

healthcare – the next five years

Edited by Michelle Mitchell



Think Ahead



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Introduction

The NHS was established in 1948. Today it faces its biggest challenge since its inception. A failure to radically reform how we deliver new models of care across the NHS over the next five years could lead to a serious threat to this much-loved public service remaining universal and free at the point of need.

The challenges we face are, in large part, due to the outstanding success of the NHS as well as life-changing medical advances. The NHS has a lot to celebrate – it has contributed to people surviving conditions that in the previous century would have been fatal, and has contributed to an increasing life expectancy. Survival in most cancer types continues to improve as a result of advances in treatment and diagnosis. Innovation in vaccinations means that smallpox has been eliminated, and polio has almost been eradicated. New treatments continue to be developed which allows us to be treated much sooner, and are available in more local settings, such as the GP practice. In the first 50 years of the NHS, life expectancy at birth increased by almost a decade. Around a third of babies born in the UK in 2012 are expected to survive to celebrate their 100th birthday.

However, times are changing. In the face of widening health inequalities, an ageing population, an increasing number of people living with more than one long-term condition, and the continuing impact of risk factors such as smoking, alcohol, physical inactivity and poor diet, the NHS must change. The pace and scale of change required is unprecedented. The 2014 NHS *Call to Action*¹ stated that the difference in disability-free life expectancy at birth between the richest and poorest parts of the country is now 17 years. According to the World Health Organization,² around 80 percent of deaths from major diseases are attributable to lifestyle risk factors such as smoking, excess alcohol and poor diet. A quarter of the population (just over 15 million people) have a long-term condition such as diabetes, depression, dementia or high blood pressure – and they account for 50 percent of all GP appointments and 70 percent of days in a hospital bed. The number of older people likely to require care is predicted to rise by over 60 percent by 2030.

A failure to spread innovation and adapt could come at a huge cost. For example, Newcastle Royal Victoria Infirmary has one of the best MS units in the country, and is host to some of the most innovative clinical trials. It provides subspecialist MS care, and people with MS are treated by a multi-disciplinary team, allowing for swift referral as necessary. As a result, access to treatments for MS is significantly higher in Newcastle than elsewhere, and the

1 NHS *The NHS Belongs to the People: A Call to Action* (2014)

2 World Health Organization *Global Status Report on Noncommunicable Diseases 2011* (2011)

service experiences fewer relapse admissions than other units nationally. Allowing for others to learn and share innovation and expertise, such as that fostered at the Newcastle Royal Victoria Infirmary MS service, will be vital to ensuring the future sustainability of the NHS.

Not that you would get much of a sense of this "burning platform" from the newspapers, TV or social media. The general public's love of the NHS is undiminished. The political parties understand all too well the significance of the NHS as the top issue. The February 2015 Ipsos Mori Issues Index shows that 41 percent of the general public see the NHS as the most important issue facing Britain, ahead of immigration (34 percent) and the economy (30 percent) in voters' minds. That is why they are falling over themselves to demonstrate that the NHS would be safe in their hands. But safe how, and until when? None of the political parties has developed a distinctive offer on the NHS, and in some cases they have exaggerated their differences.

On the other hand, NHS England and system leaders have not been quiet about what they think the future holds. The *Five Year Forward View* (FYFV) published in 2014 tells a powerful and hopeful story of the possibility of change for the NHS, for those who work in the NHS, and for those who live with or are at risk of ill health and living with one or more long-term conditions. The key elements it proposes – changing services, focusing on prevention and public health, empowering patients, creating a social movement on health – have resonated with many. So too has the approach of learning from the many initiatives that preceded it, by setting out a direction of travel rather than a blueprint – outlining care models that could be built from the bottom up, motivating and inspiring rather than dictating change, based on the needs of local populations. All are reasons to be cheerful, but how realistic is the picture of the future it paints, and what needs to happen to make it a reality?

Before exploring this issue further, it would be wise to add a note of caution. The FYFV is optimistic and, some think – in the language of Sir Humphrey – "brave". Current trends in demand, sustained rates of productivity, and rising pay and prices all suggest that the NHS will face a £30 billion funding gap by 2020/21. The FYFV predicts unprecedented efficiency gains of 2–3 percent annually in order to address £22 billion of this £30 billion funding gap – it has averaged 0.8 percent annually historically, and there remains the small issue of an additional funding requirement of £8 billion a year by 2020/21.

The FYFV requires all parts of the health system, politicians, charities, patients and the public to work together. Writing about and predicting change, however, is far easier than achieving change. Early skirmishes have highlighted the very real difference between theory and practice. Prevailing disagreements over tariff plans for 2015/16 are a clear indicator of

the scale and complexity that the NHS faces in balancing local leadership and flexibility alongside ever-increasing demands on local decision makers.

This monograph aims to make a positive contribution to the debate about change and the future of health in England. It explores the context for change, the route map for change, scaling the challenge, changes in commissioning and the workforce, the financial implications of change and the power of patients and people to change our health futures.

In chapter one, Anita Charlesworth looks at the financial context for change. She concludes: "There are viable models for a sustainable NHS, but delivering that sustainable future is an enormous challenge."

In chapter two, Mike Birtwistle looks at the political context for change and argues that the NHS "... remains the most popular British institution, and its popularity seems remarkably resilient to challenge". He states that the British public's love affair with the NHS "... can absolutely continue, but both sides will need to work at it".

Kieran Brett, in chapter three, examines the route map for change and concludes: "For the NHS to survive, it needs more change, not less." Part of this change should be "targeting the highest-cost, highest-use patients early in the change process and using personal health budgets".

How best to meet the challenge is explored in more depth in chapters four to seven. Dr Charlotte Augst argues in chapter four that the "scale of preventable illness is truly staggering", bringing "untold misery" for affected individuals and their families. She highlights that the Richmond Group of charities is calling for a national action plan for the reduction of preventable illness and mortality from major conditions by 25 percent by 2025.

Continuing on the theme of prevention, Dr Gabriel Scally in chapter three states that what action is needed to take prevention seriously must "be a concerted effort to reduce the influence of vested influences that make profit from selling unhealthy products".

That "whole-person care is not only achievable, but also both vital and inevitable" is the contention of Tom Wright in chapter six. He points out: "Making change requires strong leadership locally; time and space for innovative thinking and partnership working to develop and mature; guaranteed medium-term... funding; and, critically, support for people to take risks and the flexibility for them to do things differently." It

is this approach that will enable charities to be effective partners in change.

"It is time for a 'carer-friendly NHS'," explains Helena Herklots in chapter seven. She notes that while it is crucial that the FVfV has recognised the role and importance of carers, "it will take significant behavioural change to improve carers' experiences day-to-day". She calls for annual health checks for carers and regular breaks from caring. "At the system level, the NHS should monitor when carers are being admitted to hospital because of the impact of their caring role," she recommends.

In chapters eight to 11, we examine what the forerunner areas will need to make change a reality. Change is required from commissioners and providers.

In chapter eight, Julie Wood notes: "Clinical commissioning is already making a positive difference." However, she says, change is urgently needed "to enable it to achieve much more, at scale and pace, to support the challenges currently facing the NHS". Her six-point plan includes ensuring stability in turbulent times, putting faith in clinical leadership, and freeing clinical commissioners to act in the best interests of patients, enabling CCGs to work across boundaries.

Rick Stern in chapter nine believes that attention must be turned to providing "the support and resources necessary to ensure that first contact, especially in general practice, is as easy, rapid and effective as possible". He says: "The big opportunities in the next five years are likely to be where confident and competent providers, across both primary and secondary care, stop looking to others and create new models of care that make sense for their local communities."

In chapter 10, Rob Webster focuses on the workforce. He warns: "There remains a significant risk that the FYfV, and [the NHS Confederation's] own 2015 Challenge manifesto, will suffer the fate of strategies that have come before them: warm, even inspiring, words will achieve nothing without concerted action." In particular, the government must recognise and address the additional skills required by the health and care workforce in order to deliver personalised, sustainable and integrated models of care. He argues that "securing a workforce that is fit for the future is a leadership task," and concludes: "We have a workforce that can be fit for the future. The NHS will survive only if we work together to ensure that it is."

In his examination of the pressures on the NHS, Richard Murray in chapter 11 suggests that unless something is done, "at best we are left facing the rising demand that has historically required the NHS to spend at ever-increasing levels. At worst, the

current upsurge in demand will continue and add to this pressure, and it is likely that continued cuts to social care will only exacerbate this." Even if NHS England and its partner organisations are successful in securing an additional £8 billion, he argues, "it is... the efficiency programme that offer[s] hope for the future". Efficiencies could be delivered through transforming services, he says, "at the same time as encouraging us all to look after our own health offers a way to improve health while making best use of taxpayers' money." Time, he argues, "is now in short supply".

ACCA, in its international study in chapter 12, draws lessons from around the world to make a similar point. It is that "innovative approaches to healthcare service provision" taken from across the world "will be required to achieve an outcome that is politically acceptable, sustainable and offers value for money".

The various contributors provide details on actions that need to be taken to secure our health futures. However, the most important change of all is how the healthcare system mobilises and recognises the assets, strengths and abilities of individuals. At present we do not invest or accurately measure the things patients value – improved experience of care matters as much to most patients as clinical effectiveness and safety. Ensuring the Quality Outcomes Framework accurately reflects the experiences of all patients, and the National Quality Board places patients at the heart of its work, would be two excellent places to start. Making sure we support patients to be at the heart of their own care planning, and feel supported to manage their condition, will be crucial to bringing about the change required.

