Policies and new reforms to address the sustainability of the National Health Service and Adult Social Care in England

Stuart Redding, Richard Hobbs, Catia Nicodemo, Luigi Siciliani, Raphael Wittenberg

Abstract

Purpose: In this chapter we examine the NHS and Adult Social Care in England, focusing on policies that have been introduced since 2000 and considering the challenges that providers face in their quest to provide a high standard and affordable health service in the near future.

Methodology/approach: We discuss recent policy developments and published analysis covering innovations within major aspects of health care (primary, secondary & tertiary) and adult social care, before considering future challenges faced by providers in England, highlighted by a 2017 UK Parliament Select Committee.

Findings: The NHS and adult social care system have experienced tightening budgets and serious financial pressure, with historically low real-terms growth in health funding from central Government and local authorities. Policymakers have tried to overcome these challenges with several policy innovations, but many still remain. With largescale investment and reform, there is potential for the health and social care system to evolve into a modern service capable of dealing with the needs of an ageing population. However, if these challenges are not met then it is set to continue struggling with a lack of appropriate facilities, an overstretched staff and a system not entirely appropriate for its patients.

Keywords:

Primary Health Care; Secondary Care; Adult Social Care; Healthcare Financing; England; NHS; Sustainability

Introduction

This chapter gives an overview of recent trends and reforms in the National Health Service (NHS) and Adult Social Care (ASC) in England since 2000. It considers how a selection of key policy interventions have affected the care that the NHS and ASC provide, and the future sustainability of these services. The English NHS has been in existence for more than seventy years during which time it has overcome a series of challenges. It is currently in a period of transition, with numerous reforms implemented or proposed in recent years. The NHS and ASC have experienced tightening budgets and serious financial pressure, with historically low real-terms growth in health funding from central Government and also from local authorities. We begin by identifying some specific features of the NHS and then describe recent policy innovations designed to make the health and social care system more sustainable in the three main sectors: primary care, secondary care and ASC. We then discuss some future challenges facing the NHS and ASC, before concluding.

1. The English Health and Social Care System

The English NHS is based on the principle of universal access to healthcare, based on need, not ability to pay, and free for patients at the point of delivery. The NHS is funded primarily by general taxation. In 2014, total health expenditure accounted for 9.9% of GDP, similar to the EU-15 average of 9.8% (Health at a Glance: Europe 2018). Demand is projected to increase due to demographic changes such as an ageing population and rising prevalence of long-term conditions. Combined with technological progress, which allows for the introduction of new treatments (including but not exclusively more expensive ones), it is likely that health expenditure will continue to increase.

The Department of Health and Social Care has ultimate responsibility for the organisation of healthcare systems and for developing overall policy on health and adult social care in England, with the devolved Parliaments responsible for the systems in Wales, Scotland and Northern Ireland. There are several other organisations more directly responsible for commissioning and providing health care for patients in England. NHS England, created following the Health and Social Care Act 2012, is in charge of commissioning and general strategy in England. They allocate most of the funding to Clinical Commissioning Groups (CCGs) that are directly responsible for primary care and purchase services from a variety of providers for other aspects of healthcare. Hospital care is provided by Trusts, paid by CCGs for the activity they provide, with patients and General Practitioners (GPs) able to choose which hospital they select for secondary care. These Trusts are overseen by NHS Improvement, which became a part of NHS England in 2019. Local authorities are responsible for assessing needs for ASC and commissioning social services, mainly from independent sector care providers. The Care Quality Commission (CQC) is responsible for the regulation of health and social care.

The relationship between different organisations and contracting/payment arrangements have been reformed in recent years with the aim of increasing efficiency and quality of care. We focus our attention on three central pillars of the health and social care system: Primary Care, Secondary Care and ASC.

2. Primary Care

Primary care in the NHS has seen significant change. The management and arrangement of providers has been reformed, firstly with Primary Care Trusts (PCT) replacing Primary Care Groups between 2000 and 2004. These were then combined into 152 PCTs from 303 in 2006, before PCTS being replaced

with Clinical Commissioning Groups as part of the reforms in the Health and Social Care Act 2012 (NHS Confederation Primary Care Trust Network. 2011). PCTs were designed to 1) commission care from hospitals and other providers for populations registered with practices located in their areas; 2) provide other services such as community care; and 3) improve public health and tackle health inequalities. CCGs are consortiums of GP practices, and there are over 200 serving an average population of 226,000 people each (King's Fund). They have taken agreater role in commissioning than PCTs and now commission most health services, including hospital care, maternity services, mental health services and community care. The commissioning role of CCGs increased over time, linked to policies such as the introduction of Payment by Results and Patient Choice, which we discuss further in section 3.

One of the most significant primary care reforms in recent years was the General Medical Services (GMS) contract in 2004 (Gregory, 2009), which altered the relationship between GPs and the Department of Health (DH). These contracts, detailing the legal framework under which GPs operate and paid, were between the Department of Health (DH) and GP practices, replacing the previous, direct relationship between individual GPs and the DH. This facilitated a more structured approach to primary care, with practices able to opt in or out of providing certain services, and this new contracting arrangement also involved the creation of a financial incentive scheme – the Quality and Outcomes Framework (QOF) – which rewarded practices for providing high quality care through a range of process-based indicators. The 2004 set of indicators included 146 indicators across four domains – clinical, organisational, patient experience and additional services, although the number of indicators has varied since then. Practices scored points based on achievement against each indicator, and a higher score led to a higher financial reward for practices. GP responses to the introduction of QOF have been well studied. Most of the research has suggested QOF improved performance. Doran et al (2011) finds that indicators included in QOF saw significant improvements, while those omitted suffered only small detrimental falls. Kontopantelis et al (2014) found that performance levels for removed indicators remained stable after a similar restructuring of the scheme in April 2006, suggesting that even temporary incentives can be used to encourage permanent improvements to clinical behaviour. Minchin et al (2018) reach a different conclusion using data from 2010 to 2017, finding an immediate drop in performance for measures which were no longer incentivised post 2014. Kontopantelis et al (2012) found that increasing the threshold required to gain reward can incentivise higher levels of performance for influenza immunisation, and Harrison et al (2014) found a decrease in emergency hospital admissions for conditions that were included in QOF compared to emergency admissions for conditions that were not incentivised.

