malpractice at the earliest opportunity and clarifies their legal right to raise such concerns without any negative consequences.

## Will these policies be effective?

### Structures

There is much to be clarified under the new NHS structures with regard to patient safety.

The NHS Commissioning Board has absorbed the functions of the NPSA. These included producing rapid response reports, patient safety alerts, toolkits and guidance on best practice. It also commissioned and monitored the Confidential Enquiry into Maternal and Child Health. This has now transferred to the Health Quality Improvement Partnership, but its future remains uncertain.

The structures and staff within the NHS Commissioning Board to support patient safety are still in development. There is a concern that the focus on safety may slip when the NHS Commissioning Board and clinical commissioning groups take over management of the NHS in April 2013.

Reports of investigations into ‘serious untoward incidents’ are currently reviewed by strategic health authorities, but it has not yet been established who will review them after the strategic health authorities (SHAs) are abolished.

It is also unclear how exactly the COF indicators will be used to hold clinical commissioning groups to account under domain 5 (patient safety). It is a matter of concern that there are as yet no indicators in the COF relating to safety in primary care, even though this is where 90 per cent of patient contacts take place (Department of Health 2012u).

Finally, the NHS Safety Thermometer (Department of Health 2012f) provides an opportunity for providers to be financially rewarded through CQUIN payments for measuring performance, but its use is not mandatory. There is an inherent tension between reporting safety events and using them to performance manage. It is important that financial incentives for implementing the Safety Thermometer – which is intended to increase levels of reporting – do not adversely affect levels of reporting.

## What needs to happen next?

The issue of how to tackle under-reporting of safety incidents in primary care still needs to be addressed. Historically, safety indicators have been focused on hospital services. The advent of the GP Extraction Service in late 2012 should make much richer data available for general practice, and the development of safety indicators for general practice should be a priority. Safety in social care, where practitioners operate unsupervised in people's homes, needs to be urgently addressed. The scandal of the Bristol care home Winterbourne View (BBC Panorama 2011) highlights the need to ensure that safety reporting covers mental health and learning disability services comprehensively.

With the increasing use of independent health care providers, there is a need to ensure that all independent providers of care to NHS patients are required to meet equivalent reporting requirements to those for the NHS. Independent health care providers do now report on MRSA and *C difficile*, but are not required to report on other safety issues.

There is a key role for the CQC in maintaining and enforcing basic standards of safe care, across NHS and independent sector providers. But the CQC will need to demonstrate its competence while expanding its duties to encompass the registration of all primary care providers (around 10,500 organisations) by April 2013.

Serious attention now needs to be paid to the regulation of medical devices and to ensuring that the MHRA is effective before more harm is caused to patients through the use of unsafe devices.

Even if the issues outlined above are addressed, there is a more fundamental question of how robust the safety culture is. The first line of defence against unsafe care is frontline clinicians, who are responsible for the quality of care they provide. Without an adequate safety culture, providers will struggle to provide safe care.

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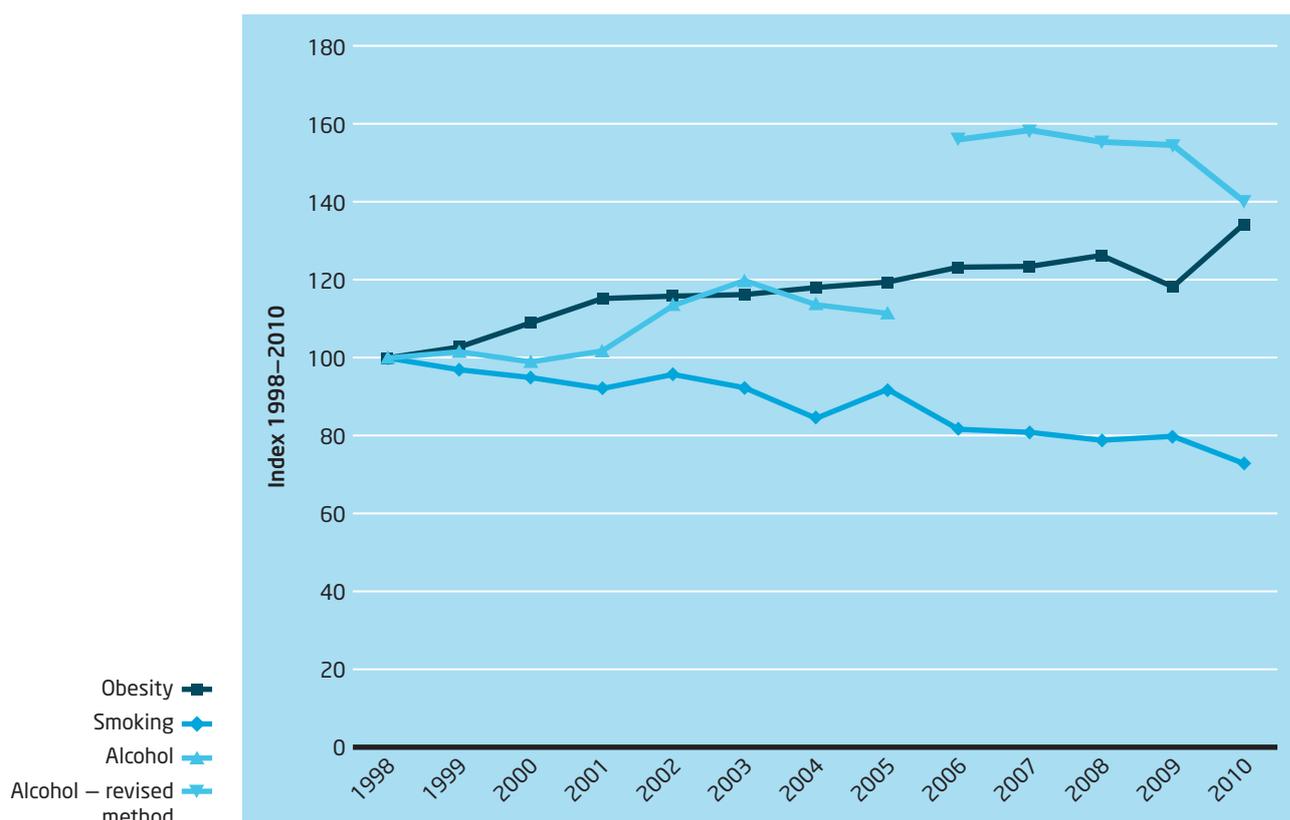
# 3 Promoting health

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*Criterion 3: A high-performing health system supports individuals to make positive decisions about their own health and acts to maximise its positive impact on the broader determinants of people's health.*

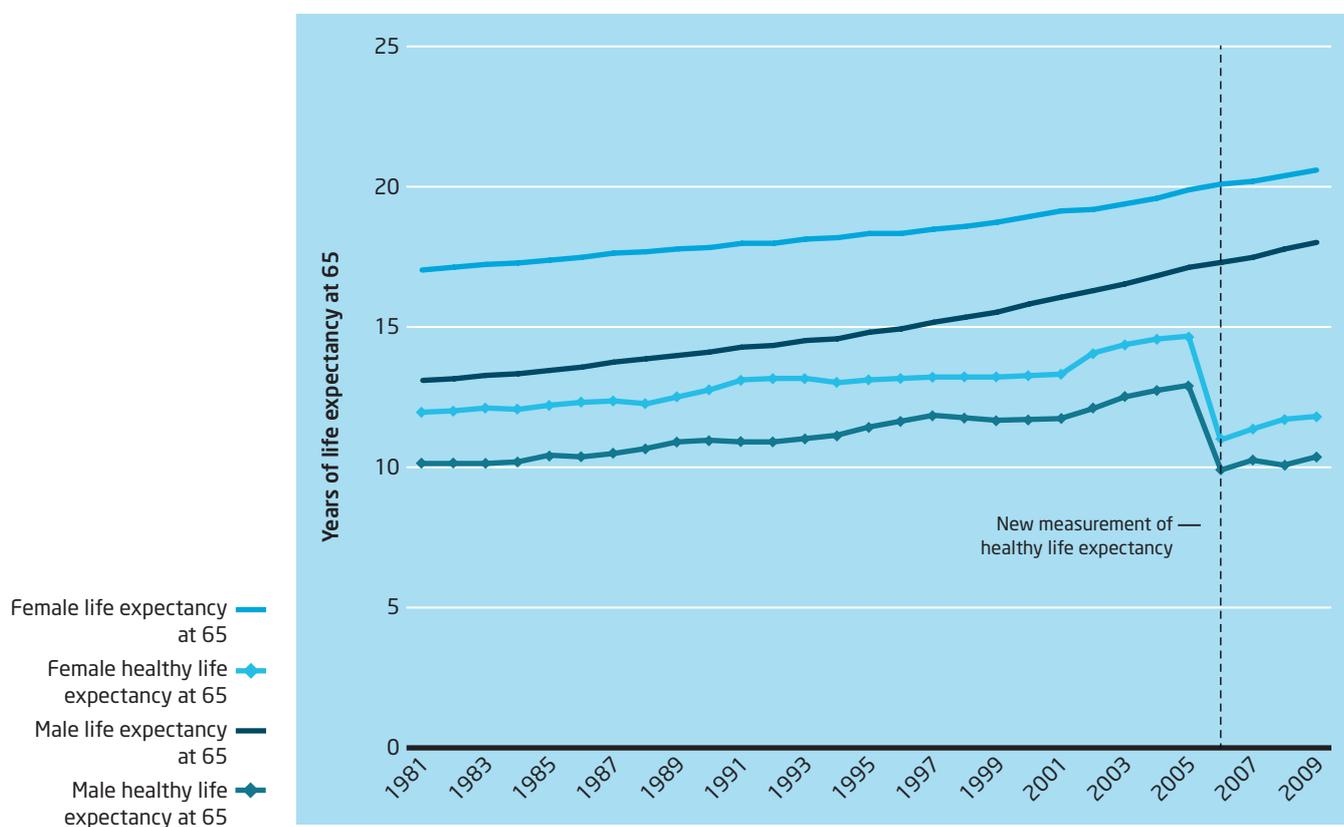
## How is the NHS performing?

- The proportion of obese adults has continued to rise, from 24 per cent of the adult population in 2007 to 26 per cent in 2010. Estimates suggest that this could rise to over 40 per cent by 2035 (Wang *et al* 2011). However, obesity levels in children seem to be stabilising. Fifteen per cent of girls and 17 per cent of boys were classified as obese in 2010, compared with 16 per cent and 17 per cent respectively in 2007 (Information Centre 2012f).
- Smoking rates have declined from 21 per cent of the adult population in 2007 to 20 per cent in 2010 (Information Centre 2012g). The smoking ban in public places was introduced in July 2007. While there has been debate on how effective the ban has been, recent research suggests that it has been successful in reducing cigarette consumption among male heavy smokers, females and younger people (Jones *et al* 2012) and is contributing to the long-run downward trend in smoking rates.
- Alcohol consumption has stabilised and started to fall. The percentage of men exceeding the recommended units per week has declined from 31 per cent in 2006 to 26 per cent in 2010, and in women from 20 per cent to 17 per cent over the same period (Information Centre 2012e). However, there continue to be increases in related health problems – the number of deaths from liver disease (37 per cent of which are accounted for by alcoholic liver disease) rose from 9,231 in 2001 to 11,575 in 2009 (National End of Life Care Programme 2012).
- There is some evidence that the previous government's strategies are beginning to have a positive impact in some areas. Figure 6, opposite, shows an index of smoking rates, obesity levels and alcohol consumption from the beginning of its time in office until 2010 (the most recently available data). The measures used here are:
  - for obesity: having a body mass index above 30
  - for smoking: being a current smoker
  - for alcohol consumption: more than six units (for females) or eight (for males) consumed on heaviest day of drinking in the past week.
- Use of illicit drugs has been declining since the British Crime Survey started to measure it in 1996, but the United Kingdom still has one of the highest rates of illicit drug use in Europe. A report in 2010 found that more than 1 in 12 adults had used an illicit drug in the previous year (Department of Health 2010d).
- In terms of overall health, life expectancy has been increasing (see Figure 7, opposite), although women can still expect to live two years longer than men, on average, at age 65 (Office for National Statistics 2012). The most recent data suggests that there has been an upturn in the rate at which life expectancy improvements have been

**Figure 6** Index of obesity, smoking and alcohol trends in England, 1998–2010

Source: Information Centre (2010, 2011)

Each series has additional caveats. See original sources for details.

**Figure 7** Life expectancy and healthy life expectancy at 65 in England

Source: ONS Health Expectancies at birth and age 65 in the United Kingdom 1981–2001, ONS Health Expectancies in the United Kingdom 2000–2002 to 2008–2010

healthier – also illustrated in Figure 7. Although this is complicated by a switch in methodology, between 2006 and 2009 healthy life expectancy increased by 0.8 years for women, while life expectancy grew by 0.6 years. The figures for men are slightly lower, at 0.5 years and 0.7 years respectively.

There are some encouraging signs from the latest data that some public health issues are improving. However, many are still at historically very high levels. Our previous report, *A High-Performing NHS?* (The King's Fund 2010), concluded that, given the scale of the challenge, the next government would need to draw on all available approaches. These could range from strong state action and regulation to providing information to support individual behaviour change in order to be effective, regardless of its philosophical or political inclination.

## What policies has the current government introduced?

### Changes to national structures and responsibilities

The White Paper *Healthy Lives, Healthy People* (Department of Health 2010d) shifted the main responsibility for public health improvement and behaviour change from the NHS to local government, supported by a ringfenced budget. A new executive agency of the Department of Health – Public Health England – will provide support to the local system and national leadership and will co-ordinate the public health response to large-scale health emergencies.

In this new system, local directors of public health and their teams are to move out of primary care trusts and into local authorities. Health and wellbeing boards are being established as committees of local authorities to assess the needs of the local population and then agree joint health and wellbeing strategies with other key players, such as clinical commissioning groups. The public health system also has a new outcomes framework – the Public Health Outcomes Framework (PHOF) – which covers the broad span of public health with the high-level goals of increasing healthy life expectancy and reducing inequalities between communities.

Moving health improvement into local government is intended to allow services to be planned and delivered in the context of other influences on health, such as employment, crime and housing. It reflects the influence of the Marmot Review (Department of Health 2010b), which highlighted the importance of these wider determinants of health.

The new system will take effect from April 2013, when Public Health England assumes its statutory duties. The system is likely to be supported by around £5 billion in funding, with more than £2 billion of ringfenced grant to be allocated to local authorities for their new responsibilities. From 2015/16, local areas are to be rewarded for success on the Public Health Outcomes Framework through incentive payments known as the 'health premium', although the criteria for payment of this is still to be decided.

### Behaviour change strategies

The government has released new strategies and specific policy documents in a range of areas, including tobacco, obesity and alcohol (Department of Health 2011g, 2011f; HM Government 2012 respectively) with associated 'ambitions' (see Table 1 opposite). It is clear that these are not targets by another name, and will not be performance managed from the Department of Health or Public Health England.

These national ambitions represent an assessment of what could be delivered as a result of the national actions described in the strategies, together with local areas implementing evidence-based best practice supported by the National Institute for Health and Clinical

**Table 1** Ambitions for behaviour change

Strategy	National ambitions
<i>Healthy Lives, Healthy People: A tobacco control plan for England</i>	To reduce: <ul style="list-style-type: none"> <li>■ adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015, resulting in around 210,000 fewer smokers a year</li> <li>■ rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015</li> <li>■ rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).</li> </ul>
<i>Healthy Lives, Healthy People: A call to action on obesity in England</i>	To achieve: <ul style="list-style-type: none"> <li>■ a sustained downward trend in the level of excess weight in children by 2020</li> <li>■ a downward trend in the level of excess weight averaged across all adults by 2020.</li> </ul>
<i>Alcohol Strategy</i>	To achieve: <ul style="list-style-type: none"> <li>■ a change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others</li> <li>■ a reduction in the amount of alcohol-fuelled violent crime</li> <li>■ a reduction in the number of adults drinking above the NHS guidelines</li> <li>■ a reduction in the number of people binge drinking</li> <li>■ a reduction in the number of alcohol-related deaths</li> <li>■ a sustained reduction in both the numbers of 11–15 year olds drinking alcohol and the amounts consumed.</li> </ul>

Source: Adapted from Department of Health (2011g, 2011f); HM Government (2012)

Excellence (NICE) and Public Health England. However, the new approach to public health delivery in England, with a focus on localism, means that local areas will be freer to decide on their own priorities and ways of improving health in their communities. They will not be compelled to act specifically to deliver these ambitions.

### Nudging versus government action

On coming to power, the current government stressed that the roles of central government are primarily to provide people with information, to support the local public health system, and to help make it easier for people to make healthier choices. Regulation will be a last resort.

The government's initial focus was on 'nudging' people – and industry – towards adopting more healthy practices. On the former, the Behavioural Insight Unit has launched nudge pilots in smoking cessation and in organ donation (Cabinet Office 2010). The government's Responsibility Deal can also be interpreted as a form of nudge in trying to support industry, rather than individuals to make the 'right choices'. The deal is based on a series of voluntary pledges – for example, to provide calorie information on food in restaurants, and to ensure that 80 per cent of alcoholic drinks are clearly labelled by 2013 (Department of Health 2011p; Department of Health 2012v). The scheme now has 425 members (Department of Health 2012w).

The government's instincts on public health are clearly liberal, but there have been signs of more recent pragmatism and ambivalence. The government has committed itself to introducing a minimum unit price for alcohol (subject to legal challenge) and has recently concluded a consultation on plain packaging for cigarettes. But the tussle between pragmatism and principles is clearly still playing out. This can be seen most clearly in its approach to obesity. The government's Call to Action on obesity (Department of Health 2011f) neglected to even mention the role of taxes, subsidies or price as a potential lever in tackling obesity. However, the Prime Minister has also said explicitly that 'fat taxes' had not been ruled out, only for the new Secretary of State for Health to reiterate his opposition.

