WHITEHALL LECTURES

The Fourth Whitehall Lecture

‘What needs to be done to secure the future of the NHS? And can it be done?’

Professor Chris Ham CBE
Chief Executive, The King’s Fund

given on
9th December 2015

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Contents

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The Cambridge University Land Society (CULS) through its Cambridge Whitehall Group forum, launched in 2013, this important series of lectures in recognition of the part its members play in contributing to public policy issues. Society members are mainly alumni of the Department of Land Economy, but also from many other academic disciplines in the University of Cambridge. Many play important, often distinguished, roles in many aspects of public policy that are covered by the work of the Department.

The Cambridge Whitehall Group is a member of CULS and is a high level influential policy discussion group of well-connected Cambridge alumni, who are mainly members of CULS. In addition to its member events it also runs this distinguished series of policy lectures. The lectures will discuss major aspects of public policy that in one way or another touch on the disciplines of policy, economics and the application of land use.

Previous lectures in this highly regarded series have been:

1. Professor Sir Malcolm Grant, CBE, Chairman NHS England – 'The Extraordinary Challenges of Future Healthcare and the Estates Implications for the NHS' – Inaugural lecture given at the Royal Institution (March 2014)
2. Lord Deighton, KBE, Commercial Secretary, HM Treasury – 'Infrastructure in the 21st Century: from the Olympics to High Speed Rail and beyond' (January 2015)
3. Dame Kate Barker, CBE, Senior Visiting Fellow, Department of Land Economy, University of Cambridge – 'How will we house our children? – The Future of UK Housing Policy' (April 2015)
4. Professor Chris Ham CBE, Chief Executive, The King's Fund – 'What needs to be done to secure the future of the NHS' (December 2015)

These lectures are published as an occasional series and copies are available by emailing fionajones@thecwg.co.uk or visit our website www.cambridgewhitehallgroup.com

Welcome from the Vice Chancellor of the University of Cambridge

The Cambridge University Land Society is an exemplary society at Cambridge – for its longevity and for its level of engagement with a wide range of sectors and contemporary issues. Over the last 50 years, the Society has built a membership base of nearly 1,000 alumni, spanning those who graduated from Cambridge in the 1950s who now hold senior positions in their fields, to current students and recent graduates of the Department of Land Economy.

The number of disciplines and interests represented in the Society's membership – as well as the broad range of issues discussed at business and social events held by the Society each year – highlight what Cambridge does so well. We recognise that the challenges we face today are increasingly complex, multi-faceted and global in nature, and that they cannot be overcome with the expertise of just one area. This is why it is so valuable that the Land Society continues to bring together fresh and diverse perspectives from those studying and working in economics, land, planning, governance, finance, environmental resources and beyond on critical public and private issues. The Whitehall Lecture series represents a great opportunity to take this debate forward – and to build the Land Society's critical mass of expertise – and I wish it every success.

Professor Sir Leszek Borysiewicz, Vice-Chancellor, University of Cambridge.

Whitehall Lecture Series, Douglas Blausten, Chairman, Cambridge Whitehall Group

Douglas Blausten is a Consultant to Cyril Leonard Chartered Surveyors and Property Consultants. He looks after their major Corporate Clients, runs his own Corporate Real Estate Strategic Consultancy Company and is a Director of Cyril Leonard GmbH in Munich. He was Vice Chairman of NHS Property Services and Chairman of its Asset and Investment Committee until October 2015.

Douglas is a Trustee of the Mental Health Foundation, a Centre Fellow of the Cambridge Centre for Climate Change Mitigation Research and a member of the Cambridge Land Economy Advisory Board. He has held a number of executive and non-executive directorships in public and private companies. Douglas is a Past President of the Cambridge University Land Society.

The Whitehall Lecturer
Professor Chris Ham CBE

Chief Executive, The King's Fund

Professor Chris Ham CBE took up his post as Chief Executive of The King's Fund in April 2010. He was Professor of Health Policy and Management at the University of Birmingham between 1992 and 2014 and Director of the Health Services Management Centre at the university between 1993 and 2000.

From 2000 to 2004 he was seconded to the Department of Health, where he was Director of the Strategy Unit, working with ministers on NHS reform. Chris has advised the World Health Organization (WHO) and the World Bank and has served as a consultant on health care reform to governments in a number of countries. He is an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, and a companion of the Institute of Healthcare Management. He is a founder fellow of the Academy of Medical Sciences.

Chris was a governor and then a non-executive director of the Heart of England NHS Foundation Trust between 2007 and 2010. He has also served as a governor of the Canadian Health Services Research Foundation and the Health Foundation, and as a member of the advisory board of the Institute of Health Services and Policy Research of the Canadian Institutes of Health Research.

Chris is the author of 20 books and numerous articles in academic and professional journals about health policy and management. He is currently Emeritus Professor at the University of Birmingham and an honorary professor at the London School of Hygiene & Tropical Medicine. He was awarded a CBE in 2004 and an honorary doctorate by the University of Kent in 2012. He was appointed Deputy Lieutenant of the West Midlands in 2013.

