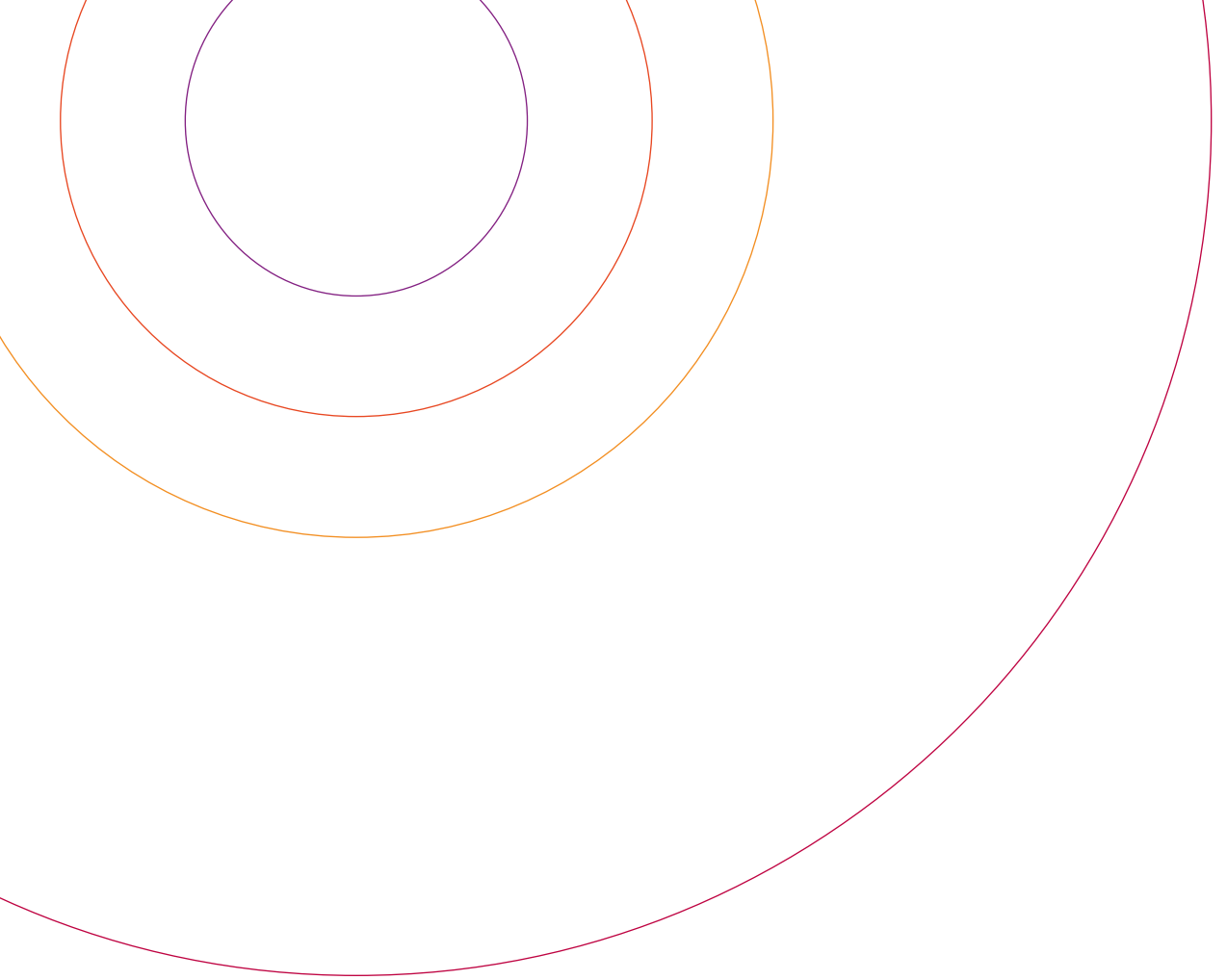
THE STATE OF THE NHS PROVIDER SECTOR

NOVEMBER 2016

NHS Providers



FOREWORD

NHS trusts account for £65 billion of the £110 billion spent by the NHS. They employ more than 1.1 million of its 1.2 million staff. They interact with more than 5 million patients and service users a week. They are, in short, the backbone of the NHS, providing the vast majority of its complex care. In the minds of patients, the media and politicians, the success of the NHS is significantly defined by the success of the provider sector.

It is therefore appropriate to create, for the first time, what we hope will be a valuable commentary on this vital sector – providing a view of how the sector is performing, identifying the challenges it faces and the successes we should be celebrating while also setting out what more support is needed. We intend to produce this report on a regular basis, as a way of tracking the performance of trusts over time.

The report is a unique combination of our own policy analysis and commentary, published data and, most importantly, the views of the chairs and chief executives who run hospital, mental health, community and ambulance services in England. It is they who are responsible for ensuring their trusts are providing outstanding patient care 24 hours a day, 365 days a year, and they who are best placed to identify key trends in the sector.

The report covers the issues chairs and chief executives tell us concern them most – performance on quality, waiting times and finances; ensuring trusts have the right number, quality and mix of staff to deliver high-quality care; and how trusts are delivering much needed transformation.

We are grateful to the chairs and chief executives from the 136 trusts who took the time to complete the survey and provide their views. The report would not be possible without them, and we hope our report does justice to their contributions.

Chris Hopson

Chris Hopson
Chief Executive, NHS Providers

OVERVIEW

INTRODUCTION

This report examines the state of the provider sector – the 238 hospital, mental health, community and ambulance NHS trusts in England. It examines how they are performing, the challenges they face and how they are responding. It combines our own analysis and commentary, published data and the views of 172 NHS trust chairs and chief executives from 136 providers surveyed in September and October 2016. This covers more than half of all trusts. It focuses on four key issues: quality and patient access, finance, workforce and transformation.

THE PROVIDER CHALLENGE

Leaders tell us their trusts are facing the biggest challenge in a generation:

- The NHS is seven years into the longest and deepest financial squeeze in its history. A record two-thirds of trusts were in deficit at the end of 2015/16 with deficits spreading beyond hospitals into mental health, community and ambulance trusts. This financial challenge will be made tougher when NHS funding increases slow significantly from 2017/18 onwards.
- Trusts are facing large increases in demand for their services as a result of demographic factors, pressures on primary and social care and increasing patient expectations. At the same time, patients have higher and more complex needs. This increase in demand is a long way beyond the levels predicted in the *Five year forward view*.
- Trusts are running at capacity levels well beyond the recommended norm and levels seen in other advanced western countries. Local health services are less resilient and less able to absorb the inevitable shocks such as flu outbreaks or local care home closures. These events now risk destabilising local services causing precipitate, temporary drops in performance that impact on patient safety and experience.
- While treating more people than ever before, extra demand has led to trusts missing nearly all of their key performance targets. This is affecting the vast majority of providers, across all sectors and across the whole range of targets.
- The evidence on quality is mixed. A near complete set of CQC inspection data rates a majority of trusts as either requiring improvement or inadequate. However, overall performance in the latest CQC patient experience survey remains high.

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- Providers are struggling to meet a series of workforce challenges. These include staff shortages, rising pressure on staff, a prolonged period of pay restraint, the legacy of a difficult junior doctors' dispute, and a workforce planning system that seems unable to match demand and supply or workforce numbers to the funding available.
- The NHS is also being asked to deliver transformation at a much faster rate than the international evidence suggests is possible. While provider leaders support the creation of local sustainability and transformation plans (STPs), producing them at a time of such high operational pressure is challenging.

THE PROVIDER RESPONSE

When given a deliverable task and the appropriate support and funding NHS providers do deliver:

- ACCESS AND QUALITY – in 2015 trusts saw 22.9 million patients in A&E (a 7% increase since 2010); they completed 8.3 million elective admissions (a 15% increase since 2010); and ambulance providers dealt with 9 million calls (an 11% increase); 1.8 million people were in contact with mental health services in 2014/15 (a 5.1% increase on the previous year). By international and historical standards the NHS continues to perform well.
- FINANCES – trusts are currently on track to deliver a £-669 million deficit by the end of 2016/17, a more than £3 billion reduction on last year's underlying deficit. Almost three quarters (73%) of trusts have reduced their agency spending this year, and the sector as a whole is forecast to reduce the total bill by a quarter in a single year. Trusts are set to realise £3.2 billion in cost improvement plan savings this year, equivalent to nearly 4% of turnover and, importantly, £346 million (or 12%) more than last year.
- WORKFORCE – trusts are working hard to address workforce shortages by recruiting from overseas, developing new roles such as nursing associates and partnering with higher education institutions to increase the supply of key roles, particularly nurses. They are using new technology to roster staff more effectively and enable staff to work more flexibly.
- TRANSFORMATION – trusts are leading NHS transformation. They are developing new care models including accountable care systems to provider chains. They are playing a leading role in the creation of much needed local STPs. This transformation is underpinned by trusts' investment in leadership capacity and capability.

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THE RISKS

There is now a clear gap between what the NHS is required to deliver and the money available. While the NHS frontline will continue to do all it can to provide the best possible service, the NHS is now running higher levels of risk. The risks include:

- **The service the NHS provides now starts to deteriorate**. Waiting lists for operations are lengthening. People are waiting longer in A&E. And the CQC has said that they are "starting to see some services that are failing to improve and some deterioration in quality". Due to financial pressures, some clinical commissioning groups (CCGs) are starting to restrict access to treatments. In our survey, less than half (46%) of chairs and chief executives said they believe their trusts will be able to provide high-quality care in six months' time. There is a danger of a long, slow decline in which the quality and access gains made between 2000 and 2010 slowly dissipate.
- **Despite good progress in reducing trust deficits in the short term, there is no credible plan to ensure the long term financial sustainability of trusts**. As the NAO has recently highlighted, there is no reliable, tested plan to address the imminent slow down in NHS funding increases which amount to real term funding cuts per head of population in 2018/19 and 2019/20. In our survey only 13% of chairs and chief executives think that finances are likely to improve at their trust over the next six months, with nearly 50% believing they will deteriorate.
- **Growing demand and staff shortages mean NHS roles are becoming more pressured, with staff increasingly overworked and stressed**. In our survey, chairs and chief executives said they regard the workforce challenge as now being just as difficult as balancing the finances. Over half of chairs and chief executives (55%) said they are worried or very worried that their trust does not have the right numbers, quality and mix of staff to deliver high-quality care. Most expect the situation to deteriorate over the next six months. This risks deterring staff from wanting to progress into leadership roles, for example at chief executive level. At the same time providers need to address wider challenges including a culture where too many staff feel bullied, and black and minority ethnic staff still experience discrimination.
- **Current NHS system level plans assume a rate of transformation that is unlikely to be delivered**. The *Five year forward view* assumed the NHS would be able to deliver £22 billion of demand management, efficiency and productivity gains by 2020, many of them from service transformation. Providers are at the forefront of creating new and better ways of delivering care to patients, which are delivering rapid and significant improvements in outcomes and patient experience.

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However, they are not at a sufficient scale or progressing at a sufficient speed to deliver the required level of gains. Over three quarters of trust leaders (79%) told our survey they were worried or very worried that their local area is not transforming quickly or effectively enough to provide sustainable, integrated patient care and financial balance.

WHAT PROVIDERS NEED

If trusts are to meet the challenges they face, they need:

- **A smaller set of key priorities with a realistic trajectory for each**. It would help if this priority setting was undertaken in close collaboration with those who have to deliver on the frontline.
- **A clear medium-term plan that sets out how we will close the gap**, at both national and local levels, between what the NHS is asked to deliver and the funding available for the rest of the parliament. A plan that, as the NAO requested, is realistic, sustainable and properly tested and one that addresses the problems in primary and social care. STPs offer the opportunity to create appropriate local plans.
- **Support for staff**: the need to invest in staff engagement, value their work, address staff shortages, ensure their roles are appropriately sized and recognise that pay restraint cannot be indefinite. Providers need to invest in leadership and management and create a culture that supports all staff at a time of increasing pressure.
- **A more mature central-local relationship**: providers need the arm's length bodies to understand the size, difficulty and complexity of the challenge trusts face. As NHS Improvement is beginning to show, support works better than grip. Solutions work best when they are developed jointly between the arm's length bodies and the frontline.
- **Time to deliver**: providers need NHS system leaders to recognise that complex transformation will take time, when set alongside an increasingly stretching task to deliver high-quality patient care.
- **A better understanding of the 2020-2040 challenge**: providers need to make decisions in the context of the significant extra demographic pressures the NHS faces after 2020. We need an officially supported analysis of the nation's likely longer term health and care needs and how these will be met and funded so we can ensure we make the right short-term decisions.

All these need to be underpinned by greater realism about what can be delivered for the funding and the management and the staff capacity available.

ACCESS AND QUALITY

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SUMMARY

Trusts are facing significant increases in demand for their services as a result of demographic factors, pressures on primary and social care provision and increasing patient expectations.

As a result, trusts are running at capacity levels beyond the recommended norm and levels in other western systems. Importantly, local health systems are less resilient and less able to absorb the shocks that any healthcare system inevitably faces, such as flu outbreaks or local care home closures.

When combined with financial and workforce pressures, this means performance on access standards is the worst it has been in a decade. This poor performance and demand pressure spans every sector and is affecting nearly every trust. The challenges are systemic rather than the result of poorer individual trust performance. But access to NHS services remains good against international comparisons.

The evidence on quality is mixed. A near complete set of CQC inspection data rates a majority of trusts as either requiring improvement or inadequate. The latest CQC *State of care* report argues for the first time that some services are now failing to improve and there is some deterioration in quality. But overall performance in the latest CQC patient experience survey remains high and 95% of trusts are rated as having good or outstanding services in the caring domain of their inspection.

Trusts are undertaking a wide range of activity to meet these challenges. These include performance recovery programmes focusing on emergency care and elective waiting lists; greater support for primary and social care; introducing improvement methodology; support for trusts in quality special measures; and implementing recommendations of taskforces to improve cancer and mental health outcomes.

Trust chairs and chief executives are increasingly nervous about the future. They told our survey they are concerned that performance against the access targets cannot be sustained, let alone improved. Three quarters are concerned that the mismatch between resources and demand will, if not addressed, result in further deterioration in access to services and negative consequences for the quality of care patients receive.

Providers are stretching every sinew to deliver high-quality care but there is a danger they are unable to recover performance against the targets and that quality begins to deteriorate, potentially at greater speed. We risk losing the hard won improvement gains made between 2000 and 2010.