An ethnographic study (McDonald et al 2007) suggests that while the introduction of QOF did not affect the working practices of GPs but there was more concern amongst nurses, with an increase in their administrative duties and less time with patients. McGregor et al (2008) also report that they felt under-rewarded for the additional work they carried out. The impact of QOF does not appear to have made much impact on pharmaceutical expenditure , with Fleetcroft et al (2011) arguing that this is likely caused by prescription behaviour that is not following "best practice", while Gutacker et al (2015) question whether QOF measures capture adequately the quality of care for people with severe mental illness (SMI), as they find higher admissions rates in high-performing practices. These studies show that the design of such incentive schemes needs to be carefully planned and furthermore needs to consider the existence of unintended consequences.

One would expect better primary care performance to generate cost savings for local hospitals. However, Dusheiko et al (2011) using a database of 5 million patients across 8000 general practices showed that only the performance of stroke care amongst ten chronic diseases is associated with

lower hospital costs, with these savings mainly due to reductions in emergency admissions and outpatient visits.

Although clinical outcomes appear to have improved as a result of the QOF, workloads have also increased. Hobbs et al (2016) find a substantial increase in practice consultation rates, average consultation duration, and total patient-facing clinical workload in English general practice between 2007 and 2015. In turn, the higher workload is having a negative impact on workforce retention, with an increasing number of GPs altering their plans and planning to retire earlier, taking career breaks or moving overseas (see e.g. Dale et al 2015; Dale et al 2017; Fletcher et al 2017; Owen et al 2019).

This increased burden on practice staff is unlikely to be sustainable and is one of several issues that the latest contract between GPs and the DH, introduced in 2019, is intended to address. The new contract promises additional funding for 20,000 extra staff by 2023/24, as well as reforming QOF, and modernising delivery of care with enhanced digital provision and community provision of urgent care.

Deprivation plays a key role in determining health care need and there are several issues relating to deprivation that could harm the sustainability of primary care in poorer areas. People in poorer areas tend to have worse health, with the Health Foundation reporting that people from deprived regions were more likely to have multiple health conditions and at an earlier age (Stafford et al 2018). This puts extra pressure on GP resources, with Robson et al (2014) showing that a typical 50-year-old from the most deprived quintile has the same consultation rate as a 70-year-old from the least deprived quintile. Furthermore, GPs in the most deprived areas have 15% more patients per full-time equivalent than those in the least deprived areas.

These issues are contributing to an even greater problem with staff retention in deprived areas than elsewhere, with the GP workforce having fallen 50% faster in practices in the most deprived decile compared to the least deprived decile (GPOnline 2018).

A major use of resources in the NHS is on clinical tests, with Lord Carter reporting that laboratory tests account for up to £3bn (Carter 2006), 4.6% of the approximately £65bn spent by the Department of Health in 2006/7 (Department of Health 2007), with approximately 45% of these requested by primary care physicians. O'Sullivan et al (2018) report that there was a 230% increase in total test-rates across 44 tests studied, and that 40 of the 44 tests saw increased rates from 2000/1 to 2015/16.

As NHS England reported in a General Practice Sustainability and Transformation Delivery Programme (2016) "there are significant challenges being faced by primary care and General Practice in particular. The growing workload and need to manage increasing numbers of patients with multiple and complex health needs, coupled with the uncertainty of future workforce, means we need to radically rethink the model of General Practice if we are to make it sustainable beyond the current decade". The next stage of primary care reform - the General Practice Forward View (GPFV) introduced in 2016 - was developed in this environment, , following discussion with a wide variety of interest groups. An additional £2.4bn per year by 2020/21 was intended to reverse a long period of underinvestment in the sector, with the nine years from 2006 until 2015 seeing the proportion of NHS funding used for general practice decline from 11 per cent to 7.9 per cent.

Significant resources were earmarked for the development of multidisciplinary teams, with funding allocated to allow practices to access practice-based pharmacists, and provide extra mental health workers. The recruitment of 5000 additional full-time equivalent (FTE) GPs in the following five years was also proposed, although this target is some way off being achieved with numbers of FTE GPs actually falling by 1018 between September 2015 and March 2018 (NHS Digital 2018).

Funding was also promised for the development of technology and to improve out-of-hours access, with increased collaboration across practices in networks and hubs. with Mental health services were provided to help GPs suffering from burn-out and stress, and this support has been well received by GPs. A pilot scheme to trial the introduction of medical assistants was also announced to help address GP workload concerns.

These policies, together with extra funding, have the scope to improve a GP care system that has been under severe pressure but it is too early to judge whether these new innovations will resolve the challenges faced by primary care in England. The struggles with recruitment show that there are many challenges to overcome if the plans are to be fully implemented.

3. Secondary and Tertiary care

Secondary and tertiary care relate to care provided in hospitals, whether it is planned elective, emergency or highly specialised (tertiary) care. According to NHS Providers, in March 2017 there were 233 NHS providers of secondary and tertiary care – 152 Foundation Trusts and 81 other providers (additional non-NHS organisations that also provide secondary and tertiary care services).

