

The NHS under the coalition government

Part two: NHS performance

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1 Overview

The King's Fund's assessment of the coalition government's record on NHS reform, published in January 2015, concluded that the changes resulting from the Health and Social Care Act 2012 had been damaging and distracting at a time when the NHS was facing unprecedented financial challenges ([Ham et al 2015](#)). Although claims that the Act would lead to widespread privatisation of NHS provision were found not to be substantiated, the reforms took time and attention away from the work needed to maintain the improvements in care achieved in the previous decade within the funding provided by the government. The King's Fund's assessment concluded that one of the effects of the reforms was to contribute to the growing pressures facing the NHS.

This report builds on that assessment and focuses on how the NHS has performed since 2010. In undertaking this review, we were well aware that assessing the performance of health services is an inexact science. Not only is the meaning of performance contested, but also there are competing views on how it should be measured, on the weight to be attached to different aspects of performance, and on the difficulties of attributing (policy) cause and (health) effect. This was starkly illustrated by the now infamous attempt by the World Health Organization (WHO) in 2000 to rank the performance of health services in 190 countries ([WHO 2000](#)). The challenges of performance assessment have been underlined more recently by studies showing differences in results in the systems used to rate the performance of hospitals in the United States ([Austin et al 2015](#)). While the NHS has traditionally been good at collecting data on work activity in secondary care, in other areas even basic activity data is sparse or non-existent – notably for community health services such as district nursing and health visiting, and general practice.

Any attempt to assess the performance of the NHS, whether in the comparative context such as the much-cited analyses by the Commonwealth Fund ([Davis et al 2014](#)), or over time as in this report, should therefore come with a big health warning attached.



Recognising these limitations, this report uses routinely available data to assess how well the NHS has performed under the coalition government. It is structured as a conventional ‘production path’, beginning with a description of financial inputs to the NHS, then moving to how these inputs are converted into resources such as labour, before considering how resources are used to produce outputs, for example, hospital admissions or accident and emergency (A&E) attendances. The report also draws on surveys of patient and staff experience, access to care as measured by waiting times, and data on outcomes, safety and quality of care such as patient-reported outcomes. It concludes by analysing the relationship between outputs and inputs – that is, productivity – and the financial performance of the NHS between 2010 and 2015.

Our verdict overall is that NHS performance held up well for the first three years of the parliament but has now slipped, with waiting times at their highest levels for many years and an unprecedented number of hospitals reporting deficits. Despite this, patient experience of the NHS generally remains positive and public confidence is close to an all-time high. The very limited data on outcomes, safety and quality of care also indicates some improvement for patients, albeit with growing concerns about the quality of mental health services and the challenges in achieving parity of esteem between mental and physical health. While the NHS has increased its workload at a faster rate than its funding has grown, it is clear that the main approaches to meet the ‘Nicholson Challenge’ – through limiting staff salary increases, reducing the prices paid to hospitals for treatment and cutting management costs – have now been largely exhausted and efficiencies are becoming harder to deliver.

In the final year of this parliament the NHS seems likely to record a substantial deficit, despite additional funds having been injected during 2014/15 and with NHS funding having increased more in real terms since 2010 than planned. Challenges in delivering key waiting time targets in A&E departments, for patients with suspected cancer and for patients waiting for diagnostic tests or hospital procedures will continue. Similar challenges exist in primary care with a decline in the proportion of patients reporting a very good experience of making an appointment and of their overall experience of general practice over the last three years. At a time when most parts of the NHS are working close to their limits and with staff morale a growing concern, the prospects for NHS performance during the next parliament are extremely challenging to say the least.



2 Inputs

NHS funding has increased more in real terms than was planned over the term of the parliament. However, the average annual real increases in spending remain small – between 0.6 per cent and 0.9 per cent. This is considerably less than funding growth of 5.6 per cent between 1996/7 and 2009/10, and less than a quarter of the long-run average annual growth since 1950 of around 4 per cent. Importantly, these increases are also less than the estimated 3 per cent to 4 per cent real growth required each year to meet increases in demand for health care and higher costs of new medical technologies.

Spending Review 2010: plans and outturns

The coalition agreement (HM Government 2010) adopted the Conservative Party's 2010 general election campaign pledge that funding for the NHS in England would increase in real terms in each year of the parliament ([Conservative Party 2010](#)).

On 20 October 2010, the Spending Review ([HM Treasury 2010](#)) quantified this promise. The Spending Review used 2010/11 as the baseline year for a planned cash rise in NHS spending of £10.6 billion over four years to 2014/15. Using the forecasts for inflation at the time, this cash rise was equivalent to a cumulative real rise of 0.34 per cent – or just under 0.1 per cent per year for four years. The plan therefore was to increase NHS spending by around £100 million in real terms each year from 2011/12 to 2014/15 inclusive.

However, the Spending Review 2010 also announced how part of the NHS budget was to be spent. In particular, it identified £3.8 billion over four years to be channelled to local authorities in order to support social care spending. In addition, historic funding from the NHS budget – for example, the personal social services grant and a grant for learning disabilities – was to be properly transferred to the local government budget.

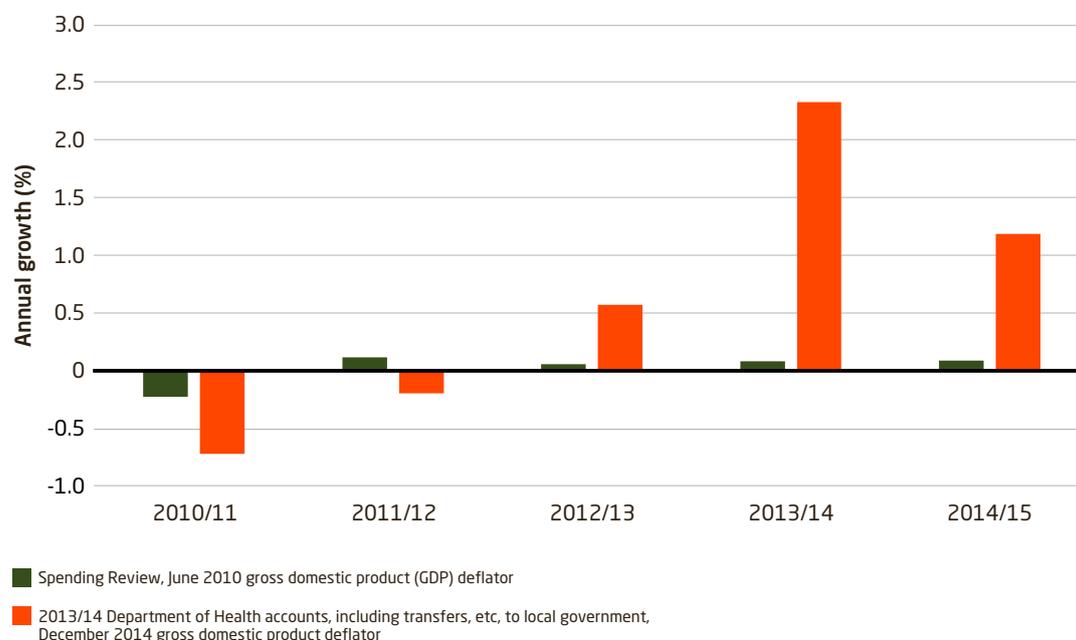


If this was the plan, what was the outcome?

While the Spending Review 2010 plans envisaged a real growth of £380 million between 2010/11 and 2014/15, the actual real growth after planned transfers to local government (such as the realignment of various budgets and responsibilities to local government as well as additional transfers to support social care), plus the effects of lower than forecast inflation and additional Treasury funding of £250 million in 2014/15, was almost £4 billion.

As Figure 1 shows, the net impact of lower inflation, additional money in 2014/15 and the various transfers and adjustments involving local government budgets meant that the total percentage real rise from 2010/11 to 2014/15 was 3.95 per cent rather than the planned rise of 0.34 per cent.

Figure 1 Annual percentage growth in NHS funding: Spending Review 2010 vs actual outcomes (and plans for 2014/15)



Sources: Department of Health (2014a, 2013); HM Treasury (2010)



We have followed the convention of the Spending Review 2010 in using 2010/11 as a baseline and in effect only detailing funding changes over the four years from 2011/12 to 2014/15. However, there is an argument to use 2009/10 as a baseline as the government could (and indeed did) determine spending in 2010/11 even though this was not a full year in parliamentary terms and budgets across all spending departments had already been set for that year. On this basis, the average annual growth for the five years up to 2014/15 (including transfers and adjustments) was 0.63 per cent.

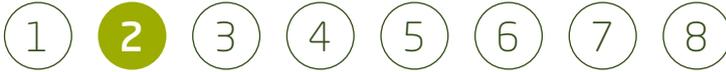
Table 1 summarises the real total and per annum changes in NHS funding based on different baselines (2009/10 to 2014/15 and 2010/11 to 2014/15) and the inclusion or exclusion of various transfers and adjustments to the NHS budget.

Table 1 Spending Review 2010 (SR 2010) plans compared to outturns: 2009/10–2014/15 and 2010/11–2014/15

Real spending change	2009/10 baseline			2010/11 baseline		
	SR 2010 plans	Outturn, excluding transfers etc to local government	Outturn, including transfers etc to local government	SR 2010 plans	Outturn, excluding transfers etc to local government	Outturn, including transfers etc to local government
GDP deflator	June 2010	December 2014		June 2010	December 2014	
Total period (per cent)	+0.11	+2.38	+3.20	+0.34	+3.01	+3.95
Average per year (per cent)	+0.03	+0.47	+0.63	+0.08	+0.75	+0.97

Data sources: Department of Health (2014a, 2013); HM Treasury (2010)

Nevertheless, while NHS funding has increased more in real terms than planned, the average annual real increases in spending remain small – between 0.6 per cent and 0.9 per cent. This occurs whatever base year is used and regardless of whether various adjustments and transfers are included or excluded. These increases are considerably less than funding growth between 1996/7 and 2009/10 of 5.6 per cent,



and less than a quarter of the long-run average annual growth since 1950 of around 4 per cent. Importantly, they are also much less than the estimated 3 per cent to 4 per cent real growth required each year to meet increases in demand for health care and higher costs of new medical technologies. Efforts to fill this funding gap through improvements in productivity are examined in section 6.



3 Resources

The government has met its pledge to cut management costs and ‘rebalance’ its workforce. Total NHS staff numbers have increased marginally since 2010. There have been large reductions in managerial staff, mostly in central, regional and commissioning bodies. Consultant, GP and nurse numbers have increased, though for GPs and nurses these have not kept pace with population growth. Difficulties in nursing recruitment have resulted in high levels of spending on more expensive agency and locum staff. While bed numbers continue their historic decline, occupancy rates are creeping up to very high levels, suggesting that many hospitals may now be operating at the limits of their capacity.

Staff

In recognition of the slowdown in funding growth and the need to reduce costs as part of its programme to improve productivity, the government pledged to reduce management costs by ‘more than 45 per cent’ and noted that ‘the NHS will employ fewer staff at the end of this Parliament; although rebalanced towards clinical staffing and front-line support’ ([Department of Health 2010](#)). Part of this rebalancing was a commitment to increase the number of health visitor staff over the course of the parliament ([Department of Health 2011a](#)).

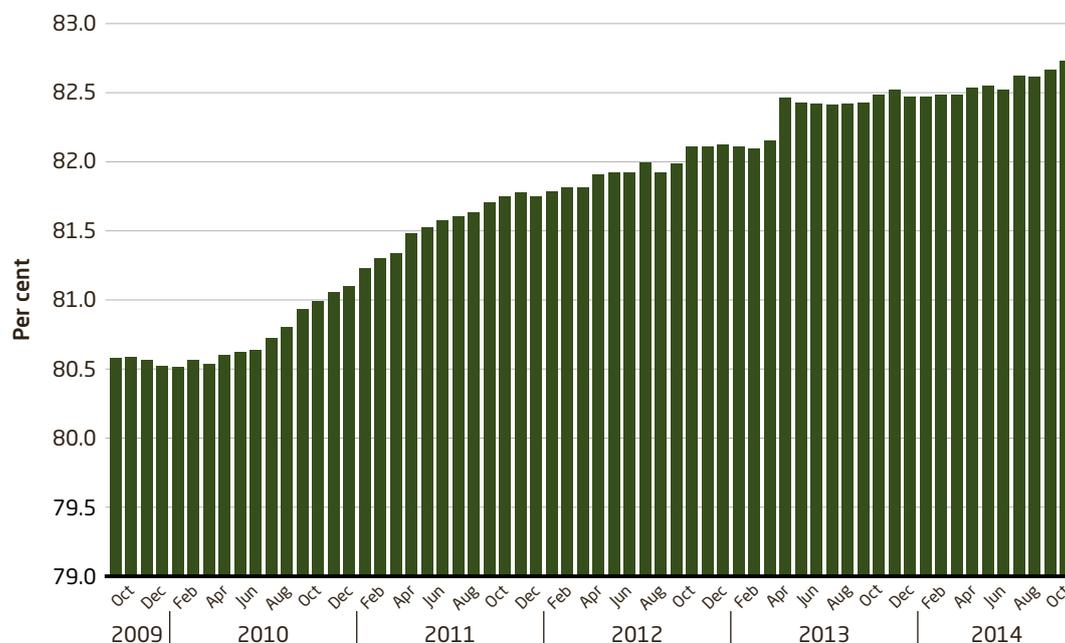
The pledge to reduce management costs was reaffirmed in the Spending Review 2010 – although rephrased as a one-third reduction in real terms (at the prevailing forecast rates of inflation at the time). Figures from the Department of Health accounts for 2013/14 ([Department of Health 2014a](#)) suggest that administration costs decreased from a baseline of £4.5 billion to £3.04 billion in 2013/14 in cash terms – a reduction of 33 per cent in cash terms and around 36 per cent in real terms.

Regarding the ‘rebalancing’ towards clinical staff, there has been a slight change in favour of clinical compared to non-clinical staff across the NHS (Figure 2).



From around June 2010 to October 2014, the proportion of clinical and clinical support staff increased from 80.5 per cent to 82.7 per cent. This increase was due to a reduction in infrastructure staff (for example, those performing estate, hotel and management functions) of around 20,000 full-time equivalents (FTEs) and an increase in clinical and related staff of around 31,000 FTEs.

Figure 2 Professionally qualified clinical staff and support to clinical staff as a percentage of all NHS staff, 2009–2014



Source: Health and Social Care Information Centre (2015c)

Although the government anticipated an overall reduction in NHS staff over the course of the parliament, it looks more likely that there will be an increase; between May 2010 and October 2014, total NHS staff increased by around 10,800 – a rise of just over 1 per cent. Figures 3 and 4 show this increase as well as the large drop in management staff (reduced by 18 per cent – taking staffing back to 2006 levels), an increase of around 12 per cent in the number of consultants and, after a fall of 2.3 per cent in GP numbers in 2010, a steady rise that has taken GP numbers back to their level in 2009.