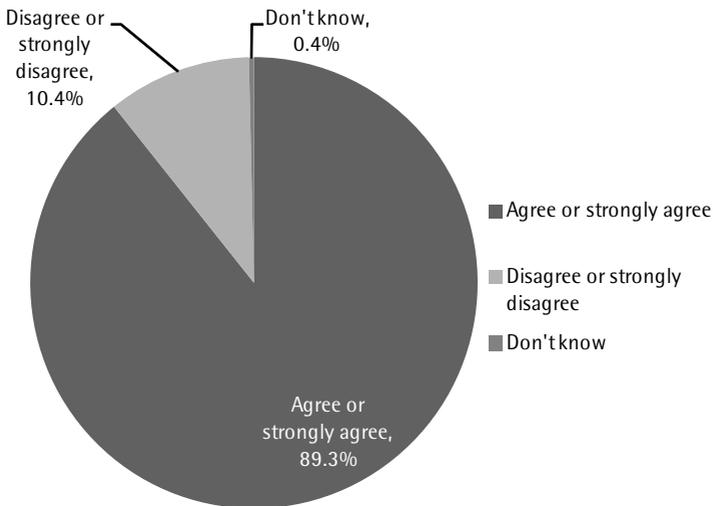
The experience of Lynne Craven, who lives with MS, epitomises the importance of patients being at the heart of the NHS. She says of her care: "I was an equal partner in [my] consultation; that's what good patient engagement feels like. I was listened to and felt my role was important and that I could do this. I was fully engaged with my care planning and it worked."

Is the NHS sustainable?

Simons Stevens, the head of the NHS in England, recently published his "manifesto" for the health service over the next five years. This *Five Year Forward View* concluded that a comprehensive tax-funded NHS is not intrinsically un-doable. Rather, it argued: "there *are* viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local".¹

Public attitude research suggests that the overwhelming majority of the public certainly hope that Simon Stevens is correct. Recent research finds that support for the core principle of a tax-funded NHS free at the point of use, based on need rather than on ability to pay, is rock solid.²

Figure 1: Public support for a tax-funded NHS providing free and comprehensive care
Levels of agreement with the assertion that "the government should support an NHS that is tax-funded, free at the point of use, and providing comprehensive care for all citizens".



Source: Gershlick, B, Charlesworth, A and Taylor, E *Public Attitudes to the NHS* (Health Foundation/NatCen, forthcoming 2015)

1 NHS England *Five Year Forward View* (2014) (<http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>)

2 Gershlick, B, Charlesworth, A and Taylor, E *Public Attitudes to the NHS* (Health Foundation/NatCen, forthcoming 2015)

Mirroring the public support for the NHS, the Coalition government has protected the health budget in England from the full force of spending cuts introduced to tackle the fiscal deficit. Over the current parliament, spending on the NHS in England will have risen by an average of 0.9 percent a year in real terms.³ The modest real-terms increase in health spending comes within the context of a reduction in spending on other public services in England. Over the five years from 2010/11 to 2015/16, the real-terms cuts to unprotected departments are expected to average almost 20 percent.⁴

Despite its relative protection the NHS is struggling. Cracks are beginning to appear in the quality of the service, with key performance standards being breached – most notably the four-hour A&E waiting target this winter.⁵ Moreover, the health service is showing signs of financial distress. Four out of five acute hospitals could not balance their books halfway through the financial year 2014/15. As a result, in December 2014, the government committed more funding to the NHS. In the current year (2014/15) the Treasury is increasing the Department of Health's budget by £250 million and is allowing money to be shifted from the capital budget to fund higher running costs (£490 million). In 2015/16 the Department of Health's budget has been increased by a further £1.25 billion.⁶ Without this additional funding the NHS would almost certainly have overspent its budget for the first time since 2005/06.⁷

Looking to the next parliament, NHS England analysed the funding pressures facing the NHS in England for the next five years (2015/16 to 2020/21).⁸ It estimates that funding pressures facing the NHS will be around £30 billion higher, in real terms, at the end of the decade. These pressures result from the impact of a growing and ageing population, rising expectations of care, new technologies and increasing input costs. Looking beyond the next parliament, pressures on the health budget are projected to rise further, with funding pressures growing to around £100 billion in real terms by 2030/31 (2014/15 prices).⁹

3 Lafond, *S Funding Overview: Current NHS Spending in England* (Health Foundation, 2015) (http://www.health.org.uk/media_manager/public/75/publications_pdfs/Funding%20overview_Current%20NHS%20spending%20in%20England.pdf)

4 Crawford, R, Emmerson, C, Keynes, S and Tetlow, G *Fiscal Aims and Austerity: The Parties' Plans Compared*, IFS briefing note BN158 (Institute for Fiscal Studies, December 2014)

5 Care Quality Commission *Annual Report and Accounts 2013/14* (2014) (<http://www.cqc.org.uk/sites/default/files/20140708-cqc-annual-report-web-final.pdf>); QualityWatch *Cause for Concern: QualityWatch Annual Statement 2014* (Health Foundation/Nuffield Trust, 2014) (http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QW%20annual%20statement%2014%20%28final%29.pdf)

6 Lafond, op cit

7 Charlesworth, A *Briefing: NHS Finances – The Challenge All Political Parties Need to Face* (Health Foundation, 2015) (http://www.health.org.uk/public/cms/75/76/313/5297/Briefing_NHS%20finances.pdf?realName=XTPxmM.pdf)

8 NHS England, op cit

9 Roberts, A *Funding Overview: NHS Funding Projections* (Health Foundation, 2015) (http://www.health.org.uk/media_manager/public/75/publications_pdfs/Funding%20overview_NHS%20funding%20projections.pdf)

Some might argue that the current problems in the health service, combined with ever-increasing funding pressures and a fiscal deficit still around 5 percent of gross domestic product (GDP), point to a model that has reached its sell-by date and that the NHS therefore cannot be considered sustainable.

The reason Simon Stevens and others conclude the NHS model is not inherently unsustainable lies in the potential for productivity improvement. As Paul Krugman observed, "productivity isn't everything, but in the long run it is almost everything".¹⁰ Krugman made this observation in relation to the economy as a whole – since productivity is what delivers and sustains economic growth – but he could also have been talking about the health service. The rate of future productivity growth across the NHS will be a crucial factor in determining whether the NHS is economically sustainable. Productivity growth will also almost certainly shape the political sustainability of the service.

The amount of additional funding the NHS will require for the next five years is hugely dependent on its rate of productivity growth. NHS England has estimated the additional funding requirement above inflation under three scenarios for productivity. These are shown in table 1.

Table 1: Estimates of funding pressures facing the NHS in England by the end of the decade

NHS England's projections of total spending are in cash terms, allowing it to explore the impact of cost pressures (such as pay) separately from assumptions for GDP deflators; the budget for NHS England is then assumed to rise with inflation.

Productivity growth assumption	Funding requirement in 2020/21 above inflation
0.8 percent a year	£21 billion
1.5 percent a year	£16 billion
2-3 percent a year	£8 billion

Source: Charlesworth, A *Briefing: NHS Finances – The Challenge All Political Parties Need to Face* (Health Foundation, 2015)

NHS England argues that by implementing the ambitious programme of service redesign set out in its *Five Year Forward View* the NHS could deliver productivity improvements in the range of 2-3 percent a year and thereby reduce the additional funding requirement to £8 billion in 2020/21 over and above inflation.

¹⁰ Krugman, PR *The Age of Diminished Expectations* (MIT Press, 1994)

Beyond this decade, productivity growth continues to have a substantial impact on the funding required to sustain the NHS. If the health service maintains annual productivity growth at the trend rate, funding would need to rise by around 2.9 percent a year, which is above the expected rate of economic growth of 2.3 percent a year.¹¹ If NHS productivity grows at the same rate as that for whole economy, health spending would need to increase in line with GDP. The results of this analysis are shown in figure 2.

Although the NHS in England delivered productivity improvements of just over 2 percent a year for the first two years of the current parliament, maintaining productivity growth at this rate to 2020/21 would represent an unprecedented level of health service productivity improvement for such a long period. Research by the University of York found that between 2004/05 and 2011/12 productivity in the NHS grew by an average of 1.5 percent a year – higher than the longer-run UK average for healthcare of 1 percent a year.¹² However, this is below the Office for Budget Responsibility's estimate of the trend rate of growth for economy-wide productivity, which is 2.2 percent a year.¹³

If NHS productivity matched the estimate of the whole-economy trend rate of productivity growth, public spending on health as a share of GDP could remain broadly constant and meet projected pressures. However, there is no evidence that productivity at this rate could be sustained in the medium term. Healthcare provision is relatively labour-intensive, and it is therefore likely that productivity growth will be slower in this sector than in the economy as a whole. Over the medium term, wages in the health sector would still need to rise in line with those in the whole economy. This would lead to what is known as "Baumol's cost disease", where the costs of health services rise relative to other sectors of the economy that are less labour-intensive.¹⁴

The Office for Budget Responsibility expects economic growth of around 2.3 percent a year in real terms over the medium to long term.¹⁵ Growth at this rate would mean that UK GDP would be a huge £800 billion larger by 2030/31 in current prices. Although making all of this available to health is clearly not realistic, it does make the figure of £65 billion look considerably more sustainable.