Of the 233 NHS providers there are:

- 105 acute providers (providing largely hospital-based services)
- 10 ambulance services
- 16 community providers (providing services such as district nursing and health visits)
- 72 integrated providers
- 13 mental health providers; and
- 17 specialist providers

These providers experienced large-scale reform in the early part of the last decade. Hospitals that performed well on a range of financial and clinical metrics could apply for Foundation Trust status from October 2002, with the first operating in 2004/5 (Marini 2008). This status gave them more independence in managing their funds, including the ability to retain surpluses for use in later years. This transferred decision-making away from central government to local groups who would be more in touch with the needs and preferences of the communities they served.

From 2003 there was also a significant change in the way hospitals were funded, with a move away from block grants towards an activity-based system called Payment by Results (PbR). Historically, hospitals in England were paid a fixed budget based on previous costs and activity regardless of actual volume of provision. However, from 2003/4 an activity-based system was introduced, with providers paid a fixed price for each patient treated within a predefined group of treatments called healthcare resource groups (HRGs), e.g for a coronary bypass or a cataract surgery. Farrar et al (2009) provides evidence that the introduction of Payment by Results led to reductions in unit costs of hospital care, with shorter mean length-of-stay and an increase in the proportion of admissions that were day cases. Farrar et al (2009) further find that the new payment system did not affect quality.

PbR also allowed financial flows to follow patients, encouraging hospitals to compete for patients and to reward with increased revenues those that were performing better. It also allowed the entry of private providers into the public healthcare system by giving them access to a source of profit from NHS funds. This was a way of increasing capacity by allowing NHS patients to use private facilities that were already operating for paying patients. The role of private providers in the NHS is relatively small, with the proportion of publicly-funded patients treated by private providers reaching only 4.5% of all

non-emergency treatments in 2013 (Moscelli et al 2018) and spending on the independent sector accounting for 7.3% of total NHS commissioning in 2018-19 (O'Dowd 2019).

The two developments, PbR and the entry of private providers, were part of a wider range of reforms designed to encourage competition between hospitals in the NHS. Patient choice and an effort to increase competition amongst providers was a key feature of NHS policy in the first decade of the twenty-first century. This began in 2002 by giving patients freedom to seek treatment from an alternative provider if their NHS waiting time was more than six months. A policy of offering patients a choice of up to five alternative providers upon referral was introduced from 2006 and extended further in 2008 to any accredited provider, including those in the private sector who were willing to provide care for the nationally defined tariff.

Cooper et al. (2011) study the effects of hospital choice on in-hospital acute myocardial infarction (AMI, more commonly known as heart attack) mortality rates as a proxy for hospital quality and find that mortality rates fell significantly in more competitive markets between 2002-8. Gaynor et al (2013) suggest that gains from the expansion of patient choice reforms could amount to approximately £302m per annum taking into account elements of quality (deaths at all locations within 30 days of AMI, productivity (average length of stay) and total expenditure per patient). Moscelli et al (2018) shows that patient choice also reduced hip fracture mortality but had no effect on stroke mortality. Bloom et al (2015) suggests that greater competition encourages better management, which in turn, leads to better outcomes across a range of medical, administrative, and workforce measures. Gravelle et al (2014) provide empirical evidence showing that across several measures, hospital quality is positively related to the quality of competitor hospitals (but this does not hold for other measures), and the effect becomes weaker in more recent years (Longo et al 2017).

A pre-requisite of competition is that patients choose a hospital based on quality and the evidence on this is mixed. Gaynor et al (2016) find for coronary bypass, hospitals with higher quality (as measured by mortality rates) had more patients. A similar result holds for hip replacement patients (Beckert et al, 2012; Gutacker et al 2016) and cataract surgery in relation to waiting times (Sivey, 2012). However, there was evidence that patients were not fully aware of their right to choose, or were not offered the full range of choices that the policy intended (Mays 2011) .Smith et al (2018) in a study of more than 200,000 admissions in Derbyshire, find that distance to hospital is the main factor in choosing a hospital and that performance information available on the internet plays a minor role.

In a similar development to QOF in primary care, pay-for-performance schemes were also introduced in secondary care (Meacock et al 2014). The Commissioning for Quality and Innovation (CQUIN) framework was introduced across England in April 2009, to encourage the achievement of specific goals for quality and innovation. This was a similar size to QOF, with the financial value of rewards reaching 2.5% of providers' annual contracts by 2012, although targets were agreed locally between providers and commissioners. Evidence suggests the impact of CQUIN was limited (e.g. McDonald et al 2013).

Best Practice Tariffs (BPT) were introduced in April 2010 and aimed to encourage providers to adopt the most clinically and cost effective ways of delivering care. They increased the HRG tariff offered to providers who treated conditions in certain ways; for example, the gall bladder removal BPT increased the day-case price while leaving the in-patient treatment price unchanged. The outcomes from BPT were more favourable, with McDonald et al (2012) showing they increased day-case rates for gall-bladder, and improved outcomes for hip-fracture, but not stroke.

Targets on waiting times for elective treatments have been pervasive within the NHS. Maximum waiting time guarantees were set respectively at 12 months in 2002-03 and 9 months in 2003-04, and then progressively reduced to 18 weeks by 2006. Penalties for missing targets were introduced in 2000-05, with strong political oversight. These contributed to significant reductions in waiting times, by about 6-9 percentage points on the proportion of patients waiting more than six months (Propper et al, 2010). In 2010 waiting times guarantees were included in the NHS Constitution, which . requires that at least 92% patients should start their treatment within 18 weeks. In 2013 about 94% of patients on the list ("incomplete pathway") were waiting less than 18 weeks but this proportion has progressively reduced to 86% in 2018. The median waiting time has increased from 5.6 weeks in April 2013 to 7.2 in April 2019.

There are also maximum waiting times for cancer treatment, patients whose operations have been postponed and for mental health treatment. There are also maximum waiting times for emergency care, more precisely a four-hour waiting time maximum in A&E hospital departments, and for attendance by an ambulance (NHS 2019with financial punishments if these targets are missed.