Introduction to

'What needs to be done to secure the future of the NHS? And can it be done?'

Of all modern day political matters, the NHS ranks either first or second as the issue that most concerns voters at a General Election. The concept of universal healthcare which is free at the point of delivery is a cornerstone of our national identity and it is a brave voice who dares to challenge this philosophy.

Yet demand rises exponentially with no let-up in the cost of the NHS. Our demographic projections will ensure that this remains the case.

Prior to the General Election the NHS Confederation publicly stated "If we do not achieve a post-election drive for change it is very possible the current basis of the NHS 'free for all at the point of need' will become unsustainable in the future".

So urgent is the matter, so great is the magnitude of the figures and so central to everyone's lives that there must come a time when, cost cutting, being more efficient and spending extra taxpayers funds are not the only viable solutions on their own.

The Cambridge Whitehall Group has devoted considerable energy in providing a platform for discussion of policies, primarily but not exclusively, centred round the NHS Estate for improving the funding of the NHS from underutilised existing resources and assets.

As part of this effort, this Lecture series has previously argued that the 340 million square feet portfolio of the NHS is underutilised and has the ability to release considerable sums to support the funding and modernisation of healthcare facilities in England. Not by selling off assets but by joint venturing with the private sector and insourcing, as part of the package of co-investment, skilled resources – as opposed to outsourcing – to help manage, develop and improve clinical care facilities.

Professor Sir Malcolm Grant, Chairman of NHS England, who inaugurated this Lecture series in 2014, has suggested politicians should stop intervening in the NHS at a time when clinicians were supposed to have been put in charge under recent reforms.

The NHS has combated attempts of the Secretary of State over attempts to interfere through the detailed blueprint, the NHS Mandate and the Sir Malcolm has had to block ministers' attempts to punish clinicians who failed to meet certain care standards by reducing their budgets. So it is a brave individual who is willing to give a public policy Lecture on the future of the NHS.

At the forefront of policy thinking on our healthcare system is the think tank, The Kings Fund, and at its head for the last six years has been Professor Chris Ham CBE. The Fund, together with the Health Foundation recognise the need for transformational change. There is doubt that the Government's commitment of £8 billion will help achieve the designated savings of £22bn by 2020/2021.

In his lecture, Professor Ham argues that the recent Spending Review last November made clear that the NHS is only half way through a decade-long funding squeeze which will continue to stretch budgets to the limit and leave services under huge pressure.

He sets out his vision for the way forward, the challenges as he sees them and who are best placed to meet these challenges and the need to deliver better value.

Douglas Blausten, Chairman, Cambridge Whitehall Group

The Whitehall Lecture given by Professor Chris Ham CBE

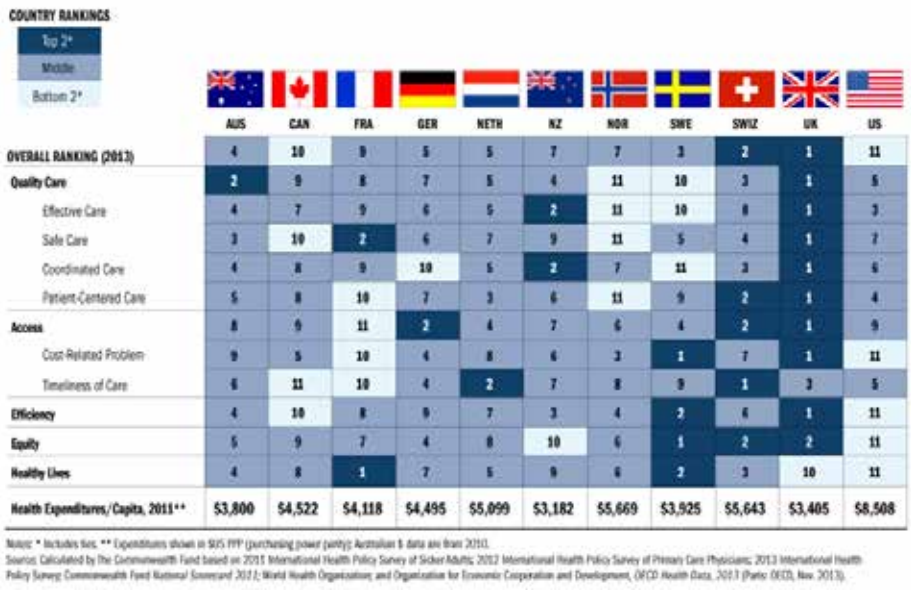
'What needs to be done to secure the future of the NHS? And can it be done?'

I want to argue today that the NHS in England faces three big challenges. They are to sustain existing services and standards of care, to develop new and better models of care, and to tackle both of these challenges by reforming the NHS 'from within'. I also want to argue that there are major difficulties in rising to these challenges with experienced leaders arguing that what is being asked of them is undo-able. There is a risk in this context that the government will seek to muddle through rather than address the fundamental causes of the difficulties facing the NHS. If this happens, the NHS is faced with the prospect of steady but inevitable decline.