11 Roberts, op cit

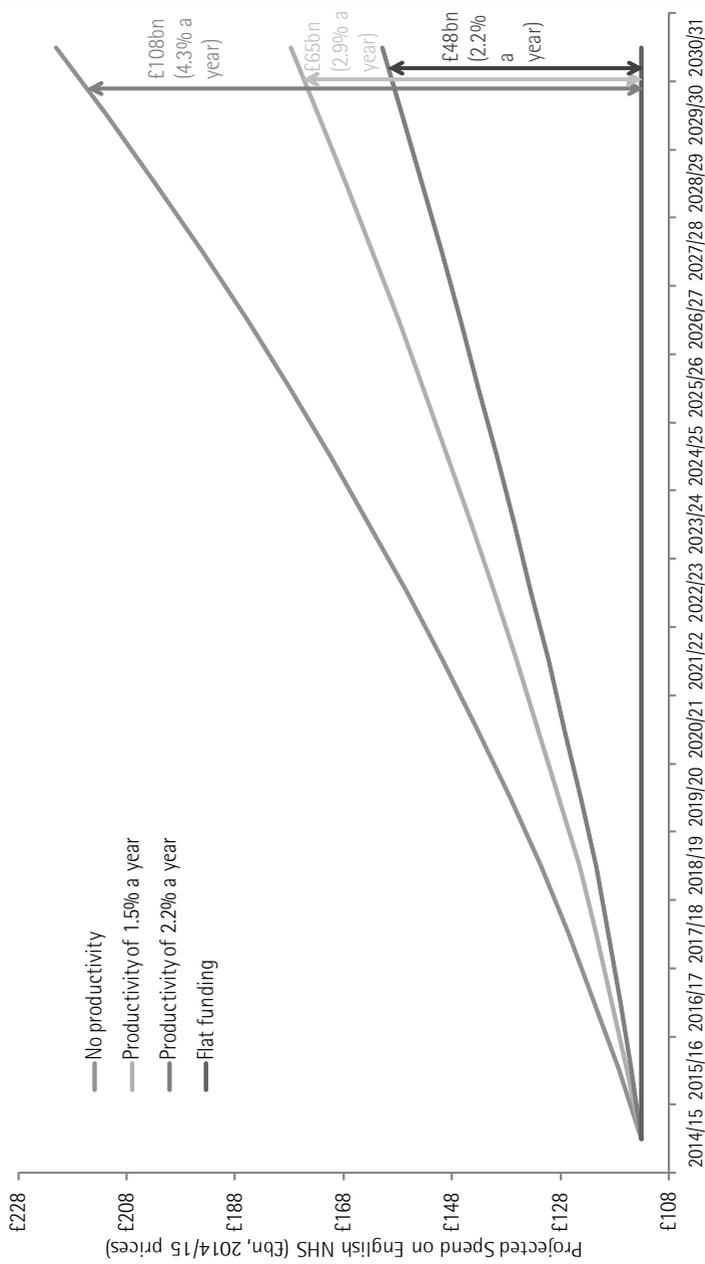
12 Bojke, C, Castelli, A, Grasic, K and Street, A *Productivity of the English National Health Service from 2004-5: Updated to 2011-12* (Centre for Health Economics at the University of York, 2014)

13 Office for Budget Responsibility *Fiscal Sustainability Report* (The Stationery Office, 2014) (<http://cdn.budgetresponsibility.org.uk/41298-0BR-accessible.pdf>)

14 Baumol, WJ, de Ferranti, D, Malach, M, Pablos Mendez, A, Tabish, H and Gomory, WL *The Cost Disease: Why Computers Get Cheaper and Health Care Doesn't* (Yale University Press, 2012)

15 Office for Budget Responsibility *Economic and Fiscal Outlook* (The Stationery Office, 2014) (http://budgetresponsibility.org.uk/pubs/December_2014_EFO-web513.pdf)

Figure 2: Funding pressures on English NHS in 2030/31



Source: Roberts, A. *Funding Overview: NHS Funding Projections* (Health Foundation, 2015)

Continuing to improve the productivity of the health service is not only an important factor in the NHS's funding requirements, it is also important for our overall economic performance. In 2012 the UK devoted 9.3 percent of GDP to health, matching the OECD average but below that of many of the UK's European partners.¹⁶ Health spending as a share of GDP averaged 10 percent among the EU-15 nations.¹⁷ While economic growth is necessary for additional health spending, it is almost certainly not sufficient. Clearly, it also depends on how we as a society choose to spend our growing wealth, and decisions about this depend not just on productivity but also on social welfare – how far citizens value the output of health spending compared with that of other services.

Over the last 65 years health spending has outpaced both inflation and economic growth in the UK and across the OECD and EU. The percentage of GDP that the UK spends on publicly funded healthcare is similar to the average for the EU-15, but lower than that for many comparable countries, including the Netherlands, Denmark and France. If NHS funding did increase by 2.9 percent a year in real terms up to 2030/31, and this was matched in Scotland, Wales and Northern Ireland, and private spending maintained its current share of UK GDP, total health spending by 2030/31 would increase from 9.3 percent of GDP to 10.1 percent – only just exceeding the current EU-15 average of 9.9 per cent (which is also likely to have grown by then). This reinforces the importance of productivity growth, as no economy can afford to have relatively poor productivity performance across almost a 10th of its economic activity.

The NHS's ability to improve its productivity will also shape the political sustainability of the service. The British Social Attitudes Survey shows that around half of adults in Great Britain believe the NHS still wastes money.¹⁸ Worryingly, those who have most recently come into contact with the health service, either as a patient or through a loved one's care, are more likely to agree that the NHS wastes money. Moreover, those concerned about waste are reluctant to see health spending increases prioritised over other public services.

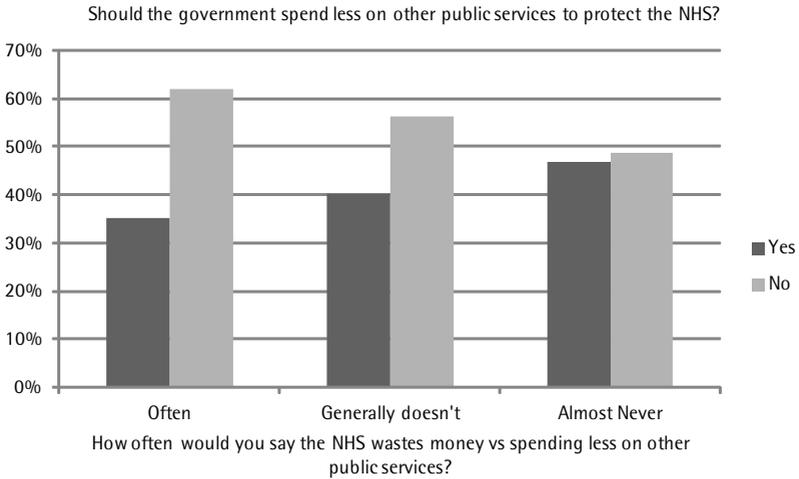
To maintain an increase in the level of service provided that is in line with increases in real output across the rest of the economy, government expenditure on health would have to increase more rapidly than GDP growth. While this is not necessarily a macroeconomic problem, it is most certainly a fiscal problem. Although health spending in the UK is comparatively modest by international standards, the share of spending that is funded by

¹⁶ 2012 is the most recent year for which international comparison data are available from the OECD. International data compares the UK as a whole with other countries. Health is devolved in the UK but English NHS spending accounts for around 87 percent of all UK spending.

¹⁷ The EU-15 are the member countries of the European Union prior to the accession of 10 candidate countries on 1 May 2004. The EU-15 comprises the following countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the UK.

¹⁸ Gershlick et al, op cit

Figure 3: Public views on NHS spending on health versus other public services



Source: Gershlick, B, Charlesworth, A and Taylor, E *Public Attitudes to the NHS* (Health Foundation/NatCen, forthcoming 2015)

taxation is comparatively high. In 2012 publicly funded health spending¹⁹ accounted for 84 percent of UK health spending, compared with 72.3 per cent across the OECD and 76.7 percent across the EU-15.

From an economic viewpoint there is no inherent maximum level of spending on health, but, in a tax-funded system, pressures on health spending have clear implications for the fiscal position. After the election, all political parties are committed to reducing the fiscal deficit, which will involve further cuts to public spending. Healthcare now accounts for almost £1 in every £5 of government spending – just sustaining, let alone improving, the quality of care while delivering fiscal balance will be one of the major challenges facing any incoming government. This may lead some to conclude that the problem for the UK is not the total amount spent on health but rather the heavy reliance on public health funding.

¹⁹ Public expenditure on healthcare is made up of all government expenditure on healthcare including expenditure in prisons and defence. Research and development and education and training in healthcare are not included. Private healthcare expenditure is defined as private household spend on medical goods and services, private healthcare insurance, expenditure by not-for-profit institutions serving households (including charities and other non-profit organisations) and private-sector capital. Private household spending on medical goods and services includes goods such as over-the-counter pharmaceuticals and services such as dental and private hospital services. See: Office for National Statistics *Expenditure on Health Care in the UK: 2012* (2012) (http://www.ons.gov.uk/ons/dcp171766_361313.pdf).

Evidence on the relative efficiency and effectiveness of the NHS varies. Work by the Commonwealth Fund ranked the UK as one of the highest-performing systems,²⁰ but research by the OECD suggested there is significant scope for improvement.²¹ The OECD grouped member countries into six categories: a group of countries relying extensively on market mechanisms in regulating both insurance coverage and service provision; two groups of countries with publicly funded basic insurance coverage and extensive market mechanisms in regulating provision, but differentiated by the use of gatekeeping arrangements and the degree of reliance on private health insurance to cover expenses beyond a basic package of care; a group where the rules provide patients with choice among providers, with no gatekeeping but extremely limited private supply; and two groups of heavily regulated public systems, separated by differing degrees of the stringency of gatekeeping arrangements and of the budget constraint.

The OECD found that efficiency varies more within country groups sharing similar institutional characteristics than between groups. It concluded: "this suggests that no broad type of health care system performs systematically better than another in improving the population health status in a cost-effective manner".²² Moreover, the OECD study authors concluded that "big-bang reforms" to healthcare systems are not warranted. Rather, they advocate that countries should look to increase the coherence of their health policy, by adopting best policy practices from within a similar system and borrowing the most appropriate elements from other systems.