Unfortunately, these targets are proving harder to reach. Despite increasing activity, an increase in demand means that the proportion of patients treated within the 4-hour Accident and Emergency (A&E) target continues to fall (Appleby 2019). In October 2019 only 83.6% of A&E patients were admitted or transferred within four hours, some way below the 95% target and the worst performance since the target was introduced in 2004. There has long been debate on the unintended consequences of policies like these. There are, for example, incentives to treat people below the threshold at the expense of patients who have already gone past it (see e.g., Gruber et al 2018; Hunt 2014).

The desire to offer care in settings outside of hospital has increased, and the 2014 Five Year Forward View (FYFV) proposed ways to encourage this. The FYFV was created with input from many different stakeholders including patient groups, clinicians, providers and regulators, and intended to show how the health service needed to change to cope with challenges faced by the NHS including widening health inequality and funding. It focused on more preventative medicine, more control of patient care, and new models of integrated care. Specific actions designed to change the delivery of care include vanguard sites, which use more joined-up care across disciplines. Integrated care puts emphasis on coordination of care and move away from the previous market-based reforms. Sustainability and transformation partnerships see the NHS collaborate with local authorities and charities, and accountable care systems, inspired by US models, are another way of working together across community providers. Fifty "vanguard" sites have been testing new models of care.

The FYFV led to the creation of a set of sustainability and transformation plans (STPs), one for each of 44 areas in the country covering an average of 1.2m people (Alderwick and Ham 2017). This new approach to healthcare requires significant changes and time to implement. As such, it is still too early to see major results from their introduction.

4. Adult Social Care

Local authorities have lead responsibility for adult social care (ASC) in England. They have a duty under the Care Act 2014 and associated guidance (DH 2015) to promote wellbeing when carrying out their care and support functions. Wellbeing is defined broadly under the guidance to the Act to include, for example, personal dignity, emotional wellbeing, protection from abuse and neglect, and social and economic wellbeing. The concept of 'independent living' is described as a core part of the wellbeing principle (DH 2015).

ASC is funded through a combination of revenue from central taxation, local taxes and charges to service users. Social care in England, unlike the NHS, is not free at point of use. Access to publicly funded ASC is subject to both an assessment of care needs and a financial means test. This means test considers the service user's wealth to decide whether they are eligible for publicly funded social care and how much the user needs to contribute in user charges. The means test takes account of both savings and incomes, and for residential care the value of the person's house is usually taken into account as well. Over two-fifths of older care home residents and around one-third of older users of home care services fully fund their own care, and about 60% of the costs of ASC for older people are met by service users and their families.

ASC is provided mainly by independent sector organisations, mostly small businesses. These include over 9,500 domiciliary care agencies and over 15,700 care homes with 80% rated as *good* by the Care Quality Commission (CQC 2019). While most care homes provide care for both publicly funded and privately funded residents, home care agencies tend to provide care for either publicly funded users or privately funded users. The market for publicly funded care is under considerable pressure with its sustainability being at risk (CQC 2019). An important factor is that local authorities are under strong financial constraints and the provider sector argues that the fees offered by local authorities are too low (UKHCA 2018).

The number of users of publicly funded ASC has fallen considerably in recent years. The number receiving long term support fell by 3.5% between 2015/6 and 2018/9 (NHS Digital 2019). This reflects a decline in local authority funding of ASC. Gross current expenditure by local authorities on ASC fell by 3.4% in real terms from 2009/10 to 2018/19 (NHS Digital 2019). This fall has resulted in deep concern about the sustainability of ASC. Age UK (2019) have estimated that 1.4 million people have unmet needs for care and that 300,000 of them need help with three or more essential daily tasks. The Association of Directors of Adult Social Services (ADASS) latest budget survey shows that only 35% of directors are fully confident that their budgets will be sufficient to meet specific statutory duties.

Demand for ASC is expected to rise markedly over the coming decades (Wittenberg et al 2018). Public expenditure on ASC for *older* people is projected to rise under the current funding system from around £7.2 billion (0.45% of GDP) in 2015 to £18.7 billion (0.75% of GDP) in 2040 at constant 2015 prices. Public expenditure on ASC for *younger* adults is projected to rise from around £8.9 billion (0.55% of GDP) in 2015 to £21.2 billion (0.85% of GDP) in 2040 at constant 2015 prices. These projections are under a set of base case assumptions, in particular that there are no changes in disability rates (by age and gender) and no changes in the balance between different types of care or in the ASC funding system. They are sensitive to assumptions about future trends in mortality and disability rates and in the real unit costs of care.

Major challenges for the future sustainability of ASC are supply of unpaid care by family and friends (sometimes referred to as informal care) and supply of staff to provide formal care services. Provision of unpaid care is associated with poorer mental and physical health and quality of life, particularly at higher intensities of caring (Brimblecombe et al 2018). Unless the proportion of the population providing unpaid care (by age and gender) rises as demand for care for older people rises, there will be a substantial shortage of unpaid care (Brimblecombe et al 2018). Such a shortfall in unpaid care will put further pressure on formal care services. Yet care providers are already facing challenges in recruiting and retaining staff. The annual turnover rate among social care staff is almost 31% and the vacancy rate is almost 8% (Skills for Care 2019).

ASC has been the subject of much debate and many reviews and proposals for reform over the last 20 years. A major topic of the debate has been the funding arrangements and the means test. The Royal Commission on Long Term Care (1999) recommended that personal care should be free of charge. Free personal care was implemented in Scotland in 2002 but not in the rest of the UK. It has recently been advocated by a number of organisations, but the introduction of free personal care would cost an estimated £3.9 billion in 2020 rising to £5.8 billion in 2035 (at constant 2015 prices) (CASPeR 2018).