THE NHS TODAY

Before I take each of these challenges in turn, let me provide some context. An analysis by the Commonwealth Fund showed the UK health care system performing best in a group of eleven countries (Davis et al 2014) (see figure 1). This might seem a reason to celebrate if it were not for a more recent assessment by the OECD which concluded that health care in the UK has fallen behind many other developed nations, and according to one report, is 'poor to mediocre' (OECD 2015).

While the truth is probably somewhere between these two verdicts, there is no doubt that the NHS is under growing pressure. Our work at The King's Fund has shown the difficulties in maintaining performance on key standards of patient care like waiting times at a time of continuing constraints on budgets and rising deficits, particularly among acute hospitals. Hardly surprising therefore that a recent Ipsos MORI poll found that for the first time more than half of the public expect health care services to get worse in future (Ipsos MORI 2015) (see figure 2).



	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	6
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Sources: Calculated by The Commonwealth Fund based on 2013 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2013; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).

Source: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

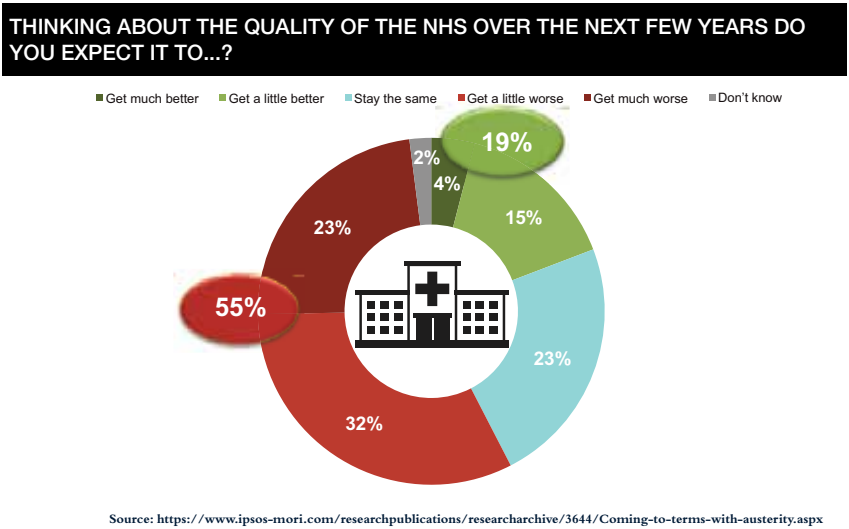
Fig 1. Commonwealth Fund overall country rankings 2013.

November's spending review offers continuing protection for the NHS with funding set to increase slowly in real terms during this parliament. While this is welcome news, we should note that spending on social care and public health will be cut and NHS spending as a share of GDP is set to fall even with the funding increases now agreed. In the face of a growing and ageing population with complex needs, there will be great difficulties in sustaining existing services let alone making improvements in care such as seven day working and transforming care. It is no exaggeration to say that the NHS is entering the most challenging period in its history. What then are the prospects?

Challenge 1: sustaining existing services

For most of the last parliament the NHS was able to maintain good performance on key standards of patient care. It did so when average annual real terms increases in spending had fallen from 6-7% under the Labour Government to around 1%

And when asked about the future of the NHS . . . most are concerned



Source: https://www.ipsos-mori.com/researchpublications/researcharchive/3644/Coming-to-terms-with-austerity.aspx

Fig 2. Ipsos MORI poll about the future of the NHS

under the Coalition Government. Our assessment of the Coalition Government's record showed that performance began to decline towards the end of the parliament with some waiting time targets being missed and deficits among acute hospital providers growing rapidly (Appleby et al 2015).

A major factor behind growing deficits, apart from low rates of growth in NHS spending, was the priority attached to safe staffing by Jeremy Hunt when he became health secretary in September 2012. In the wake of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, Hunt wisely ignored the technocratic and unpopular reforms promulgated by Andrew Lansley, and focused instead on the safety and quality of patient care. This included encouraging NHS providers to ensure they had sufficient doctors and nurses on the wards to deliver care of an acceptable standard. Many providers followed Hunt's lead and hired more staff to fill gaps in their establishments and to meet the requirements of the

Care Quality Commission. It was here that the seeds of future financial difficulties were sown with most providers having to bring in staff through agencies at a higher cost than if they employed them directly. Ministers in effect turned a blind eye to overspending in the run up to the general election. Hunt's actions were remarkably successful in neutralising the NHS as an election issue. Less than a year later, the high costs of doing so are transparent. Most hospitals are unable to balance their books and some are forecasting deficits running into tens of millions of pounds. With NHS hospitals unable to go bankrupt, money has to be found to pay staff and ensure patients are treated.

Under pressure from the Treasury, health ministers are now emphasising the need to restore financial control. This inevitably involves reviewing staffing levels when such a high proportion of NHS spending goes on the workforce. As we have noted, NHS leaders are doing so in the context of a financial settlement which leaves the NHS in the grip of the biggest sustained funding squeeze it has ever faced. National NHS bodies acting on behalf of ministers have intervened to take control of decision making. Their actions include giving every provider a spending limit and restricting the freedoms of foundation trusts to use their cash reserves. With a recent letter from health regulators stating that they are meeting "challenged" hospitals to agree staffing reductions, the implications are clear.

