

Rising to the challenge: health priorities for government and the NHS



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Introduction

The scale of the financial challenge facing the NHS over the next three to five years is now widely accepted. The NHS Confederation has played a leading role in highlighting this, alongside others, and it is clear that the resource squeeze will have serious implications for patients unless politicians and NHS leaders rise to this challenge.

There remains broad consensus across the three main political parties in England on the principles for running the NHS: tax-funded and free at the point of delivery; a commissioner-provider split; patient choice; and contestability. What is less clear is what the three main parties believe are the appropriate national and local policy levers for responding to both the financial challenge and the broader requirements to deliver high-quality healthcare and health improvement.

This paper sets out where we believe the respective roles for

national government, politicians and NHS leaders in England lie, and identifies the priority areas where each must show leadership. It is not intended as a blueprint or management plan, but we believe that the benefits of sustained investment in the NHS over the past decade can only be fully harnessed if roles are clarified and each party takes urgent action on these priorities. This paper also considers the lessons that we must learn from the past, such as the implications of widespread restructuring and overuse of national policy incentives, providing a major warning to policymakers tempted to ignore them.

“This paper sets out where we believe the respective roles for national government, politicians and NHS leaders lie, and identifies the priority areas where each must show leadership”

An overview of each chapter

Challenges and priorities for the NHS

The NHS has made significant progress in delivering improved and high-quality healthcare over the past decade, but there is much more to do.

- The NHS cannot and should not wait for government action to respond to the financial challenge.
- A rigorous approach to rooting out inefficiencies in the system, reducing costs and redesigning services is needed.
- There must be a continuing focus on the things that matter to patients: quality of outcomes; patient experience; and safety.
- Perhaps the biggest challenge and greatest imperative is to ensure the NHS is working effectively to improve the health of the whole population and reduce health inequalities.

Challenges and priorities for the next government

Whichever party wins the general election, it will need to lead the way at a national level to both continue with effective current policies and tackle areas where policies are less effective. For example, the need to integrate health and social care commissioning and support the integration of specialist and primary care services is pressing.

- The next government must show leadership on the current regulatory and inspection system, which we believe continues to be bedevilled with duplication and unnecessary bureaucracy.
- In light of a number of recent high profile failures, there is a need to look again at the purpose of regulation and whether the balance between national and local regulation is right.
- Other major areas where government has to take the lead include: social care funding; national measures to improve population health; and the model of hospital-delivered services.

Learning the lessons of the past

It is vital that the next government, policymakers and those in the NHS learn from previous experience.

- The benefits of restructuring must be set against the distraction it will create and the time it will take to fully implement.
- While top-down targets can be very effective, they also risk damaging the ability of the system to 'think for itself' and may not lead to improvements across a whole system.
- Health policy based on the model of planned surgery is no longer appropriate. We need to find new models that recognise the different relationships patients have with their healthcare providers.

01

Challenges and priorities for the NHS

The NHS has made significant progress on the reform programme over the past decade but, regardless of which party wins the general election, it must continue to work to reduce costs, raise the quality of services and improve the health of the whole population.

Improving operational efficiency

The techniques for improving day-to-day efficiency are well understood and most of them are being used across the NHS. They include:

- sickness and absence management
- agency and overtime reductions
- making more use of outsourcing and shared services
- purchasing and procurement improvements
- ensuring that staff and equipment are used more efficiently.

Staff costs represent over 40 per cent of NHS resources and employers will need to reduce the pay bill. Working in partnership with trade unions to find ways to do this, while avoiding large-scale redundancies, is likely to be the most productive approach. We cannot escape the reality that some very difficult choices will have to be made and these discussions need to start with the greatest urgency.

Redesigning services and reducing costs

Improving operational efficiency might yield savings of 3 to 5 per cent a year, but this will not be enough. Most expenditure is on providing care and so it is vital that the cost of care is reduced at the same time as the quality of care is improved and unnecessary variation is minimised.