ACCESS AND QUALITY

THE PROVIDER CHALLENGE

Pressures on demand

In recent years we have seen a sharp increase in demand for hospital, community, mental health and ambulance services. At the same time patients have higher and more complex needs – higher acuity. It is clear that a wide range of previous approaches to stemming demand, such as reinvestment of the marginal rate on emergency admissions, have signally and consistently failed.

Not only is demand up, but the rate of growth of demand also appears to be speeding up. NHS Improvement reported that emergency admissions via A&E are 4% higher for the period July to September 2016 than in the same quarter last year.[1] They also reported that the number of GP referrals has increased by 4% between July and September compared to the same time last year. Significant demand increases are also being experienced across all sectors. For example, in mental health, 1.8 million people were in contact with mental and learning disability services in 2014/15, a 5.1% increase on the previous year.[2] Community trusts report similar increases.

These levels of demand are a long way beyond NHS trust plans and the assumptions made in the NHS *Five year forward view*, published in October 2014. A recent NAO[3] report, for example, pointed out that the *Five year forward view* assumed that growth in acute hospital activity would be reduced from 2.9% to 1.3% per year through a range of transformation programmes. However, as the statistics below show, demand growth is actually speeding up rather than reducing.

INCREASE IN URGENT CARE DEMAND

September 2016 - monthly figures for NHS trusts only

Source
www.england.nhs.uk/statistics/statistical-work-areas

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Reasons for demand increases

Trust boards report that they are unable to determine the precise reasons for the growth in demand and more complex care. Commonly cited reasons include:

- a growing, ageing population with increasing prevalence of multiple long-term conditions
- a primary care system which is struggling to meet the demand being placed upon it
- a social care system which is widely accepted to have reached a tipping point due to funding cuts, increased demand, the pressures of the minimum wage and private providers exiting the market
- a society which has high expectations of its NHS, wanting ever faster access to a wider range of better services around the clock.

One important and urgent piece of work the NHS needs to undertake is a proper analysis of the reasons behind these demand increases and a better prediction of how they are likely to play out in future.

Capacity constraints and resilience

In the face of this demand growth, the NHS has been "running hot" for an extended period. Although trusts are working hard to keep pace with demand, the provider sector is operating at capacity levels beyond those which other international health systems would regard as acceptable. In the UK there are only 2.8 beds per 1000 people compared to an average of 5 beds being available per 1000 people across OECD countries, despite having very similar lengths of stay.[4]

Bed occupancy levels on inpatient wards in the acute and mental health sectors therefore now frequently exceed the recommended maximum levels of 85%, often to levels higher than 95%.

This capacity constraint is further compounded by delays in discharging medically fit patients from hospitals. The trajectory on national statistics for delayed transfers of care in hospitals shows the scale of rising pressures facing hospitals[5] from declining capacity in social care, with figures at their highest since first recorded in 2010. The latest performance data shows a record high of 385,634 bed days were lost as a result of delayed discharges – a 34.8% rise on the same quarter last year.[1] However it is important to recognise that these delays can also be a result of poor transfers inside the NHS as well as between the NHS and social care.

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Resilience is vital in any secondary healthcare system as it needs to absorb extra demand from frequent regular events such as winter flu outbreaks, the closure of local care homes, and the transition from retiring GPs to more risk averse, newer practitioners that can quickly lead to sharply higher referral rates.

The capacity levels at which we are now permanently running our hospital, ambulance, community and mental health services and the length of time for which we have been doing this has seriously reduced resilience. We are seeing precipitate drops in A&E performance in particular hospitals on particular days, which have a clear negative impact on patient experience and patient safety. Many are traceable back to an inability to cope with activity shocks that five years ago could have been absorbed but now cannot be.

3%

of trusts met the four hour standard in A&E in quarter 4 2015/16 – a substantial drop

This combination of substantially increased demand and capacity constraints, together with the harsher financial environment and workforce challenges, which we describe in the chapters on finance and workforce, is leading to growing pressures on access and quality.

Access – what the statistics and evidence show us

Overall performance figures in the NHS are now at their worst in a decade and while there are recovery programmes in place, consistent delivery of the agreed performance standards is proving stubbornly elusive.

This drop in performance is marked by a number of characteristics:

- the large number of trusts missing their performance targets – failure to meet performance targets is now widespread, as opposed to just a few trusts missing targets
- the number of targets being missed – nearly all targets are now being missed, as opposed to just one or two
- the scale of dropping performance – targets are now being missed by a much larger margin than previously with higher numbers of trusts being significantly further away from achieving their targets.

These trends are well illustrated in figure 1.1 which shows performance against the four-hour standard across the major A&E departments in quarter 4 of each of the last three financial years.

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The same profile is seen with key referral to treatment consultant-led waiting times where in September 2016, 119 trusts were meeting this target, compared to 154 at the same time last year. The latest data shows 9.4% of patients waited longer than 18 weeks to begin hospital treatment – this is the worst performance since targets were revised in 2012.[6] This again indicates that systemic issues, rather than poor performance from individual trusts, are responsible for this deterioration in performance.

Ambulance services also continue to struggle to deliver the Red 1, Red 2 and 19 minutes response-time targets with performance of 68.6%, 62.1% and 90.5% respectively against targets of 75%, 75% and 95% of cases.[1]

Performance data on access to mental health and community services is less comprehensive, but the available data, alongside trust reports, paints a similar picture of NHS trusts under heavy and rapidly rising pressures. For example, waiting lists for treatment and out of area placements, in particular for child and adolescent mental health services, are rising.[7] As capacity stretches further, it is becoming harder for people needing mental health services to access them early enough to prevent unnecessary deterioration.

Community trusts also report significant performance challenges across the full range of their services from district nursing to health visiting. This is being compounded by cuts to local authority contracts in areas like public health, sexual health, and school nursing.

However, from both an international and historical perspective this performance is still relatively strong. What is worrying is the downwards trajectory on performance and the persistent inability to recover the NHS constitutional performance standards. Trusts risk losing the substantial performance and access gains made over the last decade.

ACCESS AND QUALITY

Figure 1.1

Increase in number of trusts not meeting the four-hour A&E target for type 1 services:

Quarter 4 - 2013/14

98.1	96.3	96.0	95.6	95.3	94.7	93.9	93.0	91.9	90.9	89.3	86.9
98.1	96.3	96.0	95.6	95.2	94.7	93.8	92.9	91.8	90.9	89.1	86.3
97.9	96.3	95.9	95.6	95.2	94.7	93.7	92.8	91.7	90.8	89.1	86.2
97.7	96.3	95.8	95.6	95.1	94.6	93.7	92.7	91.5	90.6	88.9	85.8
97.7	96.2	95.8	95.6	95.1	94.6	93.6	92.7	91.4	90.5	88.7	85.2
97.5	96.2	95.8	95.6	95.1	94.5	93.5	92.6	91.2	90.5	88.6	85.1
97.3	96.2	95.8	95.5	95.1	94.4	93.5	92.5	91.2	90.5	88.5	84.3
97.0	96.1	95.8	95.4	95.0	94.1	93.4	92.5	91.2	90.1	88.2	84.1
96.8	96.1	95.7	95.4	94.9	94.1	93.4	92.4	91.0	89.6	87.9	83.4
96.7	96.1	95.7	95.4	94.9	94.0	93.2	92.4	91.0	89.6	87.8	82.9
96.5	96.1	95.7	95.3	94.8	94.0	93.2	92.2	91.0	89.4	87.6	82.6
96.4	96.0	95.7	95.3	94.8	94.0	93.0	91.9	90.9	89.3	87.1	82.1

Quarter 4 - 2014/15

98.3	95.4	94.0	92.7	90.8	89.6	88.5	85.4	84.6	82.7	80.4	77.7
98.0	95.3	93.7	92.6	90.8	89.5	88.2	85.4	84.6	82.6	80.3	77.6
96.9	95.3	93.7	92.2	90.7	89.5	87.5	85.1	84.2	82.6	79.6	77.5
96.5	95.3	93.7	91.9	90.7	89.4	87.5	85.1	84.2	82.5	79.5	77.1
96.4	95.2	93.6	91.9	90.5	89.3	87.2	85.0	84.1	82.4	79.4	74.7
96.0	95.1	93.3	91.5	90.3	89.1	87.2	85.0	84.0	82.2	79.4	71.3
95.8	95.0	93.2	91.4	90.3	88.8	87.1	85.0	83.7	82.0	79.2	70.9
95.8	94.9	92.8	91.2	90.1	88.6	86.8	84.9	83.6	81.7	78.8	63.8
95.8	94.8	92.8	91.1	90.0	88.6	86.8	84.9	83.5	81.7	78.8	
95.7	94.5	92.8	91.0	90.0	88.5	86.6	84.8	83.4	81.0	78.6	
95.7	94.4	92.8	90.9	90.0	88.5	86.1	84.7	83.2	80.6	78.5	
95.7	94.1	92.7	90.8	89.8	88.5	85.4	84.6	82.9	80.6	77.9	

Quarter 4 - 2015/16

97.5	92.3	90.6	87.7	85.6	83.5	81.6	80.1	77.0	75.2	73.2	66.6
97.0	92.1	90.2	87.6	85.4	83.4	81.5	80.0	77.0	74.9	73.2	66.1
95.6	92.0	90.1	87.5	84.8	82.8	81.4	79.9	76.9	74.8	73.2	65.6
95.3	91.7	90.0	87.2	84.8	82.6	81.3	79.6	76.9	74.8	72.9	64.0
94.7	91.7	90.0	87.1	84.7	82.6	81.3	79.5	76.8	74.7	72.8	63.9
94.3	91.6	89.9	87.0	84.5	82.6	81.0	78.9	76.7	74.7	72.4	63.2
93.9	91.5	89.5	87.0	84.5	82.5	80.9	78.9	76.6	74.5	71.5	
93.8	91.2	89.1	86.8	84.4	82.4	80.8	78.1	76.5	74.4	71.4	
93.6	90.9	88.9	86.6	84.3	82.4	80.6	78.0	76.1	73.9	70.0	
92.4	90.9	88.9	86.2	84.3	82.2	80.4	77.5	76.0	73.9	69.2	
92.4	90.9	88.3	85.6	83.8	82.1	80.4	77.2	75.7	73.8	68.0	
92.3	90.9	88.2	85.6	83.6	82.1	80.1	77.1	75.5	73.3	67.4	

Source
www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2015-16/

ACCESS AND QUALITY

Quality – what the statistics and evidence show us

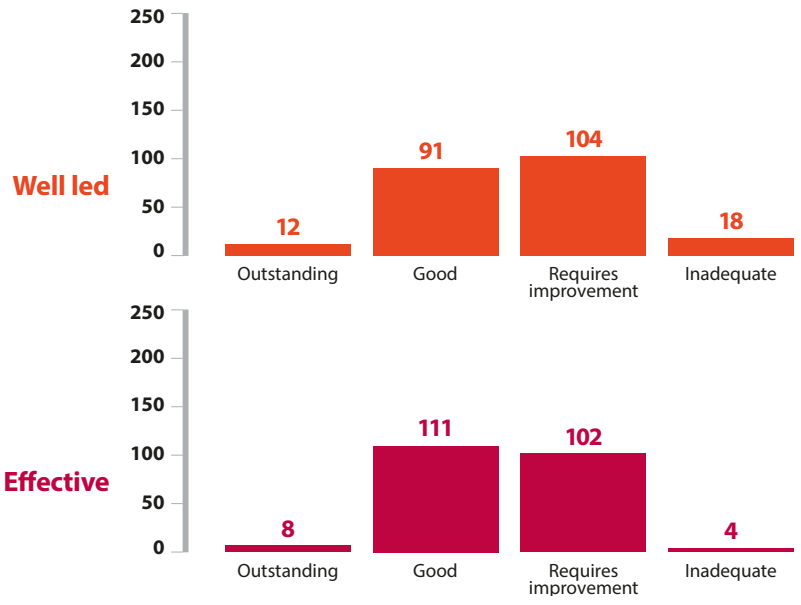
Access to services is not the only measure of performance. The quality of services is equally important. The evidence here is mixed. On the one hand there is significant evidence showing that the quality of service provision in the NHS is under pressure and potentially deteriorating. We have a near complete set of inspection results from the CQC with 225 NHS trusts now inspected.

The CQC uses a four category overall rating system. Four per cent of the trusts inspected so far are outstanding, 32% are good, 58% need improvement, and 6% are inadequate, showing there are questions around the quality of care being provided by nearly two thirds of trusts.

Looking at the results in more detail, as set out in figure 1.2, the vast majority of trusts (95%) have been rated as having good or outstanding services in the 'caring' domain.

Performance across the other domains is lower and more variable. Performance in the 'safe' domain is of greatest concern – 80% of trusts were rated by the CQC as requires improvement or inadequate in this domain. This is a particularly important domain as poor performance on safety is a key driver for a trust to be placed in special measures, with 16 trusts currently in quality special measures.