## Wellbeing

There has also been growing interest in wellbeing as an objective of all of government. As he launched the development of national indicators of wellbeing in 2010 (see Office for National Statistics 2012a), the Prime Minister said:

*If you know, both in your gut and from a huge body of evidence, that prosperity alone can't deliver a better life, then you've got to take practical steps to make sure government is properly focused on our quality of life as well as economic growth.*

(Cameron 2010)

The government's mental health outcomes strategy (Department of Health 2011) sets as one of six high-level objectives the ambition to improve the mental wellbeing of the general population. This builds on existing policy under the previous government, which increasingly acknowledged the role of public services with regard to mental health. This includes not just provision for those with mental illnesses, but also more emphasis on working to prevent mental health problems and to promote behaviours and environments that support positive mental health and resilience.

## Will these policies be effective?

### Structures

The shift in responsibility for public health to local government could lead to more concerted action on the wider determinants of health at local level, through local government responsibilities for education, housing, transport, leisure services, planning and licensing. However, there are also risks that public health will become detached from the NHS, and that the NHS will lose the necessary public health expertise.

The accountability structure for public health improvement appears weak – certainly in comparison to the equivalent in the NHS. Local areas are to be rewarded for success on the PHOF through incentive payments, known as the health premium, but there is no accountability or penalty if public health outcomes start to slide. The government seems to have an exceptional confidence in the power of the premium and the public transparency of the PHOF to improve public health, and much trust that the new system will not need stronger accountability to prevent performance from deteriorating.

### Nudging versus government action

As we have seen, there are some signs that the early preference for voluntarism is giving way to a more pragmatic approach – possibly in reaction to the debate about the likely effectiveness of nudge policies. For example, the House of Lords Science and Technology Committee is not convinced by it, saying “Nudging” on its own is unlikely to be successful in changing the population's behaviour’ (House of Lords Science and Technology Committee 2011).

The Responsibility Deal has also been heavily criticised by many in the public health profession for being at best naive, and at worst as selling out to the industry (Wright 2012). A number of public health groups boycotted the agreements. However, there have been recent positive moves, such as the decision by Tesco and the other supermarkets to adopt traffic-light labelling (Hall 2012; Campbell 2012). Whether this can be ascribed to the Responsibility Deal, or to the years of lobbying by non-governmental organisations, is hard to disentangle.

Critics continue to maintain that social responsibility commitments are no substitute for effective regulatory measures, such as statutory controls on nutritional standards

and information, bans on the use of trans fats and regulation of salt levels (Baggot 2011). The Responsibility Deal itself is being evaluated by the Policy Innovation Research Unit (*see* PIRU 2012) led by the London School of Hygiene and Tropical Medicine, with early findings due to report soon. But the House of Lords, on balance, agrees with the critics in relation to obesity, saying that ‘obesity is a significant and urgent societal problem and the current Public Health Responsibility Deal pledge on obesity is not a proportionate response to the scale of the problem’ (House of Lords Science and Technology Committee 2011, para 7.20).

### Wider determinants of health

Marmot’s findings (Department of Health 2010b) have been accepted, with the notable exception of the role of income inequalities, and the wider determinants of health feature prominently in the PHOF for local authorities. However, it is not clear who holds central government policy-makers in departments other than the Department of Health to account for the impact of their decisions on health. This is critical, since it is obvious that the public’s health is affected by wider economic and public policies. For instance, Stuckler et al (2010) found that social welfare spending has a much larger impact on mortality than economic growth. So, there is a missing role in the new public health system. While Public Health England will support local authorities, it (or no other designated body) has responsibility for holding other Whitehall departments to account for the impacts of their policies on public health. The recent decision to abolish the cabinet sub-committee on public health potentially compounds this further. Critical decisions are made in central government that have a profound impact on the population’s health.

### What needs to happen next?

We have welcomed the general direction of public health reform with its greater emphasis on the role of local government. However, the biggest risk of more localism is that public health outcomes in some areas could deteriorate as services become increasingly diverse across the country. The government needs to be much clearer about how it will avert the risks of failure, as well as how incentives for improvement will work. Local and national accountability mechanisms for public health need to be much clearer. One of the most important early challenges for Public Health England will be to develop a clear approach to averting and, as a last resort, dealing with poor performance in terms of public health outcomes.

The government also needs to monitor and act more decisively on the wider determinants of health. The government could commission – through Public Health England or another body – macro health impact assessments of core government policies, such as welfare reform, that will have significant health impacts. Low economic growth, together with high levels of unemployment, are also likely to have an adverse effect on population health and health inequalities.

Finally, the more recent pragmatism that we have seen in terms of behaviour change strategy – notably, the decision to pursue minimum unit pricing for alcohol – needs to be maintained and intensified. Public health is too important to be left to policy choices determined by ideology – be it of the right or the left – rather than evidence-based intervention.

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## 4 Managing long-term conditions

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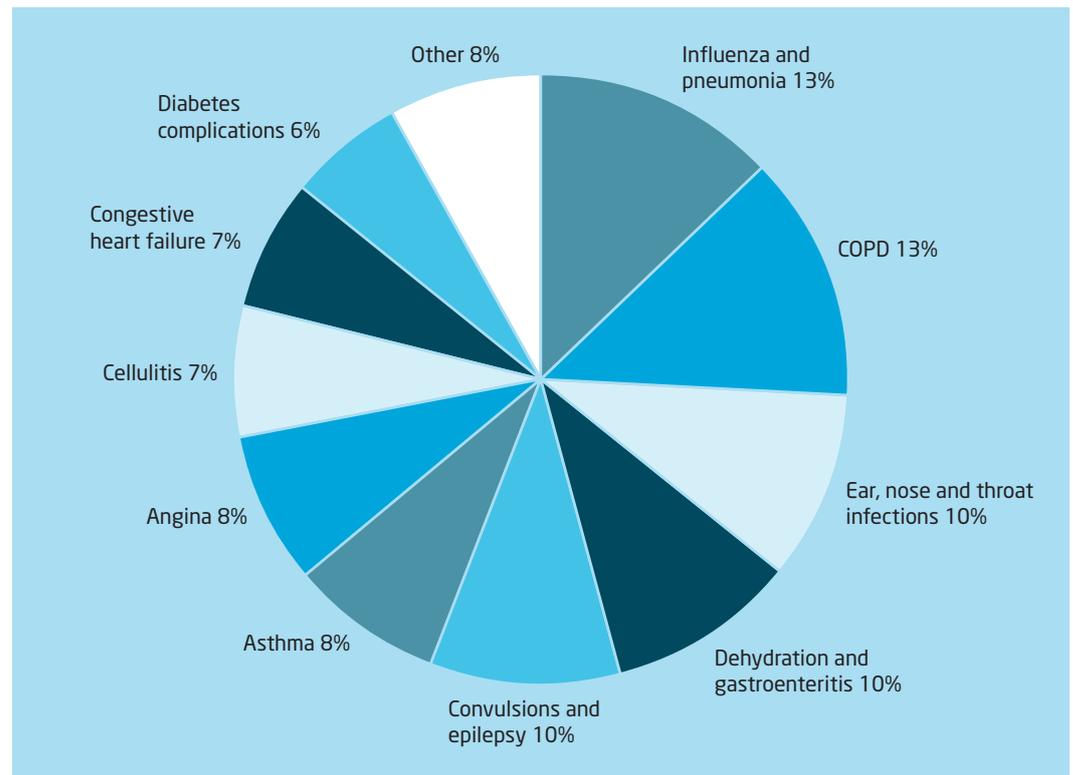
*Criterion 4: A high-performing health system supports individuals with long-term conditions to manage them effectively and achieve a high quality of life.*

### How is the NHS performing?

- Around 15 million people in England have at least one long-term condition. Between 2006/7 and 2010/11, the number of people with diabetes rose by 25 per cent and chronic kidney disease by 45 per cent (Department of Health 2012j). There remain opportunities to improve the care of people with long-term conditions and the outcomes they experience.
- Emergency admissions among people with long-term conditions that could have been managed in primary care cost the NHS £1.42 billion annually – a figure that could be reduced by 8–18 per cent through investment in primary and community-based services (Tian *et al* 2012).
- There is significant variation in emergency hospital admissions among people with long-term conditions that are usually managed within primary care, ranging from 81 to 946 per 100,000 admissions in England (Information Centre 2012c). Figure 8 opposite shows the leading causes of emergency admissions for ambulatory care-sensitive conditions in 2009/10.
- There was a fall in the number of emergency bed days of 13 per cent between 2003/4 and 2007/8, but between then and 2009/10 it rose again by 7 per cent (The King's Fund analysis of Hospital Episode Statistics). The number of people aged 75 or over with two or more emergency hospital admissions in a year rose from 228,934 in 2004/5 to 304,172 in 2010/11 (Care Quality Commission 2011c).
- Every year 24,000 people with diabetes die from avoidable causes related to their condition. £170 million could be saved each year through better understanding and management (National Audit Office 2012b).
- One-third of people with a long-term condition also have a mental health problem, and this combination is more likely to result in poorer clinical outcomes and quality of life. Patients with a mental health condition and diabetes are more likely to be admitted to hospital, while the mortality rate for people with asthma and depression is twice as high as that for other asthma patients (Naylor *et al* 2012).

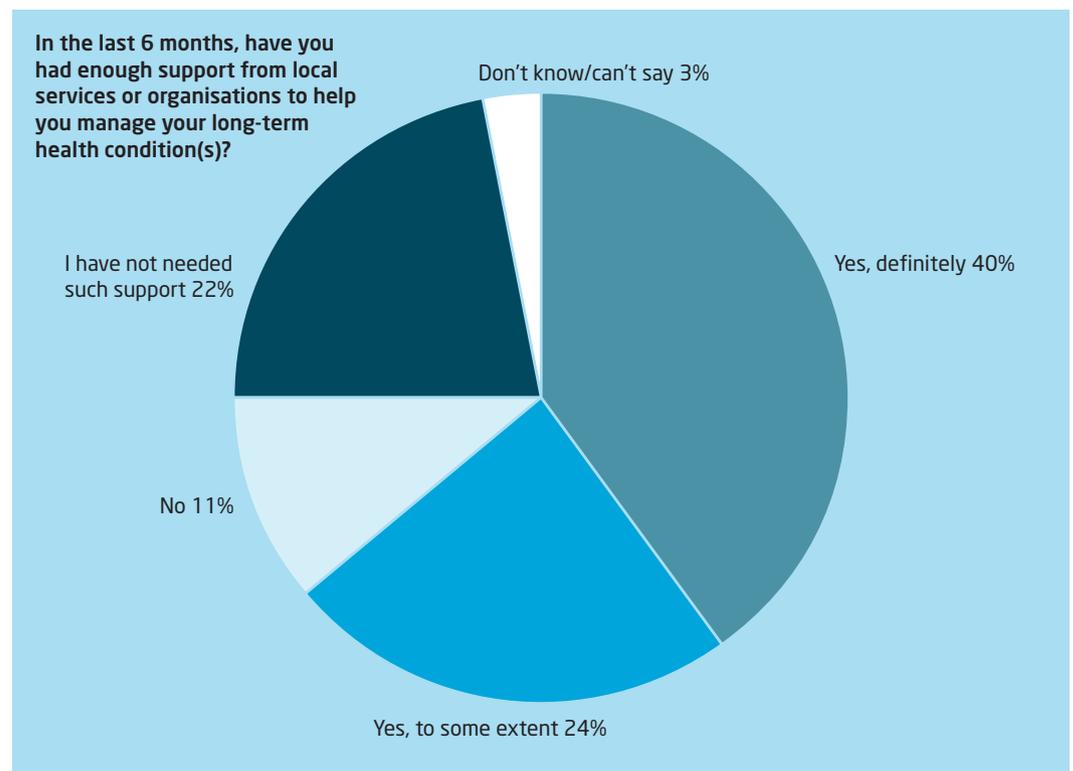
It is important that individuals with long-term conditions are supported to make positive decisions about their care and treatment options (The King's Fund 2010). In 2011, the GP patient survey included a question asking patients whether they received enough support from local services to manage their long-term condition. Figure 9, opposite, shows that 33 per cent of respondents said they had received either no support or not enough support. This indicator may prove a useful benchmark for tracking the future performance of the NHS in supporting people to self-manage their health conditions.

**Figure 8** Proportion of emergency admissions for ambulatory care-sensitive conditions, by condition, England, 2009/10



Source: Tian *et al* 2012

**Figure 9** Percentage of patients who had support from local services to manage their long-term health condition, July 2011–March 2012



Source: Department of Health 2012z GP Patient Survey summary report (July 2011–March 2012). Available at: [www.gp-patient.co.uk/results/download/\\_y6q2/Y6W2\\_Summary.pdf](http://www.gp-patient.co.uk/results/download/_y6q2/Y6W2_Summary.pdf) (page 21)

Our previous report, *A High-Performing NHS?* (The King's Fund 2010), identified that the health system should support individuals to make positive decisions about their own health. It also highlighted the need for the next government to prioritise the development of more integrated and responsive services across primary, secondary and social care.

## What policies has the current government introduced?

The Department of Health is currently in the process of developing a cross-government strategy on long-term conditions and integrated care. An associated long-term conditions outcomes strategy will outline how the key players (including government departments, the NHS Commissioning Board, clinical commissioning groups, local authorities, charities and individuals) can support the delivery of the vision through the creation of 'shared goals'. At the time of publishing, the strategy (for England only) was out for consultation, and will be published by the end of 2012.

The Health and Social Care Act placed new duties on the NHS Commissioning Board, Monitor and clinical commissioning groups to promote integrated care. There are also duties on clinical commissioning groups and health and wellbeing boards to promote integration between health and social care.

The Department of Health's mandate to the NHS Commissioning Board requires the Board to drive integration of care for people with long-term conditions – including those with dementia. The mandate also calls for improved collaboration between mental health and physical health services (Department of Health 2012aa).

Domain 2 of the NHS Outcomes Framework focuses on outcomes for people with long-term conditions. It also seeks to capture how the NHS is supporting people with long-term conditions to achieve positive health and wellbeing outcomes. The core indicator is a measure of health-related quality-adjusted life years for people with long-term conditions using the EQ-5D tool (a patient-reported outcome measure focusing on health-related quality of life).

The NHS Commissioning Board has also overhauled the current system of clinical networks. Previously, most clinical network activity focused on providing clinical advice and leadership on specific conditions. From 2013, their remit will be to facilitate necessary changes in the delivery of key services. The NHS Commissioning Board will host four new strategic clinical networks for up to five years, including a clinical network covering mental health, dementia and neurological conditions.

Since 2010, the long-term conditions Quality, Innovation, Productivity and Prevention (QIPP) workstream has brought together evidence to help spread and embed three fundamental principles of best practice in long-term conditions care to reduce unscheduled admissions:

- neighbourhood care teams, to integrate community services around GP practices
- shared decision-making, to maximise self-management and choice
- telehealth, to support the remote management of people with long-term conditions at home.

## Commissioning for long-term conditions

There have been changes to the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN) pay-for-performance schemes, strengthening their focus on the management of long-term conditions. New QOF

indicators were introduced in 2011/12 to help reduce unnecessary hospitalisations. For 2012/13, the Department of Health has introduced a new CQUIN goal for patients with dementia to support early identification, encourage prompt and appropriate referrals, and ensure follow-up after people leave hospital, so reducing lengths of stay.

The long-term conditions QIPP workstream has developed a Year of Care Funding Model (NHS Diabetes 2011) to support health and social care teams to integrate care in a more successful and sustainable way by better aligning the funding flows. This is not currently a mandated model, but a concept that has been developed using evidence and best practice. It will be formally tested from 2012 at a number of early implementer sites, with the aim of creating a national long-term conditions Year of Care Funding Model by March 2015.

There has been some action to improve the commissioning of care and support for people with long-term conditions. In July 2011, the Department of Health published an outcomes strategy for people with chronic obstructive pulmonary disease (COPD) and asthma that set out six shared objectives through the use of high-quality prevention, detection and treatment (Department of Health 2011b). This was accompanied by a commissioning toolkit for COPD, setting out how the NHS can deliver against this outcomes strategy as well as the National Institute for Health and Clinical Excellence (NICE) quality standard for COPD (Department of Health 2012b).

### Telehealth and telecare

In January 2012, the government announced mainstream adoption of telehealth to support home-based integrated care. The 3 Million Lives campaign was launched, to roll telehealth out to 3 million people over the next five years, and the Department of Health signed an agreement pledging to work with industry, the NHS and social care. This decision was based on headline results from the Whole System Demonstrator trial, which ran between 2008 and 2011 and showed that telehealth could lead to reductions in hospital admissions and mortality. However, the impact on cost savings through reduced utilisation of hospital facilities has been marginal (Steventon *et al* 2012).

### Personal health budgets

The right to a personal health budget has become a key government pledge in support of its agenda to increase patient choice and control. A pilot programme is currently testing the model's feasibility in terms of meeting the health and wellbeing needs of people with long-term illness. The personal health budget approach involves developing a care plan, calculating an amount of money, and determining how it should be spent.

### Will these policies be effective?

The Department of Health is in the process of developing a cross-government strategy on long-term conditions and integrated care. These moves to develop cross-government consensus are to be welcomed. The new duties on new bodies to promote integration must be translated into meaningful action, with clinical commissioning groups and health and wellbeing boards working in partnership to deliver more integrated and personalised care to those with complex needs.

In 2010, *A High-Performing NHS?* noted that there had not yet been a significant shift in resources from acute care to the support of those with long-term conditions in the community (The King's Fund 2010). This is still the case. Less than 20 per cent of people with diabetes receive all the recommended treatment standards, and there is still

significant variation in the provision of cost-effective interventions, such as specialist nurses and staff training across the NHS (National Audit Office 2012b).

Changes to incentives in QOF and CQUIN are unlikely to result in large-scale change. Outcomes-based commissioning might result in more rapid shifts in the location of care, but this needs to be actively supported by the NHS Commissioning Board. The draft indicators that NICE produced for inclusion in the Commissioning Outcomes Framework (COF) have a strong focus on how long-term conditions are managed and treated. These will be used to hold clinical commissioning groups to account from 2013, which should ensure they focus on improving outcomes for people with long-term conditions.