The NHS should focus on three key areas.

1) Redesigning care within organisations

There is much that the NHS can do within organisations to improve services for patients and make efficiency savings at the same time. For example:

- removing delays and duplication in patient services
- using patient experience information to improve services and remove waste

- reducing complexity and hand-offs between staff
- ensuring that patients only stay in hospital when they need to
- stopping ineffective or outdated practices
- ensuring the most cost-effective prescribing practice
- redesigning the way that community teams work.

There are a number of areas where the quality of patient care needs improving whether or not this generates efficiency savings, for example maternity services and end-of-life care.

2) Redesigning care between organisations

Ensuring people are cared for in the right place offers significant opportunities for savings, whether this is a choice between different health sectors or different organisations within a sector. Improving the management of care for people with long-term conditions and providing support for care at home will also help prevent avoidable, and costly, admissions. However, to get this right will require some very significant changes in a number of areas, such as:

- rethinking the way parts of primary care operate, and enhancing its role in managing chronic diseases
- developing more input from hospital specialists in primary care
- providing much better access to diagnostics in primary care
- changing the role and services offered by a significant number of hospitals
- transforming urgent and emergency care to reduce avoidable hospital admissions, where appropriate, and shifting the focus of services into the community and towards prevention

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- using mental health expertise to reduce costs in the acute sector and the criminal justice system
- integrating health and social care commissioning and provision to a much greater degree – there are a number of ways to improve this without necessarily resorting to structural reorganisation
- ensuring that the flow of funds around the system supports these changes.

3) Providing effective evidence-based care

More needs to be done to ensure that the most effective treatments are used and that outdated practice is stopped. In a few cases it will be necessary to make some difficult commissioning decisions about what level of services should be provided. Some variation is inevitable, but reducing the extremes will improve services for patients and improve efficiency in many cases. Examples include:

- overuse and misuse, for example of atypical anti-psychotic drugs in dementia
- underuse of effective interventions, for example preventing venous thromboembolism (VTE)

- variations that arise because of supply-induced demand, for example increased capacity and resources at A&E and walk-in centres has led to increased utilisation of services
- unwarranted variations in clinical practice, for example referral to outpatients varies significantly between GPs and practices depending on clinical acumen, knowledge and differences in approach.

One important change in this area would be to ensure that, where there is a choice of treatment options, patients are given decision support tools to help them choose the options that fit their personal preferences and priorities.

A second important change would be for the NHS to be much less tolerant of variation that is not supported by evidence, and for professional leaders and clinical managers to take a more active role in challenging this. There is much evidence to suggest that the NHS is slow in universally adopting clinical changes. The length of the lead in time is difficult to empirically define but anecdotal evidence suggests that this could be over five years in some cases. This is a luxury we can no longer afford.

4) Making the case for local change

A combination of the suggestions above, including some appropriate reconfiguration of services as well as other strategies, should allow some significant rationalisation so that costs can be shed. This could be achieved with minimal effect on patients and, in many cases, the quality of services will actually improve. However, this is not straightforward. Capital for building may be needed and this will be in short supply. Moving services, even if the level of service is being maintained or improved, will always be contentious. The NHS will need to provide a strong case for change and involve the public in developing the options at a local level.

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Improving population health locally

The Wanless report, *Securing our future health: taking a long-term view*, argued that the future of the NHS is dependent on dealing with the most significant causes of ill health and people taking more action to manage their own health. Much can also be done to work with communities to address some of the underlying causes of poor health.

While there are some actions on public health that only the government can take, for example legislative and regulatory changes, the NHS can make a very significant contribution in other areas. For example, it is important for the NHS to improve access to high-quality primary care, particularly in areas

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with too few GPs. There is more to do to improve services in the most deprived areas and to help and support the poorly performing NHS services and GP practices that tend to be found in these areas.