Figure 1.2
Number of trusts receiving each CQC domain rating:



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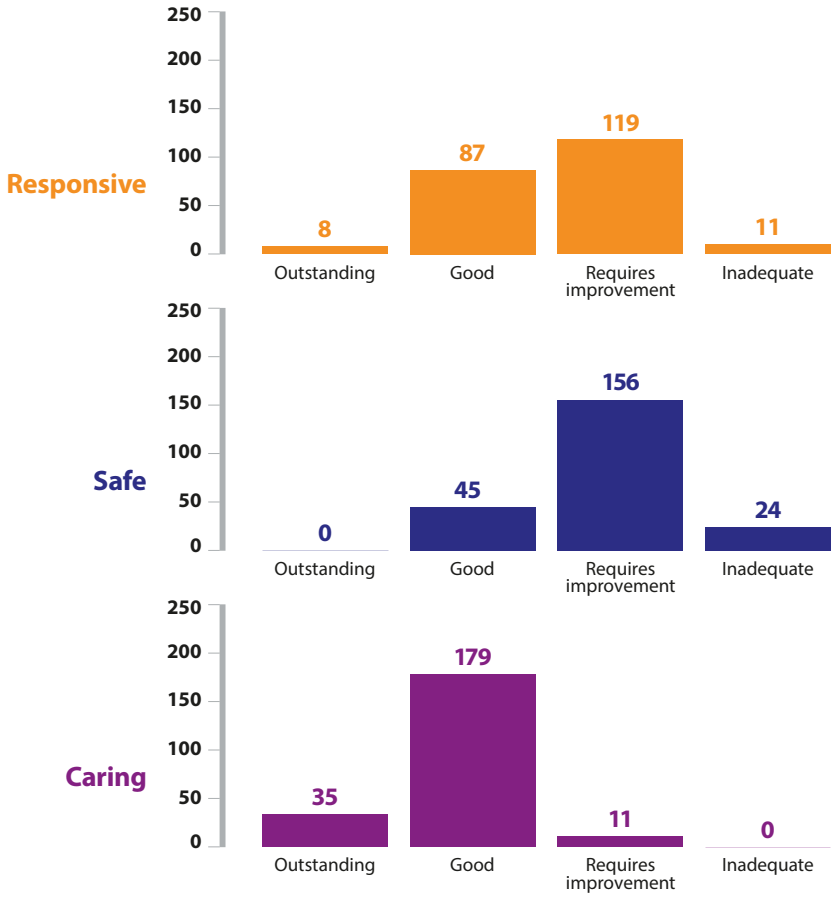


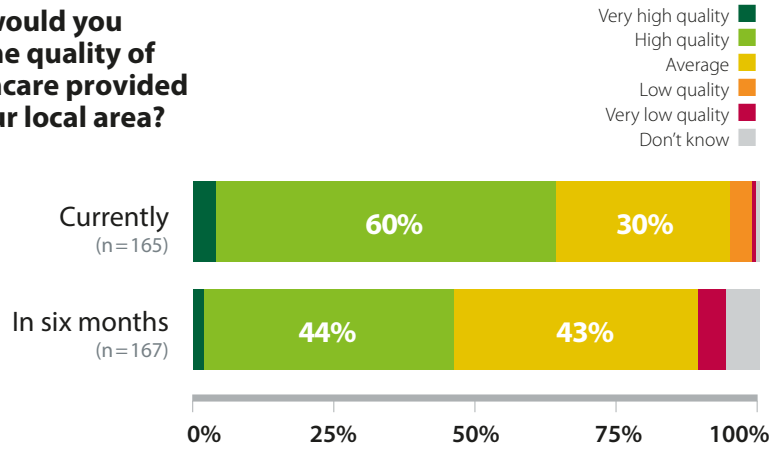
The CQC's *State of care* report[8] – its annual overview of health and social care in England – provides an even more up-to-date picture. The report states that, despite challenging circumstances, much good care is being delivered and encouraging levels of improvement are taking place. However for the first time it also argues that, due to the unprecedented demand and financial challenge, some services are now failing to improve and there is some deterioration in quality. The report also highlights questions around the sustainability of social care, and the impact this is having on the NHS.

Other evidence is more positive. Patient satisfaction with quality of care remains generally high. The latest NHS inpatient survey results[9] found that overall patient experience of adult inpatient services significantly increased between 2014/15 and 2015/16. Longer term, patient satisfaction with hospital care has made some modest gains but has declined in areas where pressures are well known, such as timely discharge and referral to treatment times.[10] Public support for the NHS overall also remains high. Polling suggests that people generally perceive the quality of access and treatment in the NHS to be good,[11] but remain concerned overall about its sustainability.[12]

ACCESS AND QUALITY

Responses to our survey of trust chairs and chief executives reflect these rising pressures. Figure 1.3 shows that two thirds of chairs and chief executives are confident they currently provide high-quality care. However, when chairs and chief executives look forward six months there is a significant drop, with only 46% of respondents thinking they will be able to provide high-quality care.

Figure 1.3
How would you rate the quality of healthcare provided by your local area?



Respondents to our survey highlighted that a lack of broader support and capability within their wider local system, particularly in social care, is posing a major problem for trusts. Respondents have highlighted that they are "*very dependent on community capacity - nursing home and residential home beds*" (chief executive) and there are also concerns about the "*inability of primary care to pick up work which could properly shift to them*" (trust chair).

THE PROVIDER RESPONSE

Trusts throughout the country are taking the initiative to tackle these challenges and improve the quality of patient care in a number of different ways, supported by NHS Improvement and NHS England. Some of these initiatives are set out below.

Coping with and managing demand – a rapidly increasing number of trusts, of which Whittington Hospital NHS Trust is just one example, are providing medical care on an outpatient basis through ambulatory care centres. They are offering rapid access to diagnostic tests, specialist skills and treatment to prevent unnecessary admissions to hospital. Hospitals such as Barking, Havering and Redbridge are changing their model of accident and emergency care by using senior clinicians at the A&E front door to redirect patients to 111 or general practice, where appropriate.

ACCESS AND QUALITY

Winter resilience planning – there has been a particular emphasis, both this year and last, on improving planning for the winter period when performance pressures are greatest. New urgent and emergency care system boards, often chaired by acute trusts and involving community, mental health, primary and social care partners are designed to oversee improved planning and delivery. A strong focus is ensuring appropriate primary and social care capacity over the Christmas and New Year periods to prevent hospitals being the only health and care facilities open over the holiday. There is also emphasis on communications to improve public awareness around the increased pressures on A&E and how to more proactively self-manage conditions to prevent people becoming more ill and to reduce the chances of unnecessary admission to hospital.

Improved accessibility and responsiveness to mental health crisis services – through street triage, single point of access for referrals, and 24/7 crisis care. Innovation in services is also driving improvement. Birmingham and Solihull Mental Health NHS Foundation Trust's psychiatric decision unit provides a responsive seven-day service to people whose complex presentations and/or social issues mean immediate discharge is not possible.

Social care provision – NHS trusts are increasingly recognising that their performance is dependent on adequate social care provision. They are therefore improving collaboration with local authorities and other social care providers or are now providing social care themselves. For example Oxford University Hospitals NHS Foundation Trust is leading the provision of a new form of integrated care for its old and frail population. They have halved delayed transfers of care following the introduction of a set of changes including directly employing social care workers to facilitate discharge into the community and purchasing capacity in the local care home market that they then intensively support. East Kent Hospitals University NHS Foundation Trust is integrating teams of health and social care professionals, working closely together to offer personalised care in the community and supporting patients with long-term conditions to remain out of hospital.

Primary care provision – trusts also are increasingly recognising that their performance depends on stable and robust local primary care, particularly general practice. Trusts are strengthening their relationships with GPs in a number of ways. Northumbria Healthcare NHS Foundation Trust, for example, has supported the development of a local GP federation, provides a range of back office services to those practices that want them and is also now designing roles for GPs which span both the Northumbria acute care setting and the GP's local practice. Royal Wolverhampton NHS Trust has now acquired three GP practices, at their request, covering 27,000 of the local population and is already reporting significantly improved patient pathways as a result.

ACCESS AND QUALITY

1

Managing the flow of patients – a number of trusts are seeking to improve their patient flow, helping patients move more quickly from admission to discharge. These include approaches such as 'proactive discharge planning', used by Ipswich Hospital NHS Foundation Trust, and 'discharge to assess', used by South Warwickshire NHS Foundation Trust. Both trusts use multidisciplinary care teams to rapidly ensure medically fit people are cared for appropriately in the community.

Performance recovery and outcome improvement programmes and initiatives – trusts are working closely with NHS Improvement and NHS England to deliver a range of agreed national initiatives and programmes to recover performance and improve outcomes. Examples include:

- **Emergency Care Improvement Programme (ECIP)** – this clinically-led programme provides intensive practical help and support to 40 urgent and emergency care systems, designed to enable them to deliver the required accident and emergency standards.
- **Referral to treatment times (RTT)** – there is a similar scheme to support trusts to improve their RTT elective surgery performance which is supplemented by regular waiting list initiatives frequently involving weekend and extra working by clinical teams to reduce the size of waiting lists.
- **Cancer and mental health taskforces** – trusts are now working to implement the recommendations of two key national taskforces designed to improve outcomes in cancer and mental health. In cancer the key emphasis is on improving early detection rates, living longer after diagnosis and a better experience of care and support. In mental health the focus is on introducing a series of access and provision targets such as early intervention in psychosis, talking therapies, eating disorders, liaison psychiatry and child and adolescent mental health services.

Special measures – particular emphasis has been placed on supporting trusts who have been identified as providing inadequate care to improve. Nineteen trusts have exited the special measures regime through consistent and usually rapid performance improvement against action plans, followed up by comprehensive re-inspections. Sixteen of those trusts that are currently in or have been through special measures have formal buddying relationships with other trusts to provide ongoing support on performance improvement.

ACCESS AND QUALITY

Improvement methodology – trusts like Western Sussex; University Hospitals Coventry and Warwickshire; Shrewsbury and Telford; Barking, Havering and Redbridge; Leeds Teaching and Surrey and Sussex Healthcare are formally introducing Lean/continuous improvement methodology to improve services and patient care. The methodology equips NHS staff with the technical and analytical skills they need to understand, model and test changes in services to improve patient outcomes, care quality, efficiency, productivity and value.

THE RISKS

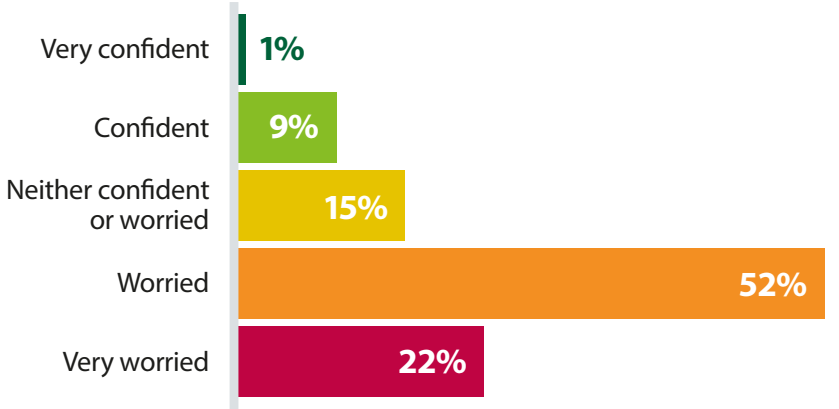
As demand, financial and workforce pressures grow, there is a real danger that access and quality will deteriorate further and faster. For example, waiting times could lengthen, clinical thresholds for access to care could be raised, access to care could be rationed by commissioners, and unmet need for early intervention services could lead to delayed access, higher acuity and less effective care. Taken together this could bring about greater inequality and inequity, problems that we already know affect English health and care provision.

Our survey found that about three quarters of chairs and chief executives are concerned that the current mismatch between resources and demand will – if it remains unaddressed – result in further deteriorating access and negative consequences for the quality of care patients receive.

Figure 1.4

Over the next six months, how confident or worried are you that your local area can continue to maintain its current level and quality of services within the resources available?

(n=172)



ACCESS AND QUALITY

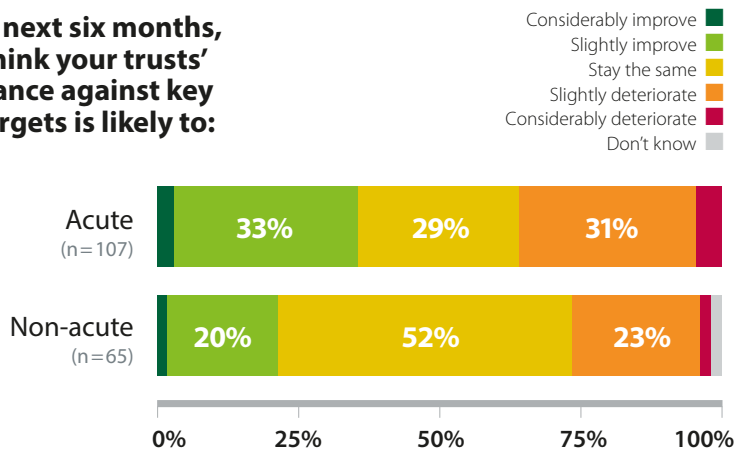
Some trusts retain a positive outlook. For example, one trust chair said: "*We are planning to deliver on everything but if it does go off, I would expect it to be the finances*". Others feel more challenged: "*We remain very focused on it. But a complete demand management impact vacuum in both outpatients and emergency department places us under real pressure*" (trust chief executive). Overall, respondents to the survey were clear that achievements were largely due to trusts themselves having a "*focus and grip*" (trust chief executive).

Trusts are increasingly making the connection between the financial squeeze the NHS is experiencing, as set out in the next chapter, and their ability to cope with the increase in demand and acuity. Recent research[13] has shown, for example, that funding for mental health has been cut and that the promised funds for mental health services in 2015/16 were not received. Respondents to our survey had limited confidence that further funding will reach the front-line, for example, a trust chair said: "*CCGs are not able to fund the increased demand and higher acuity in mental health which is deteriorating our financial position. We have higher levels of delayed transfers of care because of lack of specialist placement available, so length of stay is increasing.*"

Trusts are working hard to deliver the improved performance that is needed to meet the required NHS constitutional performance targets. But feedback from chairs and chief executives responding to our survey shows that there is little confidence the required improvement can be delivered. Over two thirds of all respondents thought that performance against the targets would either stay the same or deteriorate, implying that performance targets will still be missed. Analysis of results by type of trust differ, which may reflect the absence of and relative lower emphasis on NHS constitutional targets in community and mental health trusts.

Figure 1.5

Over the next six months, do you think your trusts' performance against key access targets is likely to:



ACCESS AND QUALITY

1

WHAT PROVIDERS NEED

No matter what sector they operate in, trusts need a smaller range of priorities and a realistic approach to delivery trajectories within them. For example it is clear that recovering the RTT elective surgery target will be significantly more difficult than system leaders are currently acknowledging.

Providers sit within a wider local system and demand can only be effectively managed across that system as a whole. Social care has reached a tipping point, with primary care not far behind, and both need rapid extra support to prevent demand being unnecessarily referred to the secondary care sector. Given the difficulty and complexity of the provider task, system leaders need to significantly increase the level of support given to providers rather than simply focusing on greater grip and control.

74%

trust leaders concerned mismatch between money and need will mean poorer quality

FUNDING AND FINANCES

2

SUMMARY

The NHS is in the middle of the longest and deepest financial squeeze in its history. NHS cost and demand rises by around 4% a year but, between 2010 and 2020, health funding will only increase by less than 1% a year on average.