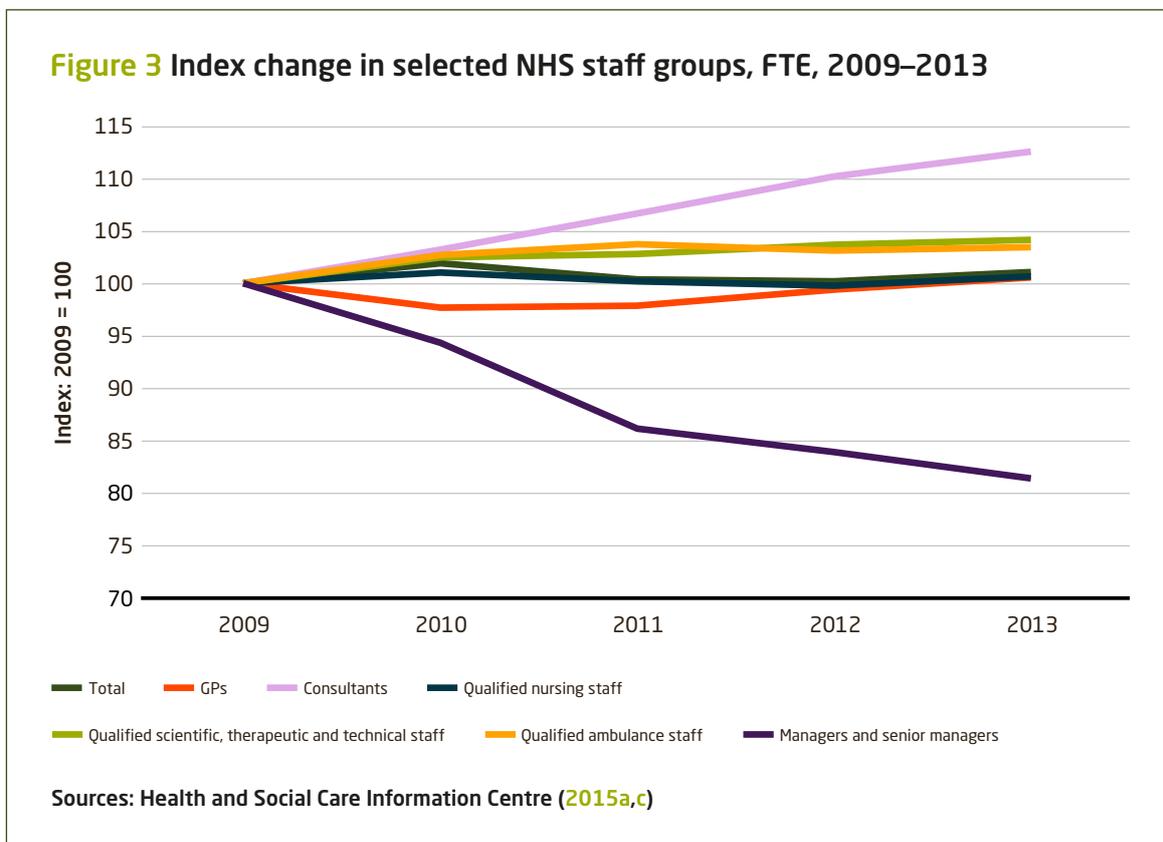
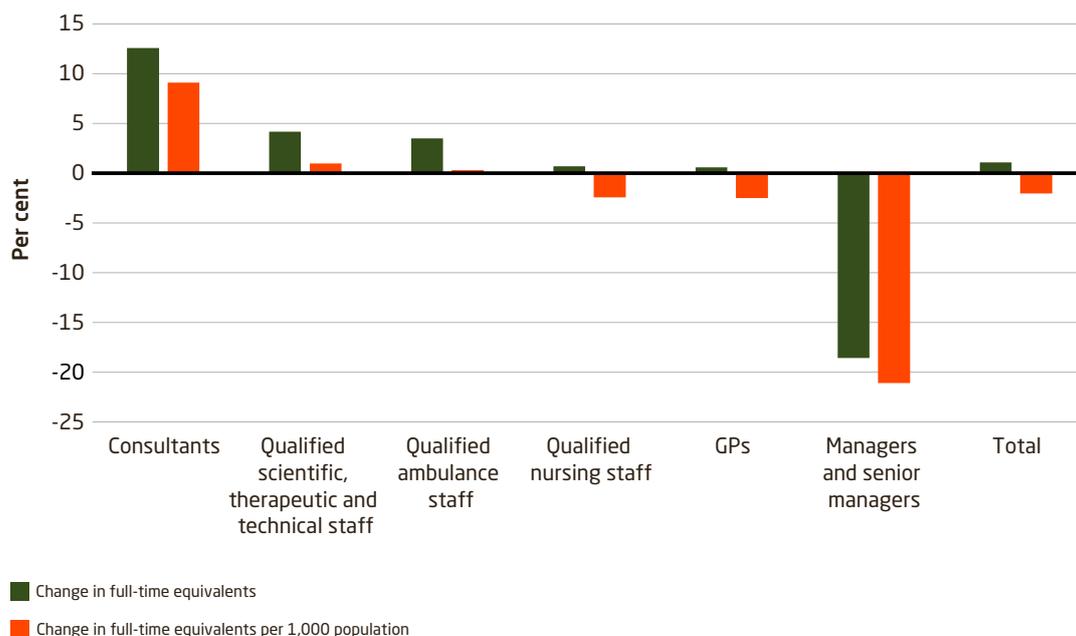


Figure 4 also shows the change in numbers of staff per 1,000 population. This provides a crude assessment of staff relative to need and suggests that once population growth is taken into account, total staff per 1,000 population has reduced by around 2 per cent as have the numbers of GPs (-3 per cent) and qualified nursing staff (-2 per cent). Taking account of demographic changes such as the growing proportion of older people would accentuate these changes.



Figure 4 Percentage change in selected NHS staff groups, 2009–2013, FTEs and FTEs per 1,000 population



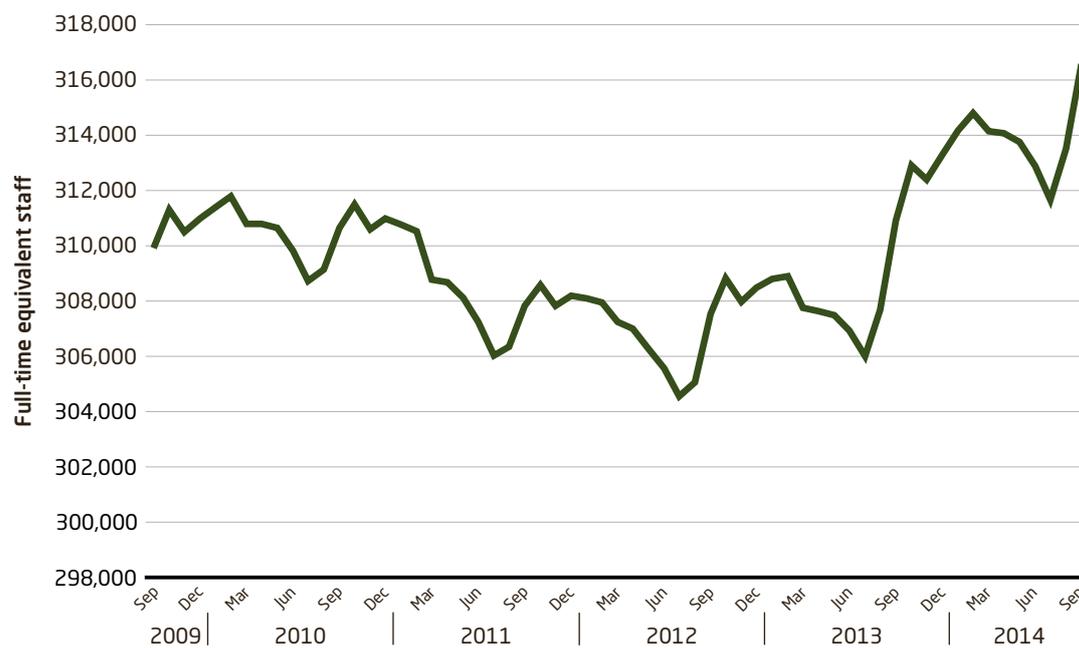
Data sources: Health and Social Care Information Centre (2015a,c); Office for National Statistics (2014, 2013a,b)

More recent monthly data on the NHS workforce reveals a changing picture for the numbers of nursing staff in particular. As Figure 5 shows, seasonal fluctuations aside, from September 2009 to around August 2013, there was a downward trend in nurse staffing numbers. However, from September 2013 to the most recent figures for October 2014, the trend has been upwards, with the nursing workforce increasing by nearly 9,000, mostly due to increases in the number of nurses working in the areas of acute, older people’s and general secondary care (although agency staff are not included in these figures and will inflate them somewhat). This increase reflects the individual decisions of trusts to boost the number of nurses in the wake of various reports on the quality of care provided by the NHS (Keogh 2013; National Advisory Group on the Safety of Patients in England 2013; The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013).



Despite difficulties in recruiting nursing staff, The King’s Fund’s regular survey of trust finance suggested that just over three-quarters (54 out of 71) planned to increase the number of permanent nursing staff over the six months from December 2014 (see Quarterly Monitoring Report 14 (Appleby *et al* 2015)). Moreover, decisions to spend more on nursing have undoubtedly contributed to increasing financial difficulties for many trusts (see section 8). Given problems with recruitment, hospitals have been increasingly turning to agency staff. For example, between April 2012 and January 2015, the total number of hours requested by acute trusts for agency and bank staff has more than doubled to 1,917,000 hours (Addicott *et al*, forthcoming).

Figure 5 Total number of FTE qualified nurses, midwives and health visitors, NHS England, September 2009–October 2014



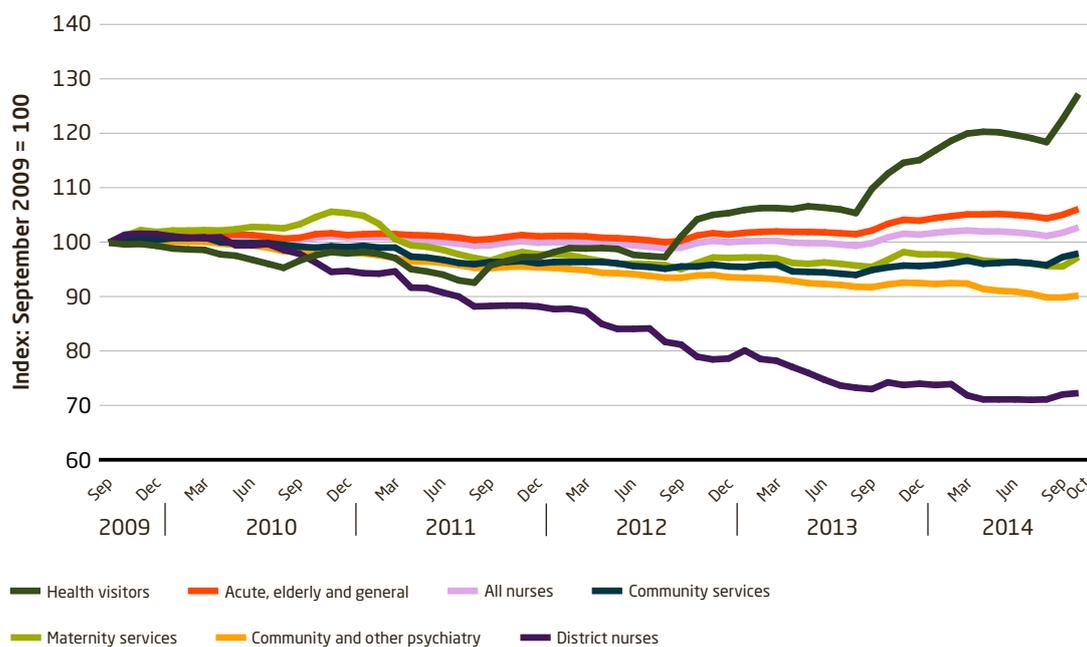
Source: Health and Social Care Information Centre (2015c)



The commitment to increase the health visitor workforce by more than 50 per cent has seen health visitor numbers rise from 8,092 in May 2010 to 10,552 in October 2014 (Figure 6). However, this leaves a gap of 1,740 – more than 40 per cent of the target increase – to be filled by April this year.

The increase in the number of health visitors has masked some significant decreases in other community nurse staff however. Figure 6 also illustrates a 27 per cent decline in the number of district nurses – from 7,813 in May 2010 to 5,681 in October 2014.

Figure 6 Index change in selected groups of FTE qualified nurses, September 2009–October 2014



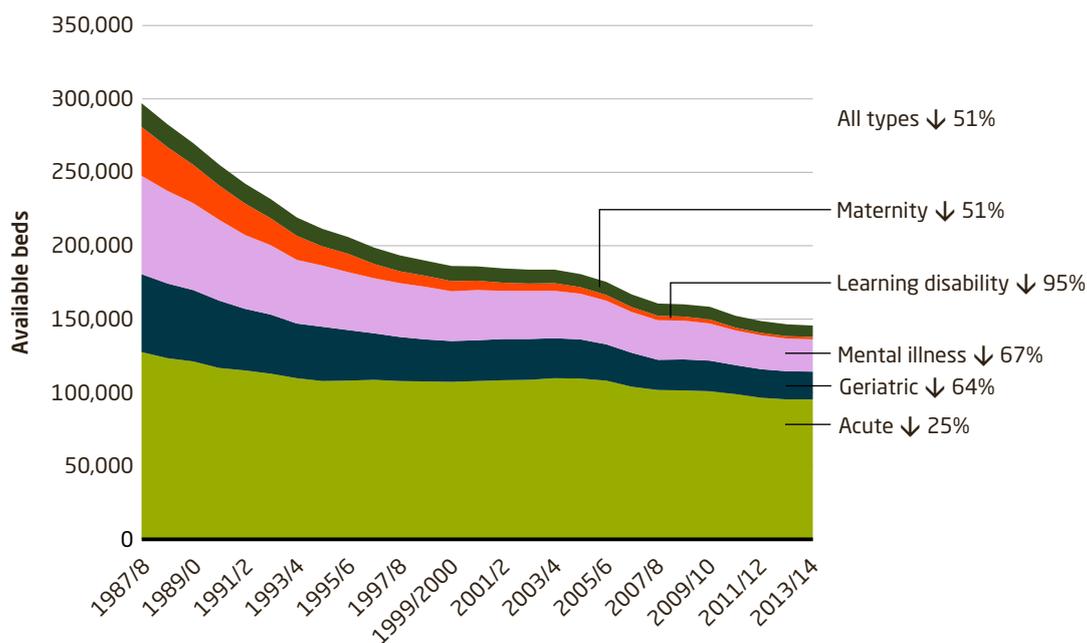
Source: Health and Social Care Information Centre (2015c)



Beds

The number of hospital beds in many countries has been declining for a number of years – largely as a result of medical advances (shortening lengths of stay) and changes in policy towards treatment and care outside hospital. The long-run trend for the NHS in England has also been down for all types of beds since 1987/8 (Figure 7). Overall, the number of available beds has more than halved over the past 26 years – with larger proportional reductions in learning disabilities, mental illness and geriatrics than for acute beds.

Figure 7 Average daily number of available beds, NHS England, 1987/8–2013/14



Sources: NHS England (2015b); King's Fund estimate for 2011/12 to 2013/14



As Table 2 shows, recent changes in bed numbers – from 2009/10 to 2013/14 – are similar to the long-run decline since 1987/8.

Table 2 Average annual percentage reduction in bed numbers by type, 1987/8–2013/14 and 2009/10–2013/14

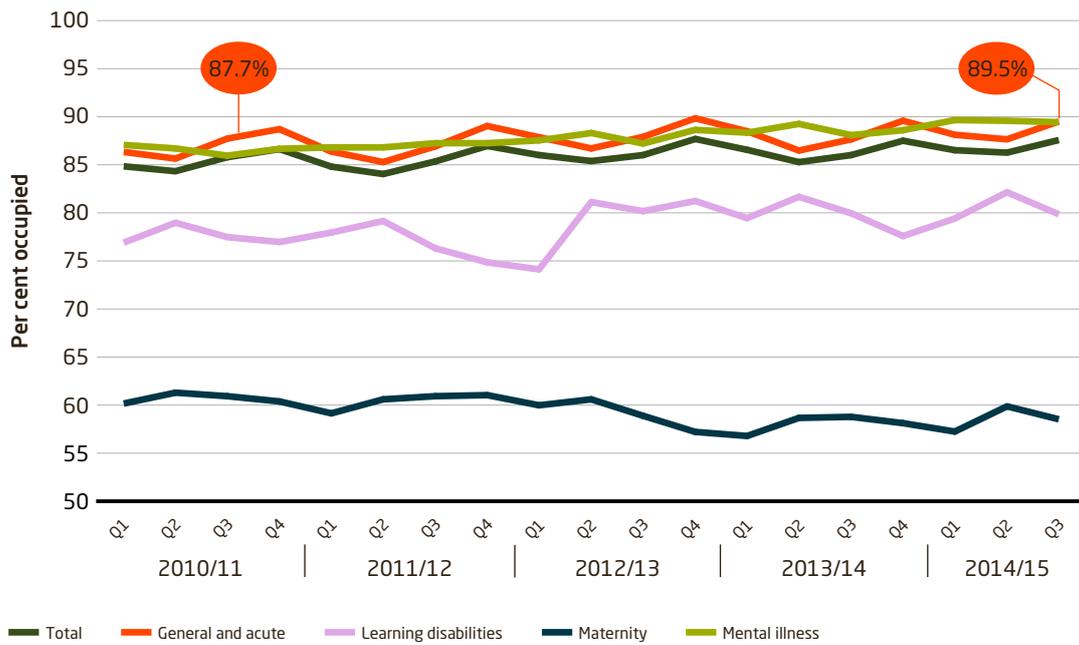
Period	Acute	Geriatric	Mental illness	Learning disabilities	Maternity
1987/8–2013/14	-1.1	-3.9	-4.2	-11.0	-2.7
2009/10–2013/14	-1.4	-2.3	-3.7	-12.2	-2.0

Sources: NHS England (2015b); King's Fund estimate for 2011/12 to 2013/14

The long-run (and shorter-run) reductions in bed numbers reflect trends in medical practice and developments in treatment that have meant patients do not have to spend so long in hospital as in previous years. However, since 2010/11 there has also been an increase in the intensity with which beds are being used – as measured by occupancy rates, which have increased by 1.8 percentage points, to 87.6 per cent by the third quarter of 2014/15 from the third quarter of 2010/11 (Figure 8). The trend for the largest type of beds – general and acute – has also increased by 1.8 percentage points (from 87.7 per cent in the third quarter of 2010/11 to 89.5 per cent – the highest third-quarter rate since 2010/11). While such increases may seem small, they hide wide variations – both across trusts and within each quarter; in the third quarter of 2014/15 around one in six trusts reported occupancy levels greater than 95 per cent. Optimum occupancy rates for hospital beds are context-dependent and will vary between organisations but the National Audit Office suggested that hospitals with average occupancy levels above 85 per cent can expect to have regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections (National Audit Office 2013).



Figure 8 Percentage of (overnight) beds occupied, NHS England, 2010/11–2014/15



Source: NHS England (2015b)

Average general and acute bed occupancy levels close to 90 per cent on average (and rising) suggest growing pressures in secondary care. On recent trends, the final quarter of 2014/15 could show occupancy rates in excess of 90 per cent as well as a possible slowdown or reversal in the number of available beds as hospitals try to manage increasing demand on their services.