Innovations in telehealth hold the promise of improving care for people with long-term conditions, but evidence suggests that without changes in how services are organised and delivered, the value of these technologies cannot be fully realised.

Early findings suggest that patients are generally positive about their experiences with personal budgets, but the process needs to be made easier (Department of Health 2012s). They are unlikely to be suitable for all patients with long-term conditions. However, elements such as patient-centred care planning should be more widely implemented if people are to be more fully engaged in making choices about their care and treatment options.

## What needs to happen next?

Across England, people with long-term conditions experience variable quality in the care they receive. This situation cannot be tackled in a single parliamentary term. A seven-to-ten-year commitment is needed to ensure that policies have time to generate significant impact (Goodwin *et al* 2012). Innovations in the way long-term conditions are managed need time to embed locally.

In the short term, the government must continue to reaffirm its commitment to integrated care generally – specifically towards the management of long-term conditions – and make sure this remains a priority for health and social care. Strategies inherited under the previous government, such as best-practice guidance on the way key conditions such as diabetes, COPD and dementia are managed, need to be pushed harder. This will help to achieve real progress in managing conditions such as diabetes and heart disease and will ensure better co-ordination of care for frail older people and people with multiple chronic conditions.

In order to achieve lasting change, the NHS Commissioning Board needs to reform financial incentives and develop new contracting mechanisms, along with more radical changes in how care is paid for. This should build on the learning from the Year of Care Programme – for example, paying providers a partial or full risk-adjusted capitation. It also needs to align the outcomes frameworks and develop new measures of integrated care, to be included in the frameworks.

Persistent barriers remain between primary and secondary care, and between health and social care and housing, that hamper the delivery of care that is more integrated for the individual. Currently, most standard measures and incentives are disease specific. Given the rising numbers of people with multiple chronic conditions, more focus is needed on how to treat and support these people. If organisations are to be held accountable for delivering more integrated care for patients, valid ways of measuring experience of care co-ordination need to be developed.

The Department of Health's consultation on the NHS Constitution proposes amending the wording of the fourth of the seven principles that should guide the NHS to refer to co-ordinated care as follows:

*...NHS services must reflect, and be co-ordinated around, the needs and preferences of patients, their families and their carers.*

(Department of Health 2012e, annexe 4, p 3)

In future it may also need to include a right for patients with long-term conditions to a written care plan and a named person who is responsible for co-ordinating their care.

More needs to be done to evaluate innovative approaches to integrated care and the way long-term conditions are managed, including telehealth. To support effective adoption of these approaches, these need to be underpinned by some means of disseminating the lessons learned.

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# 5 Clinical effectiveness

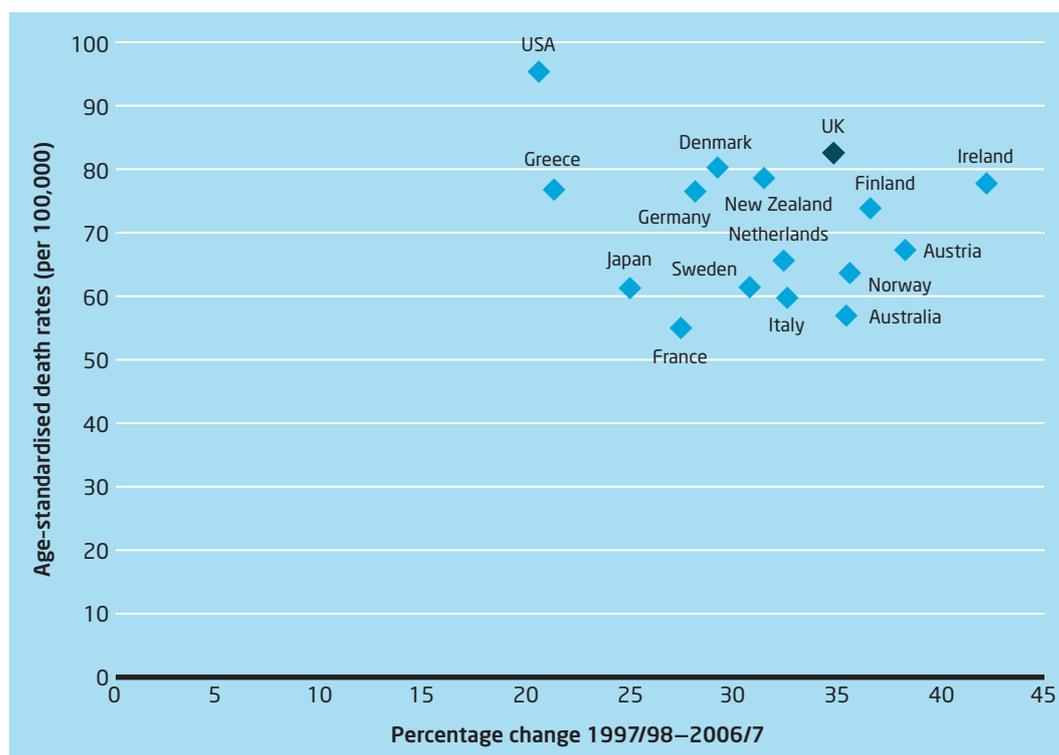
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*Criterion 5: A high-performing health system delivers services to improve health outcomes in terms of successful treatment, the relief of pain and suffering, restoration of function, and, where these are not feasible, adequate care and support.*

## How is the NHS performing?

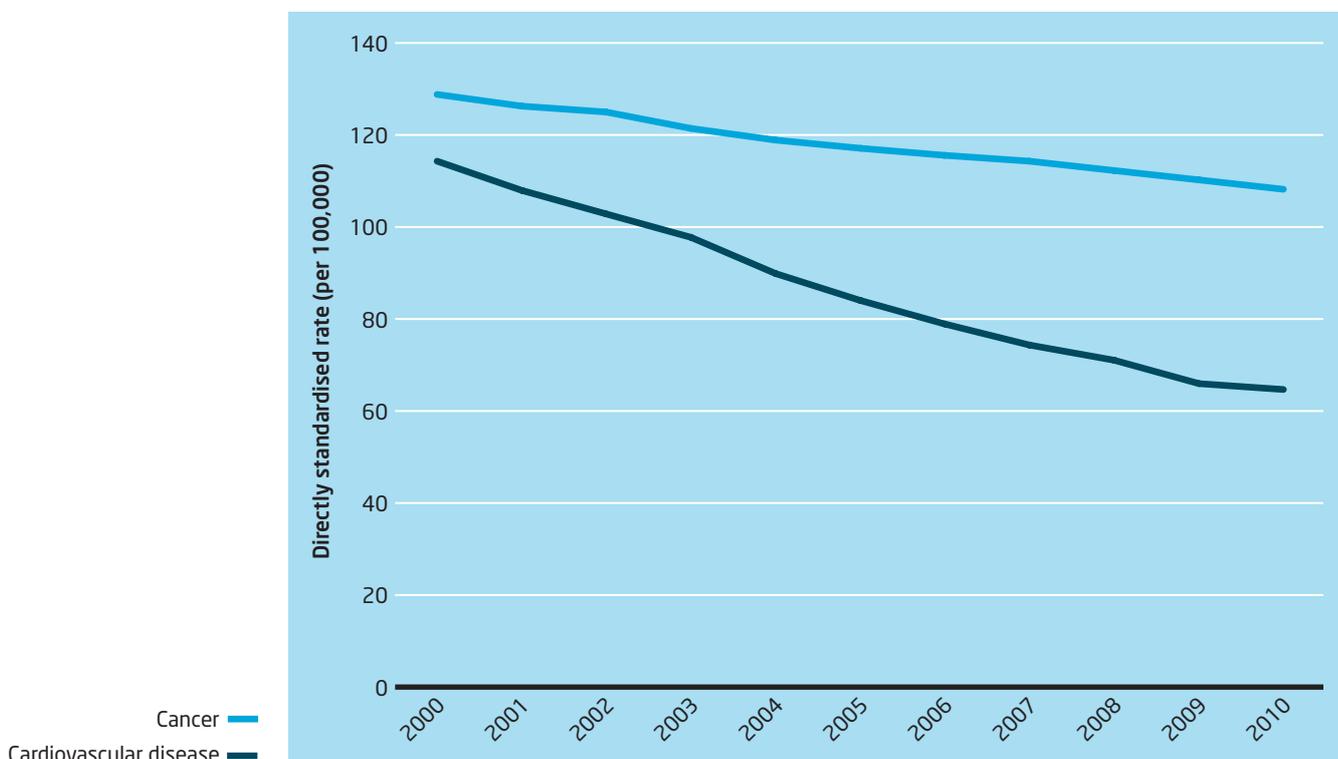
- There was a decline in mortality amenable to health care of 34.7 per cent between 1997/8 and 2006/7, but the United Kingdom still has the highest rate of 16 Organisation for Economic Co-operation and Development (OECD) countries, with the exception of the United States (Nolte and McKee 2011) (*see* Figure 10 opposite).
- Cancer mortality has fallen by 19 per cent since 2000 (*see* Figure 11 opposite), but the United Kingdom's cervical cancer five-year relative survival rate for 2004–9 (58.8 per cent) still compares poorly with the OECD average (66.4 per cent). The same is true for breast cancer (81.3 per cent and 83.5 per cent) and lung cancer (52.6 per cent and 59.5 per cent) (OECD 2011). This reflects diagnosis at a later stage, delays in diagnosis and treatment, and variable access to treatments such as surgery and radiotherapy – particularly among older patients and less affluent groups (Foot and Harrison 2011; NHS Right Care 2011).
- There is a three-fold variation in the number of patients referred by GPs for suspected cancer (National Cancer Intelligence Network 2012). Although there is no defined 'optimal' level of referrals, the figures at either end of the range could reflect unwarranted clinical variation.
- Mortality due to cardiovascular disease also fell by 43 per cent from 2000 to 2010 (*see* Figure 11 overleaf). However, the NHS Atlas of Variations in Healthcare (NHS Right Care 2011) shows significant geographical variations in access to and treatment of cardiovascular disease – for example:
  - elective admissions for angioplasty ranged from 11 to 92 per 100,000 population
  - the rate of pacemakers implanted ranged from 178 to 902 per million population
  - the proportion of transient ischaemic attack (TIA) cases with a higher risk treated within 24 hours varied from none to 100 per cent.
- Average compliance across nine key indicators measured by the Sentinel Stroke Audit has continued to rise, from 60 per cent in 2006 to 73 per cent in 2008 and 83 per cent in 2010 (Royal College of Physicians 2012).
- As in many other countries, the male suicide rate in England increased slightly in 2008 following the financial crisis, by about 8 per cent between 2007 and 2009 (Information Centre 2012c). However, this increase has since levelled off and shows signs of going into reverse. Suicide rates in the United Kingdom remain well below the European average (World Health Organization Europe 2012). However, there are reports of a significant increase in calls to GPs and mental health help lines as a result of the financial pressures resulting from the recession (BBC 2012; Soteriou 2012).

**Figure 10** Age-standardised mortality rates for amenable causes by percentage fall in mortality, 1997/8–2006/7



Source: Nolte and McKee 2011

**Figure 11** Premature mortality rates for cancer and cardiovascular disease in people under 75 years of age



Source: Information Centre 2012c

In our previous report, *A High-Performing NHS?* (The King's Fund 2010), the main areas highlighted for improvement were the need to improve health outcomes further and to reduce the variation in care that patients receive.

## What policies has the current government introduced?

*A High-Performing NHS?* focused specifically on cancer, cardiovascular disease and mental health as the three clinical areas that had been given particular priority by the previous government. The current government has continued to take specific policy action in these areas, as well as adopting a more general approach to improving clinical effectiveness.

### Outcomes framework

Domains 1 and 3 of the NHS Outcomes Framework are aligned to clinical effectiveness:

- **Domain 1** preventing people from dying prematurely
- **Domain 3** helping people to recover from episodes of ill health or following injury.

Cardiovascular disease, mental health and cancer remain important areas, and have specific indicators set out in the domains. Further indicators are likely to be added over time, in support of the National Institute for Health and Clinical Excellence (NICE) Quality Standards that are currently under development, which will cover 150 topics.

### Incentivising clinical effectiveness through payment mechanisms

The current government has extended the use of Payment by Results (PbR) to promote quality and clinical effectiveness. Best-practice tariffs pay providers according to the actual cost of best clinical practice rather than the national average cost of care (Department of Health 2012c). Best-practice tariffs were introduced in 2010/11 for cataracts, gallbladder removal, acute stroke care and fragility hip fracture. These conditions were chosen due to the high volume of procedures performed and because of the significant unexplained variation in quality of clinical practice, despite clear evidence of what best practice should look like. Best-practice tariffs have now been extended to cover 15 procedures for 2012/13, and include an incentive for higher day-case rates (Department of Health 2012q). An evaluation of the first year of best-practice tariffs has been commissioned, but is not due to report until the autumn (Department of Health 2011r).

The new government committed to continue with the Commissioning for Quality and Innovation (CQUIN) framework that was introduced in 2009/10 (Department of Health 2010a). CQUIN allows commissioners to link up to 1.5 per cent of the contract value to the achievement of pre-agreed local quality improvement goals. In 2012/13, for all standard contracts, the amount that providers can earn through CQUIN is increased to 2.5 per cent on top of actual out-turn value (Department of Health 2011o).

### Improving clinical effectiveness through increased transparency and publication of information

*The Power of Information* sets out the Department of Health's 10-year strategy for transforming information for the NHS, public health and social care (Department of Health 2012dd). The aims of the strategy include improving access to information – both for health and social care professionals, to support high-quality integrated care, and

for patients and the public. One priority is for patients to have access to their medical records (including a commitment for access to GP records online by 2015), in order to support health improvement and self-management. Another is for health and social care professionals to have access to standardised information, through IT and data linkage, to support quality improvements in service delivery.

Patient-reported outcome measures (PROMs), which were introduced by the previous government, continue to be routinely collected for four surgical procedures: hip replacements, knee replacements, varicose vein surgery and groin hernia repair. These provide evidence on the effectiveness of planned surgical procedures, and are supposed to be reported in quality accounts. The government is committed to extending PROMs to other areas 'where practicable' (Department of Health 2010a). Initial analysis of pre- and post-operative PROM data shows variation in the improvements reported by patients treated at different hospitals for hip replacement (Appleby and Devlin 2010). People in more deprived areas reported worse self-reported health pre-operatively, although treatment rates are lower in these areas (Appleby *et al* 2011).

### Clinical networks and senates

Hosted by the NHS Commissioning Board, clinical senates and networks will provide clinical advice to support clinical commissioning groups, health and wellbeing boards and the NHS Commissioning Board in local decision-making. The membership of clinical senates has yet to be determined, but will comprise a range of clinicians, patients and other partners. They are likely to play a key role in providing a strategic overview of major service change – for example, on service redesign and reconfiguration.

Four strategic clinical networks will be established from 2013, including networks for cancer, cardiovascular disease – incorporating cardiac, stroke, diabetes and renal disease – and maternity and children.

### Centralising specialist acute services

Moves to centralise certain specialist services were initiated by the previous government and have been continued by the current government. Following the publication of the *Next Stage Review* in 2008, London designated eight hyper-acute stroke centres and four major trauma units that operate 24/7 and are staffed by specialist consultant-led teams with access to the best facilities (NHS London Health Programmes 2009). Being admitted to a dedicated stroke unit is associated with better patient outcomes (Stroke Unit Trialists' Collaboration 2007), and the new system will save an estimated 400 lives each year (NHS London 2010b). Meanwhile, among trauma patients, 58 Londoners who would have been expected to die of their injuries survived (London Trauma Office 2011).

The government recently confirmed the development of a national trauma network of 22 new centres across England – a move expected to save a further 600 lives each year (Department of Health 2012m).

The NHS has also announced the creation of academic health science networks. These are intended to speed up the adoption of proven interventions and best practice through the NHS and to apply research and evidence on what works. The process of designating the networks is currently under way. These will build on, rather than replace, the academic health science centres, which the previous government established to bring together research and practice as part of a wider strategy to promote the life sciences and ensure that the NHS remained at the forefront of medical advances.

## Cancer

In 2011, the government published *Improving Outcomes: A strategy for cancer*. The paper explicitly commits to improving cancer survival – both in relative terms, compared to other countries, and in absolute terms, by saving 5,000 lives by 2015 (Department of Health 2011h). Supporting this ambition, the NHS Outcomes Framework includes indicators on one- and five-year survival rates for breast, colorectal and lung cancer patients (Department of Health 2011n), and an indicator on premature mortality from cancer (for people under 75 years of age). This has also been recommended by NICE, for inclusion in the Commissioning Outcomes Framework (NICE 2012a).

The government hopes to increase early diagnosis by reaffirming the commitment made by the previous government to extend both the breast and colorectal cancer screening programmes (Department of Health 2011h). The age range for breast screening has been extended from 50–70 years to 47–73 years. The government has also mandated that the new Cancer Drugs Fund (*see* Section 1) must collect efficacy data on the funded drugs (Department of Health 2012y).

## Cardiovascular disease

In December 2011, the government announced that it would publish a new cardiovascular disease outcomes strategy, suggesting that the government remains committed to improving outcomes for cardiovascular disease. NICE has also recommended that the indicator on premature mortality from cardiovascular disease in the NHS Outcomes Framework should be included in the Commissioning Outcomes Framework (which also includes eight indicators on stroke).

## Mental health

The 2012 Health and Social Care Act requires that the NHS places mental health ‘on a par’ with physical health, and the Department of Health mandate for the NHS Commissioning Board describes the government’s expectations for delivering on this commitment.

The government’s cross-government strategy *No Health Without Mental Health* for improving mental health outcomes (Department of Health 2011l) describes six objectives, two of which relate in particular to the effectiveness of services:

- more people with mental health problems will recover
- more people with mental health problems will have good physical health.

Others focus on prevention, patient safety, patient experience and stigma.