Outside of primary care, public health also needs to become an important and integral part of acute care and attention should be given to population groups that tend to be less well served, for example people with mental health problems and learning disabilities.

Understanding what health services are available, having the knowledge about when and how to use them, and improving wider ‘health literacy’ are important for prevention services. The NHS can do more to target investment on those population groups that do not access services appropriately; there are a number of examples of where the NHS has used social marketing techniques to achieve this. For example, Knowsley

Primary Care Trust (PCT) used social marketing as part of its smoking cessation programme, working in partnership with the local authority and The Roy Castle Lung Cancer Foundation’s FagEnds. By utilising social marketing tools, Knowsley PCT has gone from having one of the worst smoking quit rates in the country to consistently being among the top three performers. Further work is needed to develop our understanding of these techniques.

Beyond these areas and a few specific interventions, there is a limit to what traditional NHS services are able to do to improve the health of the wider population. The NHS has knowledge, data and expertise, but many of the actions required are in the realm of local government, education, housing, criminal justice and employment.

Previous partnership arrangements have produced disappointing results, and new approaches need to be found with clearer

accountabilities. ‘Total place’ initiatives – where resources from different agencies are pooled to make dealing with a particular area more effective, and to eliminate duplication, overlaps and gaps – are a good emerging example. This type of partnership working is controversial because it means a number of organisations need to surrender at least some sovereignty.

Additionally, the measurement, accountability and audit arrangements that apply in different ways to public bodies are major obstacles to this way of working that need to be removed.

The NHS can help by working with third sector groups to create an environment in which they can develop new solutions and approaches. To deal with the rising tide of health problems, NHS organisations will need to reach out to their local communities as well as work to improve the health of their own staff and their families.

02

Challenges and priorities for the next government

In the previous section we talked about how much of the reform programme remains in the hands of the NHS itself. But there are some things that only the government can do, such as leading the way nationally on health policy and talking to the public about legislative and other changes. This section sets out the priorities for the next government, whichever party wins the general election.

Continuing with policy that works

There is broad support among the three main political parties for recent reforms in the NHS in England. The NHS Confederation supports the current direction of travel which seeks to achieve the following:

- make providers much more independent and able to work flexibly to respond to the needs of patients
- give patients choice, information and other mechanisms to put pressure on providers to perform better
- strengthen the commissioners' role of holding providers to account – and giving GP practices a pivotal role in this
- involve the public more effectively in designing services, determining priorities and other key decisions
- underpin these policies with payment systems that create incentives to improve performance and quality
- create ways to ensure that quality is at the heart of the NHS, including the publication of information about quality and creating a simpler and less burdensome system of regulation
- use competition and contestability to improve services and create a challenge to existing providers
- encourage new entrants – although more needs to be done to encourage those that offer genuinely new ways of providing services, rather than new versions of the existing approach.

This set of policies is consistent with the direction of most health reform in other European countries. While we recognise these are not the only reform mechanisms, we believe it is important to continue to develop and apply these mechanisms wherever appropriate.

“Closer integration between providers, rigorous challenge by commissioners, and benchmarking and information about performance are essential”

Tackling what’s not working

A real challenge for the next government will be to deal with areas where recent reform mechanisms have been less effective. For example, much of the reform programme in recent years has focused on hospital care, but community, primary and social care are central to many of the changes that are needed.

Choice, competition, contestability and the provision of information are undoubtedly powerful mechanisms for creating a dynamic for change. But they have a less significant effect in emergency care, where there are natural monopolies; and in long-term conditions, where patients are less likely to switch providers because they have a relationship with a team. For these services, a different policy framework that allows more control and information for patients is needed. Closer integration between providers, rigorous challenge by commissioners, and benchmarking and information about performance are also essential.

We believe that change is needed now to break down silos between primary and secondary care and between health and social care.

Much of the way the NHS is set up is based on accidents of history rather than a focus on what patients actually need. The next government will need to urgently address the following three areas.