A recent joint report by two House of Commons committees (2018) argued that ”the balance needs to be redressed, aspiring over time and moving towards, as funding permits, universal access to sustainably funded social care, free at the point of delivery”.

The Commission on the Funding of Care and Support (2011) recommended a lifetime cap on liability to meet care charges. Under this proposal, service users would be required to contribute to the costs of their care until their accumulated care costs reached a set limit after which care would be free. The May Government decided to implement a lifetime cap in 2016 but then postponed its introduction until 2020.

ASC was a major topic of debate in the 2017 UK general election. The May Government planned to publish a Green Paper on ASC but did not do so. Boris Johnson undertook on taking office as prime minister that he would resolve the issue of social care but with his proposals not yet forthcoming, it is likely to remain a major political issue for some time

5. Future challenges

A UK Parliament Select Committee (UK Parliament 2017) held an enquiry into the Long-term Sustainability of the NHS and Adult Social Care in 2017 and considered evidence from a wide range of contributors. Their overriding concern was that in its current form, the system is unsustainable and will require significant reform if it is to continue to meet its key function of providing healthcare free at the point of use for all citizens.

They highlighted several issues likely to cause problems for the NHS and ASC if not addressed.

- They argue for consistent and increased funding, with a new sustainable model for social care funding.
- The focus on short-term issues makes reform difficult.
- There is a need to look at reforming service provision, with a move to more integrated care, rather than the disaggregated system that has been a feature of healthcare services in England.
- They identiy a lack of long-term workforce planning, an issue that needs to be addressed in order to provide the resources required for healthcare in future.
- Public health is an area that has been neglected and can offer ways to improve the health of the English population in a cost effective way.
- ASC is under immense pressure due to an ageing population and severe cuts to local authority funds. If this is not resolved, it is likely that there will be harmful spill-over effects on the healthcare system.

- Financing issues

There has been and it is likely there will continue to be serious financial issues within the NHS. A National Audit Office (NAO) report on NHS financial stability (2019) identified a £991m combined deficit of NHS trusts and NHS Foundation Trusts in 2017-18 (1.2% of their total income), with a forecast deficit of £558m in 2018-19. CCGs are also overspending, with a £213m deficit (equivalent to 0.3% of the money available for locally commissioned services) in 2017-18.

Additional Government funding announced in June 2018 will increase the NHS England budget by £20.5bn by 2023-24, an average annual real increase of 3.4%. A new long-term plan, published in January 2019, details what the Government expects from NHS providers in return, and their requirements are designed to provide a more sustainable future for the NHS. They include a return to financial balance, with improvements in financial and operational performance, productivity growth of 1.1% per year, a reduction in the growth of demand by utilising more preventative care and integrated care systems, a reduction in variation, and a better use of capital to improve healthcare systems. Other high-income countries are facing similar challenges to fund health and social care. Cylus et al (2018) present evidence from across the globe and conclude that "there is no single optimal, or commonly preferred, solution to achieving sustainable revenues."

- Workforce/recruitment

Perhaps the major concerns currently affecting the NHS relate to staffing, with significant staff shortages and issues relating to recruitment and training of future clinicians. The King's Fund (2018) reported that there were shortages of more than 100,000 staff in late 2018, and if current trends continued, this number could be somewhere between 250,000-350,000 by 2030.

It is likely that the NHS will need to move away from a highly specialised workforce to one which is more flexible. In particular, extra lower-skilled carers will probably be required due to the ageing population and an increase in chronic diseases. There are concerns about the reliance on immigrant staff, especially with the challenges that Brexit may bring. It will require extra funding and a serious long-term plan to ensure that these issues can be avoided, with a new or strengthened organisation likely needed to oversee workforce planning.

- New models of delivery

The House of Lords (UK Parliament 2017) noted that, like health systems across the world, the NHS was set up to "treat short-term episodes of ill health", but is not particularly well designed to deal with the needs of an increasingly ageing population with more complex comorbidities that often require long-term care. This evolution in population characteristics is unlikely to be reversed and as such, a restructuring of providers is required, with much more emphasis on treating patients in community settings rather than in hospitals. Ballard (2013) notes that "integrating care around the needs of patients, and in doing this working with small groups of trusted providers of care rather than duplicating services and operating with multiple companies, is likely to improve patient care and minimise the total resource cost". The FYFV starts to address this concern, introducing several innovative models of care, namely:

    - Multispecialty Community Provider: where several services are combined to create integrated out-of-hospital care
    - Primary and Acute Care Systems: with primary and secondary care services provided by single organisations
    - Urgent and emergency care networks: to provide more integration between A&E and other services.

These frameworks all offer the potential to provide care in a way more suited to the needs of the population. However, their introduction has so far been limited to a small number of sites and there remain concerns, from e.g. Health Foundation (2016) and NHS Providers (2016), about how service transformation will continue into the next decade.

- Public health/preventative care

The English population continues to suffer a large amount of preventative ill health, with about a third of all deaths classed as premature (LGA 2016), and about 40% of the burden on health services in England avoidable if issues such as obesity, alcohol misuse and smoking could be eliminated – obesity alone cost the NHS £5.1bn in 2006/7 (Scarborough et al 2011).

This issue came under scrutiny in the early part of the 2000s, with Sir Michael Marmot chairing an independent review, and publishing a report (Fair Society, Healthy Lives, 2010), looking at ways that health inequalities could be reduced. However, the inequalities noted in that report are proving persistent and hard to address.

It is also likely that significant savings could be realised if public health was improved, but public health budgets in the NHS and at local authorities have been cut in recent years. However, it is not hard to argue that the public have a key role to play in improving their own health. There is often debate about the consequences of Government interfering in people's personal decisions, but increasing education and encouraging people to take more responsibility for their own health could help to mitigate the ever-growing levels of demand for healthcare.