The NHS Commissioning Board, Public Health England and other bodies will be accountable for driving these improvements. Mental health indicators in the NHS Outcomes Framework, the Public Health Outcomes Framework and the Department of Health mandate to the Board (Department of Health 2012aa) include:

- excess mortality (under 75) among people with serious mental illness
- employment rates for people with mental illness
- the proportion of mental health service users in settled accommodation
- Improving Access to Psychological Therapies (IAPT) recovery rates
- seven-day follow-up on discharge from psychiatric inpatient care
- suicide.

The NHS Outcomes Framework includes a new indicator on premature mortality in people with serious mental illness (people under 75 years of age). This indicator shows that premature mortality among people with serious mental illness is 3.2 times greater than mortality in the general population. There are several new Quality and Outcomes Framework (QOF) indicators relating to physical health among people with mental illness, including checks for cholesterol, blood pressure, blood sugar, alcohol use and tobacco use, as well as cancer screening.

An estimated 6.1 million people in England are living with anxiety and depression disorders. A four-year action plan for the full roll-out of IAPT aims to increase access to psychological therapies to a minimum of 15 per cent each year (3.75 per cent per quarter) of those in need by 2014/15, affecting some 3 million people.

The policy shift to measuring recovery from mental health problems is reflected also in the move to measure employment rates in people with mental health problems. In the second quarter of 2011, data from the Labour Force Survey showed employment rates of 26 per cent (Information Centre 2012c).

## Will these policies be effective?

The current government's overall approach towards improving clinical effectiveness represents a fundamental departure from earlier approaches. Unlike the national service frameworks, which preceded them a decade earlier, the outcomes strategies contain few tangible methods of improving clinical effectiveness. Future improvements in clinical effectiveness hinge on the success of this 'hands-off' approach.

### Outcomes frameworks

The publication of strategies such as *Improving Outcomes: A strategy for cancer* (Department of Health 2011h) and frameworks such as the NHS Outcomes Framework specify key objectives and outcomes against which progress can be measured. These are positive steps. However, it remains to be seen whether the outcomes frameworks really do act as a lever for improving the clinical effectiveness of services, and how these can be embedded within commissioning and contracts with services providers. There is currently a lack of clarity about how accountability mechanisms will work, and how performance will be assessed at both national and local levels.

Clinical senates and networks have the potential to make a positive contribution to the efforts of clinical commissioning groups and providers to drive improvements in clinical effectiveness locally. However, much will depend on how effectively these multiple local stakeholders and agencies can work together.

### Information

The aims of the information strategy are laudable but highly ambitious. Given the financial constraints facing the NHS, it is questionable whether its more ambitious aspirations will be realised in the short to medium term (Raleigh 2012). However, the commitment to greater transparency is welcome. So is the commitment to increase the public availability of information from clinical audits about the quality of care at team level. The intention is for this data to be available from April 2014.

The act of simply publishing data is unlikely to result in changes in performance. Early analysis of quality accounts showed that much of the data was poorly presented, and few of them had included the relevant benchmarks or time series needed to facilitate an understanding of how well the organisation was actually performing (Foot *et al* 2011).

Evidence suggests that publishing information on the relative performance of providers can galvanise poorly performing trusts to take action to improve (Shekelle *et al* 2008). However, the impact appears to stem from providers' reputational concerns rather than the information being used by patients or the public.

## Cancer

It is likely to be some years before sufficient data is available to judge whether the continued focus on cancer outcomes is delivering improvements in England's survival rates relative to other countries. Investment in treatment – for example, through the Cancer Drugs Fund – is likely to address part of the issue, but early diagnosis and tackling inequalities in treatment are far more important.

## Cardiovascular disease

There are specific indicators relating to cardiovascular disease in the NHS Outcomes Framework, and the area has been proposed for inclusion in COF. However, it remains to be seen how much impact the focus on outcomes will have on factors such as premature mortality resulting from cardiovascular disease.

## Mental health

While the policy developments in mental health signal some welcome changes, much will depend on how much priority the clinical commissioning groups attach to implementation on the ground – especially given the unprecedented financial challenges facing the NHS. Historically, mental health budgets have been diverted to more 'visible' clinical priorities, and recent evidence suggests that there was real-terms disinvestment in adult mental health services between 2010/11 and 2011/12 (Department of Health 2012a).

## What needs to happen next?

If the focus on clinical outcomes in the NHS Outcomes Framework and the Commissioning Outcomes Framework are to have an impact on providers, these outcomes need to be embedded through the commissioning process, and in the way that providers are paid and rewarded. Clinical commissioning group accountability will be crucial to ensure delivery at a local level, as their actions will determine the overall national outcomes.

The NHS Commissioning Board needs to use NICE's quality standards work as a basis for standard contracts. Delivering improvements in outcomes will also require all parts of the NHS to work together. Clinical networks could play a role in supporting providers to work together effectively, but there is a risk that they will not have any leverage over more autonomous and competing providers.

It will be necessary to further concentrate and reconfigure services in order to improve outcomes. This requires local clinicians, as well as those involved in clinical senates and networks, to show leadership and make the case for how this will benefit patients and the public, while politicians need to resist defending local hospitals.

## Information

The Atlas of Variation, published by the NHS (NHS Right Care 2011), continues to highlight the extent of geographical variation in treatment rates and outcomes achieved across England. Analysis of PROMs and other data in secondary and primary care consistently find huge variations (Appleby *et al* 2011; The King's Fund 2011). While

some of this variation can be explained by differences in prevalence and clinical need, at least some is likely to be unwarranted, and suggests that there remains significant scope for more consistent application of clinical standards and effective models of care.

Commissioners need to have a stronger focus on reducing variation and must challenge providers to improve where evidence suggests that they are in the lower end of performance. Commissioners also need to be asked to explain variations in the rates of treatment in their areas, to ensure a greater degree of equity of access (see Sections 1 and 7).

## Cancer

Cancer outcomes are improving. However, late diagnosis and wide variations in GP referral rates, delays in treatment, access to treatment and treatment outcomes continue to contribute to England's poor international standing on cancer survival. There needs to be greater public awareness to reduce late presentation and more focus to ensure that GPs recognise the early symptoms. As cancer survival rates improve, health care services need to aim to improve quality of life for the growing number of people with cancer.

## Cardiovascular disease

The focus on cardiovascular disease now needs to shift to prevention – especially given current trends in obesity and the rising prevalence of diabetes. Work is also needed to address the wide variations in care for people with cardiovascular disease that are currently apparent in the NHS.

## Mental health

Significant investments have been made in extending the IAPT programme in mental health. It will be challenging to maintain these as budgets come under pressure. IAPT also needs to be more closely integrated with the management of people with long-term conditions. Depression is common among this group, and if it is not treated can lead to poorer outcomes (Naylor *et al* 2012). The QOF focus on physical health for people with serious mental illness is likely to help reduce differences in outcomes.

Employment and housing are key to recovery for people with mental health problems. Given the wider economic situation, NHS and local government need to work hard with other partners to deliver on these objectives, and will need public services for these individuals to be joined up locally.

Finally, while medical and surgical advances mean that patients can be offered more clinically effective treatments, more life years can be gained through even modest reductions in, for example, cardiovascular risk factors (Young *et al* 2010). With this in mind, it is important to consider clinical effectiveness in the wider policy context, and to sound a note of caution that improved incidence and mortality figures are influenced both by improved clinical outcomes and by the wider policy and legislative landscape.

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# 6 Patient experience

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*Criterion 6: A high-performing health system delivers a positive patient experience. This includes giving patients choices and involving them in decisions about their care, providing the information they need and treating them with dignity and respect.*

## How is the NHS performing?

- Patient experience of NHS adult inpatient services showed no change overall between 2009/10 and 2011/12, and the overall score for patient experience in outpatients increased slightly from 78.8 to 79.2 over the same period ( a score of 80 is equivalent to a rating of ‘very good’) (Department of Health 2012p). Both inpatient and outpatient surveys show very little change in scores on dimensions such as co-ordination of care, information and choice, relationships with staff and the physical environment (*see* Table 2 opposite).
- One-fifth of NHS acute hospitals inspected by the Care Quality Commission in 2011 did not meet essential standards in nutrition and dignity for older people. Problems reported included a lack of privacy for patients, call bells being put out of patients’ reach, and patients not receiving the assistance they needed to eat their meals (Care Quality Commission 2011a).
- A number of major reports have highlighted serious failures in the quality of care received by vulnerable patients, both in hospital and in long-stay residential settings (Care Quality Commission 2011a; BBC Panorama 2011; Francis 2010; Patients Association 2011). These raise important questions about how to ensure that providers meet the basic care needs of patients and residents, as well as maintaining functional mobility of older people and identifying and treating mental health problems, such as delirium and dementia.
- The number of breaches of mixed-sex accommodation guidance has fallen by over 96 per cent in 16 months. The Department of Health attributes this to the introduction of compulsory reporting of such breaches in December 2010 (Department of Health 2012ff).
- The number of written complaints to hospitals and community services rose by 23 per cent between 2007/8 and 2011/12, from 87,080 to 107,259 (Information Centre 2012b). The government does not view an increased number of complaints as necessarily reflecting the quality of services provided, but as an important part of all feedback available to providers (Department of Health 2010a).

Table 3, opposite, shows the 10 leading causes of complaints about hospital and community services in England in 2011/12. It shows that relational aspects to care – namely, staff attitude and communication – figure highly in patient complaints.

- There has been a decrease in the proportion of respondents saying that they were offered a choice of hospital for their first appointment, from 32 per cent in 2010 to 29 per cent in 2011. However, there has also been a corresponding increase in the proportion who say they ‘did not mind’ that they were not offered a choice: from 58 per cent in 2010 to 61 per cent in 2011 (Care Quality Commission 2011b).

England is unusual in having well-established national patient and staff surveys that can be used to measure patient experience of care over time. However, our previous report, *A High-Performing NHS?* (The King’s Fund 2010), argued that trusts need to invest in new kinds of measurement. They need to measure patient experience more frequently to ensure quality improvement and accountability. Also, progress is still needed in relation to choice, in involving patients in their care, and in some aspects of the hospital environment.

**Table 2 Overall national scores from inpatient and outpatient surveys**

	2009/10	2010/11	2011/12
<b>Safe, high-quality, co-ordinated care</b>			
Inpatient	64.4	64.6	64.8
Outpatient	83.2	NA	83.6
<b>Better information, more choice</b>			
Inpatient	66.8	67.2	67.2
Outpatient	79.1	NA	78.6
<b>Building closer relationships</b>			
Inpatient	82.9	83.0	83.0
Outpatient	87.3	NA	87.7
<b>Clean, friendly, comfortable place to be</b>			
Inpatient	79.1	79.3	79.4
Outpatient	70.9	NA	71.3

Source: Department of Health inpatient and outpatient surveys: [http://transparency.dh.gov.uk/2012/04/24/inpatient\\_survey\\_results\\_2011/](http://transparency.dh.gov.uk/2012/04/24/inpatient_survey_results_2011/)

**Table 3 Ten leading causes of complaint about hospital and community services, England, 2011/12**

Cause of complaint	Number of complaints
All aspects of clinical treatment	44,719
Attitude of staff	11,165
Communication/information to patients (written and oral)	9,750
Appointments, delay/cancellation (outpatient)	8,041
Other	4,644
Transport, ambulances and other	2,411
Appointments, delay/cancellation (inpatient)	2,247
Aids and appliances, equipment, premises (including access)	1,535
Patients’ privacy and dignity	1,082
Policy and commercial decisions of trusts	1,051

Source: Information Centre (2012a)

## What policies has the current government introduced?

### Measuring progress

The performance of the NHS Commissioning Board will be measured using indicators in domain four of the NHS Outcomes Framework: ‘ensuring that people have a positive experience of care’. The measures cover people’s experience of outpatient and inpatient care, community mental health services, and maternity services. The NHS Commissioning Board will identify indicators to measure people’s experience of care at the end of their lives and children and young people’s experience of health care. Many of the indicators are based on the Care Quality Commission’s (CQC’s) annual patient surveys. This suggests that there is an ongoing commitment to conducting regular national surveys of patients’ experiences in multiple settings.

The Department of Health mandate for the NHS Commissioning Board does not set levels of ambition for each indicator in the NHS Outcomes Framework. Instead, it has overarching objectives within each part of the framework. The overarching indicators relating to patients’ experience of care are: to improve patient experience of primary care (GP services, GP out-of-hours services, NHS dental services), to improve patient experience of hospital care, and to introduce the ‘friends and family test’ for patients and staff using NHS services. In future, hospitals that score well in the friends and family test will receive financial reward (Department of Health 2012aa). All providers will be required to collect and report data using this test. Although it is widely used in commerce and in US health care organisations to test customer views, its use in the NHS is somewhat controversial. However, some commentators consider that it may be unsuitable for health care and especially easy to game (Cornwell 2012).

### Other frameworks, standards and measures

Other bodies have continued to produce guidance on patient experience, too. The National Institute for Health and Clinical Excellence (NICE) has produced a quality standard and guidance on patients experience in adult NHS services (NICE 2012c, d) and another on service users experience in adult mental health (NICE 2011a, b).

In 2011, the National Quality Board (established in 2009) published *The Patient Experience Framework*, highlighting eight elements that are critical to good patient experience of the NHS. These are based on an evidence-based definition of a good patient experience developed by the Picker Institute (Department of Health 2011k). The eight elements are:

- respect for patient-centred values, preferences, and expressed needs
- co-ordination and integration of care
- information, communication and education
- physical comfort
- emotional support
- the involvement of family and friends
- transition and continuity
- access to care.

Proposed revisions to the NHS Constitution strengthen the third of the seven NHS guiding principles, adding the words:

*Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.*

(Department of Health 2012e annexe 4, p 3)

## Shared decision-making

The current government has placed an emphasis on shared decision-making – the principle of ‘no decision about me without me’. The implementation of shared decision-making across the NHS will be monitored using existing questions from inpatient, accident and emergency (A&E) and maternity experience surveys that ask whether patients were as involved in decisions about their care as they would have liked. The government has published a consultation document *No Decision About Me Without Me: Further consultation on proposals to secure shared decision-making* (Department of Health 2012i), but this includes very few suggestions about how shared decision-making will be implemented, and is in fact largely concerned with patient choice (Coulter 2012).

## Patient choice

The government is committed to extending patient choice (Department of Health 2012i), to include:

- choice of general practice
- choice of diagnostic test provider
- choices post-diagnosis, including choice of treatment
- choice of provider of maternity services.

Since April 2012, all patients referred for a first consultant-led outpatient appointment have had the right to choose a named consultant-led team (Department of Health 2011o). It has been reported that, from autumn 2012, the range of services that can be provided under any qualified provider is being extended to encompass 39 new services, including podiatry, psychological therapies, smoking cessation, attention deficit hyperactivity disorder (ADHD) and autism (GP online 2012). Non-NHS providers that can deliver services within NHS prices, and that meet the service quality requirements set out by the CQC and in contracts, will be able to deliver NHS-funded services in these areas.

## Patient involvement

The government has created a new body, Healthwatch England, which has a remit of ensuring that the voice of patients, users and carers is heard at national level. The organisation will be a statutory sub-committee of the Care Quality Commission. Local involvement networks (LINKs) will be replaced by local Healthwatch bodies, which will be funded by local authorities and will feed intelligence to Healthwatch England. Clinical commissioning groups will have to establish a patient reference group in order to be authorised.

## Will these policies be effective?

### Measuring progress

The focus on measuring and reporting on patient experience at national level is a positive development. This should ensure that providers and commissioners see patient experience as an essential dimension of high-quality care, alongside clinical effectiveness and safety. However, the plethora of measures runs the risk of confusing providers.

Composite measures of patient experience – used in both the Commissioning Outcomes Framework and Commissioning for Quality and Innovation (CQUIN) – are suitable for accountability purposes, but are too difficult for members of the public to understand to be useful for transparency, and too opaque to be useful for improvement. Clarification and simplification is urgently needed for NHS trusts and commissioners so that it is clear what measurement (and data collection) is mandatory, and for what purpose.

The National Quality Board framework is a good start, but with the abolition of the NHS Institute it is unclear where research and leadership on how to improve patient experience will now come from.

### Shared decision-making

There is little recognition in government policy of the extensive training and support that clinicians will need if they are to systematically embed shared decision-making in every clinical consultation that takes place in the NHS in England. Persuading the clinical community to divert their limited time from medical diagnosis to preferential diagnosis will require a huge shift in culture. Without clear clinical leadership, patients will not see any expanded opportunities to make shared decisions about their care and treatment.

### Patient choice

While patient choice of named consultant-led team and GP are likely to be popular with patients, there are likely to be challenges in implementing this initiative, given workforce restrictions and operational challenges such as rostering and work to manage waiting lists. So, it is important that patient expectations are managed.

The extension of ‘any qualified provider’ (AQP) in community and mental health services could result in a greater diversity of providers entering the market to offer these services. This could also fragment care – for example, if patients with diabetes attend separate podiatry services, they may have less opportunity for integrated care.

### Patient involvement

Local Healthwatch groups are intended to identify and communicate patients’ concerns to providers, but there are limited resources. It is unclear how concerns about the quality of care locally will be escalated to Healthwatch England and how these will impact on the work of the CQC (its host organisation) and Monitor.

## What needs to happen next?

Currently, we do not measure the experience of patients who move between different parts of the health service (care transitions) and who receive care from more than one service (care co-ordination). However, the Department of Health is working on measures of care co-ordination, and these need to be tested and implemented as soon as possible (Department of Health 2012h). Similar measures for transitions between health and social care services are also needed.

Most attention has been paid to patients' experience in acute hospitals. Primary care, community services and mental health services need to strengthen the focus on patients' experience, ensure regular and robust measurement, and take action to improve the experience of care. Senior leaders and staff in provider organisations are often highly motivated to improve patient experience, but they do not always know where to begin. Recent reports suggest that providers should give priority to the quality of care and the continuity and co-ordination of health care and social care for frail older people with complex needs.