1) Closer integration of health and social care

The government should be careful to assess social care pressures and their potential impact on the NHS. In particular, cuts in social services may lead to additional pressures on the NHS, even if the latter is protected in funding terms. Closer integration between the commissioning and provision of social care and health services is needed, for example through shared commissioning posts or basing social services commissioning around practice groups. Local organisations can take this some way, but national policy action is required to establish:

- a clearer and much more uniform approach to charging in social care
- resource allocation mechanisms for health and social care that are aligned with each other
- a unified and simpler approach to the assessment of commissioners, moving away from World Class Commissioning, the Care Quality Commission, Vital Signs, comprehensive area assessment, OFSTED (which inspects all children’s services) and other frameworks which reinforce silo thinking and create a significant burden.

“We are concerned that the regulatory system is not working and that there is no clear consensus about what the current system is for or how success should be defined”

2) Regulation and inspection

We are concerned that the regulatory system is not working and that there is no clear consensus about what the current system is for or how success should be defined. We believe that too much is expected of regulation and that it is being asked to take on responsibilities that belong elsewhere. There is also significant evidence to suggest that regulation in healthcare has moved away from the principles of good regulation as defined by the Better Regulation Executive: proportionality, accountability, consistency, transparency and targeting.

The lack of clarity about the role of regulation, along with a culture in which the regulators are defending overlapping territories and trying to reduce their exposure to scandals, has led to a burdensome regime of duplicated data collection. Many initiatives to reduce the burden of regulation have been tried, but those on the receiving end have felt little improvement. There is still a bewildering array of regulators, auditors, inspectors and accrediting bodies.

The regulator is just part of the system responsible for assuring quality: boards, clinicians, managers, commissioners and public and patient involvement mechanisms must take the lead.

We believe the focus of national regulation should be on:

- identifying those tasks/activities that pose risks to patients and which therefore require the protection of regulation
- setting minimum standards that are a condition of providing certain types of care
- having some minimum standards that cover governance as a way of ensuring some basic processes that relate to high-quality care
- ensuring minimum standards are dynamic, to take account of changes in what is regarded as acceptable standards and practice.

“An extensive inspection-based regime is not feasible and does not provide sufficient assurance of quality as it gives no guarantee that all services are meeting all standards all of the time”

The health regulator needs to develop a better understanding of where it should focus its efforts, for example on those services that pose the biggest risks or those organisations that are struggling to meet standards consistently and where there is a systemic problem. Consistently high-performing trusts should be recognised with a lighter-touch regulatory scheme and, possibly, lower fees.

An extensive inspection-based regime is not feasible (it is expensive and onerous) and does not provide sufficient assurance of quality as it gives no guarantee that all services are meeting all standards all of the time. However, inspection, including unannounced inspections, should be a key part of the regulator’s tools to reinforce compliance and public confidence.

Specialist accreditation, for example through the royal colleges’ schemes, will help provide the necessary detail of assessment of different services within a trust. This should be supported, and might help to improve clinicians’ engagement with the regulatory process.

Finally, the design of the regulatory system appears ‘unfinished’. The Department of Health needs to review how all the different standards, data requests and other activities of the various bodies fit together. It also needs to ensure that the way that regulations are set up does not impede innovation and deter small organisations, particularly in the third sector. There is significant scope to reduce the duplication of information requests.

3) Improving population health nationally

Much closer integration of specialist and diagnostic services with primary care is needed, particularly in the management of long-term conditions. National policy can support this through:

- changes to the GP and pharmacy contract to recognise, and provide incentives for, more integrated working
- a change in the tariff and contractual arrangements to encourage specialists to work more closely with primary care
- mechanisms that allow hospitals to deal with any resulting loss of income.

4) Better support for patients to manage their own health

Patients and groups of patients need more support to manage their own conditions. National policy can help by commissioning training and education, evaluation of programmes and research to support new approaches. However, most of this has to be local and may be organised by patients or social enterprises. It could include:

- telecare and homecare services
- faster procurement of aids and home adaptations
- more responsive rehabilitation services that are more accessible to both patients and professionals.