6. Conclusion

The NHS has survived a series of challenges during its seventy-plus year history and has been subject to repeated re-organisations and re-structuring, often principally driven by the will of the political party in government. However, there is a sense that the NHS and ASC are currently at a crossroads, facing new challenges and threats from many directions, and that they are struggling to maintain their longstanding core services. There is a desire from all stakeholders to ensure that the NHS continues to serve the population on a universal basis but its future will be shaped by the way its organisations react to the policies recently introduced and any that are developed in the future. With largescale investment and reform, there is potential for the health and social care system to evolve into a modern service capable of dealing with the needs of an ageing population. However, if these challenges are not met then it is set to continue its struggle with a lack of appropriate facilities, an overstretched staff and a system not entirely appropriate for its patients.

References

Association of Directors of Adult Social Services. 2019, ADASS Budget survey 2019.

Alderwick, H. and Ham, C., 2017. Sustainability and transformation plans for the NHS in England: what do they say and what happens next?. *Bmj*, *356*, p.j1541.

Appleby, J., 2019. What's the point of waiting time targets if they can't be met?. BMJ, 364, p.l845.

Ballard, T., 2013. What sustainability means for primary care: primary care leads to better overall resource use and higher quality outcomes. The British journal of general practice: the journal of the Royal College of General Practitioners, 63(614), 457–458. doi:10.3399/bjgp13X671489

Beckert, W., Christensen, M. and Collyer, K., 2012. Choice of NHS-funded hospital services in England. The Economic Journal, 122(560), pp.400-417.

BMA. 2016. Privatisation and independent sector provision of NHS healthcare. https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/bma-independentsectorprovisionofnhscare-18042016-2.pdf?la=en

Bloom, N., Propper, C., Seiler, S. and Van Reenen, J., 2015. The impact of competition on management quality: evidence from public hospitals. *The Review of Economic Studies*, *82*(2), pp.457-489.

Bottery, S., Varrow, M., Thorlby, R. and Wellings, D., 2018. A fork in the road: Next steps for social care funding reform. The King's Fund,[Online] Available at: https://www. kingsfund. org. uk/publications/forkroad-social-care-funding-reform.

Brimblecombe N, Fernandez JL, Knapp M, Rehill A and Wittenberg R (2018) Review of the international evidence on support for unpaid carers, Journal of Long Term Care, September 2018, 25–40. doi:10.21953/lse.ffq4txr2nftf

Care and State Pension Reform (CASPeR) (2018) Interactions between state pension and long-term care reforms: a summary of further findings, December 2018, https://www.pensionspolicyinstitute.org.uk/media/3002/20181212-casper-interactions-further-findings-summary-report-final.pdf

Carter, Lord. 2006. Report of the Review of NHS Pathology Services in England. *Chaired by Lord Carter of Coles* https://webarchive.nationalarchives.gov.uk/20130124044941/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091984.pdf

Cooper, Z., Gibbons, S., Jones, S. and McGuire, A., 2011. Does hospital competition save lives? Evidence from the English NHS patient choice reforms. *The Economic Journal*, *121*(554), pp.F228-F260.

Cylus, J., Roland, D., Nolte, E., Corbett, J., Jones, K., Forder, J. and Sussex, J., 2018. Identifying options for funding the NHS and social care in the UK: international evidence.

Dale, J., Potter, R., Owen, K., Parsons, N., Realpe, A. and Leach, J., 2015. Retaining the general practitioner workforce in England: what matters to GPs? A cross-sectional study. *BMC family practice*, *16*(1), p.140.

Dale, J., Russell, R., Scott, E. and Owen, K., 2017. Factors influencing career intentions on completion of general practice vocational training in England: a cross-sectional study. *BMJ open*, *7*(8), p.e017143.

Darzi, Lord (2018) Better health and care for all: a 10-point plan for the 2020s https://www.ippr.org/files/2018-06/better-health-and-care-for-all-june2018.pdf

Department of Health. Department of Health Resource Accounts 2006-07 HC 1005. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/250502/1005.pdf

Department of Health and Social Care. 2018. Care and support statutory guidance, updated 26 October 2018, https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Digital, N.H.S., 2018. General and Personal Medical Services in England March 2018, Provisional Experimental statistics. https://files.digital.nhs.uk/A5/41FD68/General%20and%20Personal%20Medical%20Services%20-%20Provisional%20March%202018.pdf

Dilnot, A., 2011. Commission on funding of care and support. Fairer care funding–the report of the Commission on Funding of Care and Support.

Doran, T., Kontopantelis, E., Valderas, J.M., Campbell, S., Roland, M., Salisbury, C. and Reeves, D., 2011. Effect of financial incentives on incentivised and non-incentivised clinical activities: longitudinal analysis of data from the UK Quality and Outcomes Framework. *Bmj*, *342*, p.d3590.

Dusheiko, M., Gravelle, H., Martin, S., Rice, N. and Smith, P.C., 2011. Does better disease management in primary care reduce hospital costs? Evidence from English primary care. *Journal of health economics*, *30*(5), pp.919-932.

England, N.H.S., 2014. Five year forward view.

England, N.H.S., 2016. General practice forward view.

England, N.H.S., and British Medical Association, 2019. Investment and evolution: a five-year framework for GP contract reform to implement The NHS long term plan.

England, N.H.S. 2016. General Practice Sustainability and Transformation Delivery Programme. https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/09/transformation-primary-care.pdf

England, N.H.S. 2016, General Practice Forward View. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Farrar, S., Yi, D., Sutton, M., Chalkley, M., Sussex, J. and Scott, A., 2009. Has payment by results affected the way that English hospitals provide care? Difference-in-differences analysis. *Bmj*, *339*, p.b3047.