These actions signal growing anxiety about the ability of the Department of Health to manage within its spending limits. They also bring to an abrupt end the post-Francis Inquiry era when leaders of NHS organisations saw failure to ensure safe staffing as more serious than failure to balance budgets. For now at least, financial control is king.

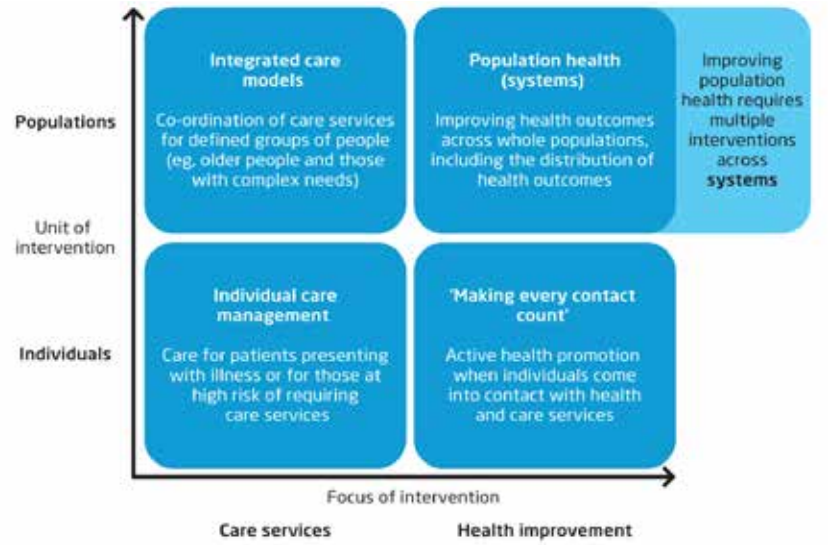
A major risk is that the failures that occurred at Mid Staffordshire will be repeated in other parts of the NHS. These failures resulted from decisions by hospital leaders to improve financial performance by cutting staff in order to achieve foundation trust status. Patient care took a back seat with predictable but tragic consequences. If the lessons of history are forgotten, this could easily happen again. There are, of course, many opportunities for the NHS to use its budget more efficiently, and these should be pursued vigorously. Smarter procurement, better use of the estate, and more effective rostering of staff can all contribute, but they will not produce savings quickly. The NHS needs time and support to realise these opportunities and I will return to discuss what this means later. Something will have to give.

For now, it is not at all clear that national NHS bodies will be able to restore financial balance. Deficits are spiralling out of control and the raft of measures already taken, such as limits on agency staffing costs, are unlikely to fill the financial gap that exists. The attempts by national NHS bodies to micromanage decision making are illustrated by guidance to NHS trusts on how to improve their financial position which includes suggestions such as reviewing the carry forward of annual leave. Experienced leaders in the NHS I have spoken to recently argue that what is being asked of them is undo-able. To be expected to balance budgets, hit key targets for patient care, and implement new commitments like seven day working seems beyond their reach. These are leaders who have many years of experience and track records of delivery that speak for themselves. Their testimony is even more worrying than the slew of performance indicators going in the wrong direction.

Challenge 2: developing new care models

The NHS is grappling with financial and performance pressures at the same time as implementing the NHS five year forward view. This is the document prepared by NHS England and other national bodies on how health and care should be transformed to better meet changing population health needs. It is a high level statement focused on the need to take prevention seriously, support people to live well and manage their own medical conditions, sustain and improve primary care, and above all achieve much greater integration of care.

The direction set by the five year forward view has been widely welcomed and supported and it has unleashed energy in areas of England involved in the 50 vanguards chosen to test and implement new care models. The King's Fund is working with some of these areas and is offering support as clinicians and managers seek to build bridges between hospitals and primary care and between health and social care. Notable innovations include primary care providers working at scale in Birmingham and Kent and whole system integration being taken forward in places like the Isle of Wight and Northumbria. These innovations echo our own work in which we have reviewed examples of specialists working across hospitals and community settings and GPs establishing federations and networks to put in place new models of care (Robertson et al 2014; Addicott and Ham 2014). There is increasing interest too in the development of population health systems which begin to join up the dots between health and care services and public health (Alderwick et al 2015a) (see figure 3). Some of the vanguards



Source: http://www.kingsfund.org.uk/publications/population-health-systems

Fig 3. The focus of population health systems

are also beginning to engage with communities and are exploring ways on enabling people to be more in control of their own health and care (Foot et al 2014).

At The King's Fund we have argued that one of the highest priorities is to develop new care models for older people. My colleagues have described what these models look like in a report that brings together best practice in health and social care from across the NHS (Oliver et al 2014) (see figure 4). I often argue that if we can implement integrated care for older people on a consistent basis across England then almost everything else will be easy because so much care is needed and delivered to this segment of the population.