Other reforms to enable change

The GP contract

We believe that a new GP contract is needed to support reform, better integration and greater choice of GP. Specifically, it should include:

- removing the minimum practice income guarantee
- reviewing seniority payments and the arrangements for paying for premises
- defining the expected core set of services within the contract
- moving to a national menu of Quality and Outcome Framework indicators that can be adapted to meet local needs
- strengthening contractual levers to deal with poor or unresponsive services
- improving alignment between the different contractual mechanisms for general practice and pharmacy

- creating incentives for practices to work federally and rewards for increased scale, allowing for much more effective integration with social, community and specialist care
- incentives for taking greater responsibility for out-of-hours care and patients' use of emergency care services
- aligning the contract and regulatory mechanisms to avoid duplication (because practices are more than the sum of individual practitioners, more than just professional regulation is required)
- allowing greater local flexibility to negotiate GP contracts
- using practice accreditation and accreditation as a basis for rewarding disease management expertise.

“We could wait for central government to redesign a new set of national incentives and mechanisms, but time is running out”

“We believe that the funding system is broken and the approach of passing the cost burden on to future generations is no longer an option”

Incentives and mechanisms to help restructure costs

While the Payment by Results system is effective for planned surgery and diagnostics, there has always been concern that for chronic disease – and conditions where the objective is to reduce admission to hospital – Payment by Results actually creates perverse incentives. A review of payment systems and incentives to ensure that all providers can offer the most cost-effective care is long overdue.

Mechanisms and incentives need to be capable of working across the whole system and should allow providers to make significant changes to the nature of their services and to reduce costs. This will be particularly challenging as income falls faster than costs. It will require a financial framework that allows a structured approach to change, the ability to borrow to fund working capital, and investment capital to allow big reductions in fixed costs.

We could wait for central government to redesign a new set of national incentives and mechanisms, but time is running out. More experiments, within some agreed parameters, may be a more effective method of developing better payment systems quickly.

Where government needs to lead the debate

Action on social care funding and entitlement

Well-run and clear funding mechanisms for social care are key to dealing with many of the challenges facing health services, and a joint approach to provision and commissioning is required. We believe that the funding system is broken and the approach of passing the cost burden on to future generations is no longer an option. This is an area where only government can act to put the following things in place:

- a clear statement of what people can expect to receive and the personal contribution that they will be expected to make
- a new approach to sustainable funding, such as a system of social insurance similar to that in most of continental Europe. To avoid the problem that only those who expect to claim are likely to buy insurance there is a strong argument for it to be compulsory, as it is in social insurance systems in Europe
- a mechanism for bridging the gap between the creation of an insurance fund and it having accrued sufficient funds to manage the risk
- incentives and co-payment mechanisms that maximise people’s ability to remain independent and that allow for a high degree of personalisation.

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Improving the population’s health

While the NHS must take responsibility for promoting improvements in the health of the population (public health), some actions in this area are only available to government. These include:

- legislative and regulatory changes relating to food, alcohol and tobacco
- investment decisions about programmes that support more healthy lifestyles
- the development of initiatives that support behaviour changes
- policies that deal with the deep determinants of poor health, such as inequality, poverty, poor housing, low educational achievement, being out of work and crime.

While there is a legitimate debate about whether it is appropriate for national government to be involved in personal ‘lifestyle’ choices, given the financial burden on the NHS and the impact on public health in areas such as alcohol, government will need to look at where further national intervention and legislation is required.

Changing services

The traditional model of the general hospital has been changing rapidly and, in many ways, it is an outdated concept. We need to be ambitious about delivering high-quality care, and that will mean looking at newer models of delivery, for example integrating health and social care, care in the community and personal management of long-term conditions.