Policy-makers and providers also need to do more to support the implementation of shared decision-making, and policy-makers need to be clearer about how this differs from choice of provider. Providers and commissioners need to promote and support effective patient involvement in the governance of the NHS, as well as involving patients in designing services.

Finally, the Department of Health and the NHS Commissioning Board need to monitor the impact of the any qualified provider policy to ensure that it does not undermine commissioners' ability to commission for outcomes and providers' ability to deliver more integrated care for patients.

There is a great deal of work still to do with patients and their representatives, and with senior leaders, clinical teams and staff to develop the systems, to collect and analyse data on the experience of care and build the capability for leading improvement across the whole system of care. However, it is not clear where, in the post-2013 NHS, such leadership will be found.

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# 7 Equity

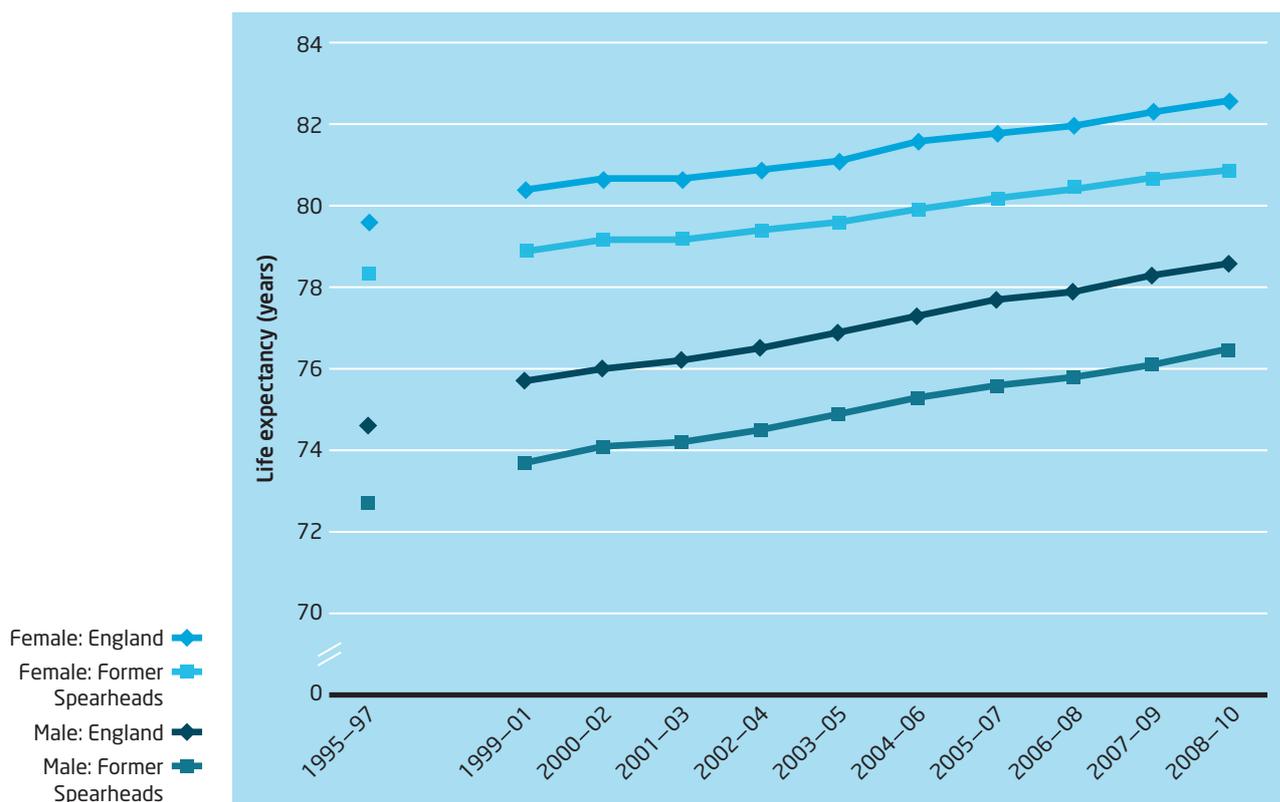
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*Criterion 7: A high-performing health system is equitably funded, allocates resources fairly, ensures that services meet the population's needs for health care, and contributes to reducing health inequalities.*

## How is the NHS performing?

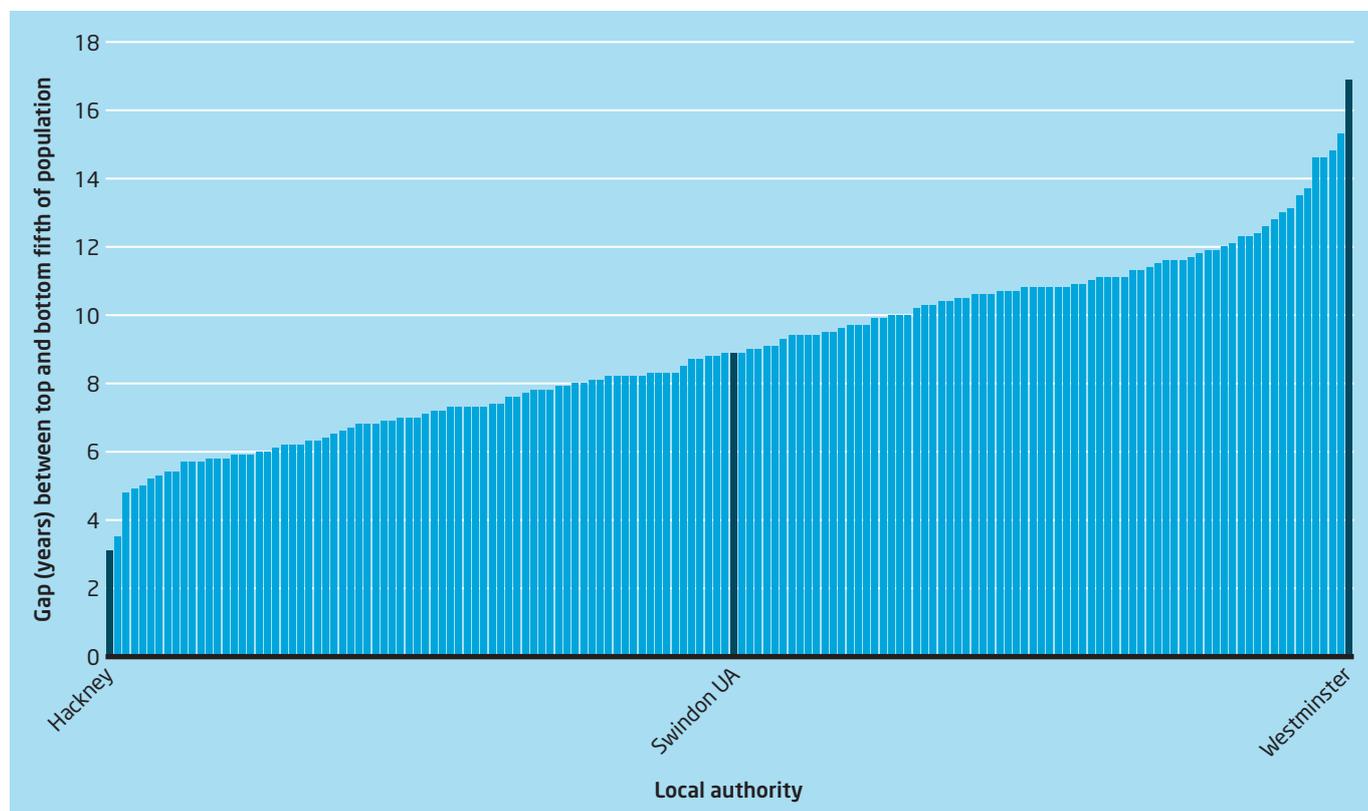
- The government has stopped performance managing the NHS on the former life expectancy and infant mortality targets. It is still publishing data that allows us to track its performance. However, there is a lag in the available data, meaning that most of it relates to the previous government. On the whole, avoidable variations in health outcomes between social, and other, groups persist.
- The gap in life expectancy at birth between former Spearhead areas (the fifth-worst in terms of health and deprivation) and England as a whole has risen, by 0.1 years for men and 0.2 years for women since 1999–2001 (Department of Health 2011j) (*see* Figure 12 opposite). However, the infant mortality target has now been surpassed, with a 25 per cent fall in relative inequalities between the rates of manual socio-economic groups and the England average (Bambra 2012).
- There remain stark differences in life expectancy within and between local authorities. Figure 13, opposite, shows that for life expectancy for Swindon (the median local authority) between 2006 and 2010, the gap between the top and bottom quintiles of the population was 8.9 years. The local authority with the largest gap was one of the wealthiest – Westminster – at 16.9 years. Hackney's life expectancy was lower overall but also the most equitable, with a gap of just 3.1 years.
- Inequalities in mental health remain stark. The gap in life expectancy between those with a severe and enduring mental health problem and those without is 10–15 years, on average, and has prompted calls for 'urgent action' to close the gap (Chang *et al* 2011).
- There are unwarranted differences in health care utilisation that reflect local inequalities in access to services and to good care (Appleby *et al* 2011). The NHS Atlas of Variation (NHS Right Care 2011) and its related publications illustrate this starkly. For example, when treating patients with Type 2 diabetes, there is a seven-fold variation between the 2.5 per cent top and bottom PCTs in their adherence to 18 core indicators of good care (*see* Figure 14, p 44).
- Access to primary care is more equitable in the United Kingdom than in most other countries, despite concerns that the large increase in numbers of GPs in the early 2000s did little to change the patterns of how inequitably they are distributed relative to need (Goddard *et al* 2010).

**Figure 12** Life expectancy in Spearheads and in England as a whole, 1995/7–2008/10



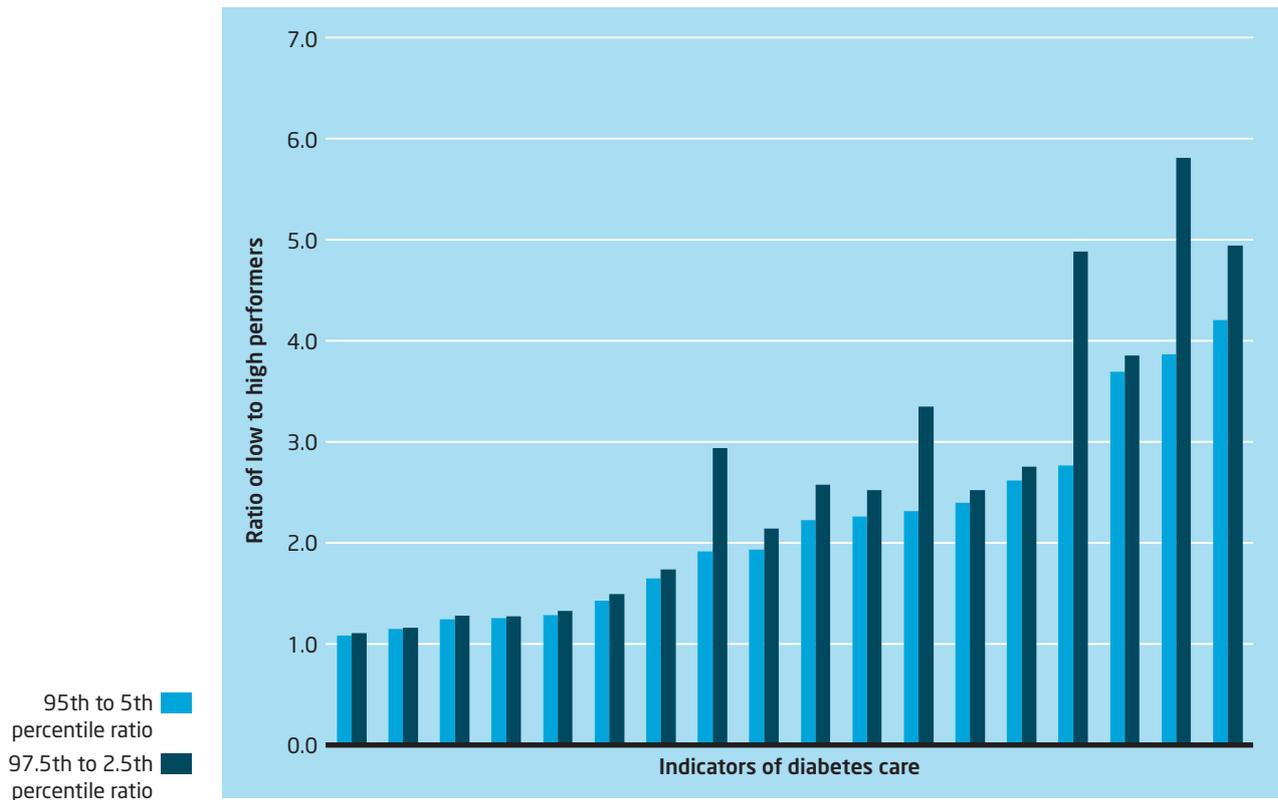
Source: Adapted from Department of Health (2011j)

**Figure 13** Gap in life expectancy by local authority, 2006–2010



Source: London Health Observatory (2012) Marmot indicators for local authorities: indicator data 2012 and including data for 2011. Available at [www.lho.org.uk/viewResource.aspx?id=17034](http://www.lho.org.uk/viewResource.aspx?id=17034)

**Figure 14** Ratios of lowest to highest adherence by PCT for 18 indicators of good diabetes care, 2009/2010



Source: The King’s Fund analysis of NHS Right Care (2011)

Our previous report, *A High-Performing NHS?* (The King’s Fund 2010), emphasised the necessity to create joint working between health and local government to tackle the wider determinants of health. The report highlighted the challenges of redistributing funds to areas of higher need as NHS resources are squeezed, and unwarranted variation in service provision. It also questioned the future of inequalities targets. Its argument was that while high-level inequalities targets have focused attention on certain areas to positive effect, they may have led to a disproportionate focus on secondary prevention among people aged 50–60 years at the expense of other age groups. This could have distorted local priorities and actions on health inequalities.

### What policies has the current government introduced?

The current government is transferring responsibility for health improvement to local authorities (*see* Section 3), and it also sees them as playing the leading role in tackling avoidable health inequalities in health outcomes. At the same time, it is strengthening, but narrowing, the role of the NHS.

The NHS has a new legal duty to reduce inequalities in access to care and in the outcomes from that care. However, the government has dropped targets for Spearhead primary care trusts to bring their life expectancy figures closer to the England average.

This marks a subtle but important change from the previous administration’s approach in terms of allocating responsibility for various aspects of inequality reduction. The NHS will be expected to do more on inequalities in access and outcomes from its own care, but with less responsibility for tackling overall inequalities in health.

Alongside this, the current government has accepted most of the conclusions of the Marmot Review into health inequalities, commissioned by the previous government (Department of Health 2010b). The major exception was the review's prescription to narrow income inequalities. The government has also been clear that it aims to 'improve the health of the poorest fastest', as stated in its public health White Paper *Healthy Lives, Healthy People* (Department of Health 2010d).

## Equity in health financing

From 2013/14, the government will separate out NHS resource allocations from the allocations for public health functions. The Secretary of State for Health will decide how to split resources between the two (roughly 95 per cent and 5 per cent respectively).

### NHS funding

Since the mid-1970s, resources have been allocated to local areas in the NHS on the basis of regularly updated formulas based on weighted capitation. This has taken the form of a given spend per head that differs according to drivers of need, such as age, gender and deprivation. In the late 1990s, a further objective was added: funding should be allocated in such a way that it would help reduce avoidable health inequalities.

From 2011/12, the government reduced the weighting on the 'avoidable inequality' element in NHS funding, from 15 per cent to 10 per cent (Gainsbury 2011). This was a strong early signal that it does not see the primary role of the NHS as tackling health inequalities in avoidable health outcomes, as opposed to its narrower role in ensuring equitable access to treatment, and outcomes from that treatment. However, in the short term, the practical effects of this shift are likely to be small (Buck 2011).

### Public health funding

The Department of Health has outlined how it will allocate the £2 billion, or more, of the public health budget (Department of Health 2012g), using an objective needs-based formula. The allocations will be based on differences in the standardised mortality ratio (SMR) for those aged under 75 (SMR <75) years between 'small area' communities – in other words, small areas within the 152 local authorities. This ratio is based on comparing the number of deaths of those aged under 75 in a 'small area' against the national average. An area with a high SMR has a higher-than-average number of deaths in people aged under 75 years. A high SMR will be used as evidence of 'high need'. Small areas with extreme pockets of need – including those in local authorities that are generally more affluent – will be allocated more funding (Department of Health 2012g).

In the short run, as under-invested areas are likely to receive priority attention, areas that have invested heavily in public health in the past may be disadvantaged at the expense of those that have not (Wiggins 2012). However, it is hard to predict what the impact of this change in approach will be, as the pace of change at which the allocation of resources based on SMR <75 will be introduced has not yet been defined (Department of Health 2012g).

The government also intends to reward local authorities that have done well on the Public Health Outcomes Framework with extra funds. It has signalled that the focus for these rewards is likely to be inequality reduction. This switch, from 2015/16, reflects the government's general approach: to rely more heavily on incentives and rewards than on targets and penalties (Department of Health 2012g).

## Equity in access

Under the 2012 Health Act, there is a legal duty on the NHS Commissioning Board and clinical commissioning groups to have due regard to reducing inequalities in health, complementing the existing Public Sector Equality Duty. The Act requires the NHS Commissioning Board specifically to:

*reduce inequalities between patients with respect to their ability to access health services, and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.*

Health and Social Care Act 2012, para 13G

For a more extensive summary, see Department of Health 2012x.

There are also other relevant duties in the new system. For example, reducing inequalities is one of the objectives under the duties of the NHS Commissioning Board, clinical commissioning groups and Monitor to promote integration. It is also one of the criteria on which the NHS Commissioning Board will award the quality premium to clinical commissioning groups.

## Equity in outcomes

The current government has dropped the previous government's health inequalities targets on life expectancy and infant mortality, along with the support and performance mechanisms that went with them. These have been replaced with a greater focus on localism, incentives and increased public transparency of variations in health outcomes.