4 Activity

While data on activity remains patchy – with little or no information on the output and activity of general practice and community services, for example – where information is available it is clear that the level of activity has risen and continues to do so. Concern has focused in particular on increasing accident and emergency (A&E) attendances and admissions to hospital. Driving these increases is a complex combination of changes in population and the demographic profile of the population (increasing numbers of older people, for example), changes in the way that services are provided, and changes in clinical practice.

Hospitals

While real-terms funding has increased by around 2 per cent in total between 2009/10 and 2013/14, as Table 3 shows, secondary care activity, as measured by referrals, attendances and admissions, increased by much more. More recent quarterly data for 2014/15 shows upward trends continuing (see Figure 9).

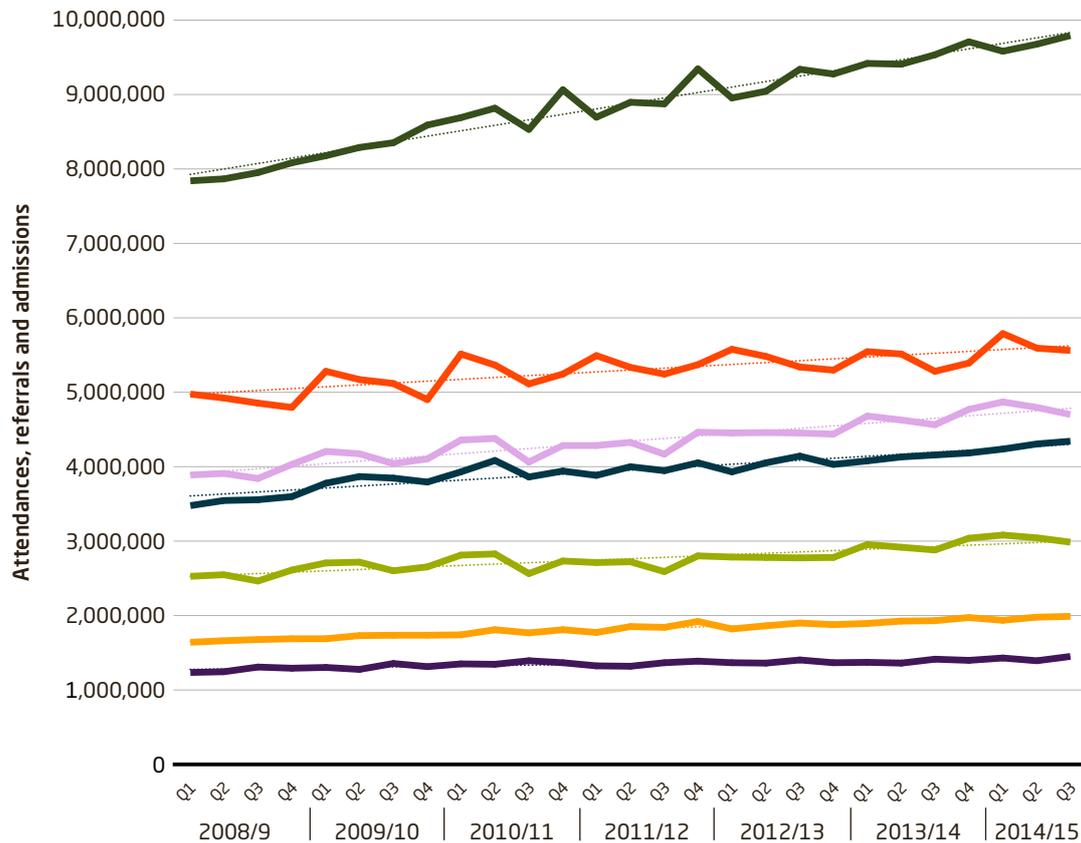
Table 3 Changes in referrals, attendances and admissions, 2009/10–2013/14

	GP referrals	All referrals	First outpatient attendances	Follow-up outpatient attendances	Non-elective admissions	Elective admissions	A&E attendances
Percentage change	+10.4	+12.8	+8.3	+14.0	+5.7	+12.2	+6.2
Percentage change per 1,000 population	+7.0	+9.3	+4.9	+10.4	+2.4	+8.7	+2.9

Sources: NHS England (2015i); Office for National Statistics (2014, 2013a,b)



Figure 9 Quarterly hospital activity (commissioner-based), 2008/9–2014/15



■ Follow-up outpatient attendances*
 ■ A&E attendances
 ■ Total referrals
 ■ First outpatient attendances
■ GP referrals
 ■ Elective admissions
 ■ Non-elective admissions

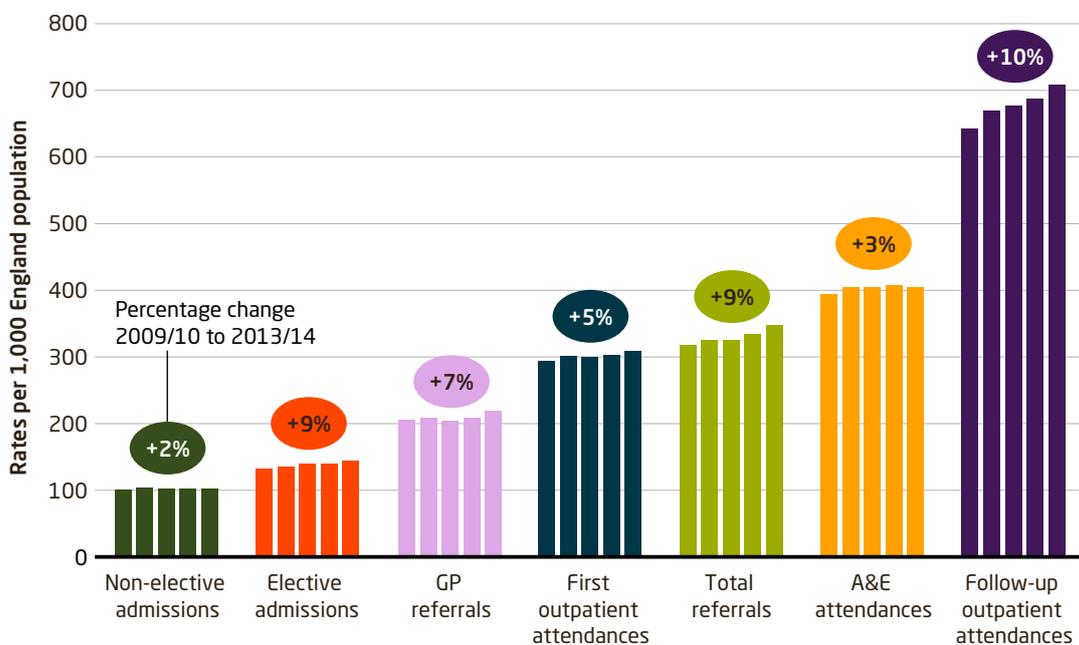
Note: Asterisk (*) for follow-up outpatient attendances refers to activity for all specialties. All other activity (apart from A&E) refers to general and acute (specialty) activity only. 'General and acute activity only' means that obstetrics, learning disabilities and mental health have been excluded.

Source: NHS England (2015i,j)



It is clear from Figure 10 and Table 3 that population change is only one factor driving increased NHS activity as work has outstripped the growth of the population of England. Other factors – such as the composition of the population (increasing numbers of older people, for example) and supply-side factors, such as changes in the way that services are provided and changes in medical practice – also combine to generate more work.

Figure 10 Elective activity per 1,000 population, England, 2009/10–2013/14



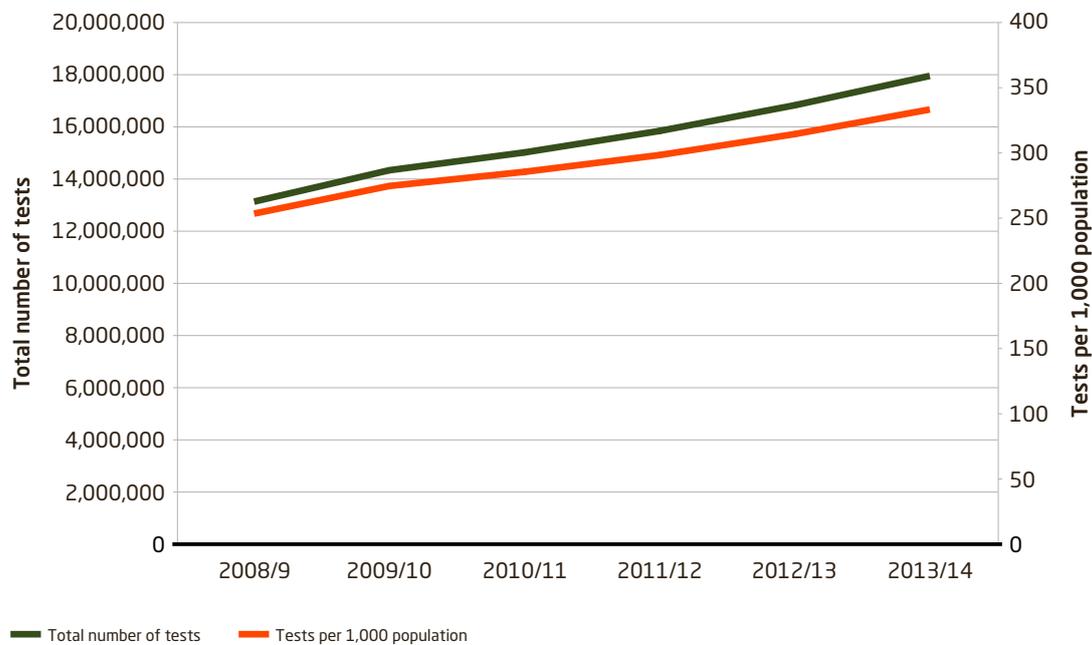
Sources: NHS England (2015i,j); Office for National Statistics (2014, 2013a,b)



Diagnositics

The general increases in referrals, attendances and admissions are also reflected in a significant rise in diagnostic tests. Between 2009/10 and 2013/14 the total number of tests performed in England rose from 14.4 million to 17.9 million – an increase of more than a quarter (see Figure 11).

Figure 11 Diagnostic activity, NHS England, 2008/9–2013/14, total tests and tests per 1,000 population



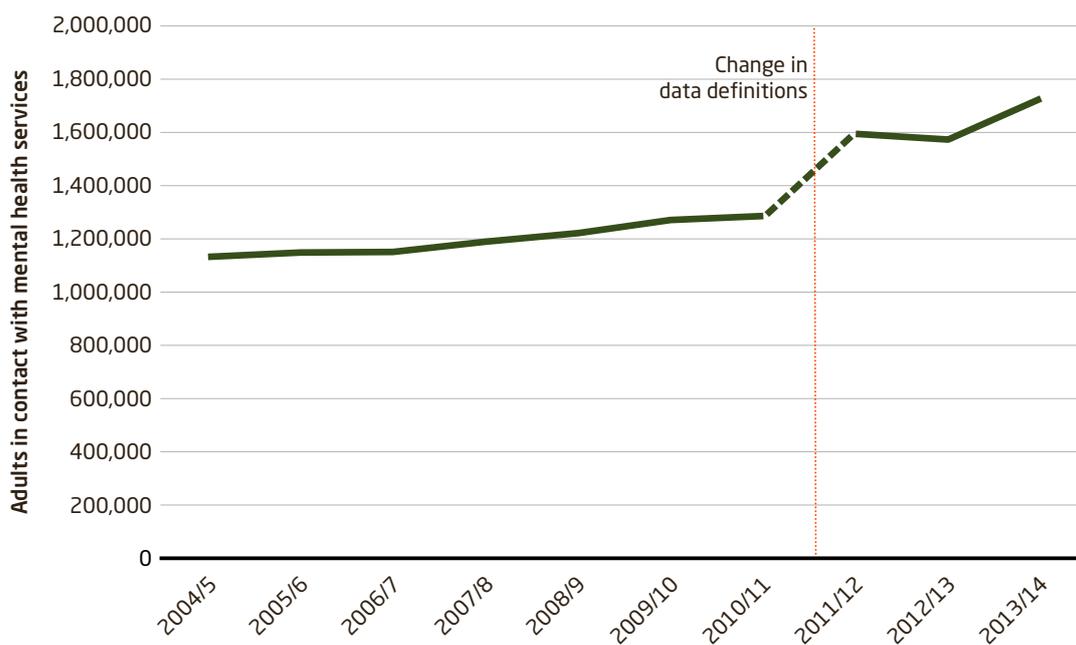
Sources: NHS England (2015f); Office for National Statistics (2014, 2013a,b)



Mental health

The number of people in contact with adult and older adult mental health services is increasing. It is not possible to review trends from 2010 as between 2010/11 and 2011/12 the data collection changed. However, from 2011/12 to 2013/14 (the latest data we have) the number of people in contact with adult and older adult NHS-funded secondary mental health services, at NHS providers, increased from 1.6 million to 1.7 million – an absolute increase of 132,637 people (or 8 per cent – equivalent to 6.7 per cent in the rate per 1,000 population) (see Figure 12).

Figure 12 Number of people using adult and older adult NHS-funded secondary mental health services, 2004/5–2013/14



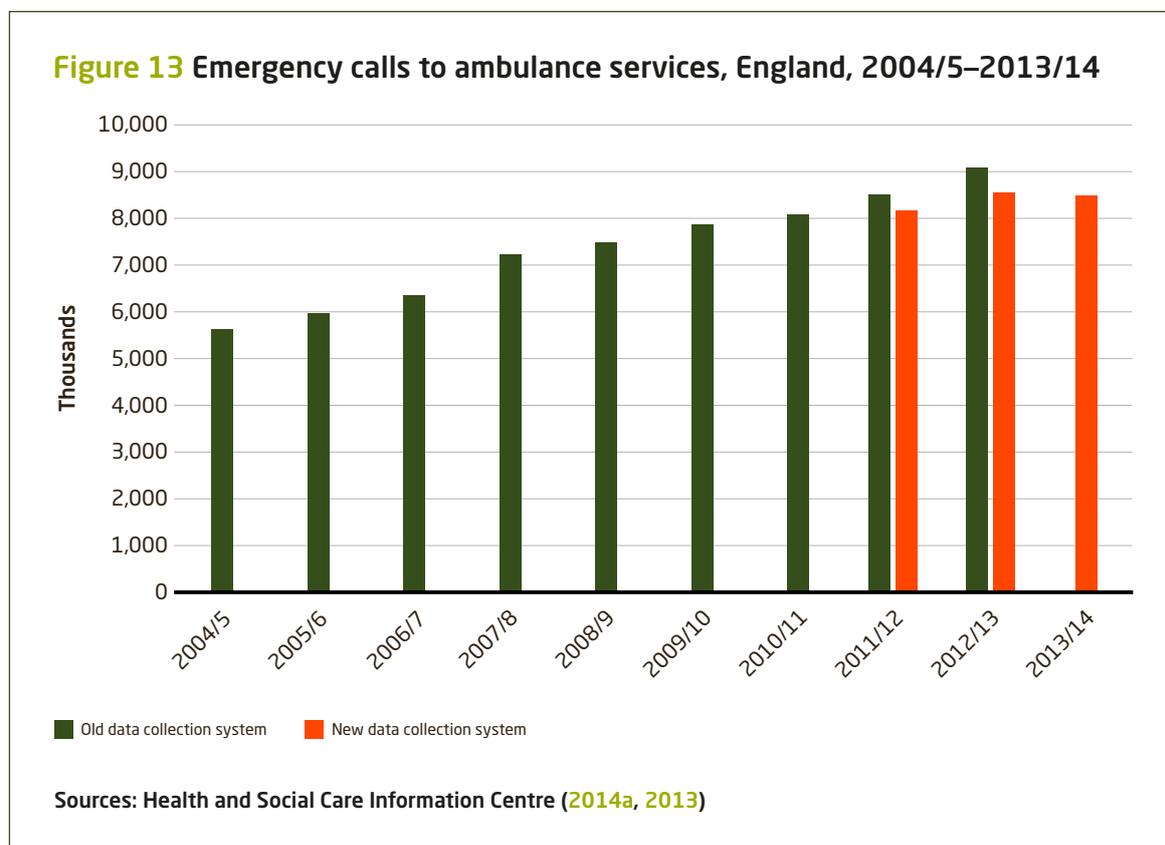
Source: Health and Social Care Information Centre (2014b)

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Ambulance services

Emergency calls to ambulance services in England have been on an upward trend for many years. From 2004/5 to 2009/10 call numbers increased by more than half. The trend to 2012/13 continued at a similar rate. New data collection systems adopted in 2013/14 make comparisons with previous years difficult. However, on a comparable basis back to 2011/12, it appears that the number of emergency calls in 2013/14 declined for the first time in a decade (see Figure 13).





5 Outcomes, access and experience

The views and experiences of patients, staff and the public regarding the NHS provide a mixed picture of the service over the past five years. While waiting times improved or held up in the first three years of this parliament, problems with timely access – in A&E and general practice, for example – have increased over the past two years. Health care-acquired infections have reached historic lows. Overall, patient satisfaction with the care received has remained generally high on a number of measures, and public satisfaction with the NHS has increased – after a fall in 2011. However, there are signs that staff satisfaction has decreased recently.