The big challenge for the NHS over the coming years is how to maximise its productivity improvement. NHS England has mapped out new models of care delivery that aim to deliver this, but, as governments have found for the last 30 years or so, the right policy mix to unlock the productivity potential of the NHS has proved somewhat elusive. We have had a range of initiatives targeted at the incentives, sanctions and support for the NHS. The policy mix has included quasi-market reforms; more professional management, targets and top-down control; organisational autonomy; networks; national service frameworks; programmes to integrate health and social care; personalisation; more transparency; and public performance reporting. Some have been evaluated, often with mixed results, but others have not. What is clear is that there is no single silver bullet to improve productivity and that successful policy will involve the skilful deployment of a range of tools.

20 Davis, K, Stremikis, K, Schoen, C and Squires, D *Mirror, Mirror on the Wall, 2014 Update: How the US Health Care System Compares Internationally* (Commonwealth Fund, 2014) (http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf)

21 Joumard, I, André, C and Nicq, C "Health Care Systems: Efficiency and Institutions", OECD Economics Department working paper no 769 (OECD Publishing, 2010) (doi: 10.1787/5kmfp51f5f9t-en)

22 Ibid

Simon Stevens is almost certainly correct in saying that the NHS is not inherently unsustainable in the foreseeable future. There are viable models for a sustainable NHS, but delivering that sustainable future is an enormous challenge that will require dogged focus and persistence. The macroeconomic challenge presented by rising health funding pressures is easy to overstate; however, the microeconomic challenge of designing and delivering a system that continues to improve while also delivering maximum health gain for taxpayer spend is much, much greater.

Will the public's love for the NHS continue?

The NHS remains the most popular British institution, and its popularity seems remarkably resilient to challenge. The question is whether this resilience can endure changes in society, changes in expectations and changes in the pressures on health services.

When the NHS is criticised, the public's reaction is often to love it more rather than to question it. Anyone who witnessed the outpouring of emotion on Twitter following Daniel Hannan's description on American television of the NHS as a "mistake" can attest to that. In many ways the public's feelings about the NHS are more akin to how you might feel about a sports team than about a public service you pay for through your taxes. A bad result simply prompts you to profess your loyalty even more vehemently. You might moan and groan about it but – ultimately – your devotion transcends its actual performance. This is not a response that many institutions would receive.

Those who are sceptical of the NHS often express bewilderment at the public's loyalty. After all, we are not short of negative stories about our health service. In a service that helps a million people every 36 hours, things will go wrong sometimes. And they get reported. It is a rare day that lacks a headline about some aspect of the NHS and, as with most news, the headlines are generally negative.

This winter has been more challenging than most. Take Wednesday 7 January 2015: the headlines screamed about an NHS at "breaking point", in "meltdown" and, with "third world" A&E departments, a health service that was "dying". Although this may have been an extreme day, these headlines give an indication of the nature of scrutiny to which our health service is subjected. Not many institutions could survive this media onslaught intact. Yet the signs are that the public's faith in the NHS has not only endured, but that its commitment to improving the service is stronger than ever.

In a world where society teaches us to be less trusting of institutions and more questioning of any form of established institution, can this endure? The NHS, is after all, now very much part of the fabric of the British establishment. To consider whether the love affair will continue, it is necessary to consider why it exists in the first place.

The scale of change embodied by the creation of the NHS is difficult to comprehend. Britain went from a system where care had to be paid for or – if you were lucky – was made available by a voluntary hospital. Insurance was patchy and tended not to extend to women or children, meaning that often those who needed help the most had to pay for it. Anyone who listened to Harry Smith's speech to the 2014 Labour Party conference

will not have failed to be moved by his description of the spectre of illness that once haunted working-class families.

That such a change could be delivered in the face of seemingly overwhelming post-war austerity is an incredible achievement. The scale of this achievement – and what it said about Britain's priorities in the post-war era – is important to the British public. The idea that society should provide for those who need it the most, irrespective of their ability to pay, appeals to the British tradition of working together to help those in need that predated the Great Depression. Yet, at the same time, the NHS was the most visible demonstration of a decisive break with what had preceded the Second World War. It showed that the country was willing to do things differently and build a society that truly justified the sacrifices that had been made.

What the establishment of the NHS said about Britain and the memory of what it replaced are powerful and enduring factors that underpin the public's affection for the health service. Yet they are factors that resonate more clearly with an older generation, which is reaching the end of its life. Someone who was 21 when the NHS was established will be 88 in 2015. The first babies born on the NHS are now beyond retirement age. These factors, alone, cannot explain the on-going support for the NHS.

When we are ill we are at our most vulnerable, and those who help us at times of vulnerability rightly earn our gratitude. Everybody uses the NHS in some way, and the majority of our experiences of the health service – which occur at a time when we will remember them with gratitude – are remarkably positive. Look on any website capturing patient experience and you will see examples of very good care. Read the results of any patient experience survey and you will see that most people have a positive experience. International studies show that in many (but not all) areas NHS services are performing at a higher standard than their counterparts in other countries. All of this should not hide or excuse the examples of poor care that are reported (after all, one poor experience is too many), but it starts to explain why public opinion about the NHS is so resilient to stories about care failures.

The public response to a health service under pressure is therefore not to question the very basis of the service, but instead to demand that the politicians responsible for it do more to ensure it can deliver the standard of care that people expect. Incisive Health commissions regular polling on public attitudes on health issues, and we see a clear pattern emerging. Contrary to the position the public takes on many issues, people say they are willing personally to pay more in income tax to fund the NHS. This willingness to pay more in tax has continued to rise despite (or perhaps because of) recent political commitments to spend more on the NHS.

Spending on the NHS has doubled as a proportion of GDP over the past 40 years, but the public do not seem particularly perturbed by this trend. The public want a well-funded health service and, in contrast to some other issues, they say they are willing to pay for it. Certainly the option of paying more for the NHS is seen as being preferable to alternatives that might dilute the principle of comprehensive healthcare for all, based on need and not ability to pay, such as charges for some services or restrictions on access.

This public support has given the NHS the political and financial capital to respond to changes in demand and to improve the services available to people, so ensuring that positive feelings towards the NHS are (largely) reinforced by positive experiences of it.

Yet this support should not be taken for granted. The history of the NHS is one of adaptation and this is why it has proved so adept at maintaining public support. The services of today are rightly very different from the services of 1948, because the needs of the population – and medical science's ability to meet them – are also very different. In the same way, the needs of tomorrow's patient will be different from the needs of today's.

The other essays in this collection identify many of the challenges the NHS will face and the ways in which it will need to adapt. The progression of ill health is no longer linear; we have an older population with more complex needs. Many of the services we provided were designed in an era when patients were younger, and we now need to adapt them to the needs of a different age.

Thanks to research, we have an ever-expanding array of effective treatments, enabling us to do more but only at an increased cost. If the pace of scientific progress is increasing, the ability of services to introduce changes at scale and pace is being questioned. Modern lifestyles have increased the risk of ill health, but our expectations of what health services can achieve are higher than ever before.

Public support for the NHS – particularly among younger generations – will not be unconditional. Health services will need to adapt to these challenges, and they will need to do so with constrained resources. Even with injections of new spending (and even if the public's stated wish to pay more in income tax for health were to be met), the NHS is likely to receive a smaller proportion of GDP than comparable services in other countries. The challenges of this winter show that the restriction on resources is not just financial; there are shortages of nurses, GPs and other professionals. Not only will the use of new labour-saving technologies be desirable, it will also be necessary.

None of this will be easy, but the support the NHS enjoys could be a major asset in achieving this. Too often in the past, the public have been seen as passive recipients of healthcare rather than partners in its delivery. As the *Five Year Forward View* sets out, this is a mistake. Patients spend the vast majority of their lives not in contact with healthcare professionals, who therefore have only very limited knowledge of the patient's day-to-day life. The patients are the only people to experience their condition in its entirety. We need to translate the public's passive support for the NHS into something more active, benefiting people's own health in the process.

Support for local services has often been viewed as a block to change. The theory goes that the public love their local hospital so much that they will oppose any change to it, even if it might actually be good for their health. This is, however, a misreading of people's support for the NHS. The NHS is a concept, not an organisation (it has never been a single organisation); moreover, public support has withstood many different reorganisations of the health service. Securing public support for change is not impossible, but it does require work and a well-argued clinical case. In any relationship it is a bad idea to take support for granted, and this is particularly the case when advocating big changes.

In any love affair, love is not automatic, and it is rarely unconditional. So it is with the public's love for the NHS. Support needs to be continually earned. Needs change over time and so must the actions of the partners within the relationship. This is a love affair that can absolutely continue, but both sides will need to work at it.

The Five Year Forward View – reasons to be (cautiously) cheerful

The *Five Year Forward View* (FYFV) invites both cheerfulness and caution. Its radicalism, ambition, analysis and shape are reasons to be cheerful. The scale of the delivery challenge is a good reason to be cautious. The NHS at its best is more than capable of recreating itself, but that will require some bold moves.

What follows is a headline assessment of the *Five Year Forward View*, followed by an assessment of the big risks and how they could be addressed.

Reflections on the Five Year Forward View

The FYFV does not lack ambition. The goals it sets on prevention, quality, equality, satisfaction, new models of care and the use of technology are all extremely difficult.

The FYFV contains a recognition that the NHS is the wrong shape and that we need a much stronger focus on *prevention*. This has radical implications for models of care, for public health priorities, and for the organisational structures as they stand. It means the NHS will have to stop doing some of what it does now. The FYFV is also admirably clear that the organisational boundaries of the past need to be broken down in the interests of patients.