This financial squeeze has translated into lower prices paid for activity carried out by NHS trusts and unrealistic assumptions about how much trusts can generate in efficiency savings. At the same time, costs in the provider sector have risen as a result of increases in staffing levels following the Francis Inquiry into the failings in care at Mid-Staffordshire.

Taken together these factors have led to a record official provider sector deficit of £2.45 billion in 2015/16 and an underlying deficit nearer £3.7 billion. At the end of 2015/16, two thirds of all trusts were in deficit, with deficits affecting all types of provider. This demonstrates that today's provider sector financial problems are systemic as opposed to poor financial management by individual trusts. Similar financial pressures are building in the commissioning sector and the NHS is also suffering from a funding crisis in social care.

There is a short term plan to eliminate the provider sector deficit in 2016/17 and 2017/18. Midway through 2016/17 this plan was on track, with the sector on course to reduce its deficit for 2016/17 to -£669 million. This reflects a significant amount of hard work by acute, mental health, community and ambulance trusts.

Substantial risk remains, however, as trusts need to increase their rate of savings to reach the desired -£580 million year-end target. This level of risk is reflected in our survey with nearly half of chairs and chief executives believing that the financial performance of their trust would either slightly or considerably deteriorate over the next six months.

Trusts are also concerned about the long-term sustainability of a deficit reduction approach that is dependent on short-term, non-recurrent, actions such as land sales, capital to revenue transfers and accounting adjustments. This echoes concerns recently voiced by the National Audit Office.[3]

Longer term, NHS funding increases are due to slow significantly over the next four years. Taking account of reductions to the wider health budget and population growth, health funding will actually decrease in real terms per head in 2018/19 and 2019/20. Given the performance pressures that already exist, tough choices will be needed to match what the NHS delivers to the funding available. There is no clear, realistic, plan to achieve this objective – again, a concern voiced by the National Audit Office.[3]

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THE PROVIDER CHALLENGE

Longest and deepest squeeze in NHS history

Despite the need to both maintain and transform services, the percentage of our GDP spent on health lags behind comparable countries.[14] For example, we would need to increase health spending by over 10% to close the gap on France and Germany, and out of the G7 group of countries only Italy spends a smaller percentage of GDP on healthcare than the UK.[15] This comparative lack of funding has contributed to the NHS facing significant financial and operational pressures.

The government is investing additional funding in the NHS but the exact amount is disputed. The government says it is handing the NHS in England a real-terms increase of more than £10 billion over the period from 2014/15 to 2020/21. This includes the commitment to fund the *Five year forward view*. However, independent experts such as The King's Fund, Nuffield Trust, Health Foundation and the health select committee, say that total health spending in England will rise by around £4.5 billion in real terms between 2015/16 and 2019/20 (the spending review period).[16] This is equivalent to a 1.1 % real terms annual increase at a point when cost and demand will increase by at least 4%.

1%

average, annual NHS funding increase from 2010-2020 – cost and demand up 4% each year

Trust leaders are particularly concerned about the lower funding increases the NHS will receive over the next four years with these dropping from + 3.7% in 2016/17 to +1.3%, +0.3%, +0.7% and +1.3% in 2017/18, 2018/19, 2019/20 and 2020/21 respectively – the so-called "NHS funding U-bend". The problems the NHS is having in balancing NHS finances in 2016/17 shows how stretching it will be to achieve financial balance within the much lower increases of the next four years.

Record deficit among trusts

The provider sector ended 2015/16 £2.45 billion in deficit. However, last year's deficit was, in reality, around £3.7 billion after one-off accountancy adjustments, central cash support and capital to revenue transfers are taken into account. Trusts have also had to absorb an additional £1 billion in pension charges. This deterioration in trust finances is unsustainable for the NHS and several factors contributed to this position.

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The first is that, in recent years, trusts have been paid less for the treatments and procedures they carry out. The national NHS tariff, which sets the prices trusts are paid, has been cut by an average 1.6% in cash terms a year over the six years to 2015/16.[17] This reduction in tariff prices fell well short of the cost and demand increases facing trusts. NHS Improvement and NHS England have now set a more realistic tariff for 2016/17, but a large deficit has already been created.

The second is that, as the NAO has recently pointed out, trusts have been expected to deliver unrealistic levels of efficiency savings. They delivered annual savings of 1.4% on average between 2008/9 and 2013/14, in line with or slightly better than historic performance. This was against an unrealistic target of 4% set for the last six years. The Nuffield Trust calculates that trusts have been asked to deliver higher levels of efficiency savings of 4% in 2017/18 and then 3% in 2018/19.[17] This level of year-on-year efficiency savings has never been achieved in the NHS before and is unlikely to be delivered.

The third is that costs in the provider sector have risen as a result of increases in staffing levels that followed the Francis Inquiry. With concerns over the provision of high-quality care, many trusts increased their staffing bill, often through additional spending on agency staff. Estimates of the increase vary, but NHS Providers believes that at least £1.5 billion of extra staff costs were added to trust pay bills towards the end of the last parliament without matching funding.

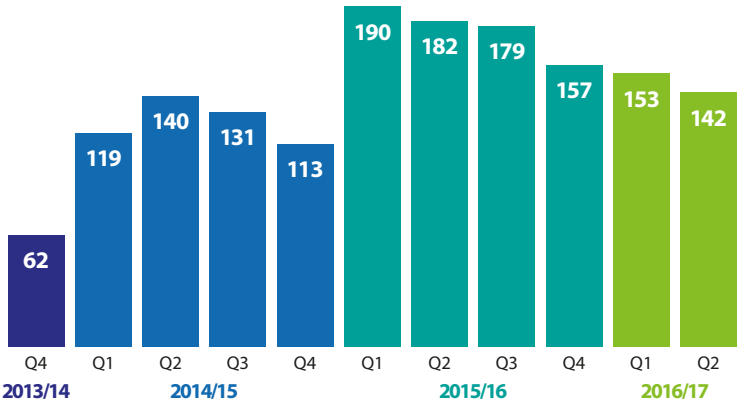
And, finally, trusts have faced a number of unfunded costs. In particular, they have been hit with additional costs following changes to pension rules. This is estimated to add around £1 billion to the pension cost of NHS trusts from 2016/17.[18] Other unfunded costs include increases in CQC fees and insurance premiums, reductions in payments for quality (CQUIN) and contractual fines.

The number of trusts in deficit

The deficit position of trusts is the most immediately pressing issue for the NHS. At the end of 2015/16, just under two thirds of all NHS trusts and three quarters of all hospital trusts – 153 trusts in total – were in deficit. This number has increased dramatically over the last four years. For example, in 2009/10 just 8% of trusts were overspent.[19] Another feature of the provider deficit problem has been its spread from the acute sector to community, mental health and ambulance trusts. Again, the number of trusts now in deficit (see figure 2.1) and the fact that deficits cover all sectors, demonstrates provider deficits are a systemic problem facing the NHS, rather than one caused by poor financial performance from individual trusts.

FUNDING AND FINANCES

Figure 2.1
Number of providers in deficit:



These financial pressures are no longer confined to trusts. At Q2 2016/17, 84 CCGs were over-spent with a total over-spend of £236 million.[20] This situation is being compounded by cuts to social care budgets. Since 2010, local government's funding from central government has been cut by 40%. Over the same period social care funding reductions have totalled £4.6 billion, a 31% reduction in real terms.[21]

31%
the real-terms reduction in social care funding since 2010

The growth of provider deficits has made provider financial control significantly more difficult as the traditional approach to financial control of setting, and then delivering, a break-even budget is no longer feasible.

Short-term plan to eliminate the deficit

There is a short-term plan to eliminate the provider sector deficit in 2016/17 and 2017/18. This is based on setting a more realistic tariff for the care and treatment provided by NHS trusts; the use of £1.8 billion of sustainability and transformation funding; and accompanying control totals for each individual trust. The financial control totals agreed between NHS Improvement and individual trusts represent "*the minimum level of financial performance, against which their boards, governing bodies and chief executives must deliver in 2016/17, and for which they will be held directly accountable*" (NHS Improvement 2016).[22] These were designed to deliver an NHS Improvement and NHS England agreed 2016/17 year end aggregate deficit for the provider sector of -£580 million.

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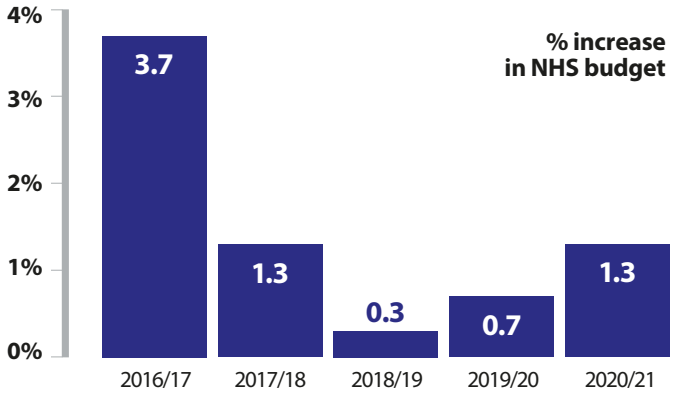
Medium-term gap

NHS funding has been 'front-loaded' in the first year of this parliament, with a 3.7% real terms increase in 2016/17. However, as figure 2.2. shows, much lower funding increases will follow over the next four years – 1.3% in 2017/18; 0.3% in 2018/19; 0.7% in 2019/20 and 1.3% in 2020/21. The gap between what the NHS is expected to deliver and the funding available will therefore increase.

Figure 2.2
NHS funding over the rest of this parliament:



Source
https://www.gov.uk/government/news/department-of-healths-settlement-at-the-spending-review-2015

As outlined in the previous chapter, some of the assumptions made in the NHS *Five year forward view*, on which the current financial and NHS delivery plans for this parliament are based, have turned out to be incorrect. Demand for care is a lot higher; social care is in a much worse state; general practice is turning out to be more unstable; and the starting point for the deficit among hospital, mental health, community and ambulance trusts has turned out to be much larger. An extra £8 billion on the health budget was the lowest amount the NHS asked for over the spending review period. In reality, the health budget only received an increase closer to the £4.5 billion mark and plans for the NHS to generate £22 billion in efficiency savings were too ambitious.

The obvious gap the NHS is now left with is a credible, realistic, mid-term plan for the rest of the parliament which matches what is expected of the NHS to the sharply lower funding increases of the next four years. This plan also needs to address the problems of social care, particularly in light of decisions taken by the chancellor in the autumn statement[23] not to provide extra funding for social care.

FUNDING AND FINANCES

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THE PROVIDER RESPONSE

Against this backdrop, trusts are undertaking a wide range of activity to maximise their financial position, including:

Deficit reduction – halfway through 2016/17, trusts are making good progress at reducing their deficits. The last four years' Q2 figures show: 2012/13 (+£60 million); 2013/14 (-£105 million); 2014/15 (-£630 million); 2015/16 (-£1.6 billion). If this trend had continued, we could have expected a provider deficit of nearly -£2.4 billion at Q2. However, supported by £900 million of sustainability funding, trusts have delivered a 2016/17 Q2 outturn of -£648 million. This is £968 million better than last year. The sector has stopped the runaway deficit train and is heading back towards financial balance.

Tight paybill control, particularly agency spend – 65-80% of an average trust budget is spent on its paybill. One of the key features of the last three years has been the growth in agency spend following the need to increase staffing levels. Almost three quarters (73%) of trusts have now reduced their spend since this was made a priority in November 2015.[24] Trusts are currently forecasting a £900 million full year reduction in costs, eliminating a quarter of the agency spend in a single year. Trusts have also deployed a variety of different ways of controlling their paybill including changing their staffing mix, reducing the size of their non-clinical workforces, developing lower banded new workforce roles and more effective staff rostering.

Efficiency, productivity and cost improvement gains – trusts are delivering significant efficiency savings and productivity gains year on year. The half year results from NHS Improvement show that cost improvements in 2016/17 are forecast to total £3.2 billion, an impressive £346 million (12%) higher than last year. This follows £2.9 billion's worth of gains in 2015/16.[1] As part of this process, trusts have also been entrepreneurial in growing alternative sources of income. For example, Leeds Teaching Hospitals NHS Trust has been commissioned to help develop radiotherapy services in new cancer centres overseas through their Medical Physics and Engineering Department.

Delivering the Carter review – trusts are also working hard to deliver savings in line with Lord Carter's review into unwarranted variation in trust spend.[25] This includes rationalising pathology and back office services across sustainability and transformation plan (STP) areas as well as reducing clinical variation, maximising efficient use of estate and reducing administrative spending.

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Financial special measures and financial improvement programme – trusts in particular financial difficulty and those seeking further support have been working closely with NHS Improvement to improve their financial position. Eight trusts are in financial special measures and have been buddied with other trusts to support their financial improvement activity. Sixteen trusts have been working with specialised management consultancy support in the financial improvement programme.

Capital – given the tight restrictions on capital, trusts have been working innovatively with private sector partners to access much needed capital. For example, Burton Hospitals NHS Foundation Trust has established a commercial partnership with Health Innovation Partners Ltd that will provide access to private sector capital to finance new projects, and help with the acquisition of land and facilities to support NHS services.

THE RISKS

Delivery of 2016-17 year-end target

Delivery of the year-end target of £-580 million will require trusts to increase their rate of savings. The provider sector will need to deliver a second half surplus of £68 million, a £716 million swing, which is very stretching. There is, therefore, significant risk to manage in the second half of the year.

This is reflected in the responses to our survey. As figure 2.3 shows, over the next six months, only 13% of chairs and chief executives think that finances are likely to improve at their trust, with nearly 50% believing they will deteriorate against plan. Some noted that the performance and finance targets they have signed up to are likely to be too stretching, which may result in them not being able to access their share of the £1.8 billion sustainability funding.