The Department of Health, through the mandate with NHS England, monitors performance of the NHS through an outcomes framework. This framework looks at performance of the NHS against a number of objectives and uses a mix of data. As we noted in the Overview, there are particular difficulties that make it hard to ascertain the effect of the coalition government's policies on population health outcomes such as mortality and morbidity. For example, in *Improving outcomes: a strategy for cancer* published in 2011 ([Department of Health 2011b](#)) the coalition government set a commitment to save an additional 5,000 lives by 2014/15; the latest annual report on the cancer strategy estimates that on average between 6,500 and 17,000 more patients per year diagnosed from 2011 to 2015 will survive cancer for five years compared to those diagnosed from 2006 to 2010 ([Department of Health 2014b](#)). However, as the report notes, this is an estimate based on projections as five-year survival rates are only available for people diagnosed from 2008 to 2012. In another example, while trends in life expectancy are improving – for example, the rate of potential life years lost (PYLL)¹ has shown a downward trend between 2009

¹ PYLL: the number of years of life lost by every 100,000 people dying from a condition, which is usually treatable.



and 2013 – this is a result of people’s lifetime consumption of health, education and other services as well as their lifetime economic experience and lifestyle behaviour.

Similarly, while the gap between the PYLL rate in the most and least deprived areas has also decreased each year from 2009 to 2013 (from 2,959 in 2009 to 2,506 in 2013) again such changes are the result of longer-term historic trends – not just in health care but other economic and social factors.

Crucially too, there is a dearth of routine health-related quality of life data that is produced in the NHS and has a bearing on the direct experiences of patients.

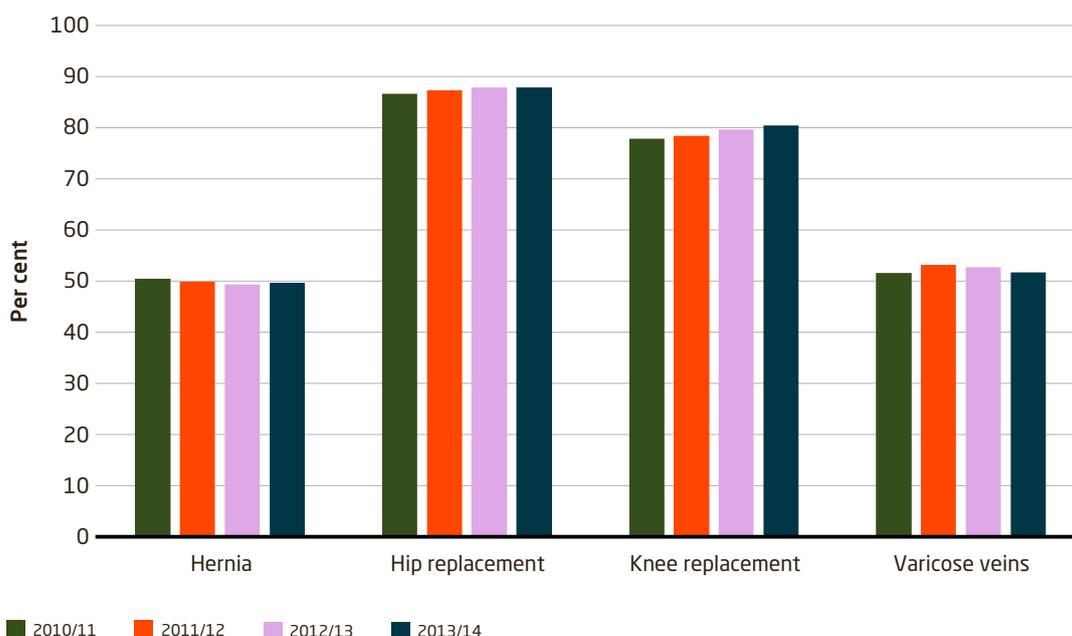
Although there is only limited data on patient-reported outcome measures (PROMs), there are a number of measures of patient experience, satisfaction and access (including staff experience and attitudes) which provide a basis for assessing NHS performance in their own right and provide some indirect insight into the outcomes of the NHS via metrics on process, quality and safety.

Patient-reported outcomes

While England was a world leader in implementing a country-wide patient-reported outcomes initiative, the regular collection of patient-reported outcomes in the NHS in England remains limited. For the four elective surgical procedures covered by the PROMs initiative, Figure 14 shows that there has been a small improvement since 2010 in the proportion of patients reporting an improvement in their health among those undergoing hip or knee replacement surgery. However, there has been little change for varicose vein or hernia patients.



Figure 14 Percentage of patients reporting an increase in post-operative health-related quality of life (as measured by the EQ-5D index, 2010/11–2013/14)



Note: The EQ-5D index is a summary measure based on a generic health-related quality of life questionnaire

Data source: Health and Social Care Information Centre (2015d)

Waiting times

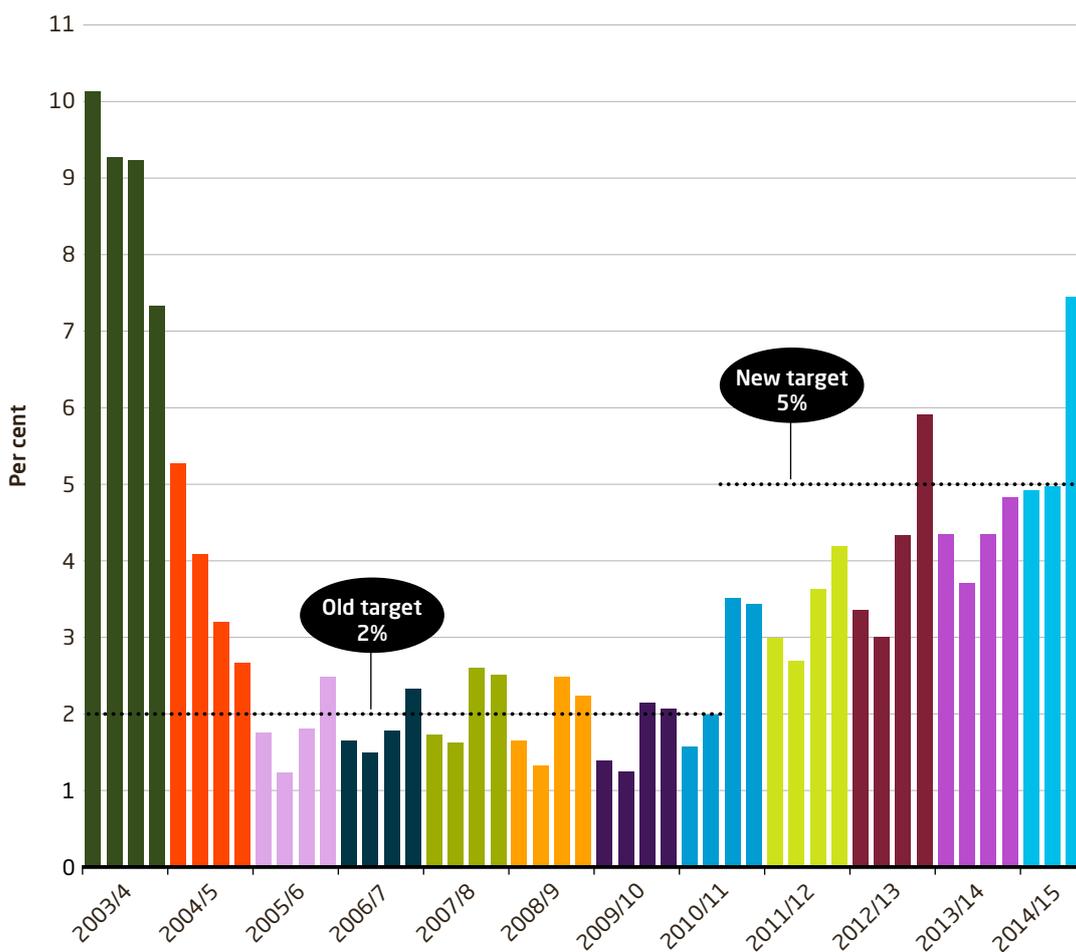
In the 1980s and 1990s, the most common criticism of the NHS was long waiting times for treatment. Huge reductions in waiting times were seen by 2008 and measures of waiting times, indicating how easy people find it to access the care that they need, have become a focus for the assessment of NHS performance by politicians and the public. As part of its commitment to meet the new legal responsibility for the NHS to deliver ‘parity of esteem’ between mental and physical health by 2020, the government has announced waiting time standards for some mental health services for the first time. From April 2015 waiting times will be measured for psychological therapies provided through the Improved Access to Psychological Therapies (IAPT) programme, with a view to reaching a target in March 2016 that 75 per cent of people referred to an IAPT programme begin treatment within six weeks of referral, and 95 per cent within 18 weeks (NHS England 2015h).



A&E

The four-hour A&E wait target, while controversial in terms of unintended consequences ascribed to it, acts as an indicator not just of performance of the A&E department but of flow into, through and out of the hospital. As Figure 15 shows, the proportion of patients waiting for more than four hours in A&E hovered around 2 per cent for a number of years – an outcome of the 98 per cent target set in 2004. That proportion then increased after the coalition government decided to relax the target to 95 per cent in 2010. Since then, the proportion of patients waiting for

Figure 15 Percentage of patients waiting more than four hours in A&E from arrival to admission, transfer or discharge: quarterly, 2003/4–2014/15



Source: NHS England (2015a)

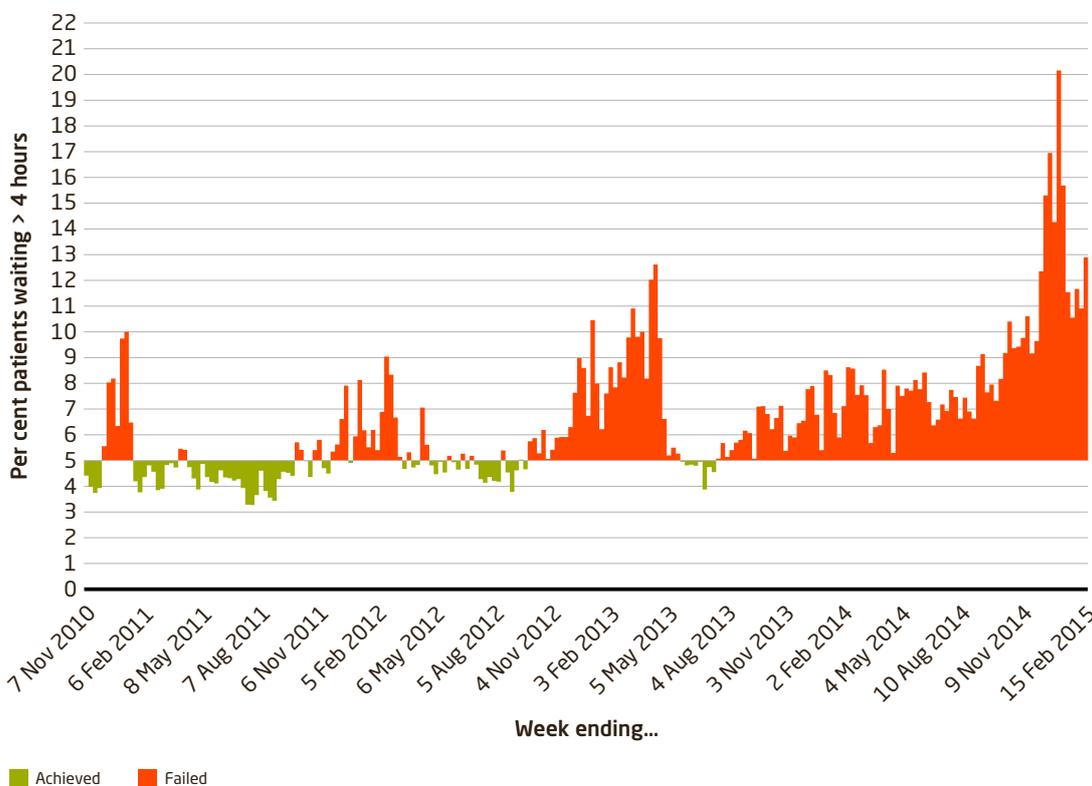
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longer than four hours has risen. In the most recent quarter (quarter 3 2014/15) 7.4 per cent of patients (more than 414,000) spent longer than four hours in A&E – this is a 47 per cent increase on the previous quarter and the poorest performance since the same quarter in 2003/4.

For major A&E units in hospitals (as opposed to single specialty units, walk-in centres and minor injuries units), trends in the proportion of patients waiting longer than four hours each week from 2010 to 2015 shows that the maximum four-hour target was achieved in aggregate in 71 out of 224 weeks and that the trend in breaches of the target has increased over the past 18 months (*see* Figure 16).

Figure 16 Percentage of patients waiting more than four hours in A&E from arrival to admission, transfer or discharge: weekly, type I units only, November 2010 to February 2015



Source: NHS England (2015a)

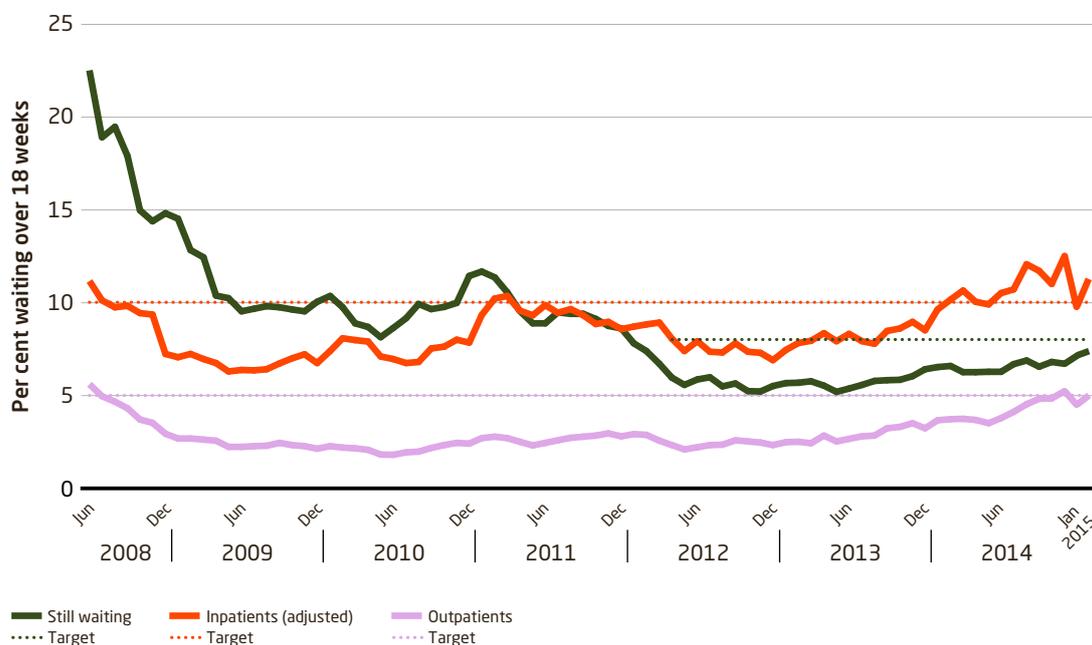


The last time the target was met was the middle of August 2013. Pressure on A&E departments can have a knock-on effect in the rest of the hospital. Indeed, during last winter, the number of cancelled elective operations peaked at 2,424 compared to 1,298 in the same week in the previous year.

18-week referral-to-treatment target

Although the target that patients should receive treatment either as an outpatient or as an inpatient within 18 weeks of referral was breached in two months at the beginning of 2011, waiting times improved up to the end of 2012. Around the end of 2012 and the beginning of 2013 the proportion of patients waiting longer than 18 weeks who had been admitted as an inpatient, seen as an outpatient or were still waiting, started to increase (see Figure 17).

Figure 17 Percentage still waiting/having waited more than 18 weeks, commissioner time series, NHS England, 2008–2014



Source: NHS England (2014)



Increases in waiting remained within the targets until the summer of 2014, when the inpatient target began to be breached in aggregate across the NHS. In August 2014, the Secretary of State announced an additional £250 million aimed at clearing a backlog of patients who were waiting more than 18 weeks for treatment and a ‘managed breach’ of the target to allow the NHS to focus on this. By November 2014 the target for those requiring an admission to hospital for their treatment had not been met for the previous six months and the outpatient target had been missed for the first time in six years. While waiting times recovered in December, in January 2015 they rose again for all stages of waiting.

Inpatient waiting times returned to within target in December 2014, but long waits and an increasing number of patients still waiting remain relatively high. In addition, the number of organisations failing to report their waiting times continues to rise. NHS England estimates that nearly 250,000 patients were waiting but were not included in official figures. Once these lost patients are included in the statistics, the waiting list remains stubbornly high at 3.2 million.