The difficulty is how to make a reality of integrated care in the face of long standing professional, organisational and financial silos. Despite these silos, progress is being made in some areas and there are an increasing number of examples of what good care looks like. There can be no more important priority

Source: http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

Fig 4. Providing integrated care for older people

than to accelerate this progress in the face of well-known demographic trends and long standing intentions to move away from over reliance on acute hospitals and deliver more joined up care in which there is greater emphasis on care provided in the community. The biggest challenge in implementing new care models is to ensure that work to transform care is not crowded out by work to sustain existing services. The latter is now the major preoccupation of national and local leaders as concern grows about escalating deficits and failure to hit key targets for patient care. The trick that must be brought off is to position work on transformation as a major part of the solution to the operational pressures engulfing the NHS.

The difficulty is how to do so when leadership and management capacity is finite. Leaders of NHS organisations naturally respond to the signals they receive from the centre and at the moment these are all about financial control and getting back on track in delivering waiting time targets. Transforming care is also a priority for many of these leaders but they can be forgiven if it is a lesser

priority than meeting targets that are seen as the absolute 'must dos' and where much of their time is spent responding to requests from regulators on progress in delivering on these.

It is in this environment that there is an emerging crisis of leadership with increasing difficulties in filling top leadership roles. The cumulative impact of funding and service pressures and ever closer oversight and scrutiny of top leaders, together with a tendency to replace leaders when performance deteriorates, helps explain why these roles are seen as unattractive and insecure. Negative perceptions of public sector managers and their 'excessive' pay and pensions add to the difficulties of recruiting experienced leaders from other sectors into the NHS. The crisis in leadership extends beyond top leaders to the challenge of involving clinicians in leadership roles and in ensuring that the NHS has the expertise it needs in operational management. The latter encompasses applying evidence based methods to improve the flow of patients within hospitals and between hospitals and other settings and work to redesign how care is delivered. Levels of understanding of quality improvement methods such as lean are variable and this needs to be addressed with urgency.

The pressures on leaders of national NHS bodies in some respects parallel what is happening to the leaders of NHS organisations. They too are focused on financial control and hitting targets for patient care with work on transformation for the time being not receiving the same attention. While the rhetoric does emphasise new care models and filling gaps in care, the reality is that operational issues take precedence in national guidance and in the behaviours of national leaders.

Challenge 3: Reforming the NHS 'from within'

The third challenge is in many ways the most important. Successive government have sought to reform the NHS and improve patient care using a variety of approaches, often in combination. These approaches have included top down performance management (referred to colloquially as 'targets and terror'), regulation and inspection, and competition and choice.

A review of the evidence on the impact of these approaches I undertook concluded that neither regulation and inspection nor competition and choice had delivered the improvements hoped for by their proponents (Ham 2014). Performance management had a bigger impact especially when used alongside increased spending under the Blair and Brown governments. There were also

some negative consequences, including misreporting of performance data and the disempowering effects of top down controls.

My review explored other approaches that have received less attention in England. These include devolution and transparency ('naming and shaming' to be colloquial again) and building capabilities for improvement among the staff delivering care. The latter is particularly promising as a reform strategy in view of the experience of health care systems around the world which have achieved high performance by training and developing their staff in quality improvement skills rather than doing so by responding to external pressures.

The lessons from these systems for the NHS are clear. They include the need for organisational stability and leadership continuity; the value of a vision focused on quality and safety; the adoption of specific goals for improvement and measurement of progress towards these goals; and the development of leaders and cultures focused on improvement. High performing systems also seek and act on patient feedback and listen to and engage staff. They create time for staff to care and remove obstacles to the delivery of safe and high quality care.

I emphasise the need to reform 'from within' to counter the prevailing mind-set that continues to believe that external pressures are the best way of improving performance (see challenge 1). I also recognise that not all NHS organisations, left to their own devices, will follow the example of high performing systems. That is why I have argued in a new paper co-authored with Don Berwick and Jennifer Dixon that the NHS in England urgently needs a quality improvement strategy that articulates how organisations can be supported to do so (Ham et al 2016). While reform must be led from within the NHS it needs to be supported by national NHS bodies and the government. This does not mean seeking to micromanage the NHS from the centre as is currently being attempted in work to sustain existing services and deal with financial pressures. Rather, it means the centre setting the financial framework and direction for health and care, being clear on the objectives being pursued, and holding NHS organisations to account for their delivery. The centre also a role in supporting these organisations to sustain and transform care.

In our paper, we recognise previous attempts to develop a quality improvement strategy and the need to learn lessons from these attempts. Our recommendations include the need for every NHS organisation to take responsibility for quality

improvement and to invest in training and developing staff in the theory and practice of improvement. Organisations should work together in improvement collaboratives and a modestly sized national centre of expertise should also be established within NHS Improvement. A concerted approach is needed in which quality improvement becomes the core priority for the NHS.