The overarching ambition of the Public Health Outcomes Framework (PHOF) is to reduce differences in life expectancy and healthy life expectancy between communities, through greater improvements in more disadvantaged communities.

However, the PHOF will play a very different role in the performance system than the NHS Outcomes Framework and Commissioning Outcomes Framework (COF). Its prime purpose is to provide transparent comparative information for local authorities, members of health and wellbeing boards and the public. It is not intended to act as an accountability mechanism in the way that the NHSOF and COF are for the NHS.

The Department of Health's mandate for the NHS Commissioning Board has set out a small number of high-level objectives and expectations around equity and inequalities. The Board will be held to account for progress in reducing health inequalities and unwarranted variations through its direct commissioning activities, and through the care commissioned by local clinical commissioning groups. The Board will also be expected to allocate resources according to the levels of local need. However, there is little detail in the mandate on how health inequalities will be measured and how progress on reducing them will be assessed. As such, the objectives lack robustness.

At the local level, the Commissioning Outcomes Framework – used to measure how clinical commissioning groups perform in relation to health outcomes and quality of services – will set 'levels of ambition' for performance of clinical commissioning groups that specifically aim to reduce health inequalities and improve quality.

The Department of Health is also supporting some specific actions, including:

- funding the Marmot Review team to continue to collect evidence and offer expert advice – particularly to local authorities – on how action on the wider determinants of health can reduce inequalities

- instituting a cross-government health inequalities programme board
- continuing to support the previous government's Inclusion Health policy, which will seek to drive improvements in health outcomes for socially excluded population groups.

## Will these policies be effective?

The significant changes to resource allocation for the NHS and public health at a time of financial constraint are likely to be disruptive. It is difficult to predict how this will play out, since the allocations will be made on the basis of different objectives and data. However, this new system is driven by the much bigger scale of NHS allocations, compared to public health allocations to local authorities. In the longer term, this could result in areas that have higher deprivation and younger populations receiving less funding than wealthier areas that have higher within-area inequalities and older populations. If so, while NHS allocations might have the desired effect of reducing inequalities in access to health care, there may be an overall increase in health outcome inequalities.

However the funding is allocated, much will depend on how it is used in practice. Although the government's switch from targets to incentives is also reinforced by new legislation, it is unclear whether this will lead to a stronger or weaker focus at local level. In particular, several commentators have argued that it was the way the previous government's life expectancy target approach was implemented, rather than the target approach itself, that was at fault in their being missed. Criticisms included that the targets set were too short term (Bambra 2012), were focused in the wrong areas (Mackenbach 2011) and were not being performance managed through the NHS as strongly as they could have been (The King's Fund 2011).

It remains unclear whether the new legal duties relating to inequalities – and, most crucially, the way they are interpreted and implemented – will be able to counter the inevitable increase in variation in service delivery that will result from the move to a more local NHS. As clinical commissioning groups at the local level take decisions on whether to fund services, the reforms may increase inequity in access to services and create a significant postcode lottery.

On the other hand, the NHS Commissioning Board – especially as the new monopoly purchaser of primary care – is in a strong position to rigorously monitor the duties. For example, if it chooses to do so, it could oversee the systematic roll-out of interventions that the Department of Health's own analytical work has shown would deliver a fast reduction in health inequalities (National Audit Office 2010).

The weaker accountability mechanisms for the PHOF means that progress to improve the performance on inequalities in these dimensions will depend on the priorities and effectiveness of local authorities. Public Health England will support local authorities in carrying out their public health responsibilities, but will not performance manage or intervene to the extent that the NHS Commissioning Board is likely to with the NHS.

Our overall assessment is that the legal duties – while welcome – are too narrow as they are currently framed. The NHS Commissioning Board and clinical commissioning groups need to have due regard to their impacts on overall health outcomes – not solely in terms of the delivery of care. A matching health inequalities duty should also have been placed on local authorities. This would ensure that both main players involved in the health and wellbeing board have matching and consistent duties on inequality reduction.

## What needs to happen next?

Given the tight financial situation, it will be important to ensure that the changes to the way that allocations are made are fair and coherent. The new system will need to help reduce inequalities in access to NHS care, the outcomes from it, and overall health inequalities – both within and between areas.

The government and the NHS Commissioning Board will also need to ensure that any increase in local variation in which NHS services are available is justifiable, and that the decision-making process has been open and transparent. Clinical commissioning groups might need support and guidance to navigate these difficult and contentious issues – for example, through refreshed tools such as health equity audits.

As the implications of the Act become clearer, we feel that there is an opportunity to revisit the duties on inequalities to ensure they are wide enough, in respect of the NHS, and also that they are placed on local authorities. This will ensure that the NHS and local authorities alike have coherent and matching objectives to reduce inequalities in health.

In recent years, there have been improvements in some health behaviours. Overall, for instance, fewer people are engaging in multiple unhealthy behaviours (*see* Section 3). However, the number of people in the lower socio-economic and educational groups engaging in several unhealthy behaviours persists (Buck and Frosini 2012). If this is not tackled, it will drive greater inequalities in health outcomes in future.

We need to see targeted, holistic approaches to address these inequalities in health behaviours at national and local level. The NHS will also need to demonstrate whether the approach of ‘making every contact count’ is effectively supporting people from these groups to reduce their multiple unhealthy behaviours. Otherwise, there is a risk that this well-meaning initiative will inadvertently widen inequalities, rather than reduce them.

Finally, the impacts of the government’s social welfare reforms, the recession and long-term unemployment have the potential to outweigh any efforts the NHS and local authorities may make to reduce inequalities. If the government is serious about narrowing health inequalities, it cannot rely on the NHS and public health sector alone. If government as a whole is to maximise its impact on reducing avoidable health inequalities, it needs to carry out proper, transparent appraisal and evaluation of government policy for its health inequality impacts. Ideally, this should be undertaken or independently commissioned through a strong Public Health England with an explicit remit to do so.

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# 8 Efficiency

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*Criterion 8: A high-performing health system uses the available resources to maximum effect. This requires higher productivity in the delivery of care, supported by economy in the purchase of the goods and services that a health service needs to deliver that care.*

## How is the NHS performing?

Our previous report, *A High-Performing NHS?* (The King's Fund 2010), found that the productivity of the NHS had fallen during the previous decade, with activity increasing more slowly than resources. Much of the increased resource put into the NHS had been absorbed by higher pay costs. However, in some areas, such as the cost of medicines, substantial savings had been made.

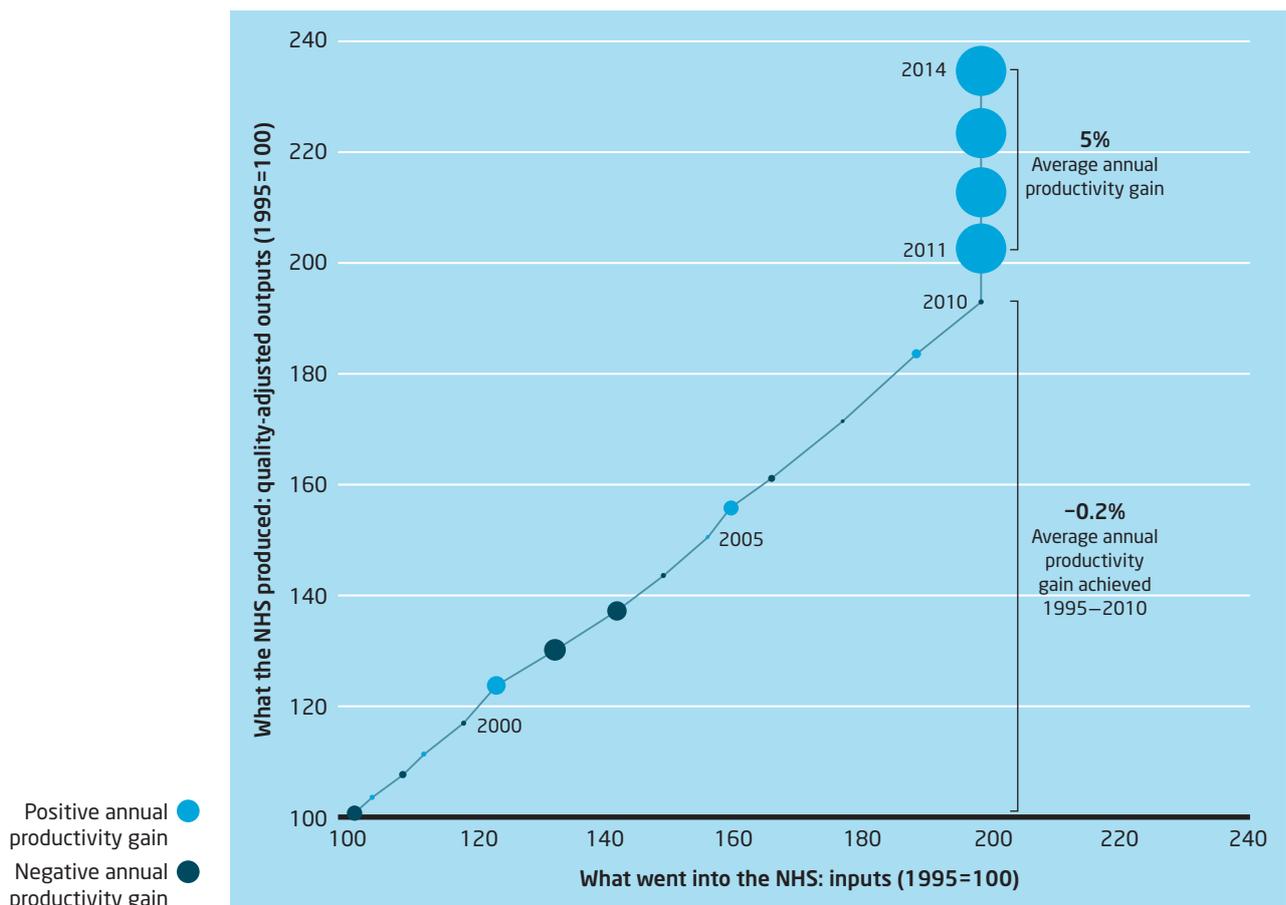
Before the 2010 election, the NHS Chief Executive stated that savings of £15–20 billion would be needed to meet the continuing increase in demand, and to meet desired improvements in quality within the resources then expected to be available (Nicholson 2009). This – the so-called Nicholson Challenge – was later firmed up as £20 billion over four years, beginning in 2011/12. Year-on-year improvements in efficiency were required at a higher rate than any previously recorded, in order to deliver these productivity improvements (*see* Figure 15 overleaf).

- Overall, the NHS ended both 2010 and 2011 in surplus – part of a continuing central policy to generate surpluses to carry over into succeeding years, in order to cover the transitional costs associated with the government's reforms.
- The NHS started 2012/13 with an estimated surplus of nearly £1.6 billion in primary care trusts (PCTs), strategic health authorities (SHAs) and NHS trusts carried over from 2011/12 (Department of Health 2012ee) and surpluses in foundation trusts totalling around £0.4 billion (Audit Commission 2012).
- Twelve acute or ambulance trusts are performing below par in respect of finance – six of them, all in London, have been placed in the most serious category (Department of Health 2012ee). Fifteen foundation trusts (out of a total of 144) finished 2011/12 in deficit and Monitor judged at least four to be not viable in their current form (Monitor 2012).
- According to the Audit Commission (2011), there were £4.3 billion of productivity gains in 2010/11. For 2011/12, the Department of Health reported that the Quality, Innovation, Productivity and Prevention (QIPP) scheme had generated £5.8 billion of savings (Department of Health 2012ff). However, it is not possible to ascertain what proportion was actually due to productivity improvements.
- At national level, the government has achieved substantial real-terms reductions in the cost of staff (through the pay freeze instituted in 2010/11), but the NHS pay bill has continued to rise through the impact of increments. This has led to a number of trusts exceeding their planned level of spending on staff (Clover 2012).

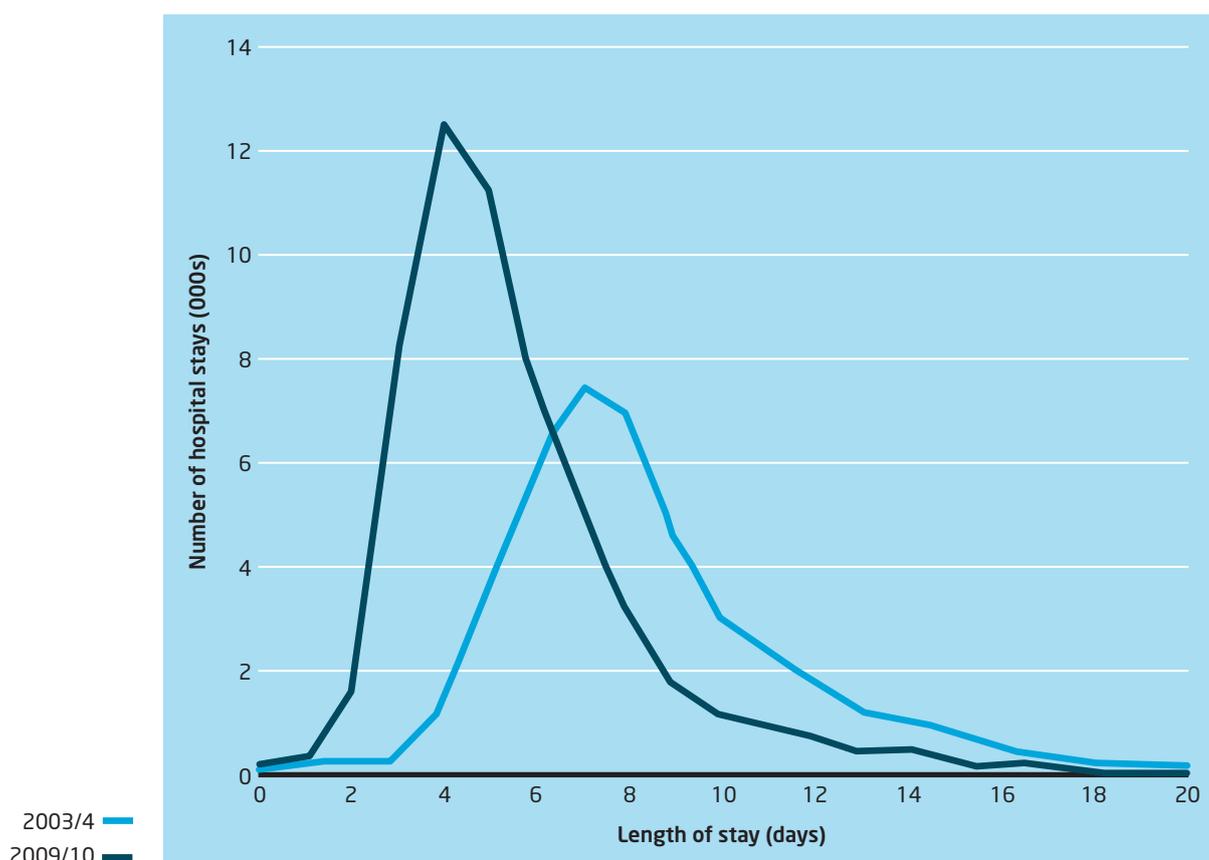
- Since May 2010, NHS staff numbers have fallen by 2.6 per cent – mainly in non-clinical parts of the workforce. Since March 2010, the number of managers has reduced by around 8,000 to 35,555 – a drop of around 18 per cent (Appleby *et al* 2012).
- There were significant reductions in the average length of stay for primary hip replacement in England between 2003/4 and 2009/10, but the variance in length of stay has not changed (*see* Figure 16, opposite) (NHS Right Care 2010). There are also large variations in length of stay for other procedures. For example, in 2010 there was a three-fold variation in the average length of stay for emergency admission with fractured neck of femur among PCTs (NHS Right Care 2011).

Our previous report, *A High-Performing NHS?* (The King’s Fund 2010), concluded that there was clearly scope for more savings to be made through greater operational efficiency, but that the challenge was to find the right levers to realise these.