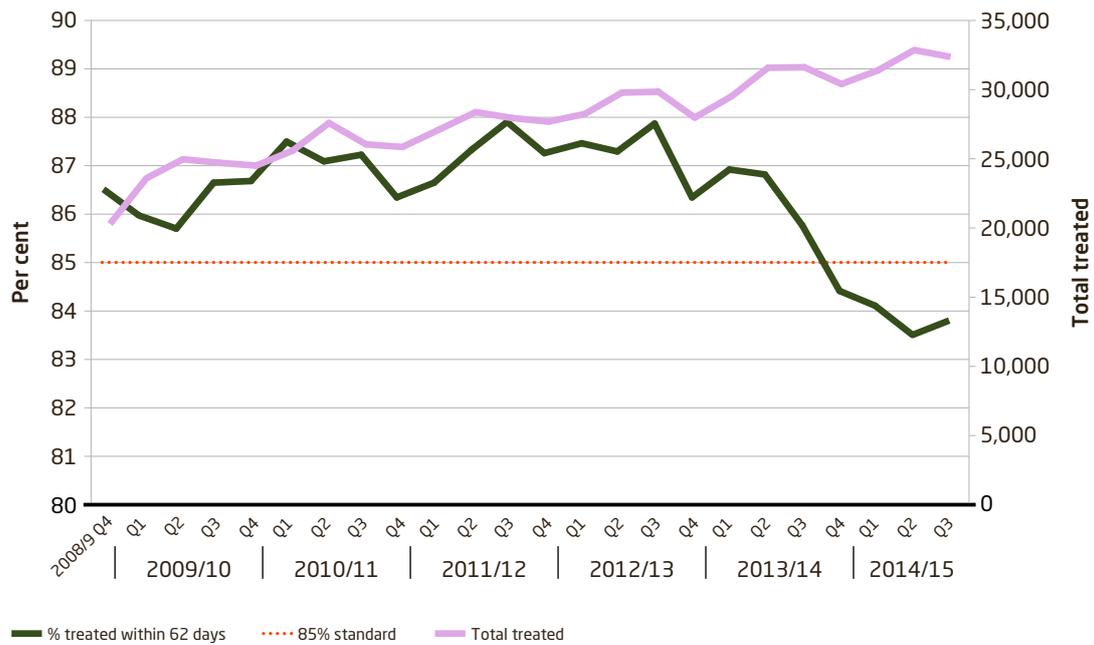
62-day cancer waiting time target

The NHS constitution sets out a number of targets for treating cancer patients at different stages of the patient pathway. The over-arching target is that a minimum of 85 per cent of patients with suspected cancer should receive their first treatment within 62 days of an urgent referral by their GP.

While the target has been met for most of the parliament, in the last quarter of 2013/14 the target was missed for the first time, as it was in the subsequent three quarters (*see* Figure 18). By the third quarter of 2014/15, 83 per cent of people referred urgently from their GP were treated within the target time. Excluding breast and skin cancers, performance was 77 per cent. The numbers of people being treated following referral have increased by nearly 22 per cent since 2010/11. Research from Macmillan Cancer Support suggested that this demand, combined with a fragmentation of commissioning and a loss of expertise in cancer networks as a result of the coalition government’s reforms, was causing the targets to be missed ([Macmillan Cancer Support 2014](#)).



Figure 18 Percentage of people urgently referred for suspected cancer receiving first definitive treatment within 62 days, 2008/9–2014/15



Source: NHS England 2015c

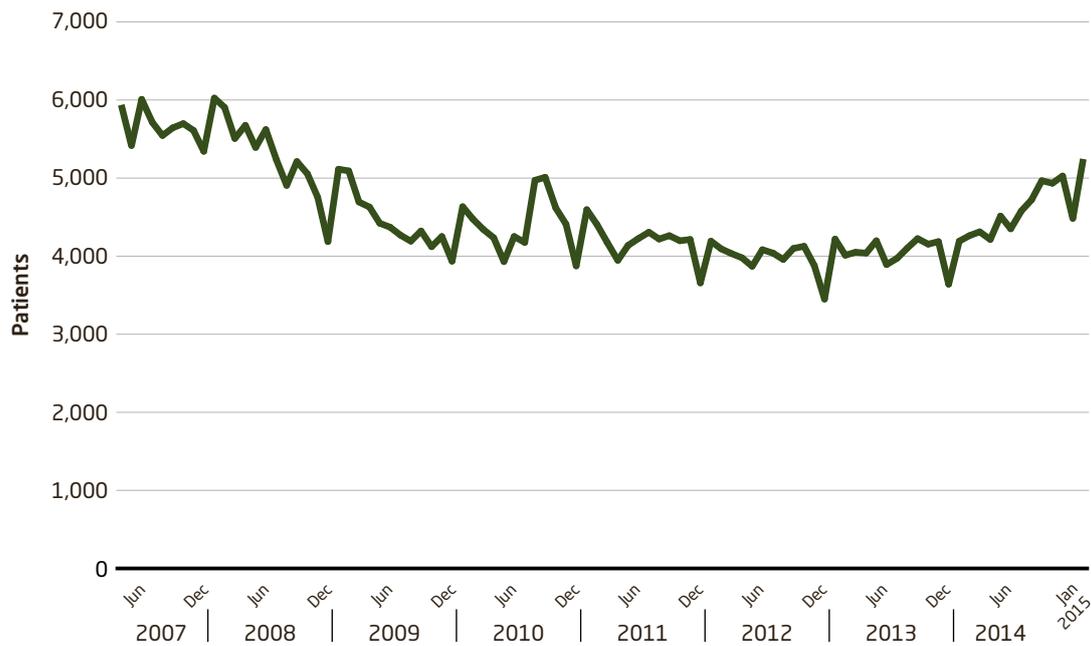
The Public Accounts Committee has also highlighted problems with cancer waiting times and has pointed out that there remain unacceptable variations across the country in the performance of cancer services more generally ([Public Accounts Committee 2015](#)).



Delayed transfers of care

Patients also experience waits in being discharged at the end of their care when they need to move home, or on to other forms of treatment. The number of discharges categorised as ‘delayed’ was relatively stable until 2014/15 but has now begun to increase (see Figure 19). Analysis of the reason for delays suggests that while the absolute numbers attributable to the NHS or social care have risen, the proportion attributable to social care has fallen, and that attributable to the NHS has risen between 2010/11 and 2014/15.

Figure 19 Delayed transfers of care, average number of patients delayed per day each month, 2007–2015

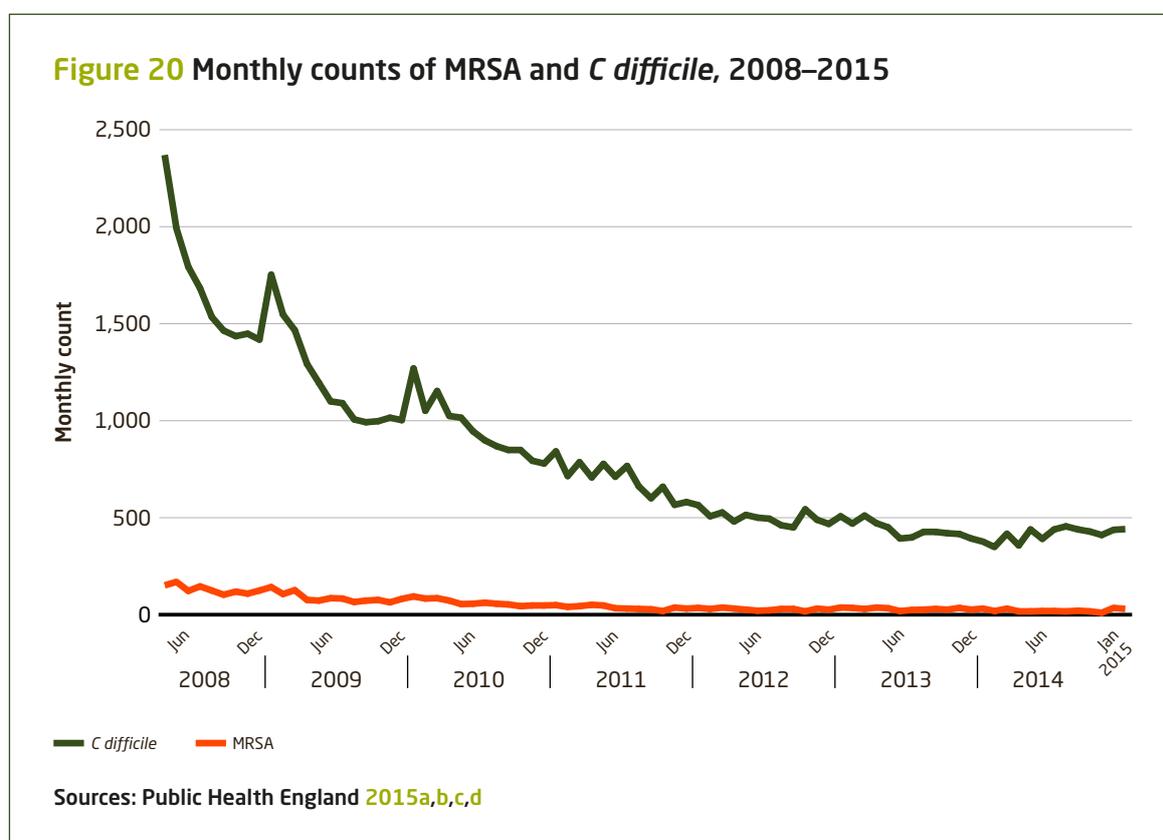


Source: NHS England 2015e



Health care-acquired infection

Health care-acquired infection rates have traditionally provided one of the indicators of safety in hospitals. The number of health care-acquired infections has continued to fall in recent years and has now broadly stabilised at an historically low rate (see Figure 20). This is a significant achievement given the high rates reported a decade ago.



Mixed sex accommodation

A particular complaint for a proportion of patients has traditionally been the experience of having to share wards and spaces with the opposite sex. Following the government pledge to end mixed sex accommodation, from April 2011 fines (and a mandatory data collection process) were introduced to incentivise hospitals to reduce mixed sex accommodation. Since then the number of reported ‘breaches’ has declined from around 2,200 to around 350 in January 2015.



Access to appropriate mental health services

Issues of access to appropriate mental health services, particularly inpatient care, close to home have been a focus of scrutiny in recent years, and data continues to highlight the disparity between physical and mental health care. While data is somewhat sparse, recent figures show that at the end of 2014 more than 400 people (5 per cent of all inpatients) were located in centres more than 50km from their home (Meikle 2015). The number of people detained in police custody (rather than a more appropriate health environment) under section 136 of the Mental Health Act has fallen significantly but still stands at around 6,000 per year (House of Commons Home Affairs Committee 2015).

Patient, staff and public experience

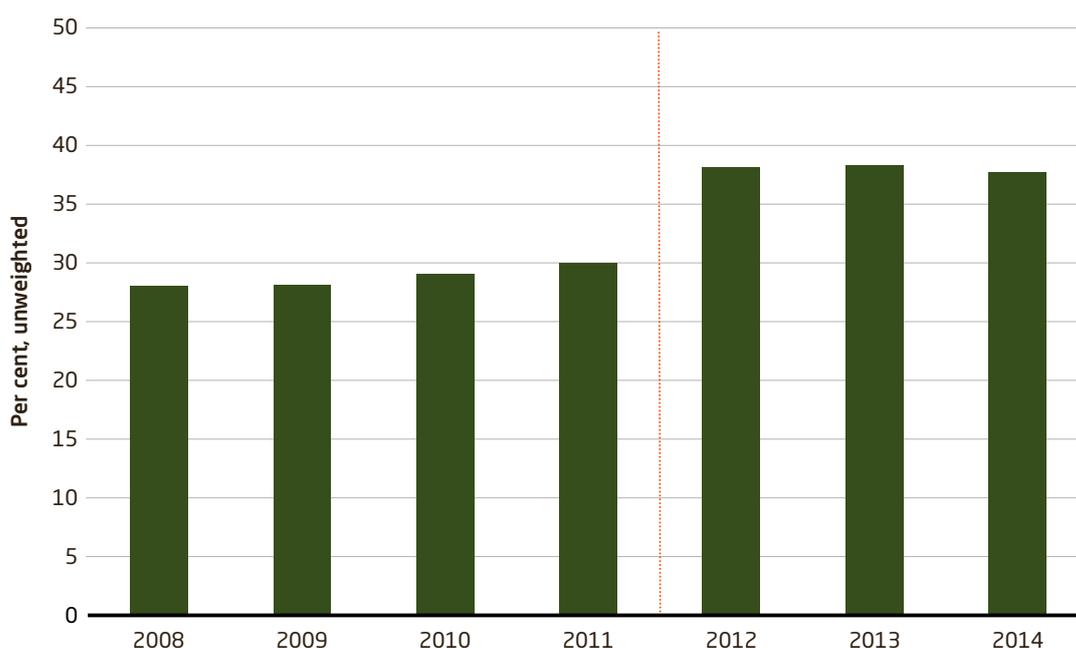
Patient surveys carried out between 2010 and 2014 indicate that satisfaction is improving across most services. In 2014, the A&E survey found that 80 per cent of patients reported that their overall experience of attending A&E was positive (scoring 7 out of 10 or more), up from 76 per cent in 2012. There was however wide variation in patients' experiences between trusts. The last inpatient survey carried out in 2013 found a 1 per cent rise in patients scoring 7 out of 10 or more for overall satisfaction between the 2012 and 2013 surveys. Both surveys reported 41 per cent of patients saying their discharge was delayed, largely due to waiting for medicines. The 2013 maternity services survey found improvements from the 2010 survey, for example, more women felt that they were always involved in their care, both antenatally and during labour and birth, and that they were treated with kindness and understanding. But there were also areas where performance declined (for example, more women reporting they were left alone during labour or birth at a time that worried them).

The GP patient survey conducted every six months has shown consistently high levels of patient satisfaction with GP services overall as well as accessibility in terms of booking appointments and waiting times in surgeries. There is, however, a small and consistent drift downwards of between one and two percentage points across many of the overall satisfaction and access measures since 2010. For example, 85.4 per cent of patients got an appointment to see or speak to someone at their surgery when they last tried, which is a decrease of 0.7 percentage points since the results published in December 2013 and around 2 percentage points since December 2011 (the wording of the question changed between 2010 and 2011) (NHS England 2015g).



The regular surveys of NHS staff show some mixed trends. For example, a key question is whether staff would recommend their own organisation to family or friends if they needed treatment; in 2009, 62 per cent of NHS staff said they would recommend their own organisations, by 2014 this had increased to 65 per cent. On the other hand, and bearing in mind the unweighted nature of the data and a change in the format of the question in 2012, between 2010 and 2014 the number of NHS staff reporting that they felt unwell due to work-related stress increased by 9 percentage points to 38 per cent (*see* Figure 21).

Figure 21 'During the last 12 months have you felt unwell as a result of work related stress?' NHS staff survey: 2008–2014



Source: [Picker 2015](#)

Notes: Question format changed in 2012; percentages are unweighted, making comparison between years problematic



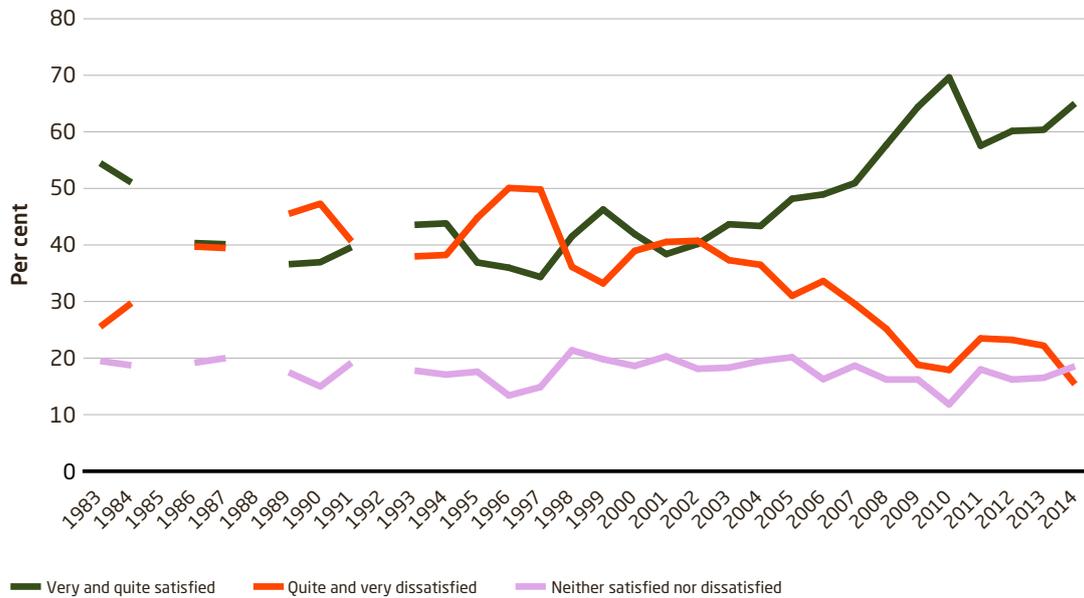
In 2014 a new set of questions was added, looking at raising concerns about unsafe clinical practice. The results showed that 68 per cent of staff agreed that they would feel secure raising concerns but only 57 per cent felt confident that those concerns would be addressed. These figures are low and there is also significant variation between the best- and worst-performing organisations, with the proportion of staff who felt confident that their organisation would address any concerns raised ranging from 37 to 73 per cent (Graham 2015).

Our latest quarterly survey of finance directors found that, for trust finance directors, staff morale remains at the top of the list of concerns along with the four-hour A&E wait target and delayed transfers of care.