Changing the pattern and content of hospital provision is inevitable. Whole hospitals may need to close, although it is more likely that they will need to adapt their character significantly. The party that wins the election will have a key role in helping to lead a debate on this, while the NHS continues to improve the way it involves local people to help them understand the difficult issues involved and the need for these changes.

03

Learning the lessons of the past

The NHS has been subject to an enormous amount of change in recent years and it is vital that the next government, policymakers and those in the NHS learn from previous experience. The areas where we believe there is the greatest danger of repeating past mistakes are set out below.

The impact of restructuring

Over the past two decades, the NHS has been subject to a very large number of managerial reorganisations, mergers and other changes, many of them centrally driven. The benefits of any new model must be set against the distraction that restructuring creates for the two years or more that it takes to plan and implement, and the loss of talent and 'organisational memory'. It can take two to three years for new organisations to become competent after they are created, so this should also be weighed up as part of any restructuring decisions.

The use and abuse of targets

Where the aim is to make a significant change in a small number of relatively easy-to-measure indicators, top-down direction and targets have proved to be very effective. However, improving one part of the system may not lead to improvements across the system as a whole. There are often unintended consequences and rapidly diminishing marginal returns on investment.

In particular, there is evidence that the effort required to deliver the last 'decimal points' of target performance is often

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disproportionate to the benefits delivered. For example, the effort involved in moving from treating 97 per cent to 98 per cent of patients within four hours may have been as great as moving from 77 per cent to 97 per cent within four hours. The scope for this to be disruptive and counterproductive is considerable.

Perhaps even more seriously, years of top-down direction and targets may have damaged the ability of the health system to innovate, think for itself and take risks. In other sectors, the organisations that succeed in dealing with a crisis tend to be those that concentrate on managing a few key indicators very tightly, and loosening the controls to allow innovation and change in other areas. Targets do have their place, but they should not come at the cost of stifling innovation that will be required if we are to meet the quality and financial challenge in healthcare.

The design of health policy

Too many policies, particularly those designed to reform the system, are based on planned (elective) surgery as the model for how healthcare works. But this is short-term, and relates to activity with a defined period of treatment, a relatively easily quantified product that is planned in advance and has a well-defined endpoint at which the patient is usually better. A significant amount of healthcare does not correspond to this model, not least the management of long-term conditions and acute emergency care.

Focus on what, not how

We believe that health policy should be much more about ‘what’ than ‘how’. In fact, any policy that needs to be implemented to a rigid, centrally defined template or timetable is a concern. We need much more tolerance of different approaches, structures, systems and

methods to allow for adaptation to local circumstances, but also to leave room for experiments that test different approaches against each other.

Localism and subsidiarity are popular themes in current policy, but the downside of these is increased levels of variability, a danger of reinventing solutions, and failing to learn from experience elsewhere. While we need local autonomy, we also need to be able to justify variation based on differences between areas and legitimate decision-making processes, and distinguish it from the results of history or unexplained variance from best practice. There is also a role for organisations to come together to reduce duplicated effort in developing solutions, and to ensure more rapid learning and adoption of new ideas.

Policymakers tend to be overly optimistic about success and can base projections on pilot projects where the best and the brightest are recruited and supported with additional resources. More realism is required, alongside research-based approaches to evaluating policy ideas to ensure that policies which are effective in one area can be more widely applied.

Fewer initiatives

In the past, the NHS has suffered from an over-abundance of initiatives. In these times of austerity, policymakers may not be able to create new initiatives quite as easily, and must resist the temptation to do so. Initiatives require management so, if NHS management is to be cut, this will need to be matched with fewer initiatives and targets.

The same applies to the introduction of organisations and processes in response to crises or scandals, often with insufficient analysis of the costs and benefits. Careful consideration should be given to how much change is needed to correct a problem and whether it could be dealt with through existing systems and structures.