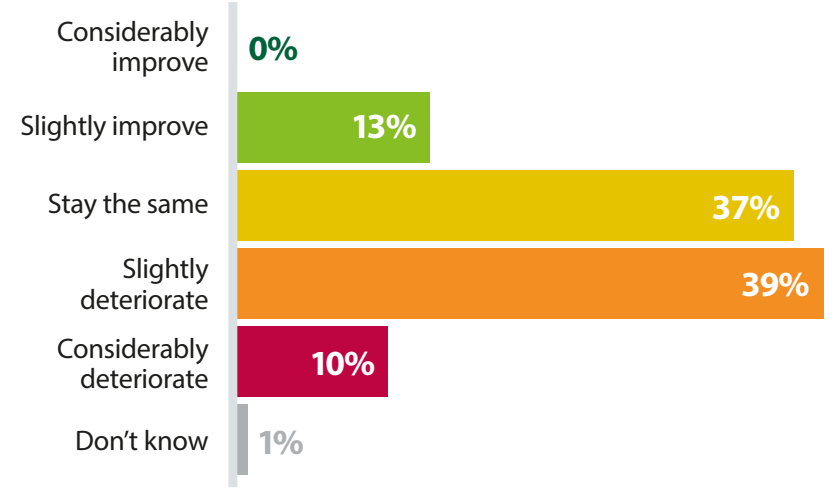
A chief executive said: "*It is absolutely clear that these initiatives will not bridge the projected financial gap and deliver aggregate financial balance. In particular, the sustainability and transformation fund allocations and control totals which have just been issued are completely disconnected from the financial realities on the ground and are not deliverable*."

FUNDING AND FINANCES

Figure 2.3

Over the next six months, do you think the financial performance of your trust is likely to:

(n=172)

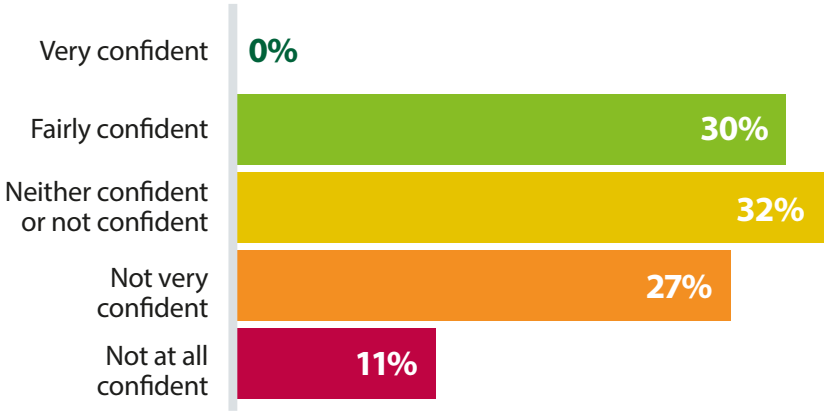


In a separate survey in August 2016, we also asked finance directors in trusts for their views on their 2016/17 control totals. As figure 2.3 shows, almost 4 in 10 finance directors (38%) were not confident about hitting their control totals at the end of 2016/17, and a further 30% were unsure. They cited not being able to further reduce agency staff costs, lack of bed capacity, the rise in A&E attendances, and the ongoing impact on the NHS of cuts to social care as key risks in managing finances in the short term.

Figure 2.4

How confident are finance directors about achieving their control totals in August 2016?

(n=84)



FUNDING AND FINANCES

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Sustainability of the current approach to deficit reduction

Trusts are concerned about the sustainability of the current approach to reducing the deficit. More specifically, many trusts are using non-recurrent, one off, items such as land sales, accounting adjustments and use of the capital budget for revenue purposes. This is reflected in the fact that only 75% of cost improvement plan savings in the first half of 2016/17 were recurrent, as opposed to the planned 91%.

73%

trusts reducing spending on agency staff since November 2015

Trusts have also said the control total regime is time consuming to administer and adds significant extra regulatory burden. It also involves a significant reduction in provider autonomy, potentially blurs trust board accountability and involves an unwelcome extension of central regulatory control.

2017-19 planning and contracting

NHS trusts and commissioners are currently creating two-year operational plans to cover 2017/18 and 2018/19 which will lead to the agreement of two-year contracts. As outlined earlier, this contracting process will need to absorb a significant reduction in overall NHS funding from +3.7% in 2016/17 to +1.3% in 2017/18 and +0.3% in 2018/19.

Early reports from this process, based on initial commissioner offers, suggest that it will be difficult for commissioners and providers to agree contracts, given the degree of financial constraint the overall funding reductions imply. There is an additional degree of pressure in this process given the need to reach agreement by the end of December.

This pressure is reflected in our survey with many chief executives and chairs saying that low funding increases means a significant adverse impact on commissioner budget allocations for 2017-19. Many felt that this would result in difficult contract negotiations for 2017-19. Several respondents mentioned that negotiations with commissioners over disputed money also have the potential to contribute to the deterioration of their trust's financial position.

One chief executive said their financial position "*will fall off a cliff if we lose the contract dispute, but if we do not, then it will fall away but remain better than break-even.*" And a trust chair stated that their local position "*depends on negotiations with CCGs for 2016/17 disputes worth £1m and the 2017/18 contract. There is no extra money in the system so it is likely that providers will have lower allocations.*"

FUNDING AND FINANCES

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Reduced capital funding

Repeated raids on capital funding to reduce deficits have created an unsustainable situation for trusts. NHS providers require significant amounts of regular capital investment to maintain buildings, modernise facilities, invest in new treatments and IT, and fund much-needed transformation. As the NAO points out[3] raiding future capital investment to prop up current revenue budgets could risk trusts' long-term ability to deliver services sustainably.

The capital budget for the Department of Health was reduced over the period 2010 to 2015 from £4.8 to £4 billion, and is set to reduce in real terms over the spending review period (flat in cash terms at £4.8 billion per annum).[26]

These reductions in capital spending to meet budgetary pressures are having consequences. For example, the amount of high risk capital backlog maintenance for buildings and equipment has increased from £296 million in 2011/12 to over £775 million in 2015/16.[27]

38%

finance directors not confident about hitting control totals by end of 2016/17

Risks for the remainder of this parliament

The biggest risk until 2020 is the current lack of national and local plans to close the gap between what the NHS is required to deliver and the lower funding increases for the next four years. Sustainability and transformation plans (see transformation chapter) offer an important means of producing local plans but, as we set out, there are a series of escalating risks that need to be carefully managed if this planning process is to be successful.

Beyond 2020

Beyond the shorter-term issues highlighted above, there is still little clarity or public debate over the long term strategy for the health service beyond the timeframe covered in the *Five year forward view*. What is required is an officially supported and impartial examination of NHS finances and demand in the longer-term for the period from 2020-2040. This should take a longer-term perspective that single parliaments and spending review periods are unable to bring. It should look instead to developing options and recommendations for the long-term sustainability of the NHS. The work should engage with national bodies and the NHS frontline, look across health and social care and examine

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long-term demographic trends. It should provide recommendations on the percentage of GDP we should commit to health and care and how this should be funded. Without this important piece of work we risk making short-term decisions that may need to be revisited or even unpicked as this longer term context plays out.

WHAT PROVIDERS NEED

Providers need greater realism and honesty about what can be delivered in the short, medium and long term. Given the level of risk in 2016/17, a year-end provider sector deficit of any less than £1 billion would be a significant achievement. We need to recognise, however, that the current approach to deficit reduction is not sustainable longer term. It is difficult to see how trusts can recover performance and sustainably deliver financial balance unless urgent extra investment is made in social and primary care. It is disappointing that the autumn statement missed this opportunity, particularly in social care.

Trusts are doing their best to realise efficiency and productivity gains, and cost improvements, including delivery of the Carter programme. However, having realised the immediately available savings over the last six years trusts lack the capacity and capability to realise the more complex savings that are now required. A judicious programme of investment could unlock these savings in larger amounts and at quicker speed than would otherwise be achievable.

We need to stop raiding capital to support revenue budgets. Instead, providers need a capital strategy with appropriate investment that properly meets long term needs.

Perhaps most importantly of all we need a realistic and honest plan to match what is required of the NHS with the lower funding increases of the next four years. A key element of this would be a much smaller number of strategic priorities with a realistic performance trajectory attached to each.

WORKFORCE

3

SUMMARY

Frontline staff, and the extra discretionary effort they give, are critical to ensuring the right quality of care. Evidence clearly shows that care quality and outcomes are related to effective staff engagement.

Trust leaders report that getting the right number and mix of clinical staff is proving increasingly difficult. Staff shortages across a range of specialties are putting growing pressure on service delivery. They are also forcing the temporary or permanent closure of individual services, as boards grapple with the near impossible trade off of keeping a service open or potentially risking patient safety. Growing demand and staff shortages mean NHS roles are becoming more pressured and difficult, with staff increasingly overworked and stressed. A prolonged period of pay restraint and the junior doctors dispute have also had an adverse impact.

As a result, trust chairs and chief executives now believe the workforce challenge is just as difficult as balancing the finances. Over half of chairs and chief executives (55%) said they are worried or very worried that their trust may not have the right numbers, quality and mix of staff to deliver high-quality care. Most expect the situation to deteriorate over the next six months.

Trusts are working ever harder to recruit and retain the right staff, for example by recruiting from overseas. More innovatively, they have been partnering with higher education institutions to deliver student funded nursing courses and making greater use of new roles, such as advanced practitioners. At the same time they are successfully delivering the agreed priority of reducing reliance of temporary agency staff and are on track to cut the agency bill by 25% this year alone. Trusts are investing in effective leadership and positive and inclusive cultures and are striving to improve staff engagement and support staff more effectively at a time of growing pressure. They are also introducing new measures to improve working conditions as part of the implementation of the new junior doctor contract.

The level of complex change the NHS needs to deliver requires not just more capacity but also greater change management capability. Staff need to be supported and remunerated to make the professions sustainably attractive. And we need to closely monitor the impact of holding down pay for as long as is proposed. The government also needs to recognise the workforce risks posed by Brexit and ensure that coherent and credible plans are in place to mitigate them. This all needs to be underpinned by a clear, system-level workforce strategy and improved workforce planning.

WORKFORCE

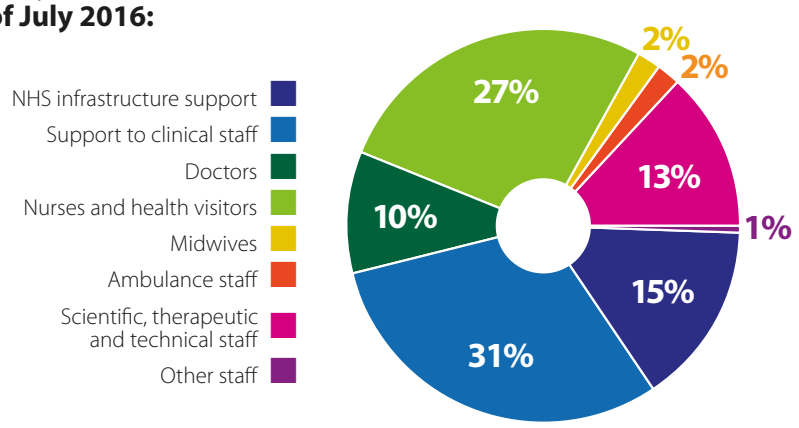
3

THE PROVIDER CHALLENGE

Staffing levels

The NHS in England employs just over 1.2 million people , with 1.1 million of those working across hospital, mental health, community and ambulance trusts.[28] More than half (54%) are clinically qualified, 31% are supporting clinical staff, and 15% provide infrastructure support (see figure 3.1). It is these people who ensure delivery of high-quality care 24 hours a day, 365 days a year, and they are working hard to maintain and improve the quality of that care in the face of rising patient demand, pressure to increase efficiency, and shortages of key staff.

Figure 3.1
Breakdown of staff employed across providers as of July 2016:



The workforce gap

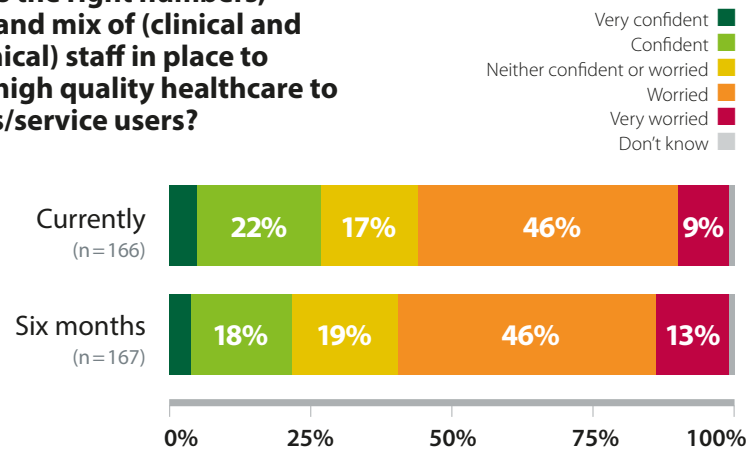
Our survey findings indicate that the workforce challenge of having the right people with the right skills in place to deliver high-quality care is now as large as the challenge of balancing NHS finances. Even if we could fund increasing numbers of staff to meet the rising demand in care, under current plans the number of available trained staff will always lag behind what the NHS needs. This is particularly the case for clinical staff. In the words of one chair: "*This concerns me more than the money.*"

It is unsurprising that workforce concerns came through strongly in our survey. More than half (55%) of chairs and chief executives said they are worried or very worried as to whether their trust has the right numbers, quality and mix of staff in place to deliver high quality healthcare to patients and service users. Looking forward six months, this number rose to 59%, suggesting chairs and chief executives see the situation deteriorating rather than improving (see figure 3.2).

WORKFORCE

Figure 3.2

How confident are you that your trust has the right numbers, quality and mix of (clinical and non-clinical) staff in place to deliver high quality healthcare to patients/service users?



Following the events at Mid-Staffordshire, the Francis Inquiry gave a clear message from government and the national NHS bodies that trusts should increase staffing numbers. NICE safe staffing guidance for nurses and a stricter regulatory approach to care quality followed. As a result, there was a significant increase in staff demand. In 2014, trusts reported to Health Education England that they needed 189,000 adult nurses (acute) in total, yet two years earlier they predicted they would need only 165,000.[29] This rise in demand was unplanned and, unsurprisingly, resulted in a considerable mismatch with staff supply.

Workforce pipeline

Staff shortages are putting growing pressure on service delivery. In the most extreme examples – often smaller hospital trusts, with smaller rotas and multiple sites to staff – shortages have led to the temporary or permanent closure of some marginal services. Trust boards increasingly report themselves as having to choose between public demand to keep services open and running a risk of providing unsafe services. Acute hospital boards report that these choices are particularly difficult to make where they involve accident and emergency or maternity services where distance of patient travel can be a key issue. Similar issues apply when considering community-based beds.