To deliver sustained improvement against the NHS constitution, while at the same time transforming care, will be demanding by any historical standard. Think of the range of tasks this implies. The shift towards the multi-speciality community provider model, or the integrated primary and acute system option, with local flexibility, would be demanding of leadership expertise and resources on its own. But when it has to be delivered alongside the redesign of urgent and emergency care; more support for older people living in care homes; the delivery of the new diabetes national model of care; increased priority for mental health services and putting 5 million people on personal health budgets, the task is enormous.

This cannot be done, as the FYFV makes clear, unless patients and carers become an engine of transformation. There is a lot of evidence that the voluntary and independent sectors and patients themselves, in the non-medical aspects of care, can help to improve outcomes. Without this shift the NHS cannot achieve long-term financial sustainability.

The FYFV also contains a welcome shift of tone to a more permissive and enabling relationship between central government and the local health economies. This will encourage local leadership to drive the necessary change. Of course, as the FYFV makes plain, health economies that are experiencing the greatest difficulties will have

more direct support, which is to be welcomed. Beyond this group, though, the precise expectations for each health economy need to be more clearly articulated, because this will be a vital part of ensuring success.

Three reasons to be cheerful

1. The NHS is good at big change (most of the time).

Disastrous cases like the Mid Staffordshire poor care scandal demonstrate that things can go badly wrong in the NHS. However, we should acknowledge the hugely impressive progress that the NHS has made too. The transformation in waiting times for operations is just one illustration.

According to the National Audit Office, 91.4 percent of patients started consultant-led treatment within 18 weeks.¹ In 1993, the then health secretary, responding to a question in parliament (in relation to a constituency matter), said: "No one in Doncaster generally has to wait more than 18 months, 12 months for a cataract operation or nine months for hip and knee operations."²

The Commonwealth Fund found³ in 2014 that in comparison with the healthcare systems of 10 other countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the USA), the NHS was the most impressive overall.

The list of large-scale transformation also includes: two-week cancer diagnostics; significant falls in mortality rates from major killers; bringing infection rates under control; smoking cessation; improved ambulance response times and (despite recent performance problems) a major reduction in accident and emergency wait times.

This is not an organisation that does not know how to do big, complex change.

2. We have an underlying political consensus.

There are genuine differences between the three main political parties, especially in relation to the role of the independent and voluntary sectors. Setting aside questions about who provides, there is actually a broad agreement on the need to develop more preventive, patient-centred, integrated care, as well as a broad commitment to additional funding for the NHS (although that is yet to be finalised). Whoever wins the general election in May, it is likely that the overall direction of travel will be maintained.

¹ National Audit Office *NHS Waiting Times for Elective Care in England* (January 2014)

² Hansard, 6 July 1993

³ Anderson, C *Multinational Comparisons of Health Systems Data, 2014* (Commonwealth Fund, November 2014)

3. The national leadership of the NHS get it.

The leaders of the NHS, both at the centre and locally, really get this – and they have strength and depth in their organisations. They combine a great deal of experience, drawn from health, social care, the independent sector and the most senior levels of government. They understand that if every leader simply delivers according to the criteria of their part of the NHS system, the system as a whole will fail. The FYFV recognises the need for working in partnership according to a shared standard of what the NHS has to achieve.

What is to be done?

The three reasons to be cheerful are matched by three solutions to the problems the NHS faces and which are not clearly articulated in the FYFV:

1. Structures versus patients: targeting the patients who cost the most.

The focus on prevention is the right place to be, but the emphasis in the FYFV could be more sharply focused on targeting high-cost, high-use patients. McKinsey analysis shows that 20 percent of the population drive 70 percent of the costs in health and social care.⁴ In England that amounts to 50,000 people on average in every clinical commissioning group. A lot more could be done to accelerate transformation by focusing on this group of patients.

This would have to be driven within local health economies, but the central NHS needs to get into good shape to support them. The Better Care Fund could be used to this end; it could even be possible to use part of this funding from 2016/17 to identify these patients and build care packages for and with them.

This could be the way to massively expand the use of personal health budgets, an explicit aim of the FYFV. The process of engaging patients and carers in care planning would not need to be modified all that significantly to encompass the personal health budget (or integrated personal commissioning budget). The third sector has already shown its willingness and ability to support care planning, and organisations like Age UK, Macmillan and others are already doing this well.

Integrating around patients in this target group is still difficult. Developing care plans takes a lot of time, but it represents an opportunity to move more quickly than can usually happen with structural reform. In partnership with Age UK, I have developed a model based on this approach which is now proving to be highly effective.

⁴ McKinsey & Co. *Understanding Patients' Needs and Risks: A Key to a Better NHS* (June 2013)

2. Modern performance management.

Strong packages of support and new incentives can help to release local energy and innovation. We can also see from the FYFV that, where required, a more direct approach will be taken for those health economies with the biggest challenges; that is to be welcomed. However, the scale and complexity of the changes create a significant risk.

The NHS is really good at big change, as I argued earlier, but the risks of failure are always present.

For example, between 2006/07 and 2009/10 spending on neurological conditions increased by £800 million to £2.9 billion. The 2011 National Audit Office report into neurological condition management stated "DH had none of the levers and incentives to implement its 11 quality requirements" and "current spending on neurological health and social services is not value-for-money".⁵

The Nuffield Trust analysed the performance of the four health systems within the UK and found an overall higher level of performance in England on most measures. It argued that some of these differences "will reflect the different policies pursued by each of the four nations since 1999, in particular the greater pressure put on NHS bodies in England to improve through targets, robust performance management, public reporting of performance and financial incentives".⁶

This strong system of accountability included the national leadership of the NHS but also a "golden thread" up to the secretary of state and the prime minister, with the prime minister's Delivery Unit playing a central role. This powerful guiding coalition was critical in both supporting change and providing a credible response when improvement lagged. Everybody in the system was aware that real consequences attached to not delivering. I mirrored this approach as Tony Blair's special adviser on criminal justice; working in partnership with the Home Office, we achieved an estimated 150,000 fewer offences in just over six months.

The new tone of partnership and local leadership is thoroughly welcome. However, that is not incompatible with ensuring that clear signals are sent through the system that transformation is required and that non-delivery will carry significant consequences. This needs to be embedded in a strong overall system of accountability, which mimics the successful approaches of the past. We know from previous failed attempts at reform that

⁵ National Audit Office *Services for People with Neurological Conditions* (December 2011)

⁶ Connolly, S, Bevan, G and Mays, N *Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution* (Nuffield Trust, January 2010)

if the changes are not tracked and actively managed, there is a danger of performance and transformation drifting.

3. The role of NHS England and other national organisations.

In his first speech as the newly appointed chief executive of the NHS for England, Simon Stevens, emphasised the idea of creating sustainable and future-proofed health economies.⁷ This whole-system view is fundamental in such a fragmented service. However, the current structures and incentives can pull in the opposite direction from integration, especially when social care is taken into account. It is quite possible to envisage a very well-run acute foundation trust performing well in the middle of a health economy that is heading into deficit.

It is also true that the transformation of services will take place in a complex political environment where public opinion is sensitive to organisational changes.

The new models of care offer some potential solutions to these tensions, but they will not be enough. Part of the conundrum here is getting the pace of change right, and this may require allowing some planned inefficiency and even managed deficits within health economies while new services take hold and patients, carers and their families can see real benefits. This would then allow a more measured approach to redeploying spare acute capacity.

Joint working between different parts of the NHS will be critical to the success of the new model. At the moment the success of partnerships is highly variable, and so it may be necessary to change the rules to introduce more powerful incentives. If a health economy is performing sustainably and well, then all partners to it, including the local authority, might share in the financial gain. Equally, if it is heading to deficit they might all share in the losses.

Conclusion

The *Five Year Forward View* is an important and welcome document. For the NHS to survive and thrive, it needs more change, not less. The FYFV embraces that idea. The scale of its ambition is its great strength but also its greatest challenge. However, the NHS can take confidence from what it has delivered in the past two decades. Those changes have often been remarkable.

This has to be tempered with caution, and I have described the reasons for being cautious. However, I have tried to suggest three ideas to mitigate these risks. These are:

⁷ Speech by Simon Stevens, 1 April 2014

- targeting the highest-cost, highest-use patients early in the change process and using personal health budgets;
- learning the lessons from performance management that worked so well in the past but within a new framework of enabling, empowering and liberating local leaders; and
- the need for new powers, flexibilities and freedoms to drive transformation.

There is a lot of detail to be worked through here, but if we chart the right course there is a great opportunity to build a new NHS. Then we really will have reasons to be cheerful.

'A radical upgrade of public health'¹ – what is preventing progress?

Background

When I found out five years ago that I had type 2 diabetes, I was absolutely devastated. I weighed over 17 stone, was very ill and had almost lost my mother to the condition less than 12 months before my diagnosis. I didn't want to die from this, as I have such a wonderful and happy life.

– Ramona, a Diabetes UK volunteer

Debates about public health can at times feel sterile and far removed from people's lives. Talk of "population-based interventions" and "risk modification" does not resonate with people's experience of what houses they live in, how they travel, what they eat, where they work, and whether they drink or smoke. The Richmond Group of Charities works with and for the 15 million people in the UK who have long-term conditions, many of them more than one.

We know that type 2 diabetes, heart disease, stroke, cancer, chronic obstructive pulmonary disease (COPD) and all the other long-term conditions that affect a growing number of people can cause untold misery for them and their families. They can also exacerbate existing disadvantage for marginalised people and communities. Preventable illness means avoidable suffering.

