Anthony Bell surveys the scale of the NHS crisis and some of the proposals for change

NHS IN CRISIS

key points

- The NHS is entering a third decade of administrative turbulence and cost pressures. Almost every measure of performance is getting worse.
- Waiting times for cancer care, accident and emergency attendances, ambulances and routine operations are all rising.
- Large efficiency savings are needed by 2020 with risks ahead for patients if healthcare becomes further fragmented.
- The latest proposals include localised sustainability and transformation plans (STPs).
- Clinicians and students need to ensure that opportunities for positive change are not missed.

A King's Fund review during the last Parliament commended NHS performance in the face of huge challenges, despite the coalition government's damaging and distracting reforms of the health service.[1] The review warned that patient care would deteriorate as service and financial pressures became overwhelming. The chief economist at the Health Foundation described the NHS financial position last year as 'dire', with three quarters of hospitals unable to balance their books.

The present government has inherited a health service that has run out of money and is operating at the very edge of its limits.[2] The extra £8 billion a year NHS England says is needed by 2020 is the minimum that will be required unless new savings materialise, and the figure was reached after assuming highly ambitious efficiency savings of £22 billion by 2020.

Simon Stevens, who became chief executive of NHS England in 2014, favours the development of new models to suit local needs. Possibilities include 'Accountable Care Organisations' as found in Spain, the United States and Singapore, to integrate primary and acute care. Some large UK hospital Trusts could do acute care and community care in their area. The Trust could employ general practitioners and community health staff as well as hospital staff, potentially uniting doctors, nurses and paramedical professionals to co-ordinate care.

Measures that could curb the rise in hospital admissions and the impact of our ageing population, which are the source of most pressure in the NHS, include hospital video links to care homes to prevent emergency admissions for cuts and grazes following falls, and to give advice on management of conditions like diabetes mellitus. Pilots in West Yorkshire have reduced emergency admissions from care homes by 35% and A&E attendances by 53%.[3]

Investment in the NHS needs to be backed by a strong economy. The July Budget in 2015 restated a commitment to an extra £8 billion in 2020, yet financial problems have been described as 'endemic' – with even the best run hospitals forecasting deficits and predicting that NHS providers could slip further into the red – and 'bleak' – with nearly 80% of Trust Finance directors predicting a worse position at the end of 2015 than the year before.

In A&E, the proportion of people waiting over four hours for treatment is at its worst level since 2004. Waiting lists for non-emergency treatments have not been so high since 2007. Whole areas of the NHS in England have been placed in special measures, including community services and social care as well as hospitals.

Doctors and nurses face the fundamental challenge of the tension between quality of care and financial performance. Maintaining quality of care is vital, not least in high litigation risk specialties. A further challenge is ensuring adequate investment in facilities

and staff at Hospital Trust level. As Robert Francis concluded in the Mid Staffs inquiry: 'there is a need for openness, transparency and candour in all staff and NHS management needs to be evidence based and accountable in the same way that doctors and nurses are… appropriate infrastructure is needed for them to do their jobs well'.[4]

A potential opportunity

In December 2015, sustainability and transformation plans (STPs) were announced in England to shape the future of health and care services within a geographical area.[5] But what will STPs really do? The five-year STPs cover all areas of NHS spending in 44 local populations ranging from 300,000 to 2.8 million, with an average of 1.2 million people. STP leaders are largely chosen from clinical commissioning groups and NHS and Foundation Trusts, but some are from local government.

The scope of STPs is broad, with three aims:

- improving quality and developing new models of care
- improving health and wellbeing
- improving efficiency of services

While the focus is mainly on NHS services, STPs must also cover better integration with local authority services. The timelines for developing and approving STPs have proved somewhat fluid, the original deadline for submitting plans was the end of June 2016, but most plans will now be further developed and re-submitted by October and are likely to be assessed and approved in phases. From April 2017, STPs will become the only way to access NHS transformation funding, with the best plans receiving funds more quickly.