Respondents to our survey consistently expressed concerns over shortage of specialist clinical staff in all types of trust. One chair said: "*There are simply not enough high quality clinical staff in the country to cover some specialties.*" Trusts are facing recruitment challenges in the face of limited numbers of trained professionals reaching the job market, especially in rural settings.

WORKFORCE

3

Health Education England is working to deliver a plan to increase staff numbers and the secretary of state for health has recently announced that from 2018 there will be a 25% increase in the number of medical students.[30] The creation of student loan funding for nurses and allied health professionals may create opportunities to increase staffing numbers to meet demand, though this is hotly debated in various parts of the service. While all these initiatives are welcomed, they have not yet demonstrated that they will consistently increase the number of trainees and clearly do not provide a quick solution. For example, it takes 12 years to turn a student into a senior doctor. There is still concern that even these increases in the number of trainees will be insufficient to maintain services, especially in the short term, given the rise in patient demand and the time taken for new staff to reach the front line.

54,000

NHS staff recruited from the European Economic Area

The approach to plugging the short-term gap between demand and supply of staff has been overseas recruitment, including 54,000 NHS staff recruited from the European Economic Area. However, Brexit has created uncertainty about overseas recruitment in future and the security of those who are already part of the NHS. There is concern that it will create further difficulties in securing required staff numbers to meet short-term requirements. In our survey, one chair noted that "*problems in particular groups, e.g. radiologists, and Brexit, has caused 'drying up' of recruitment from the rest of Europe*."

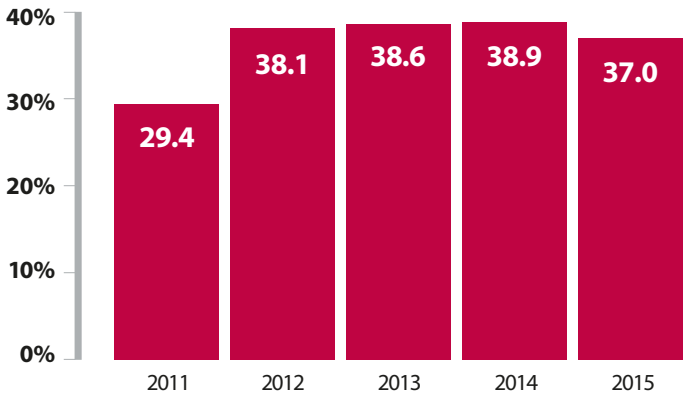
Growing pressure on staff

Increasing demand on services combined with staff shortages in key areas are adding to the pressures on NHS staff. The overall measure of staff engagement within the NHS staff survey[31] has risen over the last five years – which suggests a degree of caution is needed before being too negative. However, the survey also presents a picture of a workforce under greater stress in 2015 compared to 2011 (see figure 3.3). It also revealed that 48% of staff disagree or strongly disagree that there are enough staff at their organisation for them to do their job properly.

WORKFORCE

Figure 3.3

Percentage of NHS staff suffering work-related stress during the last 12 months:



Ensuring the right culture is in place within organisations is crucial if staff are to maximise their potential. A safe, effective and efficient environment for staff relies on an open and transparent culture. At a time of greater pressure and increasing demands on staff, this is especially important as the NHS relies on a significant amount of discretionary effort. Critically, the behaviour of organisations towards their staff is reflected in the quality of care that patients and service users receive. More specifically, there are clear correlations between staff support and engagement and patient safety.[32]

The data on staff bullying is a real concern. There was a 9% jump between 2011 and 2015 of the number of staff experiencing harassment, bullying or abuse from other staff (in 2011, 14% of staff experienced this compared to 25% of staff in 2015). Another area of concern is the 11% drop in the numbers of staff reporting the latest incident of bullying (in 2011, 53% of staff said they reported it, while in 2015 this had dropped to 41%).

The picture on race equality also remains worrying. There are well-established links between organisational culture, the success of black and minority ethnic (BME) groups and levels of staff engagement. There are still higher levels of BME staff reporting that they experience abuse, bullying and harassment from patients, relatives and carers. There are also reports of greater discrimination towards BME staff, as well as blocked career progression and reduced access to training opportunities. This inequity is also reflected in the ethnic profile of those leaders running NHS organisations. Too many trust boards are disproportionately white and male.

WORKFORCE

The workforce race equality standard (WRES) has been established to systematically tackle this issue. This has identified a baseline picture of the state of race equality in the NHS, alongside a process to ensure progress is made. Early results show that the NHS is not getting the best out of all its staff, and this needs to be rigorously pursued.

Two other significant factors contributing to the feeling of growing pressure on NHS staff are the ongoing impact of squeezed pay and contract reform for junior doctors.

25%

staff experiencing bullying or abuse in 2015, a jump of 9% since 2011

The government's policy of pay restraint, which has seen pay capped at 1% since 2010, will come under increasing scrutiny if, as expected, inflation rises. The governor of the Bank of England recently warned that inflation will rise on food and other products because of the fall in the value of the pound. This will result in NHS staff earnings falling in line with rises in the cost of living, which risks further eroding staff morale.[33]

Finally, the dispute over the new junior doctor contract has been difficult, with underlying dissatisfaction and low morale playing its part in the dispute. Effective implementation of the new contract and re-engagement of junior doctors are key challenges for trusts over the next year, along with reform of the consultant contract and Agenda for Change, which covers more than one million staff such as nurses.

Leadership and management capacity

The size of the leadership and management challenge now facing the NHS is striking. Trusts are expected to meet a wide and ever growing range of objectives and priorities, including delivering transformation and performance improvements, all within the context of constrained funding. If trusts and other parts of the health system are to rise to this challenge then staff need to work in different ways and there needs to be significant investment in change management capability.

However, leadership and front line capacity is now limited after decisions to focus pay bill resource on frontline care. This has meant that, in many trusts, previous cost improvement programmes have led to a reduction in leadership and management capacity, particularly in middle management.

Finally, the size and scale of the leadership and management challenge is putting off many senior staff from stepping up into leadership roles, particularly clinicians. As *The chief executive's tale*, our report with The King's Fund showed, the average tenure of a chief executive working in the NHS is now around three years, and the

majority of chief executives interviewed for the report said they were concerned about the attractiveness of the role to their colleagues.[34] The abolition of the strategic health authority tier in the NHS has also removed well developed leadership and talent management programmes and approaches.

THE PROVIDER RESPONSE

In the current financial climate there has been pressure on trusts to deliver savings. Trust boards describe themselves as walking a fine line between delivering these savings, maintaining safety and quality, and ensuring staff morale. Despite the challenges, trusts have made good progress as the achievements below demonstrate:

Trusts have worked hard to plug the workforce gap in the short term by **filling clinical staffing vacancies through effective external recruitment** from within the European Economic Area, for example Spain and Portugal, and the rest of the world, for example the Philippines.

Workforce is a key enabler within the STPs already published, with trusts collaborating in the **creation of staff banks that cover local STP areas**. However, these plans are clearly at an early stage. The recently established local workforce action boards covering all STP areas will also have an important role to play, but as yet are still to get fully up and running.

Some trusts have taken **innovative approaches to workforce supply**, including partnering with higher education institutions to deliver student funded nursing courses. For example, Lancashire Teaching Hospitals NHS Foundation Trust[35] and the University of Bolton[36] have partnered on a nursing course funded by students through the student loan system. Bolton NHS Foundation Trust and Central Manchester NHS Foundation Trust later joined the partnership. County Durham and Darlington NHS Foundation Trust is working with Teesside University to create nursing courses to develop nurse practitioners and elderly care as a specialty.

Trusts are making greater use of new roles, such as advanced practitioners to deliver services such as emergency care, or nursing associates to improve productivity. Over 1,000 nursing associates will begin training this year in a new role that will sit alongside existing nursing care support workers and fully-qualified registered nurses to deliver hands-on care for patients. Health Education England has announced that there will be a second wave of a further 1,000 nursing associate trainees following huge interest in the role and high demand from trusts wanting to offer training places. Eleven sites have been chosen to deliver the first wave of training that will start in December

WORKFORCE

2016 and run over a two year period. The test sites include: St George's University Hospitals, The Whittington Hospital, Barts Health and Walsall Healthcare. In addition, Birmingham and Solihull Mental Health NHS Foundation Trust is using physician associates to enhance care delivered in mental health.[37]

Trusts are using new technology to access skilled staff more effectively, for example making specialty expertise available in primary care through Skype. For example, East London NHS Foundation Trust[38] diabetes clinics are increasingly delivered over Skype to improve productivity by allowing patients to access preventative care and clinical expertise closer to their homes. Trusts are also using e-rostering software much more widely to significantly improve the efficiency and effectiveness of the highly complex task of alllocating staff to appropriate rotas. More effective rostering also enables trusts to better meet staff requests for more flexible working.

Trusts are investing in leadership – given the complexity and extent of the strategic challenges providers face, investment in developing leadership skills and capacity is vital. NHS Providers is working with the central bodies, including NHS Improvement and the NHS Leadership Academy to support the pipeline of future trust leaders through an aspiring chief executives programme. The programme has, in less than a year, seen 6 of its 28 participants appointed to permanent provider chief executive roles. All NHS bodies, under the auspices of NHS Improvement and Health Education England, have come together to develop a national framework for improvement and leadership development, which will support among other things, better system leadership skills.

Trusts have controlled pay bills, which is on average 66% of their total spend, as part of an increased national focus on workforce productivity. This focus has been seen most visibly with the introduction of agency rules and price caps. According to NHS Improvement,[24] one year on from the introduction of the agency caps "almost three quarters of trusts (73%) have now successfully reduced their agency spend, and over half of these have reduced spend by more than a quarter." For example, Dorset Healthcare University NHS Foundation Trust has reduced its agency spend by half following an event with staff to discuss how to promote the trust bank and reduce agency spend.[39]

NHS Improvement reports that £600 million has been saved so far compared to if the rules and caps had not been introduced. Trusts continue to make use of the "break glass" provision to breach the caps in order to safeguard patient safety. The Carter Review contains a range of other workforce productivity initiatives that trusts are expected to implement.

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THE RISKS

The workforce gap

The NHS will struggle to address both its short and long-term workforce requirements in the absence of a credible and coherent workforce strategy. As part of this, we need a workforce planning system that is able to both match demand and supply and workforce numbers to the available financial envelope. The Health Foundation report in March 2016 - *Fit for Purpose?*[40] - put a spotlight on the current fragmented approach to NHS workforce policy and called for the establishment of a national strategic forum for workforce policy. This is needed to improve the quality of workforce strategy and planning at a national system level.

1,000

nursing associates will begin training in 2016/17 in this new role

Failure to address workforce supply

As well as planning for the future, there is also a pressing need for adequate plans to cover shortages in the short term. The sense of urgency is heightened by the uncertainty created by the UK's decision to leave the EU. The Cavendish Coalition, a group of health and social care organisations, have come together to work to ensure that health and social care have the staff they need to deliver high quality services. Government needs to recognise the risk to workforce supply and service provision posed by Brexit and ensure that coherent and credible plans are in place to safeguard supply.

Growing pressure on staff

Given the pressures on the front line, it is essential to keep a strong focus on the recruitment and retention of staff to maintain a sustainable service. Long running pay constraints, increasing demands on staff and a risk of leadership teams having insufficient 'bandwidth' to focus on supporting their teams risks a further deterioration in staff morale and further raising staff turnover rates. Staff need to be appropriately supported and remunerated to make the professions attractive.

Ensuring much greater race equality in the NHS is one area that needs particular progress. The workforce race equality standard has identified the starting point, but the NHS is still a long way off from supporting, and getting the most out of, all its staff.

Action in these areas can make a major difference. The strongest predictor of outstanding or special measures in CQC ratings is the engagement of staff. Where the people we work with believe they are

WORKFORCE

valued and can influence what happens then they have the space to excel. When they feel disengaged, disempowered and disenfranchised, patient care suffers. Organisations like Western Sussex Hospitals, Salford Royal, East London and The Christie have placed particular emphasis on supporting their staff in the increasingly challenging environment this report describes. It is no accident that they have all received outstanding ratings from the CQC.

Lack of leadership and management capacity

59%

trust leaders believe they won't have the right staff numbers, quality and mix in six months

The level of complex change that the NHS workforce needs to implement to achieve service transformation requires significant additional capacity and capability that it will be challenging to create given current resource constraints. For example, rapid and effective delivery of the Carter Review savings will require NHS trusts to address current gaps in the analytical, project management and change management skills needed. The depth of senior leadership in the provider sector is also now thinly spread running increasingly unstable individual institutions, leading transformation and co-creating and delivering system-wide sustainability and transformation plans. There is a significant mismatch between the leadership and management resource available and what the NHS is asking its leaders and managers to deliver. It obviously follows that, unless we can quickly address this gap, the NHS will not deliver all that it is being asked to deliver.

Progress is also needed on ensuring there is a pipeline of emerging leaders in the NHS that are ready to take on director and chief executive roles. At the moment, there is a shortage of applicants for executive board level roles, with fears that the position is becoming increasingly tough, demanding and impossible to succeed in. This is particularly the case when it comes to attracting clinicians into senior leadership roles. There is also an emerging risk that the current pressures in the NHS will also start to impact on the number of appropriately skilled and experienced external leaders willing to become non-executive directors, who play a key role on trust boards.

WORKFORCE

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WHAT PROVIDERS NEED

The Department of Health and its arm's length bodies need to develop a comprehensive workforce strategy that takes account of what the NHS is being asked to deliver in both the medium and long term. This needs to be accompanied by an improved approach to workforce planning. Staff need to be appropriately supported and remunerated to make the professions attractive, and we need to be better at adapting and developing the NHS workforce to deliver new models of care. We also need to properly and realistically plan to deliver the government's key priority of introducing seven-day services.

The leadership challenge in the NHS is complex. Given the scale of the task we need to make sure we: have the right development and improvement framework in place, and make the role of running NHS organisations as attractive as possible to secure future leaders. We also need to create the right cultures to foster an inclusive, open and transparent environment for all staff to realise their potential.

Finally, we need to ensure that the financial envelope and regulatory regimes are aligned to support the recruitment and retention of the right numbers and mix of staff.

3yrs

the average tenure of an NHS trust chief executive

TRANSFORMATION

4

SUMMARY

The existing NHS model of care is increasingly inappropriate for 21st century health needs. Service transformation to integrate health and care is a potential answer to addressing the complex challenge of rising demand, changing needs, greater efficiency and preventing ill health.