And the scale of preventable illness is truly staggering:

- 80 percent of strokes are preventable;²
- 75 percent of cardiovascular disease is preventable;³
- up to half of all cancers could be prevented by changes in lifestyle behaviours;⁴
- more than 80 percent of lung cancers and COPD are caused by smoking;⁵
- one in four of the UK adult population is at high risk of type 2 diabetes,⁶ but up to 80 percent of cases could be delayed or prevented;⁷ and
- up to 30 percent of cases of Alzheimer's disease are attributable to modifiable risk factors.⁸

1 NHS England *Five Year Forward View* (October 2014)

2 Gorelick, PB "Primary Prevention of Stroke: Impact of Healthy Lifestyle" in *Circulation* no 118 (2008), pp904–906

3 World Health Organization *The Atlas of Heart Disease and Stroke, Risk Factors* (2004)

4 Department of Health *Improving Outcomes: A Strategy for Cancer* (2011), p35

5 Health & Social Care Information Centre *Statistics on Smoking: England, 2012* (2012)

6 Diabetes UK *Position Statement*

7 World Health Organization *Overview – Preventing Chronic Diseases: A Vital Investment* (2005)

8 Brayne, C et al "Potential for Primary Prevention of Alzheimer's Disease: An Analysis of Population Based Data" in *Lancet Neurology* vol 13, no 8 (2014), pp788–794

Imagine there was a pill that tackled this degree of ill health. The failure to prescribe it would be considered negligent and open to legal challenge. There is no simple pill, but there clearly are things we can do. The increase in incidence of type 2 diabetes, obesity and inactivity is not to do with our genetic makeup suddenly changing over the last 30 years. It is to do with how we live our lives. A continued failure to tackle poor diet, inactivity, excessive drinking and persistent smoking is clearly health economic madness, but also shows a lack of political commitment to address the human suffering behind the statistics.

This is why the Richmond Group of Charities has come together to call for a national action plan for the reduction of preventable illness and mortality. We are using the WHO initiative 25by25, which sets the target of reducing preventable mortality from major conditions by 25 percent in the year 2025 for all national governments, including the UK.⁹ And we are injecting a sense of urgency into public health debates. We therefore warmly welcome the NHS *Five Year Forward View's* starting point of a "radical upgrade for public health". But we focus on real people with real lives, resisting all suggestions of blame and avoiding talk of "lifestyle factors". People do not choose behaviours that lead to ill health in the way we choose our telephone contracts. Behaviours that damage your prospects of a long and disability-free life are far too strongly associated with your mental well-being, your sense of self-worth, your income, your education and your postcode to treat them as simple "lifestyle choices".

Unhelpful dichotomies, institutional and political barriers

As 10 leading patient organisations, we at the Richmond Group of Charities believe that too much of the public health discussion in this country is stifled by unhelpful distinctions between approaches that should not be considered mutually exclusive, but in fact are part of a wider and comprehensive move from medicine towards health.

Firstly, we think that in the age of comorbidities and longer life expectancies the distinction between primary and secondary prevention is unhelpful. Many physical conditions share common causal factors, some conditions can trigger further complication, and there are clear links between mental and physical ill health. So offering support to people to change their behaviours, strengthening people's ability to self-manage their conditions, diagnosing early, and configuring care to prioritise early interventions are all part of the same cultural shift that is required. This shift will require improvements in all five areas previously identified by the Richmond Group as needing the urgent and sustained attention of the whole health and care system:¹⁰

⁹ World Health Organization *Draft Comprehensive Global Monitoring Framework and Targets for the Prevention and Control of Noncommunicable Diseases* (March 2013)

¹⁰ Richmond Group of Charities 2010, 2013. "How to deliver high-quality, patient-centred, cost-effective care?"

- prevention and early diagnosis;
- supported self-management;
- people engaged in decisions about their own care;
- emotional, psychological, practical and financial support for people with long-term conditions and their carers; and
- better care co-ordination.

So even where a condition was not preventable, or has already occurred, deterioration, loss of independence and crisis can often still be prevented. Such prevention can be based on behaviour change (such as weight loss, staying active and stopping smoking), but also on good conditions management. For example, Asthma UK showed in a recent review of asthma deaths that a shocking two-thirds of such deaths could be prevented through better patient education and proactive management through primary care.¹¹

Secondly, reducing preventable ill health needs to happen inside and outside the health system. Again, too much of the public health discourse tries to decide what, if any, responsibility the NHS has for public health. This is clearly nonsensical. We live most of our lives elsewhere than in hospitals or GP surgeries. Whether our flats are damp and cold, whether we are able to prepare healthy meals for ourselves, whether we are sedentary at work or not – all these factors have a huge impact on our health. So health cannot be confined to the NHS, but needs to be the business of town planners, landlords, employers, industry, schools, and the whole of government. But while we spend around £100 billion per year on the NHS in England alone, and most of us use the health system every year, health professionals see people who suffer from the impacts of preventable illness all the time. So, clearly, we need to make sure we get as much "health" out of our investment into the NHS and wider care system as we possibly can.

The fruitless debate about whether public health is the job of the NHS or not could be safely ignored if it did not lead to unhelpful barriers to making the required change. The patchy implementation of the NHS health check and the fragmentation of obesity services are indicative of the confusion over the role of the NHS in public health.¹²

This is where the *Five Year Forward View's* contribution proves to be most helpful. It clearly assumes that the NHS is responsible for the health of the nation, and not only through what the NHS does itself (behaviour change interventions, making every contact count, hospital food, employee health). But it also, and refreshingly, gives the NHS permission

11 Royal College of Physicians *Why Asthma Still Kills – The National Review of Asthma Deaths* (May 2014)

12 Diabetes UK *NHS Health Checks in Local Authorities: The Story So Far* (2014) (<http://www.diabetes.org.uk/Documents/Position%20statements/0222A-NHS-health-checks-local-authorities-0414.pdf>)

to have a view on what goes on outside its (considerable) remit: it points at the role of industry, local authorities and national government, and reserves the right to demand that all these partners need to become part of the solution, rather than part of the problem.

The *final* unhelpful juxtaposition is between two opposed public health "belief systems". The first understands public health improvement as requiring strong government action, through regulation, taxation and pricing. The second wants to see public health improvements come about through empowering individuals to make better choices, through education, nudging and so on.

Bearing in mind the size of the challenge, but also the now considerable evidence base for how behaviour change actually occurs, it is clear that we cannot afford to pursue only one of these approaches. The size of the challenge on prevention demands that all political, cultural and economic levers are brought to the table.

A recent hard-hitting report by McKinsey on the burden of obesity states this very clearly:

Any single intervention is likely to have only a small overall impact on its own. A systemic, sustained portfolio of initiatives, delivered at scale, is needed to address the health burden. [...] Education and personal responsibility are critical elements of any program to reduce obesity, but not sufficient on their own. Additional interventions are needed that rely less on conscious choices by individuals and more on changes to the environment and societal norms. [...] Successful precedents suggest that a combination of top-down corporate and government interventions with bottom-up community-led ones is required to change public-health outcomes.¹³

When management consultants not normally known for their cheerleading of state intervention ask for the inclusion of regulatory approaches in any serious prevention strategy, we know that the current "either/or" debate about personal versus government responsibility totally misses the point.

Political leadership at all levels

The above McKinsey report also identifies 44 possible policy interventions (for which there is evidence of efficacy) that the UK government could take to tackle obesity. It concludes:

If the UK were to deploy all the interventions that we have been able to size at reasonable scale, the research finds that it could reverse rising obesity and bring about 20 percent of

¹³ Mc Kinsey & Co *Overcoming Obesity: An Initial Economical Analysis*, discussion paper (2014), "In Brief" section

*overweight and obese individuals [...] back into the normal weight category.*¹⁴

This conclusion aptly illustrates the futility of continuing discussions of *which one* public health measure might be the "best buy" or might make it into a party political manifesto. We need much more than one or two measures (welcome though announcements on plain packaging, food labelling or bans on advertising are). We need a whole-government, whole-society movement towards improving health and well-being by creating conditions that make it easier for people to make healthy choices.

In order to turn the *Five Year Forward View* ambition into reality:

- We need to enable and require local authorities to bring all their powers to the public health challenge: planning, transport, leisure, education, licensing and taxation.
- We need infrastructure investment into walking and cycling that allows the UK to catch up with European neighbours who have far greater levels of active travel.
- We need to get behind any "active workplace" initiatives tackling the high number of hours most of us spend sitting at work, and we also need to make progress on wider workplace health, for example through engaging with the workplace well-being charter.
- We need to help make the healthy choice the easy choice, by making both alcohol and fatty, sugary and salty food less normal and harder to access, and we need to protect children from developing unhealthy habits through further legislation and/or regulation around food content, marketing and advertising.
- We need to enable and require all health professionals to support all those at risk of, or living with, long-term conditions to make and sustain changes to their behaviour that can help them remain independent and active.
- We need to identify individuals at risk and diagnose problems early through turning the health check into an effective, sustained behaviour-change intervention.
- We need to design pathways and care plans that focus on preventing deterioration and crisis, supporting independence and self-management.

¹⁴ Ibid, p3

The *Five Year Forward View* tells a hopeful story of the possibility for change: change for the NHS, for those who are at risk of developing health problems, and for those already living with one or more long-term conditions. It is welcome that NHS England wants to become a "more activist agent of health-related social change".¹⁵ This movement for change needs everyone to come together: government, society, individuals, industry, patient and third-sector organisations. But this partnership approach must not be used to mask the significant contribution that the next government will need to make to overcome the many formidable obstacles in the way of progress.

Let's go back to Ramona, from whom we heard at the beginning of this chapter: when she received her diagnosis, she immediately changed her eating habits and, supported by an NHS Activity for Life programme at her local gym, she now runs regularly, which has enabled her to lose more than seven stone. She says her aim is "to raise awareness and to inspire others so that we as a country can tackle obesity and diabetes". Adding dementia, cancer, heart disease, stroke, mental ill health, COPD, asthma and neurological conditions and their preventable complications to this ambition describes well the Richmond Group's mission for the next five years.