It is important to acknowledge the effort needed to successfully 'reform from within'. Systems like Intermountain Healthcare in the United State, Jonkoping County Council in Sweden and Canterbury Health Board in New Zealand demonstrate that real and sustainable improvement takes years not months. Their work exemplifies the importance of constancy of purpose in delivering and sustaining high performance. The absence of constancy of purpose explains why previous attempts to develop a quality improvement strategy in England have met with limited success. Our analysis shows that improvement typically occurs through the aggregation of marginal gains not big leaps forward. It is much more like a marathon than a sprint. And it requires leaders to lead by example by showing their personal commitment to quality improvement. Reform from within is not an easy option but it offers the best hope for the NHS to meet the challenges it faces.

CONNECTING THE DOTS

What might reform from within look like in enabling the NHS to sustain existing services and transform care? Let me offer two suggestions.

Sustaining existing services will not be achieved simply by reducing management costs, rationalising back office functions and being smarter about the procurement of goods and services. All of these approaches have a part to play but they are of secondary importance compared with the need to improve clinical care. The key decisions on how NHS resources are used are taken by thousands of clinical staff in their interactions with patients and this is where attention must focus.

There is voluminous evidence on the existence of unwarranted variations in clinical care in all health care systems, including the NHS. There is also evidence that care could be provided more appropriately by reducing overuse, underuse and misuse (Alderwick et al 2015b). Making better use of NHS resources means engaging clinical staff in understanding unwarranted variations and reducing

them where appropriate. It also means building on past experience of changing clinical practices to deliver better value.

My colleague, John Appleby, has shown how this has been done in his analysis of changes in GP prescribing, the use of day surgery and the time patients spend in hospitals (see part one of Alderwick et al 2015b). Changes such as these cannot be mandated by politicians or indeed managers. They typically occur when clinicians become aware of the existence of variations in care and are supported to reduce them. The benefits accumulate over time as innovations in care spread and achieve system wide impact. The important point is that most changes in clinical care do not result from organisational reforms, changes in legislation or any of the other policy instruments used by governments. Rather, they arise out of the clinical community itself as doctors and others identify ways of improving care and implement new and better ways of treating patients. As Appleby's work illustrates, changes in clinical care enable more care to be delivered with available resources.

In the case of GP prescribing, the greater use of generic drugs has saved the NHS an estimated £7.1bn. Without changes in day surgery, the NHS would have performed 1.3 million fewer elective procedures. And if the time patients spend in hospitals had not fallen, the NHS would have required nearly 10,000 more beds. All of these changes illustrate how better value has been delivered and this is where effort must focus if the NHS is to get anywhere near filling the financial gap with which it is faced. This will not happen if the focus is on cost cutting and efficiency. The experience of high performing health care systems like Intermountain Healthcare in the United States shows that better outcomes can be delivered at lower cost through changes in clinical care and the NHS must seek to do the same. If clinicians are to be engaged and motivated to play their part, the challenge facing the NHS must be framed as a challenge to deliver better value through improving the quality of care and outcomes. Improved financial performance will then follow.

A second suggestion relates to transforming care through collaboration between the organisations and clinicians responsible for providing care for the population living in a defined area. We have referred to this as place based systems of care, by which we mean alliances and networks that come together to take decisions jointly on the resources they control (Ham and Alderwick 2015). It is in these systems of care that many of the best opportunities can be found for implementing

new care models, as is beginning to happen in the vanguards through closer integration of acute hospital services and GPs in areas such as Northumbria and the Isle of Wight.

Major changes in stroke care in London illustrate this process at work. The designation of eight hyper acute stroke units in the capital in place of the 32 acute hospitals that previously provided stroke care resulted from a process of discussion and negotiation between stroke specialists supported and encouraged by the strategic health authority at the time and commissioners. It was about as far removed from central or regional planning as could be imagined and owed nothing to the belief in some quarters that competition was the best way of bringing about changes of this kind (Turner et al 2016). Similarly, improvements in specialist care in central London, involving the relocation of cancer and cardiac care at UCLH and Barts Health, were brokered by UCLPartners, an academic health sciences partnership. This resulted in cardiac care being concentrated at Barts Health and cancer care at UCLH with the aim of delivering better outcomes for patients. The leadership provided by experienced and credible clinicians was of crucial importance in enabling these improvements in care to be implemented.

The relative ease with which agreement was reached in both examples stands in stark contrast to the fate of long standing plans to reconfigure paediatric heart surgery that remain to be implemented 13 years after they were published. These plans encountered strong opposition from the hospitals who stand to lose their designation as specialist centres to the point where one of these centres launched a judicial review. The sense among some that the plans were being imposed from above contributed to problems in taking forward implementation.

WHERE NEXT?

Old habits die hard and at the time of writing the prospect of 'reform from within' becoming the preferred approach to bringing about change in the NHS in England seems remote. Default to performance management and central control of decision making is baked into the governance of the NHS with parliament holding politicians to account for performance and 24/7 media scrutiny reinforcing the imperative for politicians to act, or at least to be seen to act, when problems emerge. The political rhetoric may at times embrace devolution and

autonomy, as in plans under development in Greater Manchester, but the reality is usually different. This is exemplified by the current response to escalating deficits and failure to hit key targets for patient care.