**Figure 15** English NHS productivity challenge



Source: Peñaloza *et al*; 2009–10, The King’s Fund estimates

**Figure 16** Changes in lengths of stay, primary hip replacement, 2003/4 and 2009/10

Source: NHS Right Care (2011)

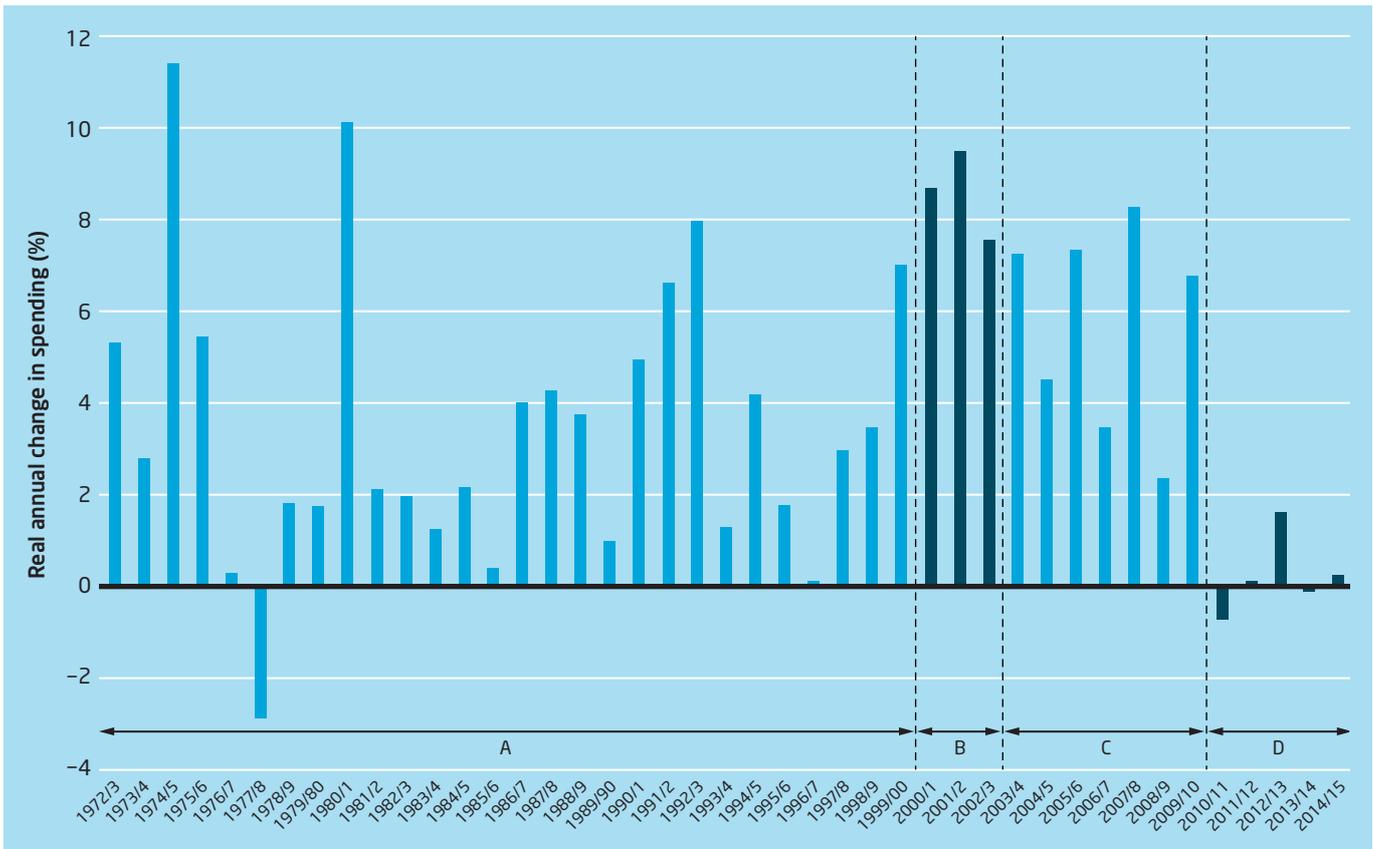
### What policies has the current government introduced?

The policies announced in the current government's first White Paper – largely implemented in the Health and Social Care Act 2012 – were not generally aimed directly at improving the use of resources in the NHS. However, the revised impact assessment for the Health and Social Care Bill (Department of Health 2011e) claimed that abolishing SHAs and PCTs, and replacing them with (what was hoped to be) cheaper clinical commissioning groups, would substantially cut management costs. It offered no quantitative estimate of the benefits of competition, greater provider freedoms or economic regulation.

The coalition's programme for government pledged to maintain real-terms spending on the NHS but with minimal increases (HM Government 2010). Over the 2010 Spending Review period, the average annual increase was planned to be 0.1 per cent. However, small fluctuations in actual inflation and movements of spending from one year to another can – and will – mean that changes in any one year might be more or less than this (see Figure 17 overleaf).

The policies adopted to meet the Nicholson Challenge are mostly a continuation of those adopted by the previous government. The current government has continued to use the Department of Health's central price-setting power to create incentives for hospitals to reduce costs. For example, it has set Payment by Results tariffs at 1.8 per cent below national average costs for 2012/13, following a similar cut in 2011/12 and a freeze in 2010/11 (see Figure 18 overleaf). It has also raised the national efficiency requirement to 4 per cent for 2012/13, and has introduced best-practice tariffs to provide incentives for quality as well as efficiency (see Section 5).

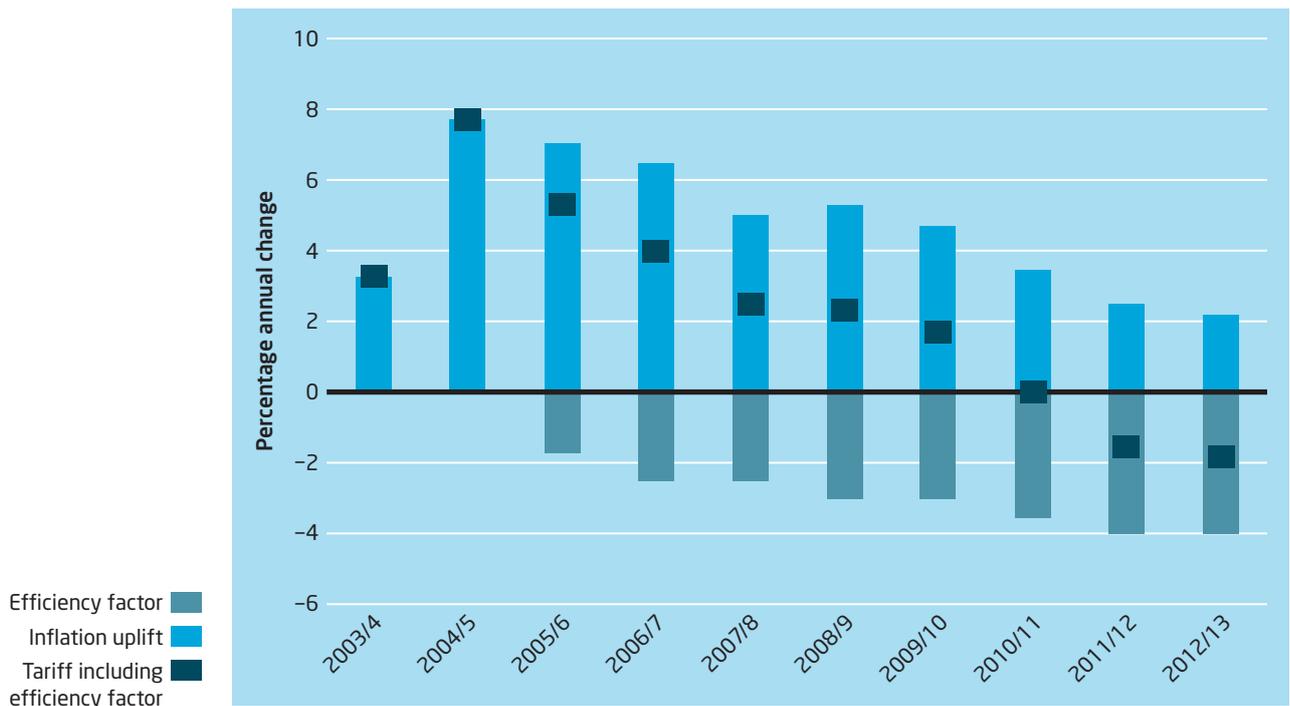
**Figure 17** Annual real changes in NHS spending, England, 1972/3 to 2014/15



Note: Spending figures are not consistent between the periods A, B, C and D due to revisions in accounting methods.

Source: The King's Fund analysis of HM Treasury figures

**Figure 18** Trends in percentage annual change in Payment by Results tariff and efficiency factor



Source: Department of Health (2011c)

## QIPP initiatives

The government is also pursuing a number of other policies, within the Quality Innovation, Productivity and Prevention (QIPP) framework – an umbrella term for a diverse range of initiatives. The main ones are described below.

- **Staffing** The government instituted a pay freeze across the entire public sector. As a result, NHS pay for all but the lowest paid was frozen for 2011/12 and then again for 2012/3. Although the freeze is due to end in 2013, the government has indicated that it does not expect to see increases of more than 1 per cent in subsequent years.
- **Back-office functions** A review carried out for this QIPP workstream found that between £600 million and £1 billion could be saved through the measures it proposes (NHS Confederation and Foundation Trust Network 2010).
- **Purchasing goods and services** In 2012, the Department of Health published new measures to make procurement more effective. The National Audit Office had previously found that despite various earlier measures, NHS procurement continued to be fragmented and wasteful (National Audit Office 2011). The Department's proposals (Department of Health 2012o) set out a wide range of actions that, it claimed, might produce £1.2 billion savings. However, at the same time it issued a call for evidence in the hope of producing new ideas on how to improve procurement.
- **Medicines** The Pharmaceutical Price Regulation Scheme, negotiated by the previous government, continues to produce savings across the board. The patient access schemes introduced at that time have allowed the NHS to make medicines available that had proved too expensive until then. The current government's proposals for value-based pricing is not yet in place.
- **Assets** The Department of Health has continued to press for the release of unused land as part of a government-wide initiative designed to release land for housing. However, much of the land already identified in returns sent to the department is owned by foundation trusts – over which it has no control. So, it is not surprising that no forecasts are available of how much land will, in fact, be released.

The initiatives listed above focus on reducing input costs. However, work is also being done to improve the understanding of how to use resources more effectively. QIPP is also running a number of workstreams aimed, for example, at:

- promoting better use of resources
- new ways of managing and paying for services for people with long-term conditions
- redesigning access to urgent care
- improving management of medicines
- using the Productive Series (NHS Institute for Innovation and Improvement 2010).

## Will these policies be effective?

The NHS Operating Framework for 2012/13 noted that the NHS was on track to meet QIPP objectives. However, it stated that progress had largely been met through pay and cost reductions – in other words, through central action and local efficiency programmes.

It went on to say that now, emphasis had to shift towards transformational service change, and that a priority was for the NHS to adopt effective innovation and best practice.

The main central action – real reductions in NHS staff pay – cannot be repeated indefinitely if the NHS is to attract and retain staff. However, ending the national pay

freeze would add substantially to NHS expenditure and to financial pressures on services. An average increase of 1 per cent in staff pay would add around £400–£500 million to NHS expenditure (Appleby *et al* 2012).

Meanwhile, as the labour market tightens when general economic conditions improve, some of the recent productivity gains may slip away. Similarly, some of the cost reductions achieved by abolishing organisations such as SHAs and PCTs may be reduced if the organisations replacing them grow to meet the scale of the tasks facing them.

Savings from service redesign and demand management are even more difficult to deliver. There is undoubtedly scope for reducing costs while maintaining quality through innovations such as enhanced recovery (NHS Institute for Innovation and Improvement 2012), further reductions in lengths of stay (Hurst and Williams 2012; Imison *et al* 2012) and new clinical practices (Department of Health 2010g). However, the evidence from service reconfigurations is that financial savings are often difficult to realise – at least in the short term. So, it seems unlikely that the current approach to QIPP will deliver productivity savings on the scale required.

## What needs to happen next?

To date, financial balance and productivity improvements have largely been achieved through levers available nationally, such as freezing pay, topslicing allocations, providing subsidies to trusts in difficulty (particularly with large private finance initiative commitments) and continuing to put downward pressure on tariff. But under the new arrangements SHAs will no longer be in place to manage financial balance across the system. Neither will cross-subsidies nor government bailouts be possible, due to Monitor's requirements for a level playing field and greater transparency in financial transactions.

A more fundamental change is needed to develop models of service delivery that deliver greater value (Ham *et al* 2012). However, change in the NHS takes time, and evaluations of innovations such as integrated care and telehealth have shown only limited cost reductions, though they also have other benefits (Goodwin *et al* 2012).

Crucially, the NHS needs to be clear what the productivity challenge actually entails. It should not be a simple cost-cutting exercise, or a programme to generate savings (as the official reporting on QIPP achievements appears to be). Rather, given its constrained budget, the NHS needs to produce higher-value outputs to benefit patients. Reducing costs is a means of reinvesting savings in order to produce better quality and, where needed, higher volumes of care. Even if the transformational changes do not produce cash savings, if they generate better-quality care within the same budget then they will be helping to improve productivity.

There are also opportunities to improve productivity through tackling variation. The NHS Atlas of Variation (NHS Right Care 2010, 2011) has highlighted variations in expenditure by area. These variations are not always justified by differences in need, and are often more to do with historical spend, suggesting an opportunity to improve efficiency in allocation. NHS Right Care has also developed a range of tools to help commissioners make more informed investment decisions.

It now seems that the scale of productivity savings to be achieved by 2015 will continue into the medium and long term (Appleby 2012). If the NHS as a whole, and individual organisations, are to track progress, then more sophisticated measures of productivity are needed to capture the full range of services provided by the NHS and properly account for quality improvements. For example, if the NHS were successful in reducing inappropriate hospital activity, current measures would report this as a fall in productivity.

NHS finance directors remain reasonably confident of meeting their cost improvement targets this year, but are less confident that the NHS as a whole will meet its productivity targets (Appleby *et al* 2012). Ironically, there is a chance that the NHS will deliver productivity improvements on the scale required but that we simply will not know, given the inadequacy of the measures.

There is also a significant challenge to putting all provider trusts on a financially sustainable footing and managing the pipeline of organisations seeking foundation trust status. The National Audit Office (2011) suggests that almost all the trusts in the pipeline will find it hard to meet Monitor's criteria for financial viability. Of 19 trusts due to submit foundation trust applications to the Department of Health by the end of 2011/12, 10 were rated as 'red risk' at the end of March 2012 because of the danger that they will not remain on course to meet foundation trust requirements (National Audit Office 2012a). An increasing number of trusts are also in deficit, and it is highly likely that they will also have to undergo restructuring. Significant merger and restructuring activity will need to take place, as well as major service redesign, if the NHS is to be not only an efficient health system, but one that can live within its means.

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# 9 Discussion and conclusions

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## Summary of performance

In general, it appears that the performance of the NHS is holding up despite financial pressures and the disruption of reforms. However, cracks are emerging – for example, with a deterioration in waiting times in A&E (*see* Section 1) – and significant variations remain by geography and socio-economic status in access to care, health outcomes and the quality of care received. While patients report improvements in transactional aspects of care (access and food), there remain concerns about the relational aspects of care, such as emotional support, dignity and empathy, particularly in acute hospitals.

Data from the latest British Social Attitudes Survey (National Centre for Social Research 2012) also suggest that the levels of public satisfaction with the NHS have reversed. This shift follows a long period of annual increases in the proportion of the population who reported they were satisfied. This peaked in 2010, with 70 per cent of people very or quite satisfied, falling to 58 per cent in 2011. It is hard to know whether this reflects the negative media coverage of the Health and Social Care Act or the direct experience of patients or NHS staff. It will also be important to see if this was a one-off response or whether it indicates the start of a downward trend.

There has also been a rise in emergency admissions among those with long-term conditions and in emergency bed days among the over-65s, suggesting that the NHS is still not doing enough to support these people to remain well at home or cared for in the community.

Mortality from the big killers, cancer and cardiovascular disease, has fallen, but the United Kingdom still has higher levels of avoidable mortality than other countries, and inequalities in health persist and in some cases have widened. Although smoking rates are falling and the rising trends in childhood obesity of recent years appear to be levelling off, excess alcohol consumption has stabilised and alcohol-related deaths continue to rise as do rates of adult obesity.

The long-term financial constraints on the NHS require rapid improvements in some areas to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge. The pace of change has been slow, and faster progress is needed in improving productivity, prevention and quality. At least part of the solution to the productivity challenge lies in understanding and then reducing the persistent variations in care. This requires concerted action at every level of the system to deliver unprecedented efficiency savings.

## The government's approach to driving NHS performance

The past two and a half years have been dominated by discussions of the NHS reforms legislated for in the Health and Social Care Act 2012, but the current government has pursued other policies too. In this section we review the different approaches used to drive improvements in performance and look ahead to consider their impact.

### The end of targets and performance management?

Much has been made of the current government's early commitment to abolish targets, and yet for the period covered by this report the government has continued to measure against targets and report data on them. This has enabled us to continue to track waiting times, infection rates and progress on health inequalities in this report.

The focus is shifting to outcomes, where targets are still being set but under other names, such as 'levels of ambition'. In future, some national standards will be framed more in terms of rights embodied within the NHS Constitution, which, for example, enshrines waiting time guarantees. The onus here will be on patients and individuals to exercise and enforce their rights – for example, seeking care in the private sector in order to be treated within 18 weeks – rather than on providers to meet the standards.

Performance management of providers has also continued. Trusts have been required to report on their performance against targets to strategic health authorities (SHAs), while foundation trusts report to Monitor. Only from April 2013 onwards, with the abolition of SHAs, will the performance management that has underpinned the targets be removed. However, the NHS Trust Development Authority will continue to have oversight of performance as part of its role in preparing trusts for foundation trust authorisation, and Monitor will continue to monitor the performance of foundation trusts, for the next few years at least.

Similarly, to date primary care trusts have continued to be accountable to SHAs and the Department of Health, but in future, local commissioners will be accountable to the NHS Commissioning Board, and it is not yet clear how this relationship will be operationalised. The NHS Commissioning Board was not given general powers of direction over clinical commissioning groups, and original policy documents described it as a 'quasi regulator of commissioners operating on the basis of clear and transparent rules' (Department of Health 2010e, p 63). The potential for the NHS Commissioning Board to play a strong performance management role remains.

The regional and local structures being put in place by the NHS Commissioning Board suggest that the grip of SHAs over PCTs might yet be recreated. The government has also claimed to strengthen the democratic legitimacy of commissioning decisions by creating health and wellbeing boards, though these bodies will have little direct authority over clinical commissioning groups (Department of Health 2010e).

The one area where performance management is being removed entirely is in relation to public health and inequalities targets. With the shift to local authorities, there are no mechanisms for accountability. *Healthy Lives, Healthy People* (Department of Health 2010d) set out a dramatic shift in responsibility for public health improvement, from the NHS to a local government. For the first time, public health will have a separate allocation – likely to be around £5 billion – of which more than £2 billion will be a ringfenced grant to local authorities. A new national body, Public Health England, will support the local system in providing evidence on what works. But unlike in the NHS, there is no direct accountability for local authorities to deliver on the outcomes in the Public Health Outcomes Framework.

A more limited central role is also reflected in the government's approach to public health policy, which, initially at least, preferred voluntarism to government action. However, recent moves suggest that the government wishes to be pragmatic and will intervene where it is convinced of the case or commercial interests align (for example, in the case of minimum alcohol pricing).

### A focus on outcomes

Another major shift is a focus on outcomes. In future, the NHS Outcomes Framework and the mandate for the NHS Commissioning Board will be the main mechanism by which the government will set objectives and levels of performance for the NHS.

The NHS Outcomes Framework sets out five quality domains.