Fleetcroft, R., Cookson, R., Steel, N. and Howe, A., 2011. Correlation between prescribing quality and pharmaceutical costs in English primary care: national cross-sectional analysis. *Br J Gen Pract*, *61*(590), pp.e556-e564.

Fletcher, E., Abel, G.A., Anderson, R., Richards, S.H., Salisbury, C., Dean, S.G., Sansom, A., Warren, F.C. and Campbell, J.L., 2017. Quitting patient care and career break intentions among general practitioners in South West England: findings of a census survey of general practitioners. *BMJ open*, *7*(4), p.e015853.

Gaynor, M., Moreno-Serra, R. and Propper, C., 2013. Death by market power: reform, competition, and patient outcomes in the National Health Service. *American Economic Journal: Economic Policy*, *5*(4), pp.134-66.

Gaynor, M., Propper, C. and Seiler, S., 2016. Free to choose? Reform, choice, and consideration sets in the English National Health Service. American Economic Review, 106(11), pp.3521-57.

Gravelle, H., Santos, R. and Siciliani, L., 2014. Does a hospital's quality depend on the quality of other hospitals? A spatial econometrics approach. *Regional science and urban economics*, *49*, pp.203-216.

Gregory, S., 2009. *General practice in England: An overview*. King's Fund.

Gruber, J., Hoe, T. and Stoye, G. 2018. Waiting time targets and patient outcomes in emergency departments. https://voxeu.org/article/impact-waiting-time-targets-emergency-departments

The Guardian (2018) "Jeremy Hunt confirms individual costs for social care to be capped" Guardian 20th March 2018 https://www.theguardian.com/society/2018/mar/20/jeremy-hunt-confirms-individual-costs-for-social-care-capped

Gutacker, N., Mason, A.R., Kendrick, T., Goddard, M., Gravelle, H., Gilbody, S., Aylott, L., Wainwright, J. and Jacobs, R., 2015. Does the quality and outcomes framework reduce psychiatric admissions in people with serious mental illness? A regression analysis. *BMJ open*, *5*(4), p.e007342.

Gutacker, N., Siciliani, L., Moscelli, G. and Gravelle, H., 2016. Choice of hospital: Which type of quality matters?. Journal of health economics, 50, pp.230-246.

Harrison, M.J., Dusheiko, M., Sutton, M., Gravelle, H., Doran, T. and Roland, M., 2014. Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions: controlled longitudinal study. *Bmj*, *349*, p.g6423.

Hobbs, F.R., Bankhead, C., Mukhtar, T., Stevens, S., Perera-Salazar, R., Holt, T. and Salisbury, C., 2016. Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14. *The Lancet*, *387*(10035), pp.2323-2330.

Hood, A. and Simpson, P. 2017. Social care – a step forwards or a step backwards? Institute for Fiscal Studies Observation 19 May 2017 https://www.ifs.org.uk/publications/9243

House of Commons Communities and Local Government Committee. 2017. Adult Social Care HC1103 https://publications.parliament.uk/pa/cm201617/cmselect/cmcomloc/1103/1103.pdf

House of Commons Health and Social Care and Housing, Communities and Local Government Committees. 2018. Long-term funding of adult social care HC 768, page 3. https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf

Hunt, J. 2014. https://www.gov.uk/government/speeches/nhs-waiting-times-job-not-done

Iacobucci G. Is the NHS being privatised? BMJ 2019; 367 :l6376

Independent Age and the Institute and Faculty of Actuaries, 2017. Will the Cap Fit? https://www.actuaries.org.uk/news-and-insights/public-affairs-and-policy/ageing-population/social-care-funding

Institute for Fiscal Studies, 2019. English council funding: What's happened and what's next?

King's Fund, 2018. The health care workforce in England: make or break?

King's Fund, 2017. The Autumn Budget: joint statement on health and social care.

Kontopantelis, E., Springate, D., Reeves, D., Ashcroft, D.M., Valderas, J.M. and Doran, T., 2014. Withdrawing performance indicators: retrospective analysis of general practice performance under UK Quality and Outcomes Framework. *Bmj*, *348*, p.g330.

Kontopantelis, E., Doran, T., Gravelle, H., Goudie, R., Siciliani, L. and Sutton, M., 2012. Family doctor responses to changes in incentives for influenza immunization under the UK quality and outcomes framework pay-for-performance scheme. *Health services research*, *47*(3pt1), pp.1117-1136.

Longo, F., Siciliani, L., Gravelle, H., Santos, R., 2017. Do Hospitals Respond to Rivals' Quality and Efficiency? A Spatial Panel Econometric Analysis, *Health Economics*, 26(S2), pp 38–62.

Marini, G., Miraldo, M., Jacobs, R. and Goddard, M., 2008. Giving greater financial independence to hospitals—does it make a difference? The case of English NHS trusts. Health Economics, 17(6), pp.751-775.

Marmot, Sir M. 2010. Fair Society, Healthy Lives. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

Mays, N., Dixon, A. and Jones, L., 2011. Return to the market: objectives and evolution of New Labour's market reforms. *Understanding New Labour's market reforms of the English NHS*.

McDonald, R., Harrison, S., Checkland, K., Campbell, S.M. and Roland, M., 2007. Impact of financial incentives on clinical autonomy and internal motivation in primary care: ethnographic study. *Bmj*, *334*(7608), p.1357.

McDonald, R., Zaidi, S., Todd, S., Konteh, F., Hussain, K., Roe, J., Allen, T., Fichera, E. and Sutton, M., 2012. A Qualitative and Quantitative Evaluation of the Introduction of Best Practice Tariffs: An evaluation report commissioned by the Department of Health.

McDonald, R., Kristensen, S.R., Zaidi, S., Sutton, M., Todd, S., Konteh, F., Hussein, K. and Brown, S., 2013. Evaluation of the commissioning for quality and innovation framework final report. University of Nottingham.