Eliminating deficits and hitting key targets will be the overriding priority for the NHS in 2016/17 with most of the additional funding agreed in the spending review set aside for this purpose. A major uncertainty is whether these objectives can be achieved. Deficits among providers, especially acute hospitals, are bigger and more extensive than at any previous period in the history of the NHS, and it may not be possible to eliminate them while maintaining standards of care, especially if staffing levels are cut. This is why experienced leaders are saying that what is expected of them is undo-able.

Growing pressures in primary care and mental health services will add to the impression of an NHS in crisis. These services have received a declining share of NHS resources and recent planning guidance seeks to reverse this. But with most of the deficits in acute hospital and services and most of the additional funding in 2016/17 being used to cut these deficits it is hard to see how primary care and mental health services will benefit in the immediate future. The prospect is therefore of all areas of care struggling to meet increasing demands from patients, underling the extent of underfunding. There is no sign of the government wanting to find more resources with ministers insisting that they are 'continuing to back and fund the NHS's own plan for the future' (Department of Health 2015, p5). By this they mean they have found the £8bn extra resources identified as being needed in the NHS five year forward view and expect leaders in the NHS to respond by sustaining and transforming services, including finding the £22bn productivity improvements required to implement the plan. Many leaders within the NHS would beg to differ about whether it is indeed their own plan as opposed to one negotiated by others on their behalf.

Ministers take the view that funding for other public services has been cut significantly without serious adverse consequences, and they are looking to the NHS to rise to the challenge it has been given. I have even heard ministers say they would be letting the NHS 'off the hook' by providing additional funding when there are so many opportunities to improve productivity in the NHS. While there is some truth in this argument, it exposes the gulf of understanding between Whitehall and the reality on the ground. This gulf was revealed in a related context by the prime minister's complaints to the Conservative leader of

Oxfordshire County Council about the impact of cuts in public services in his constituency caused by the spending decisions of his own government.

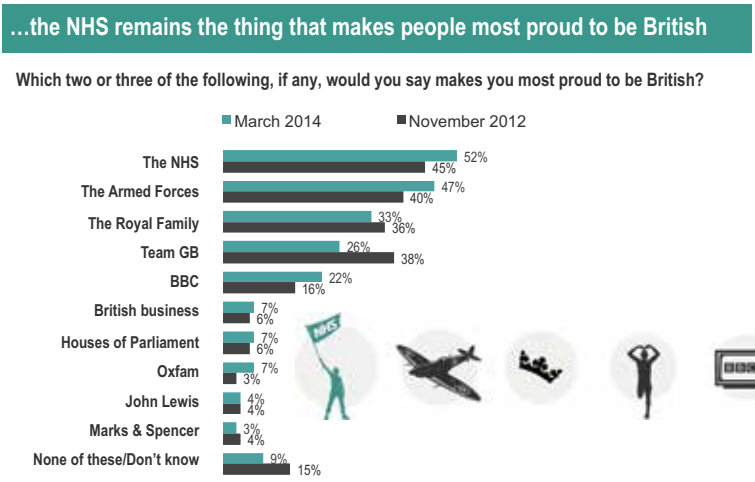
If the government is unwilling or unable to find the funding for health and related services needed, then what will give? In the short term the prospect is of continuing pressure on key targets for patient care with waiting times for treatment lengthening and patients experiencing declining standards of care if there are fewer staff to provide it. There may also be increasing tension between national leaders of the NHS and government ministers over the failure, as ministers would construe it, of the NHS to deliver its side of the bargain over NHS funding.

This 'failure' may increase the reluctance of the Treasury to find additional funding for fear of committing more resources to an apparently black hole. Pressures on other public services facing deep cuts in their budgets and an economy vulnerable to global instability add to an already heady mix. What this demonstrates is that there are no easy choices for the government and this helps explain increasing signs of anxiety in Whitehall about the state of the NHS. There is also likely to be increasing tension between national leaders of the NHS and their local counterparts. An example is rejection by around one third of NHS providers of spending controls and financial support offered by NHS Improvement for the 2016/17 financial year. The prospect is of further disagreements of this kind as local leaders resist interventions they see as adding to the difficulties they face in delivering what is expected of them.

ALTERNATIVE SCENARIOS

In this context it would be foolish to attempt to predict the outcome but alternative scenarios can be outlined. One would be for the government to declare that the 1948 vision of a universal, comprehensive and largely free at the point of use NHS is no longer sustainable and that the time has come for an honest debate about the future. At a minimum this would include being more realistic about the NHS offer by accepting that current standards of care can no longer be delivered, as de facto is already the case on many waiting time targets.

A more radical scenario would be for the government to use an NHS crisis as an opportunity to explore alternative ways of funding care. The menu here would



Source: https://www.ipsos-mori.com/Assets/Docs/News/Blogs/nhs-maintaining-pride-health-slides.pdf

Fig 5. Ipsos MORI poll about pride in the NHS

include a greater role for user charges, tax incentives to encourage more people to take out private medical insurance, and a switch from tax funding to social insurance. The difficulty with these options is that they encounter public attitudes which remain strongly supportive of the NHS whatever its failings. This is best illustrated by Ipsos MORI research in which a majority of the public identify the NHS as the institution that makes them most proud to be British (Ipsos MORI 2014) (see figure 5). The strength of public support for the NHS helps explain why it has been relatively protected at a time of cuts in most other public services. If nothing else, ministers whose natural inclination is to favour greater diversity in how health care is funded and provided are reluctant to advance the case for radical change for fear of losing electoral support.