**Domain 1:** preventing people from dying prematurely

**Domain 2:** enhancing quality of life for people with long-term conditions

**Domain 3:** helping people to recover from episodes of ill health or following injury

**Domain 4:** ensuring that people have a positive experience of care

**Domain 5:** treating and caring for people in a safe environment and protecting them from avoidable harm.

Overall, there are currently 60 indicators across the five domains of the NHS Outcomes Framework, with further indicators under development. Underpinning the framework is a supporting suite of National Institute for Health and Clinical Excellence (NICE) Quality Standards currently under development (NICE 2012b). The Department of Health expects the framework to evolve over time.

As we shall discuss in the sections on patient safety, health promotion, managing long-term conditions and clinical effectiveness (Sections 2–5), the NHS Outcomes Framework, Public Health Outcomes Framework and Social Care Outcomes Framework provide a comprehensive set of outcomes measures that can be used to judge performance in future.

Patient experience has now – rightly – taken its place as a key aspect of quality of care, alongside patient safety and clinical effectiveness. However, there needs to be further development of measures in some areas – for example (The King's Fund 2012):

- patient and user experience of integrated care delivered by multiple organisations over time
- shared decision-making
- integration of mental and physical health.

The unresolved issue is how these high-level outcomes can be used to hold organisations to account – in particular, the NHS Commissioning Board and clinical commissioning groups. Doing this requires clear measurable and stretching goals to be set, with consequences if they are not met: a challenge given the complexity of factors that influence these outcomes.

A Commissioning Outcomes Framework (COF) is also being developed for the NHS Commissioning Board to use in measuring clinical commissioning group performance from April 2013. COF indicators are yet to be chosen, but will be based on the NHS Outcomes Framework indicators; indicators developed by NICE based on existing NICE standards (44 to date); and other sources.

The government has published a number of high-level strategies on specific clinical areas, such as cancer and dementia. However, compared with the national service frameworks and plans published by the previous government, they lack detail about implementation. By setting out the ‘what’, government expects local organisations to work out the ‘how’. This may indeed liberate the NHS to be more innovative, but it does raise the risk that a gap will open up between national ambitions and local performance.

### Information and transparency

The focus on outcomes highlighted in the previous section is linked to a second strand of policies introduced by the current government relating to transparency of data (specifically, data being released into the public domain). These policies are founded on a belief that transparency will, in and of itself, drive improvements. There is some evidence that publishing comparative reports can impact on the performance of organisations – particularly poor-performing ones (Shekelle *et al* 2008), but there is also evidence that simply publishing data is not enough (Dixon *et al* 2010; Foot *et al* 2011). It is important also to pay attention to presentation, the selection of indicators, the audience, the source and medium, and the use to which the data will be put – whether judgement or improvement (Raleigh and Foot 2010).

The government’s desire is to encourage a market in information intermediaries who will analyse the raw data and present it in innovative ways for different audiences. This might have some benefits, but also risks information overload for users, lack of comparability, confusion about methods and indicators (for example, the debacle over the hospital standardised mortality ratio), and conflicting performance information.

As we have seen in the sections on patient safety, clinical effectiveness and patient experience (Sections 2, 5 and 6), some requirements to collect and report data are now linked to contracts and incentives. It is important that information is available to organisations for improvement purposes, and that the fear of it being used to judge or reward does not result in gaming.

### Greater reliance on commissioning and regulation

The government’s reforms seek to give more control to local clinicians to drive service improvements (through clinical commissioning groups). However, there is a dearth of evidence of the effectiveness of commissioning. Where GP-led commissioning has been tried previously, it has generally led to extended provision of primary care services (Smith and Curry 2011). The reorganisation of commissioning organisations may set back the development of commissioning rather than advance it – at least in the short term. The expectation is that commissioners will commission for outcomes, although it is not clear what this will mean at a practical level in terms of the contracts and payments used to pay providers. As argued elsewhere (Appleby *et al* 2012) there is also a risk that too much is expected of financial incentives and that these are not aligned to the objectives of the system.

Independent regulation was increased under the previous government, and was seen as an important means of ensuring high-quality, safe care across all providers, including the private sector. The Care Quality Commission (CQC) sets minimum standards, and has powers to suspend services and close down providers that fail to comply with standards. There has been criticism of the CQC, and there is little evidence currently on the effectiveness of regulation. However, its role is set to continue and appears to be vital in ensuring the performance of the NHS on patient safety, highlighting the failure

to meet the essential care needs of patients (and care home residents). The CQC's role in improving the clinical effectiveness of services is less clear, as the standards do not relate either to the Outcomes Framework or to NICE standards.

Monitor was created as a regulator of foundation trusts, to authorise new foundation trusts and oversee their governance and financial performance. Trust performance does appear to improve in the period immediately around the time of authorisation, but these improvements do not continue. Over the next two to three years, Monitor will be authorising all the remaining trusts. While it intends to maintain the level of the bar, there is a risk that the tougher financial context will make it difficult for trusts to meet the requirements for authorisation. Indeed, 20 or so trusts have already declared that they will not make it. Monitor will also need to keep a close eye on existing foundation trusts, to ensure that they continue to meet standards and remain financially solvent.

It is already clear that a number of organisations are underperforming, in respect of both quality and financial performance, and are unlikely to be sustainable in their current form. One option often considered is merging providers. But there is a tension between creating organisations that are of sufficient scale to safely provide services and to manage financial risks while equally allaying potential concerns of the Office for Fair Trading (which will rule on mergers in future) about creating monopoly providers. There is also evidence that the performance of merged organisations tends to decline – at least initially.

Another option is to put the trust or foundation trust into special administration – in effect, declaring it insolvent. The administration regime introduced by the previous government is being used for the first time by the South London Healthcare Trust, and Monitor has taken steps to intervene at Mid Staffordshire NHS Foundation Trust to resolve its financial difficulties. For both these organisations, this is likely to result in major restructuring and service reconfiguration. It is hoped that such major changes will have a positive impact on NHS performance, including clinical effectiveness and efficiency. However, there is a risk that they will have an adverse impact on access and patient experience (depending on which solutions are pursued) as well as on performance during restructuring.

Monitor's role is being significantly expanded. In future, it will be responsible for licensing all providers of NHS-funded care, setting prices (in conjunction with the NHS Commissioning Board), ensuring continuity of services when providers get into financial difficulty, and tackling anti-competitive behaviours. Given the enormity of the task that Monitor and other regulators have, and the lack of information and evidence on which they can make decisions (Dixon *et al* 2011a), Monitor's change in role alongside other developments in health and social care regulation create a real risk of regulatory failure.

The actions of regulators, whether in response to concerns about quality or financial problems, are likely to have a significant impact on the NHS in future and its performance. It remains to be seen whether regulation or commissioning will ultimately drive changes in the NHS. Both may be subject to further change following the report of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust, which is expected to make far-reaching recommendations on the role of regulators and commissioners in ensuring that patients receive safe, high-quality care.

## Choice and competition

During the passage of the Health and Social Care Act, it was sometimes argued that the main logic of the reforms under the current government was to strengthen the role of choice and competition. Yet to date there has been little evidence of this as a driver of performance in any of the areas addressed in this report.

In future, Monitor will have a role in tackling anti-competitive behaviour where this is not in the interests of patients or the public. How it will apply this public interest test, and what actions it will take to remedy any abuses of dominant position, are still to be determined. Monitor also has a duty to enable integrated care, so the regulator will have to find ways of promoting both competition and integration where these benefit patients. How effectively it will be able to do this remains to be seen.

The government has emphasised the role of patients in decisions about their care and treatment – captured in the slogan ‘no decision about me without me’. However, recent policy documents focus more on choice of provider than shared decision-making. Despite the prominence of shared decision-making in early policy documents, the government has not made any specific commitments about how to support it.

The government has, however, made a number of pledges to extend the range of choices that patients are able to exercise over where they are treated, including choice of named consultant-led team and provider of diagnostic tests and general practice (Department of Health 2012i). It has also committed to extending the choice of policy of any qualified provider to a range of community services, although the extent of this is more limited than was originally envisaged.

Clinical commissioning groups will be expected to put services out to tender, creating opportunities for non-NHS providers to bid to take over the running of services in a particular area. It remains to be seen whether new providers will be able to deliver greater improvements in care, and whether the threat of competition will improve the quality of care provided by incumbents. Critically, comparable data needs to be collected from all providers in order to benchmark performance.

Looking at the government’s policies implemented so far, it is possible to detect an intention to shift away from central control to localism, and from performance management to a greater role for competition and transparency. However, as with previous governments, these policies are layered on top of previous policies. The implication is that performance improvement will be driven through a variety of levers and incentives for the foreseeable future. Much will hinge on how bodies such as Monitor and the NHS Commissioning Board interpret ministerial intentions.

It is clear that the new system will be even more complex than the one it is replacing. The process of implementing the government’s policies will be critical in determining whether the rhetoric of the reforms is translated into practice. The transition to the new system carries serious risks to the performance of the NHS, as well as some opportunities for driving performance improvements (*see the box overleaf*).

## NHS reforms: risks and opportunities

### Risks

- The reorganisation has resulted in a huge loss of experienced people from the NHS – particularly experienced managers involved in commissioning and strategic planning.
- The changes are disruptive and distract boards, management and other staff from focusing on driving improvements in performance.
- The new bodies will take time to get established. In particular, clinical commissioning groups may lack the capacity to hold providers to account, lead change and keep a grip on arrangements such as finances.
- Many organisations that previously supported the NHS to improve performance have been abolished or reduced in size, including the national support teams, the National Patient Safety Agency and the NHS Institute for Innovation and Improvement.

### Opportunities

- The focus on outcomes could drive further improvements in clinical effectiveness.
- New duties on integration could have positive impact on the management of long-term conditions and care of frail older people.
- Greater transparency of data could motivate organisations and clinicians to focus on improvement and to learn from each other.
- Increased role for local authorities in public health could lead to greater efforts to tackle the wider determinants of health and reduce inequalities.
- A greater role for clinicians in commissioning could result in greater clinical effectiveness of services.

## Looking to the future

The main message from our analysis is that NHS performance is holding up at the aggregate level. However, much of the most recent data used in the report relates to 2010/11. It is therefore too early to judge whether the NHS has been able to hold on to the gains of the last decade, in the context of major changes to the NHS, the loss of experienced managers and increasing financial pressures. The NHS has been able to protect itself to some extent against the full impact of reduced budgets through prudent management of finances – for example:

- topslicing allocations to primary care trusts to create reserves to deal with deficits in individual organisations
- the government-imposed freeze on pay
- the downward pressure and other revisions to tariff, which have shifted more risk to providers
- the continued grip on performance exercised by the Department of Health (of trusts and PCTs) and Monitor (of foundation trusts).

One of the unanticipated consequences of prudent financial management is that the NHS has underspent its budget and nearly £3 billion has been returned to the Treasury in the past two years (Dowler 2012). This represents a significant lost opportunity to improve priority areas of care such as for people with dementia or to pump-prime new models of care.

Looking ahead, the NHS faces a further two and a half years with no real increase in the overall budget. There is a real possibility that financial constraints will continue, and possibly deteriorate, in the next spending review period. There are few signs of a return to economic growth, and the government's fiscal policies have yet to make a dent on the level of public debt. It is therefore likely that there will be continue to be significant constraints on public spending as a whole. The NHS may have to plan for a future of flat cash rather than flat real-terms increases in funding after 2015. How the NHS responds to this challenge is more uncertain than in the past if (as anticipated) the government's reforms result in budgets and decision-making being devolved to a local level.

There are a number of risks to the performance of the NHS. Most worrying would be if financial control were maintained but quality of patient care deteriorated. This could happen if NHS organisations prioritised balancing their budgets at the expense of protecting quality. A further risk is the potential difficulty for the NHS in maintaining staffing levels when the current national pay freeze comes to an end, as any pay increases are likely to be at the expense of jobs. Widespread reductions in staffing levels are likely to result in poorer quality of care and reduced staff morale. This, in turn, would impact on patient experience in view of the well-established link between staff morale and engagement on the one hand, and the experience of patients on the other.

These risks are accentuated by the cuts being experienced by local authorities – especially in social care. The government has recognised the interdependence of health and social care. The transfer of some of the NHS budget to local authorities has enabled them to maintain higher levels of spending and service provision in adult social care than might otherwise have been possible. However, despite this additional funding, many local authorities restrict access to adult social care to people with substantial and critical needs, and give lower priority to prevention and early intervention services.

With further cuts to local government in the pipeline, there is likely to be a deterioration in the care of older people and people with disabilities. There will undoubtedly be increased pressure on care home providers, as fees for publicly funded patients are held down by the funding constraints faced by local authorities. This pressure could lead to the failure of some providers, as well as reductions in quality, as providers cut staffing levels to live within the funding available to them.

It is also likely that acute providers will find it increasingly difficult to maintain current standards. For example, increases in the number of patients waiting to be discharged to the community could have a negative impact on waiting times in A&E departments because of the lack of available beds. Similarly, if beds used for planned admissions are occupied by patients admitted as emergencies, there could also be difficulties for acute providers in sustaining current levels of performance on waiting times for treatment in hospital.

How, then, can these risks be managed to avoid a deterioration in patient care? The answer to this question, as we have argued in a previous paper (Appleby *et al* 2010), depends critically on the whether the NHS can release around £20 billion of efficiency savings during the current spending review to reinvest in services. This will happen only if leaders at all levels play their part – for example, with:

- clinical leaders in frontline teams ensuring that care is right first time, driving out waste and redesigning services

- boards of those organisations charged with commissioning and providing care ensuring that they focus on the quality of care and not just finances, and working together to lead change
- national organisations responsible for determining pay, the tariff used to reimburse providers, and other decisions that influence how resources are used on the ground making prudent decisions
- politicians speaking up in support of major changes to local services.

At least 20 per cent of the QIPP programme depends on service reconfigurations. Improvements in local services will proceed only if politicians are willing to sanction changes in the role of hospitals and other services that are often unpopular with the public. If they fail to do so, lives may be lost and quality of care impaired. This has already happened in London, where long-overdue changes in the location of services have only recently been implemented (Carnall 2012). The length of time it takes to develop and consult on proposals for service changes means that the potential savings from service reconfigurations are unlikely to be realised in this parliament.

## Future drivers of change

The financial pressures facing the NHS and local government for the foreseeable future call for innovation in models of care at an unprecedented scale and pace (Ham *et al* 2012). This requires:

- a willingness to make it easier for new entrants with innovative models to enter the market in some areas of care
- an ability to decommission outmoded services that are no longer appropriate to the needs of patients and the public
- a much greater investment in building the skills and capabilities of staff working in existing organisations in service improvement
- a willingness on the part of politicians to support risk-taking, even when this may lead to failures.

If the government is serious in its commitment to move away from targets and performance management as the principal levers to drive change and improvement in the NHS, then much hinges on clinical leaders – especially clinical commissioning groups and their partners in local government – stepping up to the challenge. However, as clinical commissioning groups are at different stages of development, it would be unrealistic to expect too much of them. Likewise, health and wellbeing boards are still in the process of being formed and their role is yet to be tested in practice.

At the same time, given the history of previous attempts to introduce market principles into the NHS and their limited impact (Dixon *et al* 2011b), it is equally unrealistic to rely on competition and choice alone to create the stimulus needed to improve performance. In any case, in view of the diversity of health and social care services and the need for a nuanced approach to their improvement (Ham *et al* 2011), competition must go hand in hand with collaboration and integration. New providers do have the potential to support innovation and improvement, but they form only one part of the solution and not the entire answer.

Some national organisations could provide a backstop while local organisations gear up – namely, Monitor, the NHS Trust Development Authority and the NHS Commissioning Board. However, they too are going through considerable change. With the dismantling

of the old system nearly complete, and the construction of the new one still under way, it is no exaggeration to say that the NHS is heading into treacherous waters, and the risks are high.

In these circumstances, much will depend on the ability of experienced leaders – wherever they may be – to focus on the quality of patient care and financial control to ensure that performance does not slip back. It is critically important that this is done through an approach that looks at the whole system of health and social care on a city-wide or county-wide basis. The challenge this presents is that many of the current levers and incentives are focused on organisational performance, and create barriers to organisations working in partnership.

As in high-performing organisations in the private sector, effective change means working across a series of dualities, including (Pettigrew 1999):

- empowering frontline leaders while also providing leadership in organisations and local and national systems
- promoting competition in areas of care where it offers the greatest potential benefits, and supporting collaboration and integration where organisations and services need to work together to improve performance
- valuing the role of clinicians in leading change and at the same time recognising the contribution of experienced managers
- continuing to promote the development of high-performing organisations alongside the imperative to work across whole systems.

In making the case for a combination of different approaches, we are arguing implicitly against simplistic approaches to driving change in the NHS, which typically alternate between top down versus bottom up, competition versus collaboration and a range of other false dichotomies.

Having spent the first half of the parliament legislating for radical changes to the *organisation* of the NHS, the government now needs to focus on the mundane but much more important challenge of implementing and executing the *service changes* on which its record will ultimately depend. Much hinges on the ability of the new ministerial team to work with leaders at all levels, and to engage thousands of clinical staff in rising to this challenge. As we have argued, government must implement overdue service changes and new models of care at a scale and pace never seen before. Failure to do so will inevitably result in more organisations finding themselves in deficit and the quality of care being compromised.

## Conclusions

The NHS remains in the foothills of what is certain to be the longest period of financial constraint in its history. Already there are signs that the impact on patient care could be felt as early as 2013 (Appleby *et al* 2012). There is also an increasing number of providers (including foundation trusts and NHS trusts) in financial distress, with some experiencing serious challenges in delivering services of an acceptable quality. Meanwhile, the pressures facing social care departments in local authorities are increasing by the day, and the effects are already being felt in parts of the NHS.

Leaders at all levels face a huge challenge to sustain the improvements in performance of the past decade. Failure to do so creates political risks for the government, but even greater risks for patients, if the pressures affecting some organisations spread widely and rapidly. The stakes could hardly be higher.

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