Public satisfaction with the NHS remains historically high. In 2010, overall satisfaction with the NHS among the general public reached a high point of 70 per cent. However, satisfaction fell dramatically in 2011 to 58 per cent – largely, we concluded at the time, an expression of worry about the future of the NHS at a time of controversy and debate surrounding the government’s plans for reform rather than an actual fall in satisfaction with, or performance of, the NHS (Appleby 2011). In 2012 and 2013 satisfaction remained more or less at this new lower level – although still high by historic standards. In 2014 satisfaction rose to 65 per cent – the second highest level since 1983 and driven largely by an increase in satisfaction with the NHS among Labour Party supporters (Appleby and Robertson 2015) (see Figure 22).



Figure 22 Public satisfaction with the overall running of the NHS, 1983–2014



Note: data unavailable for years 1985, 1988 and 1992.

Source: **Appleby and Robertson (2015)**



6 Productivity

Faced with the biggest productivity challenge in its history, it would appear that the NHS has gone a long way to achieving the target it was set, although it is difficult to be precise given the paucity of data that bears directly on productivity in the NHS (and in particular, in terms of the quantification of the challenge). However, increasing overspends, funding additions and examples of slippage in performance (such as increasing waiting times) suggest that after nearly five years of unrelenting pressure to do more with less, it has now become extremely difficult to generate the level of gains required to close the funding-needs gap.

As the first section of this review set out, arguably the dominant issue the NHS has faced over the past five years has been the impact of the government's austerity programme. With NHS funding growing at less than 1 per cent per year in real terms on average, yet faced with increased demands estimated to require real annual growth of around 4 per cent ([Appleby et al 2009](#); [McKinsey & Company 2009](#)), the unavoidable policy response to meet this demand (while maintaining quality and performance standards) has been to improve productivity.

The strategy to bridge the funding-needs gap through increases in productivity was first set out in 2008/9 as the likely knock-on effect on the public finances of the global financial crisis and associated recession became clear. What became known as the 'Nicholson Challenge' (after the then chief executive of the NHS, Sir David Nicholson) valued the challenge at around £20 billion over five years.

The unarguable aim of the Nicholson Challenge was to generate the extra activity and quality of services that the NHS could have provided if its budget had increased by £20 billion; the aim was not to cut services by this amount.



Despite the central importance of the strategy to improve productivity, assessment of its success or otherwise is severely hampered by a lack of direct productivity measures. Here, therefore, we draw on a variety of evidence of changes in productivity: aggregate UK-wide estimates produced by the Office for National Statistics, a 2013 assessment by The King's Fund, a number of crude productivity metrics (such as activity per NHS staff) and The King's Fund's regular quarterly survey of trust and clinical commissioning group (CCG) finance directors.

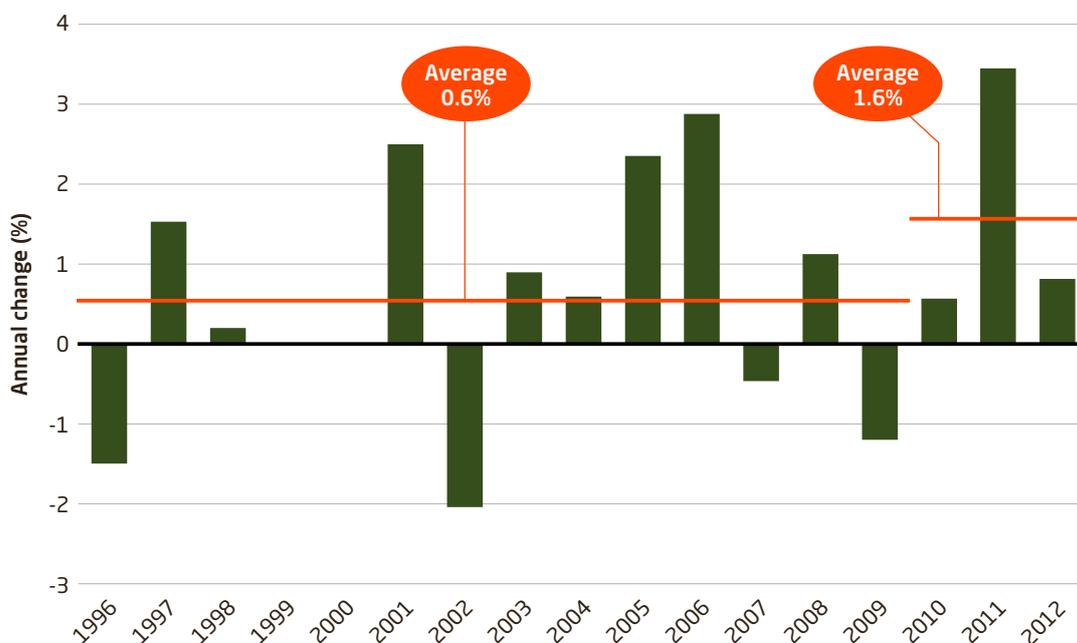
Productivity trends for the United Kingdom

The latest aggregate calculations from the Office for National Statistics (2015) – which lag by around two years and cover the period 1995 up to 2012 – showed a positive association between inputs (labour and capital) to the NHS and its outputs (quality-adjusted activity). As might be hoped, as inputs increase, so do outputs.

More than this however, the NHS has tended to produce proportionately more than the rise in its inputs. In other words, productivity has generally increased – although not every year and at a relatively low level. Historically productivity increases have averaged around 0.6 per cent per year between 1996 and 2009 – though changes have been somewhat erratic. But following the squeeze on funding, and a determined effort to improve productivity, productivity has increased by an average of 1.6 per cent a year between 2010 and 2012 inclusive (Figure 23).



Figure 23 Annual UK NHS change in productivity, 1996–2012



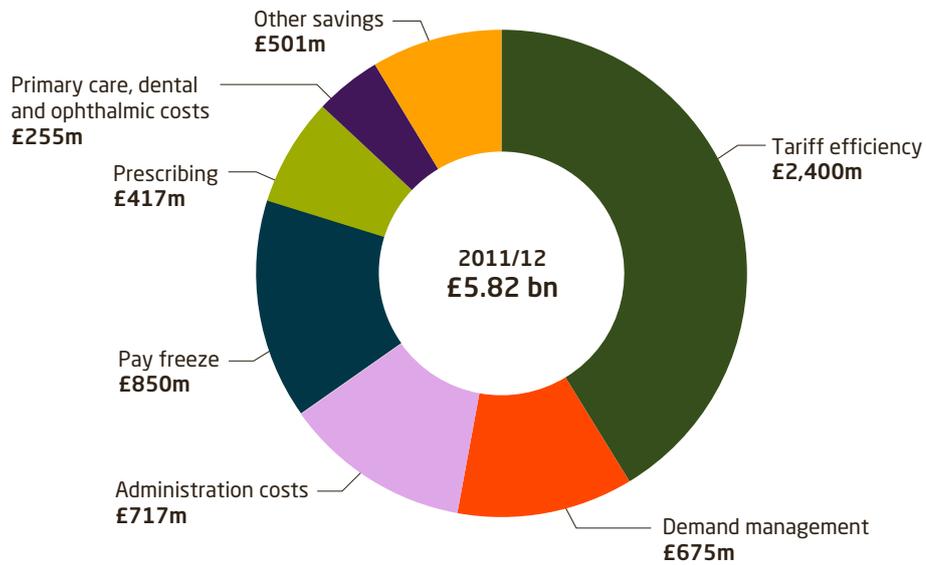
Data source: Office for National Statistics (2015)

Sources of productivity improvement

The King’s Fund review of the NHS productivity challenge in 2014 ([Appleby et al 2014](#)) noted that in evidence to the Health Select Committee in 2012, the Department of Health outlined the main sources of productivity gains for 2011/12 and estimates for 2012/13 ([Health Select Committee 2013](#)). The total value of Quality, Innovation, Productivity and Prevention (QIPP) gains were valued at around £5.8 billion in 2011/12 and £5 billion in 2012/13 – equivalent to around 5.5 per cent and 4.6 per cent of the total NHS budget respectively (Figures 24 and 25). These improvements were mainly a result of reducing tariff prices and were estimated to have generated gains to the value of £4.8 billion over the two financial years. Cost savings as a result of a pay freeze for NHS staff were estimated at around £1.7 billion. Other major sources include, ‘prescribing’ (£0.9 billion), ‘administrative costs’ (£0.9 billion), ‘demand management’ (£0.9 billion) and ‘other’ (£1.26 billion). There have been no updates to these estimates for 2013/14 and 2014/15.

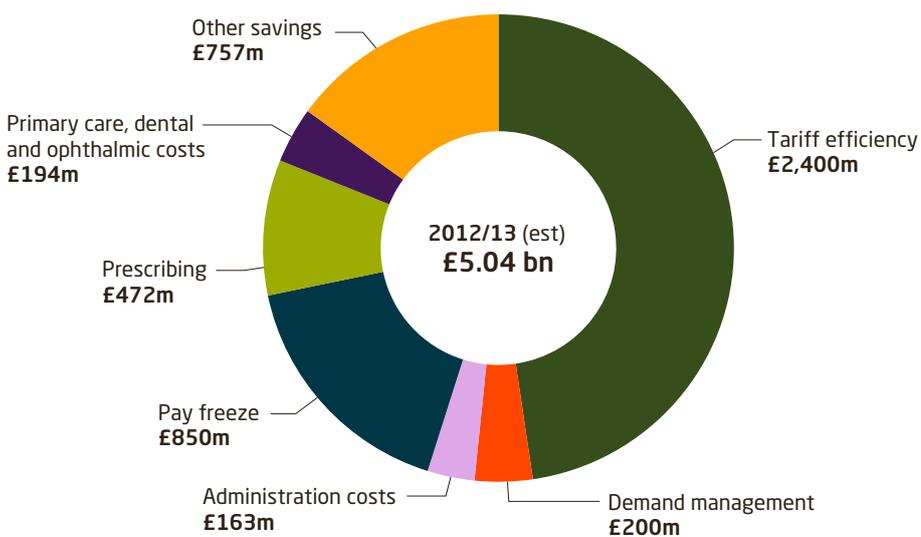


Figure 24 QIPP gains by source, 2011/12



Source: [Appleby et al \(2014\)](#)

Figure 25 QIPP gains by source, 2012/13

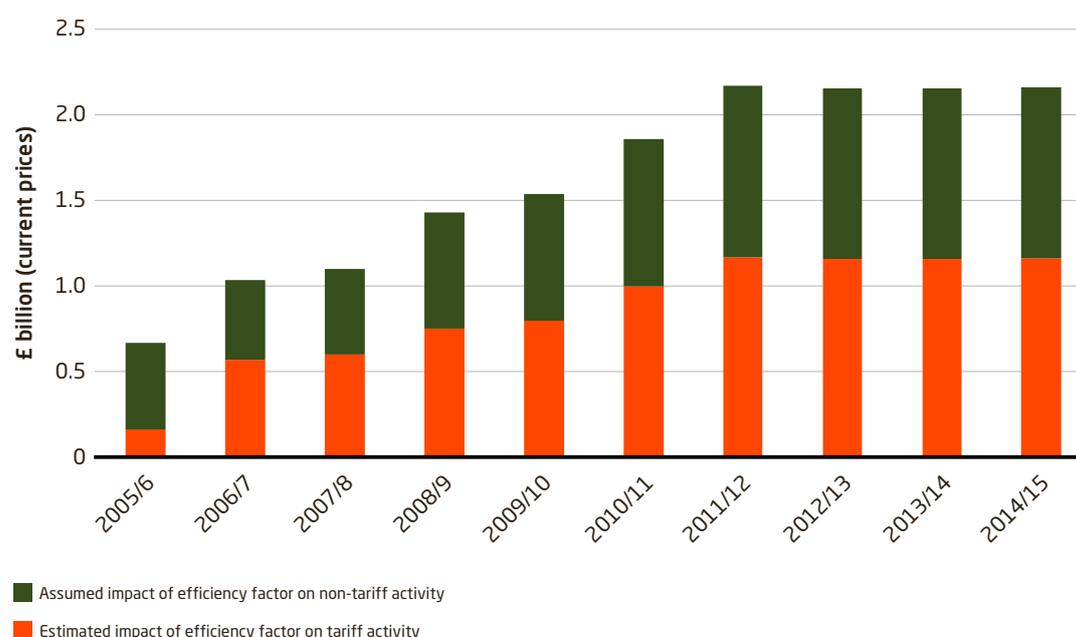


Source: [Appleby et al \(2014\)](#)



The King’s Fund’s analysis of productivity changes attempted to provide more detail for the impact of the tariff reduction to 2014/15. Applying the efficiency factor each year to the value of services provided under Payment by Results (PbR) and assuming that the same level of efficiency also applied to non-PbR income, Figure 26 shows the notional savings each year from 2005/6 to 2014/15. This suggests that squeezing prices had the potential to generate more than £2 billion worth of productivity gains each year between 2011/12 and 2014/15.

Figure 26 Estimates of productivity gains attributable to tariff price reductions, 2005/6–2014/15

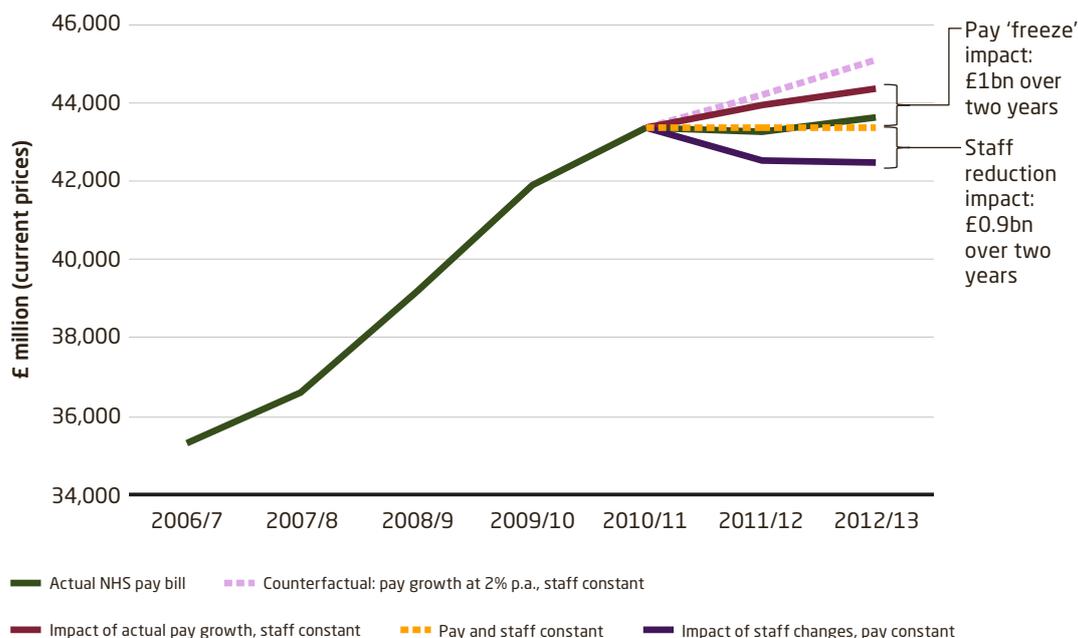


Source: Appleby *et al* (2014)

On the combined impact of the pay freeze and a reduction in NHS staff numbers between 2010/11 and 2012/13, we estimated that a saving of around £1.9 billion had been generated over the two years to 2012/13 (Figure 27).



Figure 27 Impact on the English NHS pay bill of pay freeze and staff number reductions, 2010/11–2012/13



Source: [Appleby et al \(2014\)](#)

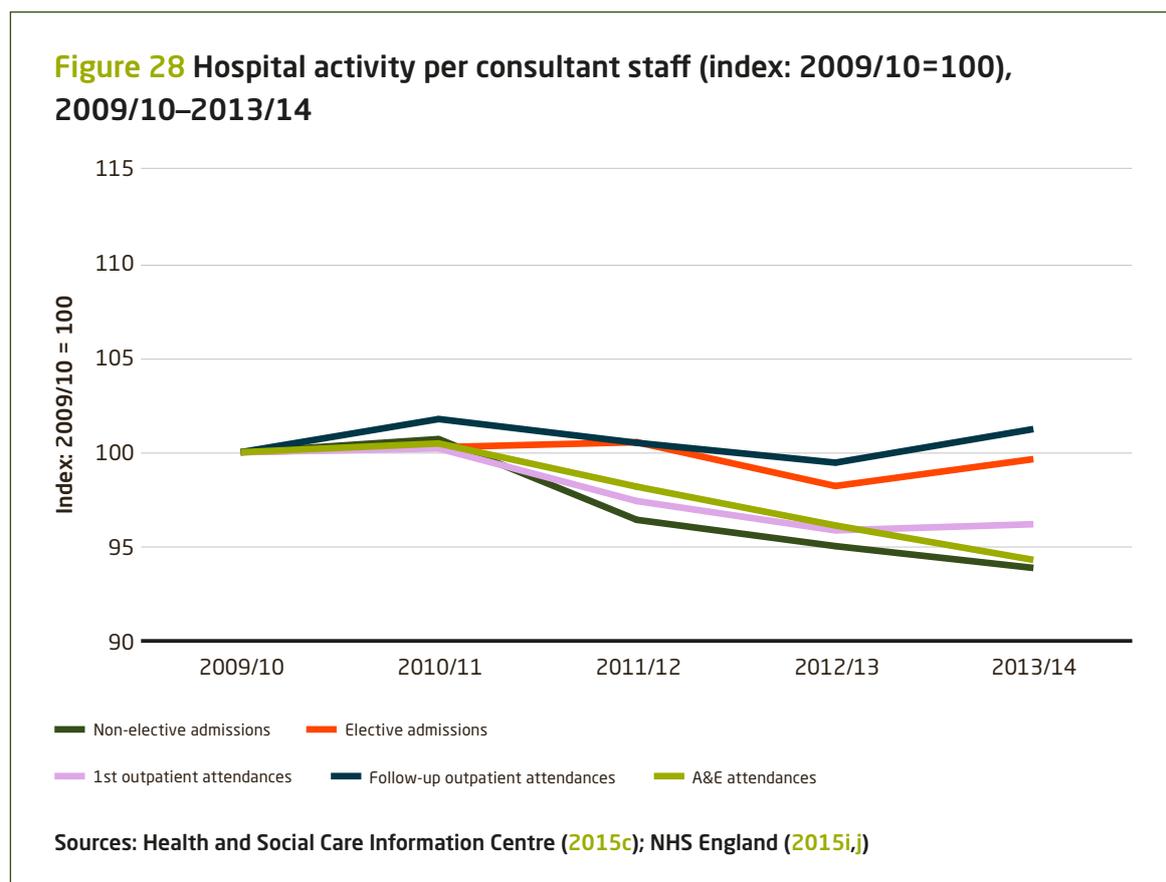
All these estimates for the impacts of various tactics to make cost savings and productivity gains need to be treated with caution. Moreover, the bulk of the task in achieving productivity gains remained predominantly with frontline providers even though actions at national level have no doubt made major contributions in improvements to productivity – either by reducing costs through actions on staff pay, or reductions in nationally administered budgets to allow expansions in frontline commissioning spending. Reductions in tariff prices do not in themselves directly improve productivity, but were intended to act as an incentive for providers to find more efficient and less costly ways of providing care.