Changing priorities

STPs represent a shift in the way the NHS in England plans services.[6] They reverse the 2012 Health and Social Care Act, which strengthened competition, and instead encourages organisations to collaborate, reflecting a growing consensus that integrated care is required to meet the needs of the population.

The shift acknowledges that the financial problems in different parts of the NHS cannot be addressed in isolation, and providers and commissioners are being asked to come together to manage the collective resources available for NHS local populations. In some cases this may lead to 'system control totals' (financial targets) being applied to local areas by NHS England and NHS Improvement.

This represents a very 'new' way of working for the NHS. It might also include collaboration with other services beyond the NHS to focus on the broader aim of improving population health and wellbeing, not just on delivering better quality healthcare.

But developing STPs is not a simple task. Some STP footprints are large and involve many different organisations, each with their own cultures and priorities. Finding time to work on STPs can be challenging, given the severe service and financial pressures facing NHS organisations. Moreover, the timescales set by NHS England to write STPs are tight.

Perhaps the biggest challenge is to develop STPs in an NHS environment that is no longer designed to support collaboration between organisations. NHS providers are under significant pressure from regulators to improve organisational performance by focusing on their own services and finances rather than working with others for the greater good of the local population. The dissonance between place-based planning and the continuing focus on organisational performance in the NHS is stark.

The task of developing STPs may be challenging for some areas; making it happen will be altogether more difficult. There has been limited time for public involvement in the plans so far and changes to incentives and performance management in the NHS may be needed to overcome the barriers that get in the way.

The ultimate prize on offer from STPs is the opportunity to integrate health and social care services more closely and to provide a platform for improving population health. But there are some reasons to be cautious about the kind of benefits that will be delivered and concerns have already been raised that leaders have focused on plans for reconfiguring acute hospital services, despite evidence that major acute reconfigurations rarely save money and can fail to improve quality (and in some cases even reduce it).

Doctors and nurses must be able to work within a structure that balances care quality and safety with efficiency, that ensures unfettered patient access to care based on clinical need, and that builds and sustains the skilled clinical workforce. The present infrastructure for clinical care across the UK fails to deliver this in many areas. Innovation and ground-breaking ideas also need to be nurtured and not stifled. Clinicians need to be able to innovate and validate new advances in patient care free from commercial pressures and overburdening bureaucracy.

With the new 'post-Brexit' government, the NHS will change and clinicians will change with it. The worldview of Christian clinicians, driven by love for our neighbour and Jesus' parable of the Good Samaritan, make our engagement with these transformations essential to ensure that care is centered on patients' needs and that quality is not compromised. Our patients risk being short changed if we become back footed and unable to take the lead to make the most of the opportunities ahead.

Call to action

- Christians are a morally distinctive voice, called to be salt and light at all levels in the NHS
- There is scope for Christians to be engaged in working for change and shaping the future, for instance from the ground up within STPs
- There are growing opportunities for partnership between Christian students and clinicians to work with local churches to offer integrated social care

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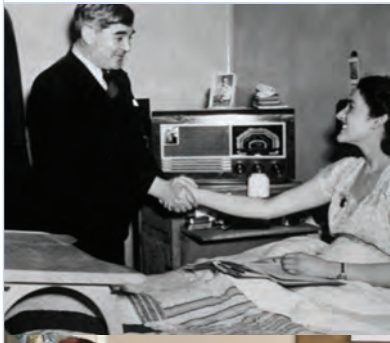
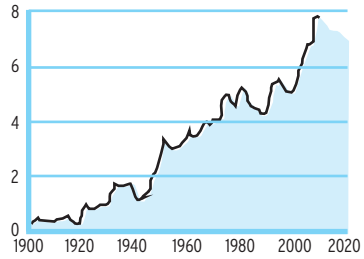


Healthcare: UK from 1900-2020



Percentage of Gross Domestic Product spent on UK Healthcare

Clinicians need to be able to innovate and validate new advances in patient care free from commercial pressures and overburdening bureaucracy

references

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Based on a seminar at the CMF Junior Doctors' conference in October 2016