15 NHS England *Five Year Forward View* (October 2014)

Doing more to prevent ill health

It is difficult to find anyone who is against prevention. The old and tired adage that "prevention is better than cure" is regularly trotted out in discussions about health. But there is a real difficulty when it comes to taking an active role in prevention and putting the effort behind concerted attempts to reduce ill health. In a country like the UK, where health spending rarely comes anywhere near meeting need, the pressure of funding services to provide healthcare to the ill almost inevitably means that public health measures and the public health system are underfunded.

Of course, it has not always been like this. The "sanitary revolution", as it was known, of the 19th century was based on a clear societal understanding that the only way in which the country could avoid repeated and extremely serious outbreaks of typhoid or cholera was to invest heavily in dealing with what were believed to be the causes of the problem, namely poor housing, contaminated water supplies, and completely inadequate sewage and waste disposal.

The nature of the threats to health may have changed – although, as the recent ebola outbreak has reminded us, the threat of devastating outbreaks of infectious disease remains – but the need for concerted and determined action to prevent ill health should be as much a priority now as it was in the 19th century. The burden of illness due to problems such as obesity, smoking, excessive alcohol consumption, unhealthy diet and environmental pollution remains enormous. Not only is it clear that much of our burden of ill health can be prevented – with consequent improvements in life expectancy and, importantly, quality of life – but it is also true that unless we take determined and decisive action our national health service faces being swamped. The consequence would almost inevitably be that we would have to devote a substantially higher proportion of our GDP to the provision of healthcare. It would also be likely to precipitate calls for a move to an insurance-based healthcare system with all the inefficiency and inequality of access that this might involve.

Prevention, forever on the long finger

We need to stop thinking about prevention as something the NHS does when it gets around to it. The NHS can engage in prevention, but it rarely does so unless such action is in the very direct interests of the healthcare system. Also, it tends to rely on an occasional alignment of the planets rather than a purposeful, planned approach. If the leadership of an individual NHS body is sympathetic to a public health approach, if they have available resources and, importantly, a dynamic and skilled director of public health in their patch, then perhaps things can happen.

There would appear to be five important things that should happen if we want to take prevention seriously and reduce the pressure upon our healthcare system:

1. The burden of illness on individuals, families and society will never be properly addressed unless the prevention of ill health is recognised as a task that should properly engage all of civil society and not just the NHS.

A good example of this is housing. We have in the UK a very poor record for excess winter deaths. This is defined as the number of deaths that occur in winter months compared proportionately with the number during the rest of the year. These deaths can be attributed in large measure to the poor state of our housing stock. Countries in the rest of Europe with substantially harsher winter climates have far fewer excess winter deaths. For every death that occurs, it is estimated that up to eight acute hospital admissions occur. Addressing the issue of cold houses of elderly people is not seen as an NHS matter, but despatching ambulances to take them to hospital is.

2. There needs to be a concerted effort to reduce the influence of vested interests that make profits from selling unhealthy products while exerting considerable financial and lobbying influence on the political process.

This has been highlighted by the failure of the so-called Responsibility Deal led by the Department of Health.¹ The Responsibility Deal groups working on alcohol and food have been dominated by producer and retail interests, mostly through direct representation on the working groups but also via academics who have, in some cases, clear conflicts of interest.

It was George Bernard Shaw who wrote, in his preface to *The Doctor's Dilemma*, "Of all the antisocial vested interests, the worst is the vested interest in ill health."² It is about time that all organisations, including the Labour Party, revisited their associations with those who make profits from damaging health. The tobacco industry in particular should no longer be seen by political parties of all persuasions as a source of funding.

3. At all levels of civil society, from national government to local authorities, we need to see the adoption of a "health in all policies" approach.

This requires a profound change in attitude. It needs to be accompanied by recognition

1 Scally, G "Is England's Public Health System Still Fit for Purpose?" in *BMJ* no 348 (2014)

2 Shaw, GB *The Doctor's Dilemma* (Brentano's, 1911)

that almost every action affecting the lives of significant numbers of people will have health consequences, for good or ill. This may be as easily by inaction or neglect of an issue, as through something that in itself damages health.

A good example is roads policy. At present 38 percent of primary school children in England travel to school by car. We also have an alarming rate of childhood obesity, and much of that increase in children's weight occurs during the primary school years. The adoption into roads policy of a principle that all children living within half a mile of their primary school should be able to walk or cycle to it would revolutionise our town and cities and change our children's physical and mental health for the better.

4. There is a real need for the creation of effective mechanisms at national, regional and local level to ensure that joined-up government takes place at all tiers of civil society.

The failure of the Cabinet subcommittee on public health created by the Coalition government is a sign that the silo mentality in Whitehall runs very deep indeed. The supposed reason for the abolition of the committee was that ministers from departments across government simply failed to attend. A possible mechanism for addressing the balkanisation of Whitehall might be to have a smaller number of government departments. In a situation where substantial powers are devolved to regions and cities, as well as to local government, it is feasible that the reduced role for central government departments could, with benefit, be dealt with in a smaller number of organisations. The location within each central government department of a public health team to support health improvement through the policies of the department might inject a new dynamic.

While it is not apparent how government will operate in future between the Whitehall and local authority levels, it is clear that for many policy areas there is enormous benefit in a degree of regional co-ordination. The benefits were perhaps most effectively realised through the programme of local area agreements put in place between individual local authorities and central government. Although both regional government structures and local area agreements were early casualties of the Coalition government's changes, it has created a vacuum in the structure and organisation of integrated working between different sectors.

5. The NHS should facilitate suitably committed and skilled clinicians to take part in public health campaigning activities to change public and, ultimately, political opinion on key issues.

The history of prevention in the UK shows that the intervention of organised groups of clinicians can have a powerful political and societal influence. The introduction of beneficial measures such as compulsory wearing of seatbelts and restrictions on the promotion of tobacco have their origins in the campaigning activities of relatively small groups of committed clinicians. Changes in the contracts of hospital doctors and increased work pressure on GPs have meant that fewer doctors take the lessons they have learned from their experience of treating patients with avoidable illness and apply them in lobbying and advocacy for political and legislative changes.

The power of activist clinicians is not fully understood within the medical and nursing professions. Although the public may not entirely trust journalists or politicians, they retain a high level of trust and respect for doctors and nurses. Unfortunately, doctors and nurses rarely appreciate the influence that they could potentially have on wider society. Encouraging and developing this potentially highly powerful influence would be a powerful public health achievement. If the NHS wishes to assist the cause of prevention, it should facilitate this.

The public health system

The UK has been long known for the excellence of its public health system. The presence in every local area of the country, except for Northern Ireland, of a director of public health with a remit to analyse, comment upon and improve the health of the local population has been in place since the late 1800s. Although the title, role and influence have varied over time, the principle of an independent professional voice for public health has been a consistent feature. Similarly at national level, the presence of a chief medical officer in each of the four component parts of the UK has, in theory at least, provided a voice at the highest levels of government capable of promoting the health of the population in major discussions about health and well-being.

Successive NHS reorganisations have disrupted the public health system, with the inevitable toll of redundancies at the local level, and subsequent disillusionment that has driven senior and experienced people out of the system. Those that remain or have been newly appointed, while often of high calibre, have frequently found themselves downgraded in status and with reduced professional support staff. Similarly at a national level, the failure to appoint individuals with public health training and experience to chief medical officer and other national-level public health posts has weakened and degraded both professionalism and influence.

If one thing is vital in fuelling advocacy for preventive measures, it is the availability

of timely and accurate data on health and the expert interpretation of that data. The recent abolition of the public health observatories in England has robbed the country of a regionally based source of high-quality and independent data on health and well-being. Data-free debate and decision making is, generally speaking, bad for public health as it both allows major issues to remain undescribed and underexplored and permits vested interests to have an undue and unanswered influence in public debate.

The restoration of the integrity, professionalism and independence of the public health system is crucial in laying a basis for widespread action on prevention. But such a goal requires a more widely dispersed application of public health principles and science than has been seen heretofore. There is a good case for the development of public health skills and understanding across many sectors of civil society. The widening and promotion of access to public health education for a broad sweep of civil and public servants, as well as elected politicians, would be an innovative and potentially highly effective step.

Conclusion

If we want the NHS to survive, then robust and scientifically based public health action is needed urgently. The NHS itself is unable to deliver such a drive. The revitalisation of a broadly based and empowered public health system with a mandate to advocate and drive change depends on high-level political support being forthcoming. The clash with vested interests, predominantly those who have a commercial interest in selling unhealthy products or who hope to profit from private care for a continually unhealthy population, will be a test of political commitment and resolve as crucial as that which established the NHS in 1948.

Can we achieve whole-person care?

The question posed by this essay – *can we achieve whole-person care?* – has a very straightforward answer, in my view. We *can* achieve whole-person care, because we must. As any observer of the NHS knows, our current model of provision is under extreme pressure. Moreover, we are rapidly running out of road to make the changes required to set the health and care systems on a sustainable footing for the future.

It is no surprise that the emphasis on whole-person care among policy makers and system leaders comes at the same time as older people's care has risen to the top of the agenda. Our population is ageing and, with the number of people aged over 85 set to double in the next 20 years, the "oldest old" are the fastest-growing group. Yet overall life expectancy has risen further and faster than healthy life expectancy, meaning more of us are living into older age with multiple long-term conditions, frailty, dementia and social care needs.

In far too many respects the health and social care system has failed to keep pace with these emerging challenges.