The *Five year forward view* set out a vision of the NHS moving from fragmented individual institutions to more collaborative, place-based, local health and care systems. Forty-four areas are developing STPs. Trusts have been working hard with key local partners on these plans and are now about to enter important discussions with local communities over the future shape of their services.

Our survey shows that there is growing concern that high expectations around transformation will be undeliverable unless some key barriers and challenges are addressed. While there is strong support for the principles behind the STP process, trust leaders fear the plans are progressing too fast; lack appropriate governance frameworks; and that the public and other key stakeholders such as local councils are insufficiently engaged. They also want more realism about the scale of the challenge and the expected delivery timescales.

Trusts are often at the forefront of driving transformation. For example, providers are leading the creation of a range of new care models, working with local partners to improve care through integration of services around the patient. New models include accountable care organisations; provider chains; and joint ventures between providers to share back offices and provide specialist treatments at scale. Nearly half of the 44 STP plans are co-ordinated by trust leaders. Some areas are making significant progress, often due to strong previous working relationships, with devolution in Manchester being a good example.

The NHS is being asked to deliver a breadth and scale of transformation that many other international health systems have taken at least a decade to achieve. The task is difficult. Providers must manage an increasingly unstable service, deliver transformation and develop complex new local system relationships at a point when leadership and management capacity is already under pressure. Alignment and clarity over local and national objectives are needed, as well as explicit political and regulatory support for innovation and different models. There also needs to be open and realistic acceptance by the national bodies that the required transformation will be stretching, complex and will take time.

TRANSFORMATION 4

THE PROVIDER CHALLENGE

The need for a new model of providing health and care

As the table below sets out, it is increasingly clear that the existing NHS model of service delivery is no longer fit for purpose. The notion that individual institutions will provide highly specialised, inpatient care, focusing on treatment rather than prevention is outmoded.

THE EXISTING NHS MODEL– FIT FOR PURPOSE?

Too fragmented?	**Between health and social care, primary and secondary care, and physical and mental health**
Too medicalised?	**Treating illness as opposed to ensuring health and well being**
Too hospitalised?	**Model based on assuming all illness capable of remedy by hospital intervention, leading to excessive focus on acute hospitals**
Too specialised?	**Hospital care dominated by increasingly specialised specialists**
Too much history?	**Importance of / attachment to existing buildings and institutions, service structures and patterns**
Too little funding?	**Ageing population and rising expectations**
Too much demand?	**Ten years of national austerity**
Too little innovation?	**Insufficient harnessing of technological, scientific and clinical innovation**
Too much variation?	**In clinical outcomes, efficiency and staff usage, and persistent health inequalities**

TRANSFORMATION

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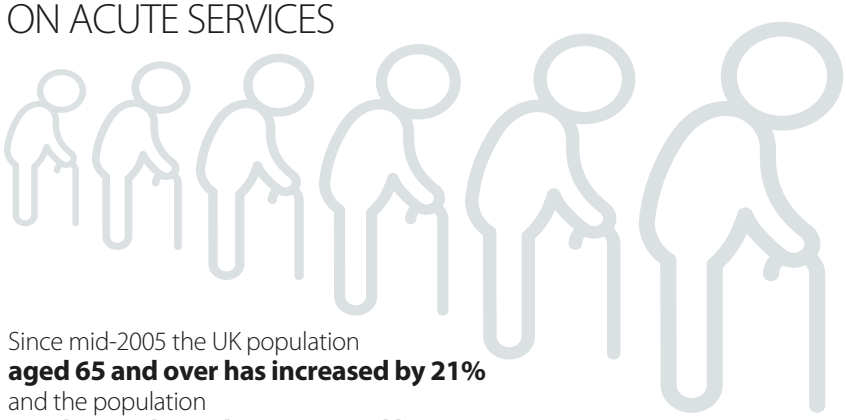
It is difficult to see how the existing NHS model will be able to cope with the significantly increased levels of demand our heath and care system are now facing, as the number of people over 65 rapidly rises over the next few decades. As we show below, the longer people live, the more likely they are to consume health and care services.

THE EFFECT OF AN AGING POPULATION ON ACUTE SERVICES



Since mid-2005 the UK population
aged 65 and over has increased by 21%
and the population
aged 85 and over has increased by 31%

62% of hospital bed days were occupied by older patients (those aged 65 or over) in 2014-15

2.7 million hospital bed days were occupied by older patients no longer in need of acute treatment in 2014-15

It is estimated that **85% of patients with a delay in discharge** from hospital are aged 65 and over

An estimated gross annual cost to the NHS of treating older patients in hospital who no longer need to receive acute clinical care is **in the region of £820 million**

Sources

ONS mid-year population estimates Jun 2016
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest

NAO report on discharging older patients from hospital (2015)
https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf

No single service, trust or sector can tackle these issues, particularly within the existing NHS model. A new care model based on integration and collaboration is required.

Service transformation to integrate patient care is rightly seen as the potential answer to address the challenges the NHS faces.

TRANSFORMATION 4

Transformation initiatives

This need for transformation has been widely recognised and, over the past three years, a series of centrally-led approaches have been established to support local transformation, as listed below with a summary provider view on each.

TRANSFORMATION INITIATIVES OVER THE LAST THREE YEARS

2013

The Better Care Fund
to support better integration between health and social care to create seamless patient pathways

Primarily focused on funding and planning arrangements, with no new funding added so far and, in the view of providers, adding significant planning complexity.

2014

DevoManc
including devolved control of health and social care integration across Greater Manchester

Increasingly successful, local authority driven, integration starting to drive real change like acute service integration and integrated commissioning, benefitting from long standing relationships and wider non health working. Other devolution a long way behind Manchester on health and care.

2014

New care models programme
50 vanguard sites lead the development of new ways of delivering services for specific population groups or services

Good progress with developing range of new integrated care models at small scale, and a rigorous approach to knowledge development and dissemination, but still early days.

2013

Integration Pioneers
initially 14 sites, now 25, developing and testing new and different ways of joining up health and social care services across England

Early local attempts to drive local integration with varying success but little focus on developing shareable learning for others to implement.

2014

Five year forward view
a strategic vision for the future of the NHS developed by the arm's length bodies and endorsed by the government

A widely acclaimed and welcomed vision of how NHS should develop, with strong emphasis on prevention, integration and whole local system working. Long on vision, short on implementation detail and growing questions on demand and financial assumptions.

2015

Sustainability and transformation plans
local health and care economies requested to come together and develop local plans

Strong support for principle of whole local health and care system working and planning but risks to manage around process speed; realism and deliverability of task; governance structure and local community involvement.

TRANSFORMATION 4

Barriers to change

Successful implementation of change requires trusts to overcome a number of system and frontline barriers. Quality, governance and operational regulation are still institutionally focused. This misalignment creates a complex scenario in which trusts must balance institutional and STP performance, which can inhibit change. Successful STPs and other forms of system collaboration are dependent on the collective performance of all those in a local footprint. In the words of one trust leader, commenting on the STP process: "*The process is entirely reliant on goodwill which is vulnerable to the challenges of demand, acuity and regulation*."

On the frontline trusts are grappling with issues that inhibit more effective day-to-day collaboration: the need for improved and harmonised data systems, streamlined contracting processes, and new governance approaches that reflect the roles and responsibilities of all those involved. One survey respondent commented that there is a "*need for a more formal governance framework for decisions underpinned by risk/gain share*".

System overload

Providers report there are four different sources of power and authority in the NHS, each with its own set of priorities:

- NHS Improvement wants providers to achieve financial balance, meet performance targets, maximise their CQC rating, realise efficiency savings and cut agency spending.
- NHS England wants providers to implement the *Five year forward view*, co-lead their local system towards new care models, help create local system sustainability and transformation plans and implement the outcomes of the cancer and mental health taskforces and the maternity review
- CQC wants providers to deliver the right quality of care and guarantee the right levels of staffing in every setting
- Department of Health wants providers to move to seven-day services, create a paperless NHS, and focus relentlessly on patient safety issues.

Each of these individual priorities on their own are sensible and command provider support. But, taken together, they are far too large a collective set of priorities to deliver consistently and effectively.

TRANSFORMATION

4

THE PROVIDER RESPONSE

Trusts are leading much needed NHS transformation. Often, in a local health and care system, it is providers who can best offer the required management capacity and capability and experience of driving change. Set out below are examples of types of transformation and integration being pursued by providers. They are designed to improve patient experience and better meet patient needs while also improving efficiency. This can be achieved in a number of different ways, including providing more care closer to home or out of hospital; focusing on prevention and greater levels of patient self care; managing demand for hospital services; or better focusing on whole population health.

Accountable care organisations/systems – trusts like Salford and Northumbria are moving to integrate acute, community, primary and social care with large parts of the commissioning function to create single organisational structures that provide care closer to home more efficiently.

Primary and social care integration – trusts like Northern Devon and Royal Wolverhampton Hospitals are becoming involved in the direct provision of GP services and social care.

Provider chains – trusts like the Royal Free, three mental health trusts in the West Midlands led by Birmingham and Solihull and three hospital trusts in Essex led by Basildon and Thurrock are creating chains of providers with a single shared management team to achieve efficiencies, standardise processes and realise economies of scale.

Joint ventures – trusts are creating joint ventures to deliver treatment across a single pathway. South West London Elective Orthopaedic Care (SWELEOC) has combined the orthopaedic case load of four district general hospitals on a single site, improving outcomes and increasing efficiency.

Specialist franchises – trusts like Moorfields are sharing their specialist expertise in the district general hospital setting by running franchises to provide high-quality eye care.

Specialist chains – the specialist orthopaedic hospitals in England are piloting the development of a chain in which they can benchmark outcomes and share expertise.

Integrated services – trusts like Sandwell and West Birmingham, Walsall and Dudley, with short patient travel times between them are creating single single specialist services covering all three district general hospital trusts in specialties like rheumatology, urology and dermatology.

TRANSFORMATION 4

Trusts are also working hard to develop the underlying enablers to integrate health and social care effectively. These include:

- teams with the full range of skills required to assess and meet patient physical, social and mental health needs in an integrated way
- IT applications that integrate GP, community, acute hospital and social care patient data and present it in a single integrated care record
- new ways to contract and manage finances that facilitate and incentivise integrated care, such as capitation
- approaches to managing whole population health such as identifying those most at risk of illnesses that are likely to require hospital care and intervening to avoid this.

THE RISKS

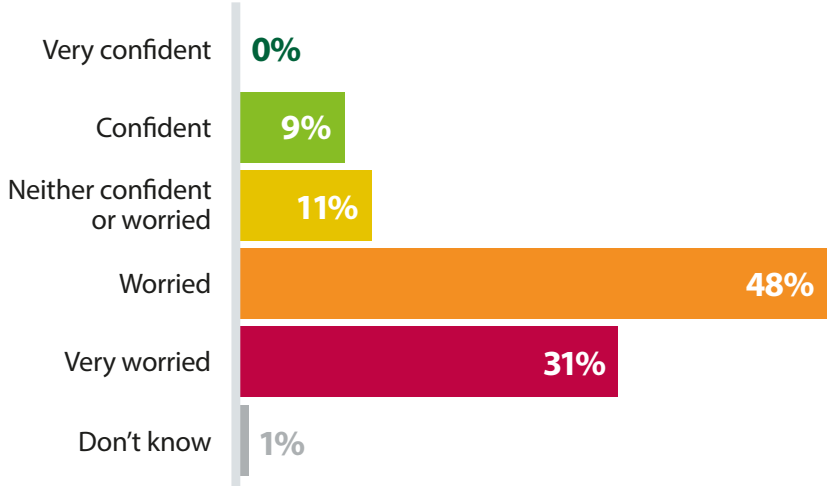
Successful transformation requires some key barriers and challenges to be addressed. The issues that pose the greatest risk are a lack of clear focus, overly ambitious timescales, local engagement and appropriate central support.

Overall there is little confidence among trust leaders that local transformation is happening quickly enough to bring about sustainable integrated patient care and financial balance. As figure 4.1 below shows, fewer than one in ten trust leaders felt confident of this and 79% were either worried or very worried these priorities would not be delivered.

Figure 4.1

How confident or worried are you that your local area is transforming quickly and effectively to provide sustainable integrated patient care and aggregate financial balance?

(n=169)



TRANSFORMATION 4

Lack of clear focus

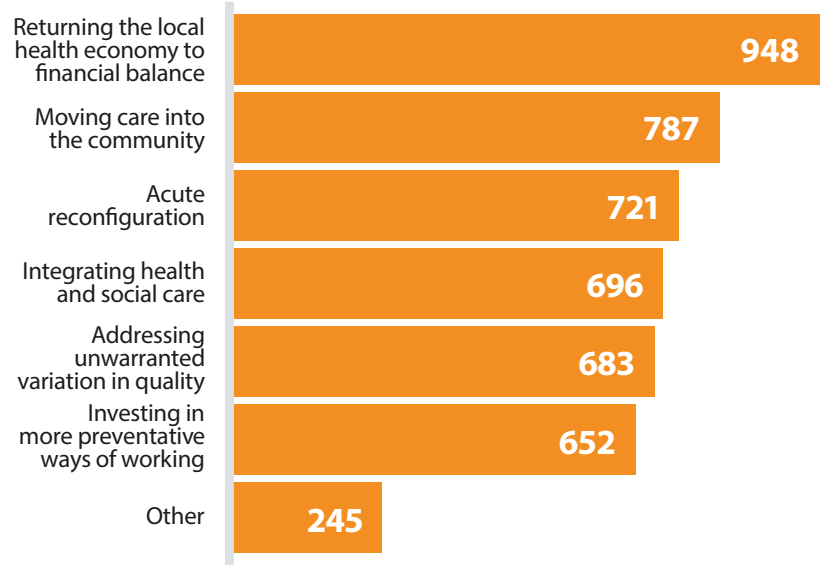
Central initiatives to support transformation are making some progress. But the number of different approaches, the latest being STPs, and a lack of consistent focus and priorities within these is proving challenging for trusts.

The changing nature of the STP process illustrates this problem. STPs were originally described as 'the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances' by bringing all health and care partners around the table to address long-term challenges. Trusts acknowledge the potential of this process. However, they are concerned it has become too focused on issues of immediate financial sustainability as opposed to long-term strategic direction and transformation.