McGregor, W., Jabareen, H., O'Donnell, C.A., Mercer, S.W. and Watt, G.C., 2008. Impact of the 2004 GMS contract on practice nurses: a qualitative study. Br J Gen Pract, 58(555), pp.711-719.

Meacock, R., Kristensen, S. and Sutton, M., 2014. Paying for improvements in quality: recent experience in the NHS in England. Nordic Journal of Health Economics, 2(1).

Minchin, M., Roland, M., Richardson, J., Rowark, S. and Guthrie, B., 2018. Quality of care in the United Kingdom after removal of financial incentives. *New England Journal of Medicine*, *379*(10), pp.948-957.

Moscelli, G., Gravelle, H., Siciliani, L. and Santos, R., 2018. Heterogeneous effects of patient choice and hospital competition on mortality. Social Science & Medicine, 216, pp.50-58.

Moscelli, G., Gravelle, H., Siciliani, L. and Gutacker, N., 2018. The effect of hospital ownership on quality of care: evidence from England. Journal of Economic Behavior & Organization, 153, pp.322-344.

National Audit Office. 2019. NHS financial sustainability. https://www.nao.org.uk/report/nhs-financial-sustainability/

N.H.S England and British Medical Association, Investment and evolution: a five-year framework for GP contract reform to implement The NHS long term plan. 2019.

OBR. 2018. Fiscal Sustainability Report. July 2018. https://obr.uk/fsr/fiscal-sustainability-report-july-2018/

OECD/EU (2018), Health at a Glance: Europe 2018: State of Health in the EU Cycle, OECD Publishing, Paris/EU, Brussels, https://doi.org/10.1787/health_glance_eur-2018-en.

O'Dowd, A., 2019. NHS is spending more on private providers despite government pledges. BMJ: British Medical Journal (Online), 366.

O'Sullivan, J.W., Stevens, S., Hobbs, F.R., Salisbury, C., Little, P., Goldacre, B., Bankhead, C., Aronson, J.K., Perera, R. and Heneghan, C., 2018. Temporal trends in use of tests in UK primary care, 2000-15: retrospective analysis of 250 million tests. *bmj*, *363*, p.k4666.

Owen, K., Hopkins, T., Shortland, T. and Dale, J., 2019. GP retention in the UK: a worsening crisis. Findings from a cross-sectional survey. *BMJ open*, *9*(2), p.e026048.

NHS Confederation Primary Care Trust Network. 2011. The legacy of Primary Care Trusts.

Parliament, U.K., 2017. House of Lords Select Committee on the Long-term Sustainability of the NHS.Report of session 2016–17 the long-term sustainability of the NHS and adult social care.

Propper, C., Sutton, M., Whitnall, C. and Windmeijer, F., 2010. Incentives and targets in hospital care: evidence from a natural experiment. Journal of Public Economics, 94(3-4), pp.318-335.

Robertson, R., Wenzel, L., Thompson, J. and Charles, A., 2017. Understanding NHS financial pressures. *How are they affecting patient care*. King's Fund.

Robson, J., Hull, S., and Boomla, K. 2014. GP funding formula masks major inequalities for practices in deprived areas. *Bmj*, *349*, p.g7648.

Royal Commission on Long Term Care of the Elderly. 1999. With Respect to Old Age, Cm 4192, London: The Stationery Office.

Scarborough, P., Bhatnagar, P., Wickramasinghe, K.K., Allender, S., Foster, C. and Rayner, M., 2011. The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs. *Journal of public health*, *33*(4), pp.527-535.

Sivey, P., 2012. The effect of waiting time and distance on hospital choice for English cataract patients. Health Economics, 21(4), pp.444-456.

Skills for Care. 2019. The state of the adult social care sector and workforce in England.

Smith, H., Currie, C., Chaiwuttisak, P. and Kyprianou, A., 2018. Patient choice modelling: how do patients choose their hospitals?. Health care management science, 21(2), pp.259-268.

Stafford, M., Steventon, A., Thorlby, R., Fisher, R., Turton, C. and Deeny, S., 2018. Briefing: Understanding the health care needs of people with multiple health conditions. The Health Foundation, London.

United Kingdom Homecare Association (UKHCS). 2018. The Homecare Deficit 2018: A report on the funding of older people's homecare across the United Kingdom.

Wanless D. 2006. Securing Good Care for All London: The King's Fund https://www.kingsfund.org.uk/projects/wanless-social-care-review

Wittenberg, R., Hu, B., & Hancock, R. 2018. Projections of demand and expenditure on adult social care 2015 to 2040, DP2944, https://www.pssru.ac.uk/publications/pub-5421/

https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2019-20/ (accessed November 2019)

https://www.bbc.co.uk/news/health-50397856 (accessed November 2019)

https://www.kingsfund.org.uk/projects/new-nhs/clinical-commissioning-groups

Local Government Association – Written evidence (NHS0125)

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/nhs-sustainability-committee/longterm-sustainability-of-the-nhs/written/38843.html

The Health Foundation – Written evidence (NHS0172)

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/nhs-sustainability-committee/longterm-sustainability-of-the-nhs/written/39736.html

NHS Providers – Written evidence (NHS0110)

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/nhs-sustainability-committee/longterm-sustainability-of-the-nhs/written/38720.html

King's Fund – Written evidence (FSC 174)

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/housing-communities-and-local-government-committee/long-term-funding-of-adult-social-care/written/80060.html

https://www.skillsforcare.org.uk/About/Skills-for-Care-and-Development/The-economic-value-of-the-adult-social-care-sector-UK.aspx

https://www.gponline.com/gp-workforce-falling-50-faster-deprived-areas-official-data-show/article/1465701

https://nhsproviders.org/topics/delivery-and-performance/the-nhs-provider-sector