Policy that's best for patients

Creating a large number of national policies can have the unintended consequence of diverting effort from delivering day-to-day services, and creating a culture in which innovation and development is defined nationally. This, in turn, drives out local initiative and necessitates the creation of systems to put a brake on local innovation.

Policy and incentives should always support doing what is best for patients, in clinical or population terms. They should never create incentives to act in ways that are against the interest of patients. Market mechanisms and financial incentives do have their place, and it is certainly desirable that payment systems and incentives relate to aspects of care that are important to patients. However, we are concerned that policymakers' default position is to use financial incentives. It shouldn't be. Applying these alone risks devaluing other types of motivation, such as professionalism.

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04

Conclusion

Our *Dealing with the downturn* paper, published in 2009, set out the scale of the financial challenge facing the NHS in the three years from 2011. But the quality of the public debate about finding solutions to the funding problems has been very poor. While protected funding for the NHS has been promised from all sides in the political debate, these promises are not seen as credible.

First, the idea that the financial pressures can be met simply by cutting management and bureaucracy is plain wrong. While there are significant savings to be made here, such proposals greatly underestimate the scale of the problem and overestimate the size of NHS management.

Second, too much of the debate has so far focused on elements of the reform machinery, and repeated reorganisation focused on governance and structures. These issues are important, but they are dwarfed by the need to deal with the growing problem of long-term conditions and the potential to unlock social and primary care as a major source of change.

NHS organisations need freedom and support to take bold action across a wide range of issues to improve health services and reduce costs. This means that government must grant much greater autonomy and discretion to the front line and be willing to deal with the consequences of any necessary difficult decisions.

The reform process in England needs to continue, and some additional mechanisms are needed for those areas where current policies are not so effective, or where they are more appropriate for an environment of financial growth. In particular, support is needed for much greater integration of primary, secondary and social care.

Some of this can only be dealt with by national policy interventions or through a debate that goes beyond specific local issues and addresses some significant issues of principle; social care funding is one such example.

Raising difficult political issues on the eve of a general election may not find favour in Westminster, but the long-term problems raised in this paper urgently need decisions and action – not only from politicians but from NHS leaders in England.

There are also issues that have not been specifically raised in this paper. Being realistic about the inevitable trade-off between pay levels and jobs is one example, and these sorts of issues are being grappled with in other countries that face financial problems similar to those in the UK. Further discussion is needed about some of the difficult decisions we may have to take, and the NHS Confederation expects to explore this in the near future.

For more information on the issues covered in this paper, please contact Abigail Stapleton, NHS Confederation senior public affairs officer by emailing abigail.stapleton@nhsconfed.org

“Raising difficult political issues on the eve of a general election may not find favour in Westminster, but the long-term problems raised in this paper urgently need decisions and action – not only from politicians but from NHS leaders”

Further information

Other NHS Confederation and NHS Employers publications of relevance include:

NHS Confederation (2009),
Reforming leadership development... again

NHS Confederation (2009),
Developing NHS leadership: the role of the trust medical director

NHS Confederation (2009),
Leading innovation

NHS Confederation (2009),
Dealing with the downturn: the greatest ever leadership challenge for the NHS?

Primary Care Trust Network,
NHS Confederation (2009)
Commissioning in a cold climate

Royal College of Psychiatrists,
the Mental Health Network,
NHS Confederation and the
London School of Economics
and Political Science (2009),
*Mental health and the
economic downturn*

NHS Employers (2009),
*Leading the NHS workforce
through to recovery*

NHS Confederation (2010),
*The heart of the matter: patient and
public engagement in today's NHS*

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Rising to the challenge: health priorities for government and the NHS

The scale of the financial challenge facing the NHS over the next three to five years is now widely accepted. The NHS Confederation has played a leading role in highlighting this, alongside others, and it is clear that the resource squeeze will have serious implications for patients unless politicians and NHS leaders rise to this challenge.

This paper sets out where we believe the respective roles for national government, politicians and NHS leaders in England lie and identifies the priority areas where each must show leadership.

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