96%
trusts that felt engaged or very engaged in the STP process

This concern is emphasised by our survey (see figure 4.2). When respondents were asked to rank the most important aspects of their STPs, 'returning the health economy to financial balance' was considered to be the most important issue, with 'investing in more preventative ways of working' ranked as lowest in importance.

Figure 4.2
Please rank the importance of the following issues in your STP(s):
(n = 169)



TRANSFORMATION

Overly ambitious timescales

There is concern that the STP process, which in many cases relies on creating new, cross local system relationships, is being rushed. And, based on current experience, consistently realising the benefits and improvements from new care models will be a 10-15 year, not a 3-5 year process. National bodies need to accept that the required transformation will take time.

Cultural differences across local health economies means that it takes time to build up the trusting and constructive relationships needed to navigate difficult and sensitive conversations. A key enabler in areas where transformation is most advanced is the longevity and strength of local relationships. One trust leader said: "*[we] have been working with CCG/LAs/providers for some years and we already had a strategic vision*". Yet, the timescales attached to both vanguards and STPs are very tight and overly ambitious, as another leader describes: "*good progress is being made in collaboration across sectors, but the challenge is significant and the timescale short*".

79%

trusts concerned that integrated care and financial balance would not be delivered

TRANSFORMATION

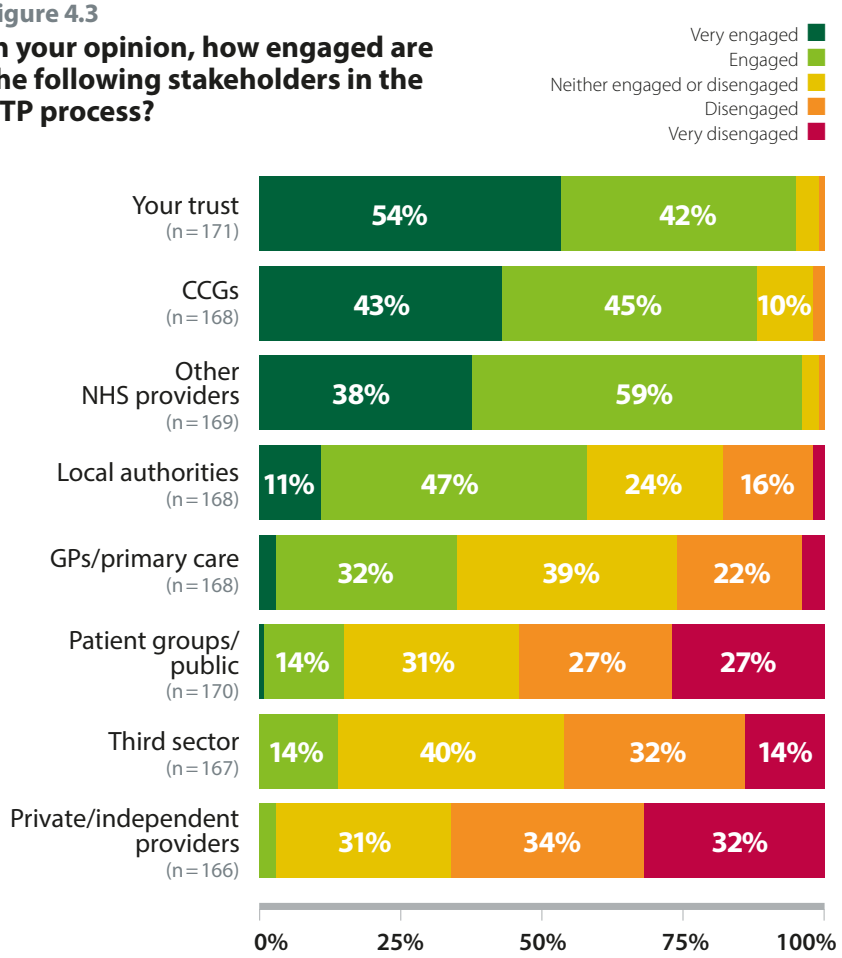
4

Lack of engagement at a local level

For transformation to succeed, all stakeholders in each locality must play their part. However as figure 4.3 shows, respondents to our survey believe that, in a significant number of areas, there is a lack of engagement in the STP process from primary care and local authorities, as well as local communities. This is worrying considering that local stakeholders and partners will need to be fully engaged if successful outcomes are to be achieved.

Figure 4.3

In your opinion, how engaged are the following stakeholders in the STP process?



The role of central support

Effective local collaboration, essential for success, depends on allowing local areas to identify and agree their objectives and action plans. However, as figure 4.4 shows, the majority of chairs and chief executives responding to our survey felt that the STP process has been completely or mostly top down (62%). And, as figure 4.5 shows, only 7% were also confident that plans and activities from the national NHS leadership are effectively supporting the delivery of a sustainable service in their area.

Figure 4.4

To what extent has your experience been of a national top-down process or a local bottom-up process?

(n=171)

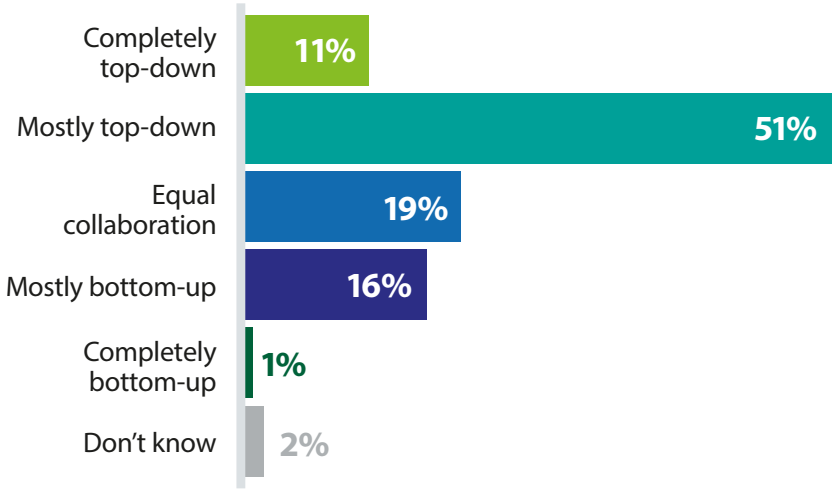
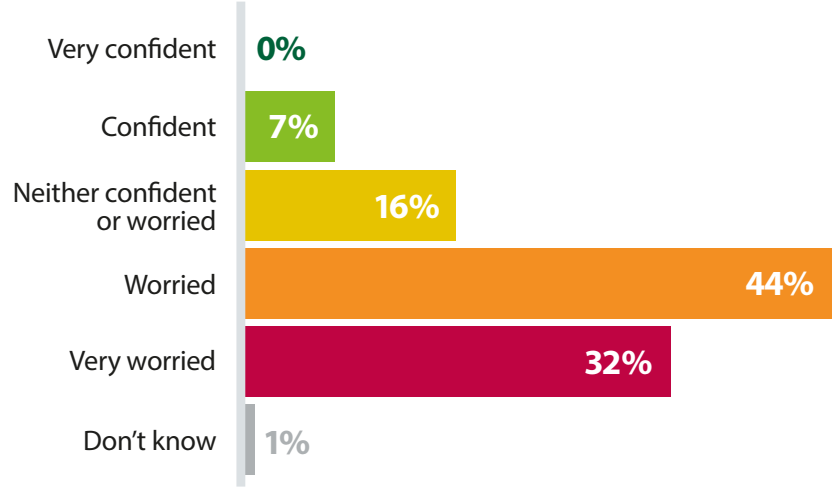


Figure 4.5

How confident or worried are you that plans and activities from the national NHS leadership (the DH and its ALBs) are effectively supporting the delivery of a sustainable service in your area?

(n=171)



TRANSFORMATION

4

As The King's Fund recently described,[41] some progress has been made by the national bodies to adapt national policy to support the delivery of the *Five year forward view* and the wider transformation agenda. However, more is needed. Although STPs are progressing at speed, accountability and governance frameworks are lagging behind. In our survey, almost three quarters (73%) of respondents were worried or very worried about this issue and had concerns that STPs have no legal status or authority.

System leaders also must be realistic about the benefits of implementing new care models. The evidence of integration delivering greater efficiencies is weak, relative to the more proven benefits for improving patient experience and some outcomes.[42]

WHAT PROVIDERS NEED

Transformation at the scale required to meet the financial, quality, demand and workforce challenges the NHS is facing will take time, investment and support. It also needs system leaders to support the development of new governance and accountability structures and to ensure that the current, institutionally focused, regulatory structure develops into one focused on local systems.

System leaders need to be realistic about how much can be achieved given the pressure on trust leaders, the current absence of money to invest in transformation and the time it will take to change for the long term.

APPENDIX

The state of the provider sector – survey of chairs and chief executives

NHS Providers, conducted a survey of chair and chief executives from member organisations during September 2016 to strengthen our evidence base on how NHS trusts and their local area is faring.

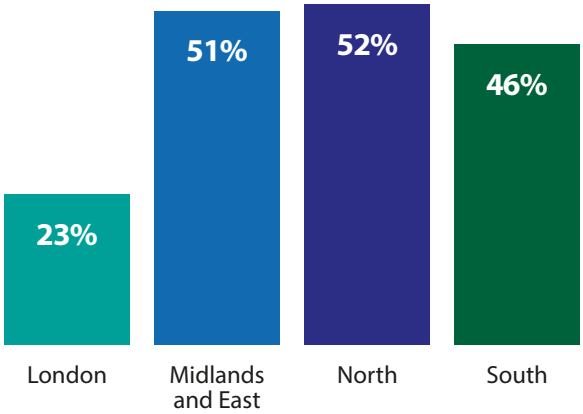
This survey, which will be updated regularly, is divided in two sections:

- A stable set of questions collecting leader's views on how they see their performance changing over the next six months, and
- A changing section asking detailed questions on a hot topic of importance to providers. In this survey we have focused on the STP process.

The survey, which was closed on 5 October 2016, received 172 responses (40% of all audience) from 136 trusts (60% of all members). There was good representation from providers across England and from all types of trusts. Just over a third of respondents were from non-acute trusts (65 responses). There was equal representation of chairs (85 respondents) and CEOs (87 respondents).

Number of survey respondents (chairs and CEOs) by region

(n=172)



The full survey results are available as a briefing document on our website www.nhsproviders.org/stateofthenhs1-briefing

Acknowledgements

Many thanks to our chairs and chief executives for completing the survey and providing us with case study material.

This document draws on the skill and expertise of NHS Providers' analytical, policy, communications and design teams.

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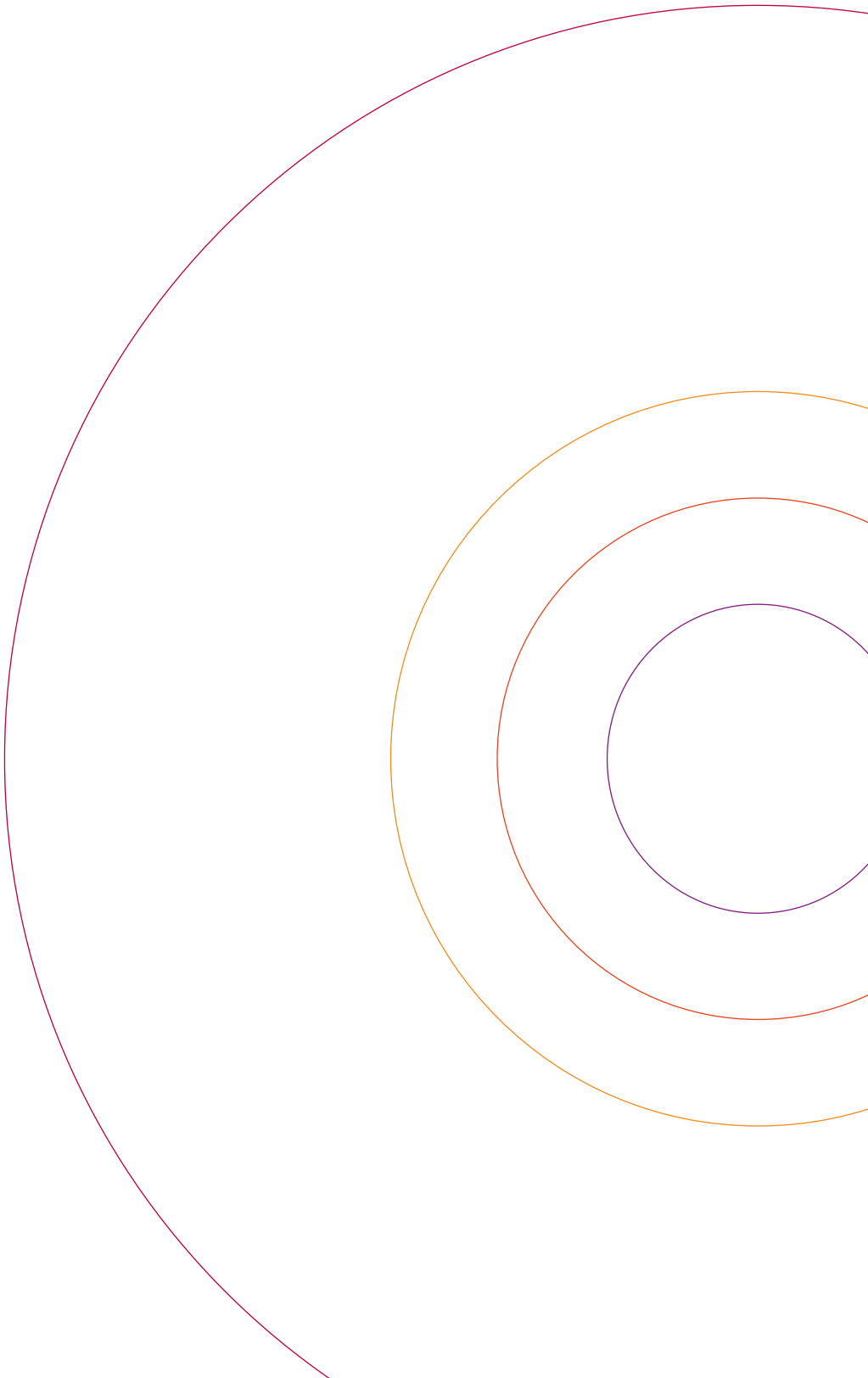

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NHS Providers has 95% of all NHS foundation trusts and aspirant trusts in membership, collectively accounting for £70 billion of annual expenditure and employing more than 964,000 staff.

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