Crude hospital productivity

Two additional metrics that provide some albeit crude insight into the productivity of one sector of the NHS – hospitals – can be simply derived by dividing various types of activity (outpatient attendances, elective admissions, etc) by numbers of hospital staff or total NHS funding (after accounting for inflation).

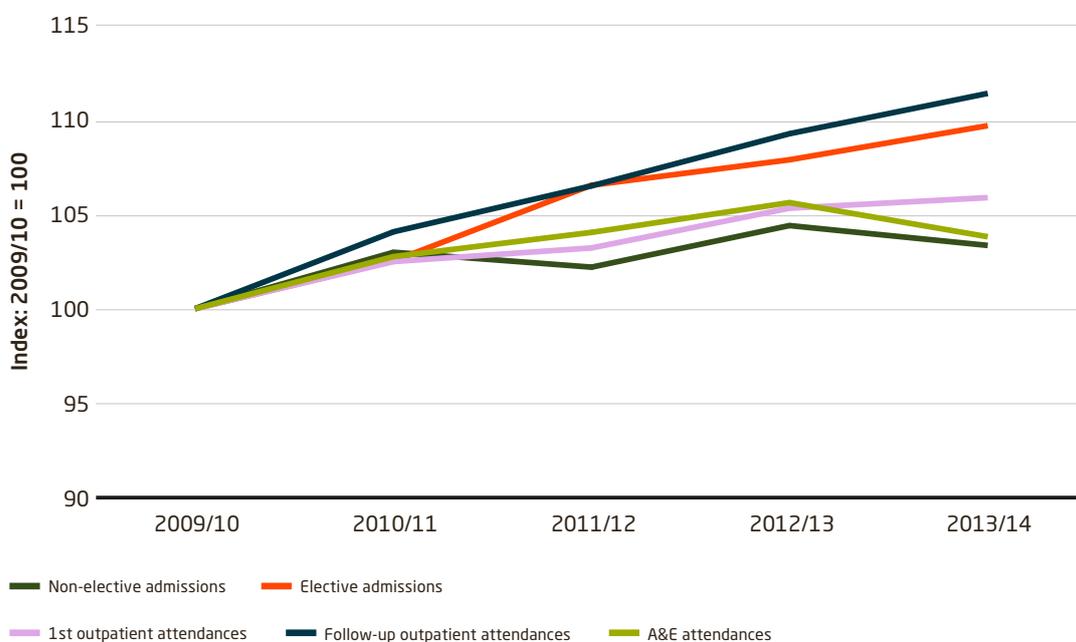
Figure 28 shows the change in various hospital activities per consultant FTE from 2009/10 to 2013/14. As the number of consultants has been increasing over these years at a faster rate than increases in first outpatient attendances, A&E attendances and non-elective admissions, the crude labour productivity for these areas has decreased by between 4 per cent and 5 per cent over the whole period.





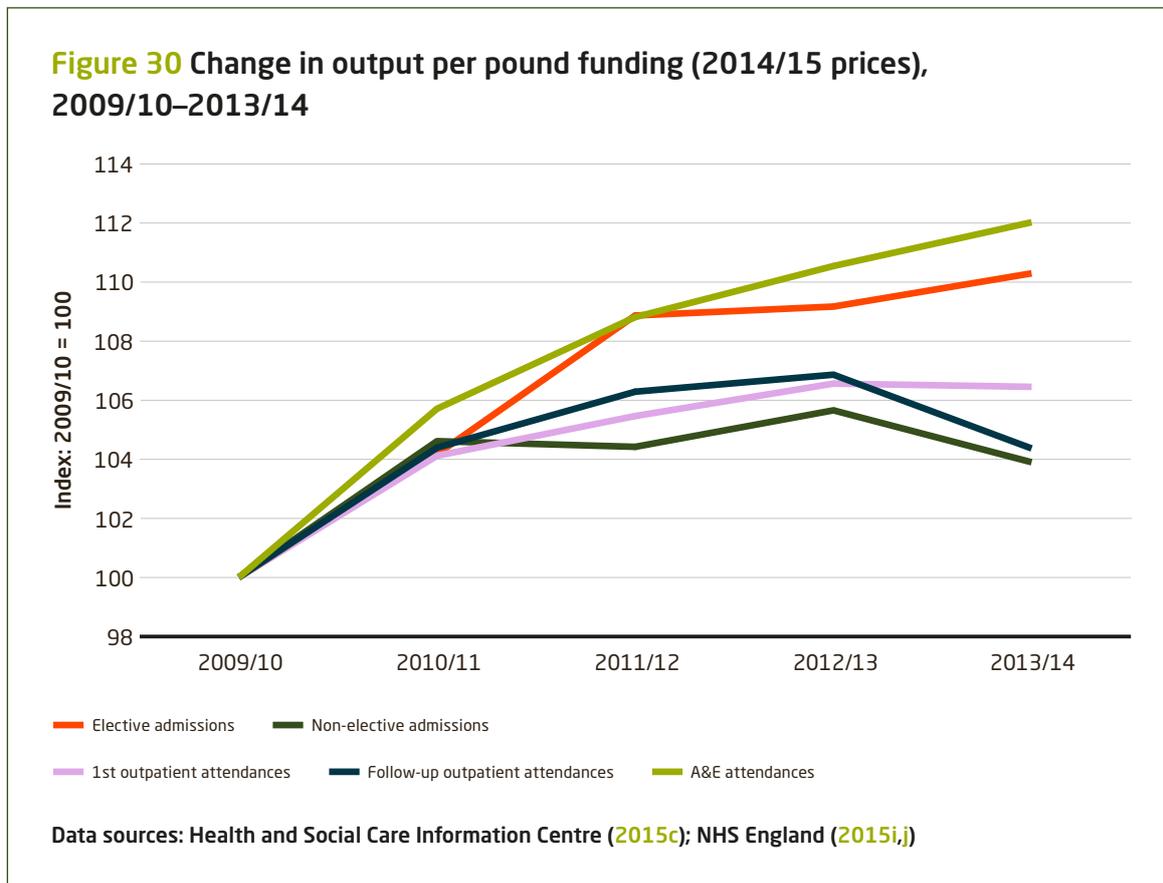
On the other hand, crude labour productivity measures for acute and general nurses in hospitals has risen in all areas of hospital activity from around 4 per cent for non-elective admissions to more than 11 per cent across the whole period for follow-up outpatient attendances (see Figure 29). More recent increases in nurse staffing are likely to reduce these increases however.

Figure 29 Hospital activity per acute and general nurse staff (index: 2009/10=100), 2009/10–2013/14



Sources: Health and Social Care Information Centre (2015c); NHS England (2015i,j)

In terms of hospital output per pound of input, as Figure 30 shows, with real funding increasing at around 0.8 per cent to 0.9 per cent per year, the larger increases in activity mean that output per pound has increased across all types of hospital output at between 1 per cent and nearly 3 per cent per year on average.



These measures of productivity are perhaps indicative and provide some mixed evidence on changes in the ratio of outputs to labour and financial inputs, but they cannot be said to be definitive.

Views from the front line

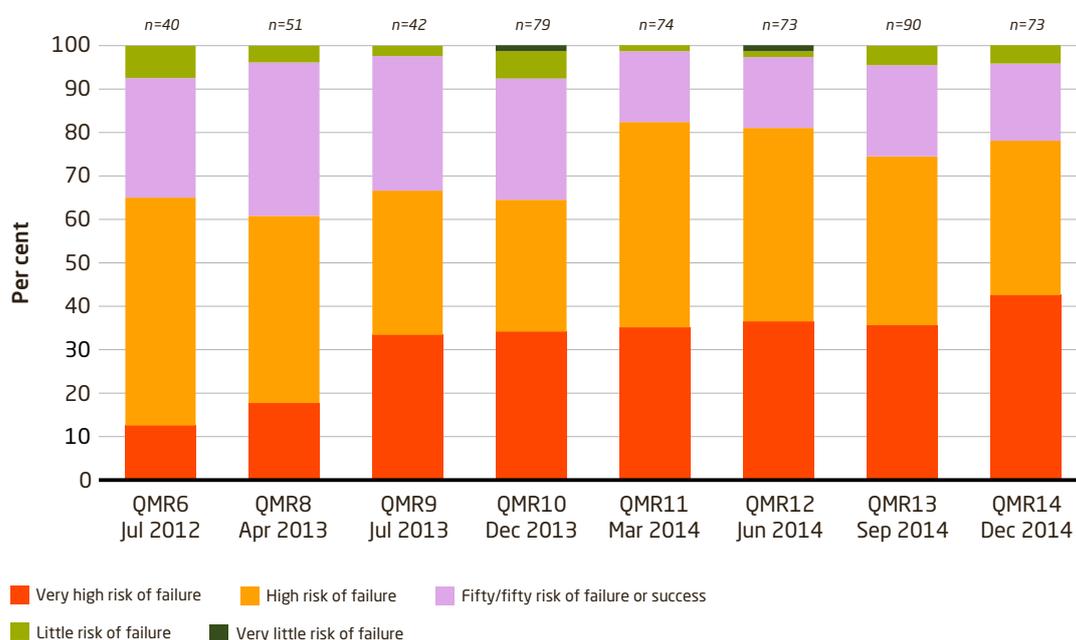
Another perspective on the original £20 billion productivity challenge as well as the business of making ends meet through cost improvement programmes comes from The King’s Fund’s quarterly survey of finance directors.

Our latest survey – carried out in December 2014 – detailed trends in finance directors’ views about the likelihood of the NHS achieving the £20 billion productivity goal. As Figure 31 shows, between 60 per cent and 80 per cent of



finance directors have felt that there was either a very high risk or a 50/50 risk of failure for the NHS in achieving this goal, with the latest survey showing that more than 4 in 10 directors thought there was a very high risk of failure.

Figure 31 'What is your estimate of the risk involved in achieving productivity gains of the value of £20 billion by 2014/15?'



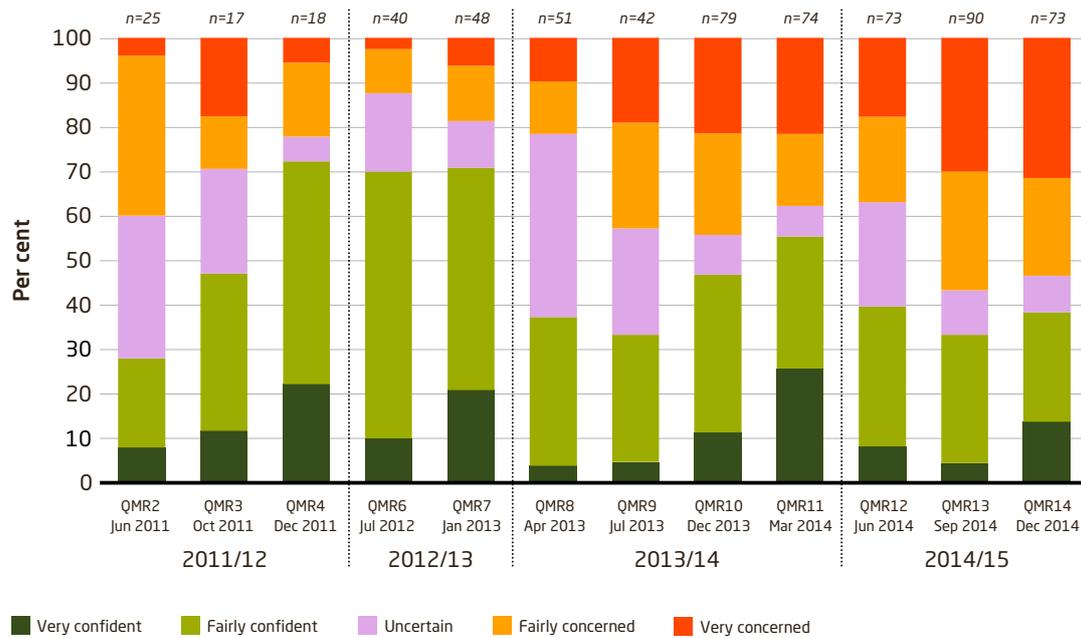
Source: [Appleby et al \(2015\)](#)

Note: Question not asked in QMR7

While there remains some scepticism about the achievability of the global £20 billion productivity goal in the aggregate, at a local level, on average, trusts have consistently planned annual cost improvements of around 4 per cent to 5 per cent of turnover. However, as Figure 32 shows, confidence in actually achieving these plans has waned somewhat over time and, in our latest survey, more than half were either very or fairly concerned about meeting their plans.



Figure 32 'How confident are you of achieving your planned cost improvements?'



Source: [Appleby et al \(2015\)](#)

Note: Question not asked in QMR1 and QMR5



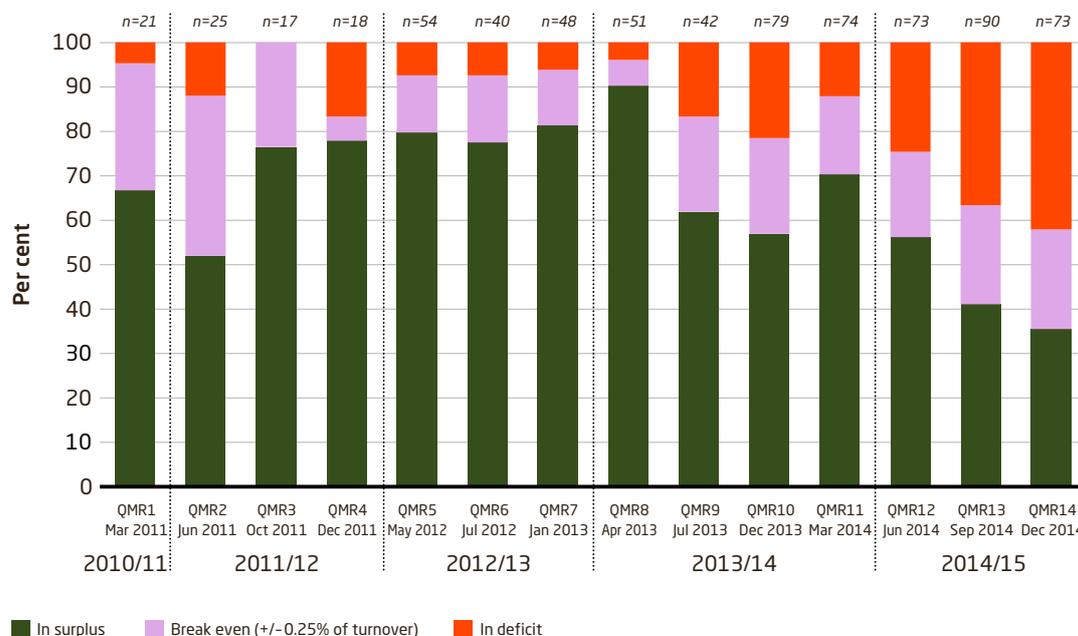
7 Financial performance

The financial position of most NHS provider organisations has deteriorated towards the end of the parliament. NHS trusts and foundation trusts have moved from surplus to deficit in increasing numbers since 2012/13. This is an indication of the mounting difficulties that trusts have faced: responding to the downward pressure on tariff prices; increasing difficulties in realising cost savings; and the need to assure quality standards (through increasing nurse staffing, for example) in the wake of the Francis Inquiry. While budgets on the commissioning side and those controlled centrally are likely to be more robust, it is also likely that these will not be enough to offset provider overspends this year.