Another scenario would be to explore ways of increasing funding for the NHS through tax increases. Frank Field has outlined one way of doing this in his proposals for a national health and social care mutual funding scheme. This would involve raising extra funds through national insurance contributions with these funds to be used only on health and social care. It echoes previous arguments in favour of hypothecation as the most likely way of persuading the

public to pay more in taxes for the NHS. A related proposal by Bob Kerslake has been for a 3p increase in income tax to raise additional funding for the NHS.

All of these options carry dangers for the government which is why the most likely outcome is to muddle through for as long as possible by denying the extent of the problems facing the NHS. The risk in this scenario is that the debate the country needs to have about how to fund a new health and social care settlement, as proposed by the Barker Commission, will not take place. Were this to happen it would illustrate the argument of former Labour cabinet minister, Charles Clarke, that there are some public policy issues that are so complex they end up in the too difficult box (Clarke 2014). The NHS crisis could then become a political crisis if the public perceives the government to be avoiding an issue of great importance to them. This would further undermine the credibility of politicians whose stock is already low in the eyes of the public. The result could be greater disenchantment with the political process with consequences just as serious as the gradual undermining of the NHS.

The stakes could hardly be higher. These issues are being played out in a context in which the UK is a relatively low spender on health care. Countries as diverse as Germany, France, Australia and Canada spend a much higher share of their national incomes to health care than the UK. What looks like overspending to the government appears much more like underfunding from within the NHS.

The sense of unreality is heightened when ministers raise expectations of the future with promises of seven day working and a paperless NHS just at the time when leaders are working overtime to deal with operational issues. These leaders are also expected to deliver a very large number of priorities set out in NHS planning guidance issued in December. They can be forgiven for wondering if the emperor has any clothes in the face of multiple demands and constrained resources. For now, the public may not experience an NHS creaking at the seams but it is only a matter of time before the reality is understood. At that point they may well ask what the government was doing when it was presiding over the steady but inevitable decline of the public service they hold most dear. All the more important therefore for organisations like The King's Fund to speak truth to power by monitoring and reporting on the impact of funding pressures on the NHS and outlining the choices available.

CONCLUSIONS

The health and care system is at a crossroads. There is still time to avoid a major crisis in care even if the financial crisis in the NHS is real and growing and publicly funded social care has already been cut significantly. The crisis will only be avoided if ministers are willing to heed the warning signs and be honest about what needs to be done to respond to them. Sticking plaster solutions will not be sufficient and a fundamental review is needed building on the work of the Barker Commission (Commission on the Future of Health and Social Care in England 2014). This means moving over time to a single health and care system in which entitlements to health and care are increasingly aligned with those that exist in the NHS. Additional public funding will be needed to pay for such as system with the aim of spending reaching 11-12% of GDP by 2025. It also means embracing new care models in which services are integrated and where people needing care are empowered to take decisions about that care.

For its part, the NHS needs to redouble efforts to deliver better value to patients and the public. This means engaging and supporting all staff to contribute with a particular focus on clinicians who hold the key to how resources are used. It means engaging patients and the public to play their part by sharing in decision making and taking greater responsibility for their own health and wellbeing. And it means addressing the growing leadership crisis in the NHS by developing a pipeline for the future and doing more to support clinicians to move into leadership roles.

The primary focus for the NHS should be on delivering better value by improving clinical care, learning from how this has been done in the past. Better value can also be delivered by organisations working together in place based systems of care. While the last thing the NHS needs is another reorganisation, place based systems of care have the potential to bring organisations together around the populations they serve with the aim of using available resources for the benefit of these populations through shared governance and joint budgets.

Examples are already emerging in some areas of England and their development needs to be accelerated. This may happen as local areas prepare sustainability and transformation plans as required under the shared NHS planning guidance issued in December 2015. The requirement on organisations to come together

to produce plans for their areas is designed in part to stimulate collaboration and act as a counter to the risk that organisations will act independently in the use of scarce resources.

Although the government may not yet be willing to acknowledge the seriousness of the pressures facing health and social care, other politicians have done so and have called for a commission to be established to review the options and make recommendations. We have argued this could play a useful role if it reports within a year, engages with the public and staff, and is led by a credible individual rather than being a royal commission. It would also need cross-party support. A time limited review is both necessary and realistic given that the Barker Commission has already covered much of this territory.

As I write these words, the image that keeps occurring to me is of a car crash replayed in slow motion. I hope I am wrong but the NHS seems set on a collision course that could be avoided but only the driver and navigator have power to act. Those of us watching can issue warnings and offer advice but it will take political will to avert a disaster happening.

Professor Chris Ham CBE

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