The relative lack of confidence among finance directors in meeting cost improvement plans is also reflected in an upward trend in the numbers forecasting an end-of-year deficit. As Figure 33 shows, our latest survey suggests that 42 per cent of trusts were forecasting a deficit by the end of the 2014/15 financial year. This was up from around 12 per cent at the beginning of the year and is despite additional spending of nearly £1 billion directed at reducing waiting times and alleviating winter pressures. Sixty per cent of trusts in our survey are now drawing on their reserves and/or taking up loans or additional funding of one sort or another from the Department of Health to support their financial position.

Increasing numbers of trusts overspending, drawing on loans and other support from the Department of Health as well as straight additions to the front line from central reserves and budgets (including additional Treasury money of £250 million in 2014/15) are direct indicators of the problems that providers are facing in meeting the overall NHS productivity challenge. In effect, the challenge has been attenuated by additional funding, reprioritising spending to frontline services and cuts to capital spending.

Figure 33 'What is your organisation's forecast end-of-year financial situation?'



Source: Appleby *et al* (2015)

Financial reports from Monitor and the NHS Trust Development Authority

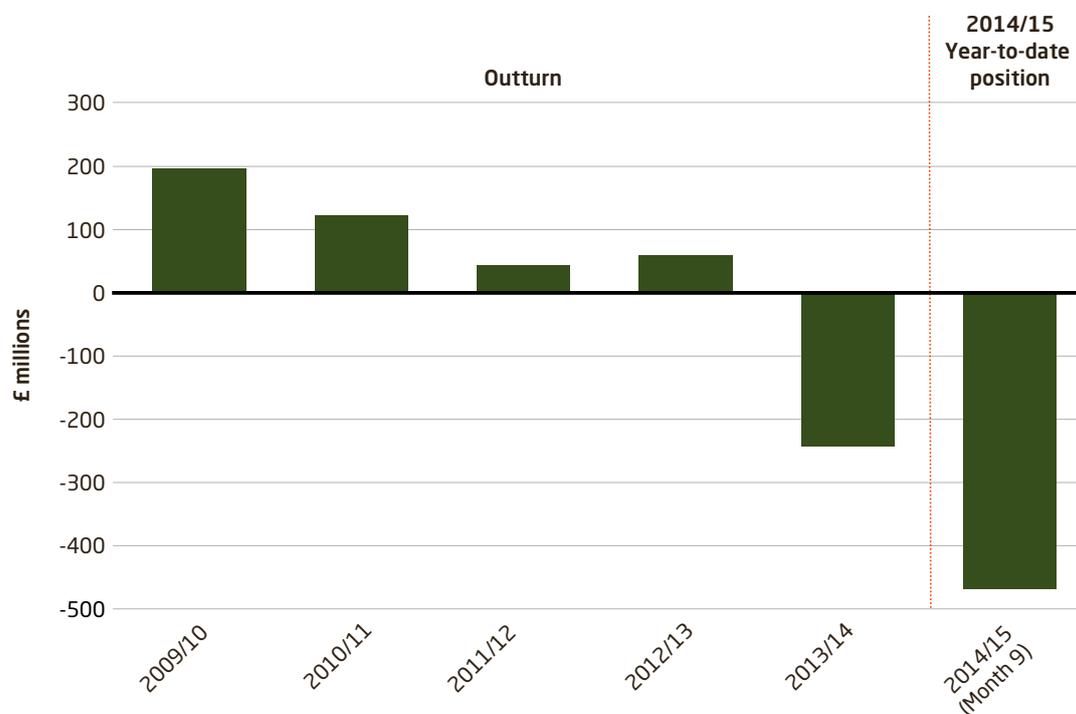
Signs of a deteriorating financial position are clearly evident in recent reports from Monitor and the NHS Trust Development Authority.

While the trust sector reported aggregate surpluses in 2010/11 and 2011/12, by 2012/13 the surplus had shrunk by more than two-thirds, and in 2013/14 NHS trusts reported an overall net deficit of £241 million. Starting with a year-end surplus of £57 million in 2012/13, the situation has worsened. By month nine of 2014/15, the NHS trust sector was running a year-to-date deficit of £467 million with a forecast end-of-year deficit of £448 million (NHS Trust Development Authority 2015) (see Figure 34).



The deficits reported by the NHS Trust Development Authority include, as we noted above, additional support from the Department of Health that reduced the reported size of these deficits. The NHS Trust Development Authority have indicated that by month 6 of 2014/15, additions of non-recurrent deficit funding to a cohort of NHS trusts amounted to around £165 million (NHS Trust Development Authority 2015, personal communication).

Figure 34 Net operating deficit/surplus for NHS trusts, 2009/10–2013/14



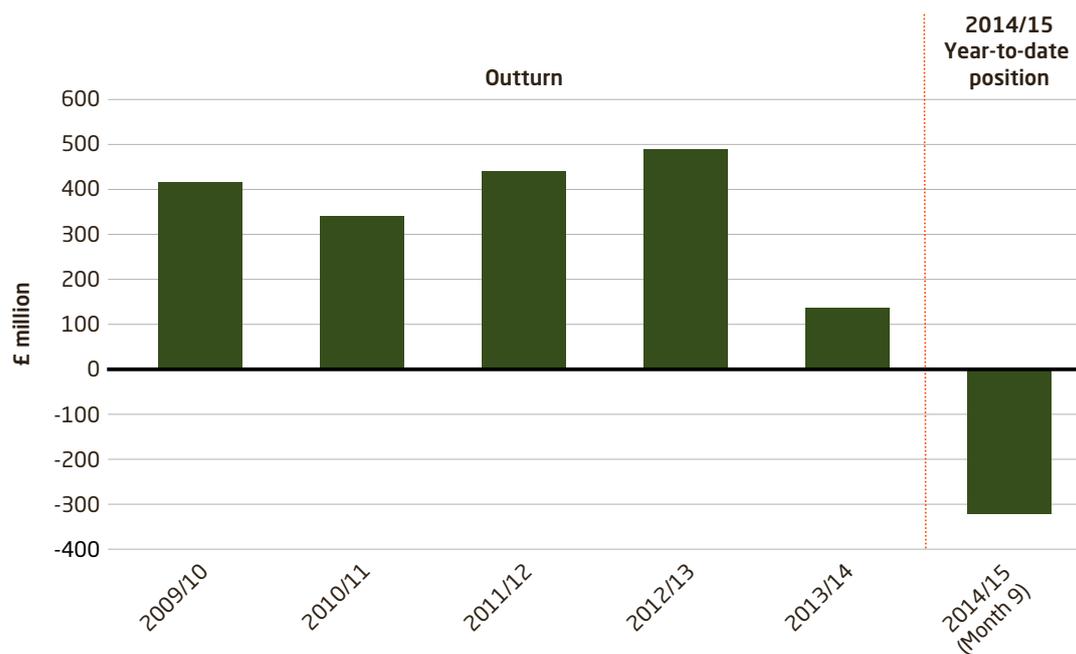
Note: Excludes impairment adjustments

Sources: Department of Health (2014a, 2013); NHS Trust Development Authority (2015)



Financial pressures have also grown in the foundation trust sector. Although net operating surpluses grew from 2010/11 to 2012/13 from just over £300 million to nearly £500 million, in 2013/14 there was a sharp drop in the surplus to £134 million. For 2014/15, the year-to-date deficits at month 9 stood at £321 million – double the deficit in the first quarter. Increasing agency staff numbers and increases in patient demand (particularly in A&E departments) reportedly drove deficits. Monitor reports the forecast end-of-year financial situation to be an overspend of around £375 million.

Figure 35 Net operating deficit/surplus for foundation trusts, 2009/10–2013/14



Note: Excludes impairment adjustments

Sources: Monitor (2015; 2014; 2013; 2012; 2011; 2010)



Increasing numbers of trusts are now facing difficulties. In 2011/12, 24 per cent of trusts and foundation trusts overspent. The latest figures for 2014/15 suggest this is likely to increase to between 40 per cent to 50 per cent.

Overall, by month nine of the 2014/15 financial year, the Department of Health had paid £841 million in various ways and under a variety of repayment conditions to help trusts and foundation trusts running deficits compared to a total of £760 million for the whole of 2013/14 (Clover 2015).

While the surpluses on the commissioning side will offset some of the provider-side deficits, with a forecast end-of-year surplus of £425 million (NHS England 2015d), the overall position is likely to be a deficit.



8 Conclusion

Our analysis shows that NHS performance held up well for the first three years of the parliament but has since come under increasing strain. This has been particularly evident on finance and the achievement of waiting time targets, especially in 2014/15 when winter pressures catapulted the NHS back into the headlines. Failure to hit the target that 95 per cent of patients should wait no longer than four hours in A&E departments, increases in the number of patients waiting to be discharged from hospital and rising numbers of providers in deficit pointed to a service operating at and sometimes beyond the limits of capacity.

The King's Fund's analysis of the experience of the NHS in delivering productivity improvements, published in May 2014, warned of the growing pressures on providers and the risk of the health and social care system heading towards a 'major crisis' (Appleby *et al* 2014, p 68). To avert this crisis, we argued that additional funding was needed for two purposes: first, to deal with deficits and ensure continuity of services; and second, to provide resources to support the transformation of care by enabling investment in new services. We also argued that alongside additional funding there was considerable scope for getting more value out of existing budgets but that time and expertise were needed to achieve this.

The government has since responded by finding some additional funding in 2014/15 – some new, most reallocated from within existing budgets – to support direct patient care. It has also announced plans to increase the NHS budget by £3.3 billion in 2015/16 with some of the increase earmarked for service transformation. NHS England together with other national bodies has also published the *NHS five year forward view* (NHS England *et al* 2014). This estimated that without improvements in productivity and/or additional money, a £30 billion funding gap would open up by 2020/21. NHS England argued that the NHS could deliver £22 billion of the £30 billion in productivity improvements but would require £8 billion a year of additional funding by 2020/21. Most independent commentators suggest that delivering productivity improvements on this scale, on top of the £20 billion already demanded under the Nicholson Challenge, will be a very tall order and



that £8 billion is therefore the bare minimum in additional funds that will be required.

As we have shown, one of the reasons why deficits have been growing is that providers have responded to concerns about patient safety and quality of care by recruiting additional clinical staff, especially nurses, often by making use of expensive agency and locum staff. Although difficult to quantify, this ought to mean that safety and quality have improved, reinforced by measures to strengthen the regulation of care and to promote the transparent reporting of information about performance. This example illustrates the trade-off between achieving financial balance and responding to evidence from Mid Staffordshire and elsewhere that providing safe care requires more staff even if this results in overspending. Our review of NHS reform since 2010 ([Ham et al 2015](#)) argued that the government should take credit for having given priority to patient safety and quality of care, even if this has increased the size of provider deficits.

A related point is that the analysis in this report is based on routinely available data about different aspects of performance and this may not fully capture changes under the coalition government. A good example is the planned move to seven-day working, which has the potential to contribute to improvements in quality of care by ensuring the availability of senior medical staff in the evenings and weekends. A counter example is the relative neglect of general practice that appears to have resulted in lower priority being given to primary care during this parliament as measured by the share of the budget allocated to it, although steps are now being taken to tackle this. In both examples, it is not possible to quantify the impact on patients, even though the consequences are likely to have been real. The relative lack of timely data on mental health is also a concern particularly given some of the worries raised about, for example, out-of-area placements and vulnerable people being held in police cells.

There is little doubt that compared with earlier periods when the NHS was faced with tightly constrained budgets, there is now much less scope for containing or cutting costs by diluting the quality of care. Deliberately allowing waiting lists to lengthen or not filling staff vacancies when they arise – methods used in the 1990s, for example – are off the agenda because of the priority attached by successive governments to improving access and quality of care combined with ever closer



scrutiny of NHS performance by regulators and others. In these circumstances loss of financial control becomes the main safety valve, providing that government is prepared to sanction overspending. With the NHS now topping the list of the public's concerns ahead of the election campaign, ministers have had little choice other than to find additional resources to deal with deficits to reassure voters about their intentions and commitment to the NHS.

The next parliament

What then are the prospects for NHS performance over the course of the next parliament? To begin with the positives, a serious debate is now under way about future funding levels with the Conservatives, Labour and the Liberal Democrats all committed to finding additional resources. However, it is not yet clear exactly how much funding each party will provide and when it will be made available. There is also uncertainty about future funding for adult social care which the Association of Directors of Adult Social Services (ADASS) has argued requires a further £4.3 billion a year by 2020/21 ([ADASS 2014](#)) on top of the estimated £8 billion a year needed by the NHS.

If these funds are not provided – and to reiterate the estimate of funding requirements for the NHS should be viewed as the minimum likely to be necessary – then there is a real prospect of an accelerating decline in NHS performance. This could mean staffing cuts that affect patient safety and quality of care (because staffing costs make up half of all NHS spend) together with longer waiting times for patients to access services. To return to a previous point, this could only happen if regulators relax their scrutiny of the NHS and if the next government moves away from using targets as a way of improving performance. Without changes of this kind, it is difficult to see how it would be possible to reinstate traditional controls over finance to avoid deficits increasing still further.

This scenario could be avoided if the NHS is successful in renewing its commitment to productivity improvements in order to recycle funds to meet rising demands for care. As we have argued, there are many opportunities to do this, ranging from smarter procurement, better use of the estate and changes in clinical care. A particularly promising route is to seek to reduce waste during transitions of care, for example delayed transfers from hospitals, by achieving closer integration between



hospitals, community services and social care. Plans for the local integration of health and social care budgets in Greater Manchester and implementation of the new care models in the *NHS five year forward view* are emerging examples of how this might be achieved.

The challenge of relying on the NHS to free up resources from productivity improvements is the time needed to do this and in some cases the need to provide clinical staff with skills in quality improvement. It will also be necessary to establish a transformation fund to pump prime investment in new models of care on a scale commensurate with the challenges facing the health and social care system. If the fund could be used in part to invest in new information and communication technologies that enable care to be provided differently, this could also contribute to filling the financial gap and sustaining performance. The King's Fund with the Health Foundation is currently working on proposals for the size of the fund and how it should be used to support innovations in care.

In an NHS already operating at its limits, and with leaders focusing on operational issues, it is often difficult to create the time for staff to engage seriously in work on service transformation. All the more important therefore that the lessons of high-performing health care systems are heeded ([Ham 2014](#)). These lessons include the need to see performance improvement as a long march rather than a short sprint and the importance of supporting and engaging NHS staff in the work to be done. Successive governments have used a range of external pressures such as targets, regulation and competition in the quest for performance improvement. Experience suggests that while such approaches have their place, none are panaceas. A particular danger of such performance tactics is that they can crowd out the intrinsic motivation of staff to perform to the best of their abilities. A greater priority now needs to be given to reforming the NHS 'from within'. Among other things, this means developing leadership (with a particular emphasis on clinical leadership), nurturing cultures focused on safe and high-quality care, and making a sustained effort to strengthen skills in quality improvement at all levels. The next government should avoid big gestures that appear to promise a breakthrough for the NHS. Instead, it is – to borrow from David Brailsford's cycling performance concept – the 'aggregation of marginal gains' that will build over time to improve productivity and performance.



Beyond the next parliament

As the country finally emerges from one of the longest recessions on record, now is the time to think about public spending choices – not just over the next parliament but over the next 10 or 20 years. As part of our long-term look at health and social care we asked: What sort of health and social care service do we want? What are we prepared to pay collectively and how? ([Commission on the Future of Health and Social Care in England 2014](#)).

Seven years after the start of the recession and following five years of austerity, there is a danger of thinking nothing will or can change; money will always be tight and choices limited. But even in the toughest of times financially there are always choices that can be made. Now, as the economy recovers, if the NHS is to play its part in ensuring that each health care pound is used as effectively as possible to ensure that we have the sort of health service we want, there needs to be a matching commitment on the part of the public and future governments, which both must play their part in ensuring that the right level of funding is made available. The debate should not be about how parsimonious we need to be – but about how generous we want to be.



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How has the NHS performed under the coalition government – and what are its prospects for the next parliament and beyond?

With the 2015 general election focusing debate on the health service, this second part of *The NHS under the coalition government* looks at its productivity and financial performance over the past five years. It builds on our assessment of NHS reform in the same period, which found the top-down nature of the reorganisation to be distracting and damaging.

Assessing the performance of any health service is an inexact science, as the report notes. It uses routinely available data to create a conventional 'production path' – describing the financial inputs to the NHS, its resources, for example staff, and its outputs, such as hospital admissions or A&E attendances.

The report concludes that:

- NHS performance held up well for the first three years of the 2010–2015 parliament but has since come under increasing strain
- patient experience generally remains positive; public confidence is close to an all-time high; there has been some improvement on outcomes, safety and quality
- there are concerns over the quality of mental health services and challenges in achieving parity of esteem between mental and physical health
- most of the NHS is working close to or beyond its limits, and staff morale is a growing concern.

The report predicts that the NHS will end this parliament with a substantial deficit, despite extra funds have been made available in 2014/15 and with funding having increased in real terms since 2010. It argues that the NHS should renew its commitment to productivity improvements and service transformation – reforming itself 'from within'. It urges the next government – and the public – to pledge additional resources for the NHS. The debate should not be about how parsimonious we need to be – but about how generous we want to be.

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