At its core the NHS is still broadly organised along the same lines as at its inception in 1948 (while the roots of the social care system can be traced back even further, to the Victorian poor laws). During the intervening decades, as medical technology has advanced, we have built up this basic blueprint with layer upon layer of services, specialities and sub-specialities. Meanwhile we have failed to address the Cinderella status of social care or community-based support in a system dominated by the medical model.

As a result, we have a service capable of delivering some incredibly sophisticated healthcare – indeed, with every year that goes by, we hit new milestones in the treatment of chronic diseases and can now provide the means for people to live for a very long time with complex conditions – but also one that is too often fragmented and unresponsive to individual needs. Despite many excellent examples of services leading the way in person-centred holistic care, the system as a whole remains focused on individual body parts and conditions, and trapped on the treadmill of treatment and cure.

The recent NHS *Five Year Forward View* has clearly articulated the nature and scale of the challenge we face. It argues for a "radical upgrade" in prevention and identifies the need for integration on three fronts – of mental and physical health, across primary and secondary care, and between health and social care services. This drive towards prevention and integration is underpinned by the concept of whole-person care, and the recognition that sustainability will not be achieved by simply trying to do the same things a bit more efficiently.

Instead we must move towards what Derek Wanless originally described as the “fully engaged scenario” – where people are empowered to manage their health, engaged in their care and supported by effective services – resulting in improved outcomes for individuals and reduced demand for high-cost interventions. However, achieving the “fully engaged scenario” is not a question of narrow structural reform, but something that will require whole-system change. This undoubtedly means greater integration, but it also means profound changes in professional culture with services taking on new roles and working towards personalised goals within new partnerships as part of a much bigger, richer network of support.

Building resilience

Embedding health and care services within wider systems of support is critical to the success of whole-person care. It is a self-evident truth that an individual's health and social care needs do not exist in isolation from their relationships, communities or the environment in which they live. Traditional models that try to slice and dice people's lives into neat boxes that reflect professional silos are inevitably inadequate.

Instead new models of care and new approaches to service delivery must start from the basic premise that the purpose of their work is to support and enhance well-being and independence. This is based on the principle that, with the right tools and support, people will be able to live independently for longer than is often now possible and will find themselves able to overcome challenges they face. Age UK research on frailty found people coming up with inventive solutions to everyday problems, helping to deal with physical challenges while also improving mental well-being.

Central to this concept is the idea of enhancing resilience. That by building up people's own resilience – their ability to manage and improve their mental and physical health, enhancing the depth and breadth of their social networks and helping them address practical problems like poverty or poor housing – improves their well-being and reduces their dependence on health and care services.

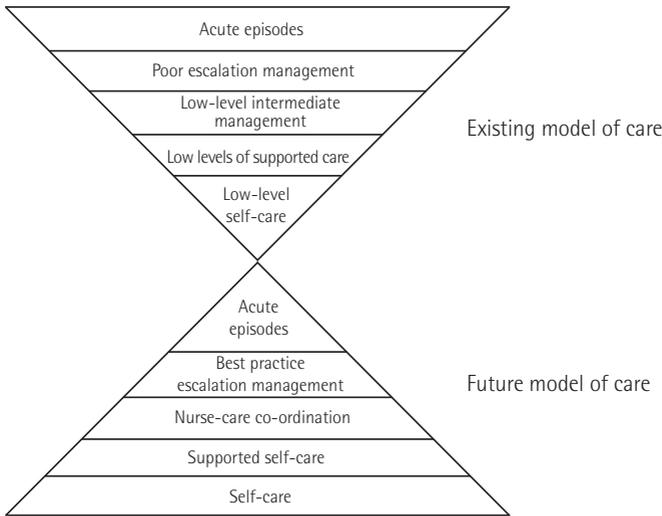
This is something that can only be truly achieved by working in partnership with individuals, their families and carers, and community-based organisations (as well as other professionals) able to access support services and vital local networks.

Unfortunately, services frequently fail to support, and in some circumstances actively undermine, people's resilience. A lack of investment in preventive approaches, early intervention and individual support means that services are usually responding to a crisis rather than acting to prevent one. Furthermore, the response is too often disempowering and leads to increased levels of dependency.

For older people living with frailty and multiple long-term conditions, the story is all too familiar. An individual is not receiving the support they need at home to stay well. A crisis occurs, typically a fall or an infection, and they are admitted to hospital. They are provided with treatment for the immediate presenting need, but the opportunity for a more holistic assessment is missed. After several days, and quite possibly a number of moves between wards, they have lost mobility and functionality. They are discharged and sent home without a recovery plan, leaving the individual and their carer to cope with increased support needs until the cycle begins again.

Shifting from this acute-centric, crisis-led model of care to one that makes well-being its primary goal will require us to “up-end” the existing pyramid of care (see figure 1).

Figure 1: Up-ending the pyramid model of care



Moving towards whole-person care

Making this change a reality is the overall goal of Age UK’s integrated care pathway. Our aim is to deliver a fundamental shift away from managing conditions through siloed medical interventions. Instead the programme seeks to support older people to rebuild their resilience and regain control of their own health and well-being, enabling them to enhance and sustain their independence and improve their quality of life. This is a hugely ambitious undertaking and one that requires transformational whole-system change to take place.

Our approach is based on strong local health and social care partnerships that empower

professionals to set aside organisational interests and constraints to work towards a common set of outcomes, first and foremost improving the quality of life for individual older people. This sees commissioners and local Age UKs, along with NHS and other providers, coming together to co-design the service based on a model of integrated care that targets identified cohorts of older people. The partnership is underpinned by risk-sharing protocols between organisations as well as measures to monitor and review achievements.

We use risk stratification to identify those older people most likely to be admitted to hospital. This is key to improving efficiency – not every older person is frail (indeed, even among over-85s frailty rates are only around 25 percent) or requires an intensive intervention. Research from the US has demonstrated that an evidence-based approach to risk stratification that targets key high-risk cohorts has a positive impact on reducing non-elective admission rates, in particular for those living with angina, chronic obstructive pulmonary disease, dementia, diabetes, pneumonia, stroke or at risk of urinary tract infections.

The pathway itself starts with a guided conversation with an Age UK co-ordinator, in which older people, and if appropriate their carers, are able to talk about what is most important to them. They discuss the challenges they face, are encouraged to set goals they would like to achieve, and look at what changes would make the biggest difference to their lives. Detached from the usual healthcare environment, these conversations are able to move well beyond clinical or single issues into a rich discussion about personal priorities, well-being and independence.

This is then the starting point of an individual's care plan, which incorporates any medical and social care needs as well as identifying wider services or support that would help achieve the goals identified. The plan is used as a shared tool to co-ordinate and integrate support.

A multi-disciplinary team based within a primary care setting, including the Age UK co-ordinator, work to co-ordinate health and care. The plan is reviewed regularly, and there are clear safeguarding and escalation protocols in place to ensure that if and when medical attention is required, this is delivered effectively and in a timely way.

The individual is also connected to services that already exist locally through public and private providers, charities and community-based initiatives so that support "wraps around" the older person. This could include benefits advice, social activities and home help or connecting to more informal support. For example, where someone is not leaving the house because there is no one to drive him (along with his walking aid and his dog) to the local beach, it could include finding a local volunteer to facilitate this.

All older people on the pathway are encouraged to take a lead role in managing their health and

well-being. However, moving from dependence to independence can present huge emotional and psychological challenges as well as practical ones for an individual. To ensure that people have the support they need to reach their goals and regain confidence and control, each person is matched with a volunteer and provided with an intensive support service for three months.

Although an older person can always receive further support or renew contact with the programme, the evidence to date suggests that once someone has received the help they need to set their feet on the right path they are able to sustain their own progress, reversing the cycle of dependency on health and care services. As one of the GPs involved in the Age UK integrated care programme observes:

For me personally, I have been encouraged to look at patients where I thought their dependency levels would only increase and see that with a relatively small level of intervention, they can be encouraged back to a much lower level of dependency.

The early evidence generated by initial pilot sites is also highly encouraging. Using the Edinburgh and Warwick mental well-being scale, we have seen a 23 percent average improvement among older people in the assessed cohorts and a 30 percent reduction in non-elective hospital admissions. Early financial calculations suggest there is potential for significant cash savings as well.

Where next?

We believe that whole-person care is not only achievable, but also both vital and inevitable. In light of mounting demographic and financial pressures on our health and social care system, it hardly needs saying that we cannot afford to carry on as we are.

But this does not mean we are complacent. We can see whole-person care starting to work; our own programme, among other examples across the country, is successfully putting policy and principle into practice. However, while financial challenges facing the NHS could act as the catalyst for spreading such examples, there is no guarantee. As pressure mounts and services find themselves running faster and harder simply to stand still, there is a real danger that we lack the capacities required.

Making change requires strong leadership locally; time and space for innovative thinking and partnership working to develop and mature; guaranteed medium-term (as opposed to ad hoc short-term) funding; and, critically, support for people to take risks and the flexibility for them to do things differently. Therefore this also requires strong national leadership and a single strategy across government and the national bodies. The *Five Year Forward View* offers a real opportunity, but it is everyone's responsibility to make whole-person care the 'new normal'.

Carers – partners in care?

There are 6.5 million people in the UK caring, unpaid, for a loved one – perhaps caring for an elderly parent with dementia, or a partner who has had a stroke, or a disabled child. It might be caring for a few hours a week, or caring full-time; at a distance or in the same home. Most care in this country is provided by family and friends, and any view of the future shape and role of the NHS must recognise and understand its implications for how the NHS is configured and run.

A more detailed look at the statistics shows that each year over 2 million people start caring for a loved one, and around that number find that their caring experience comes to an end – perhaps because the person they are caring for has recovered from a serious illness, or become more independent; but often because the person they were looking after has died. Every day, therefore, many thousands of people, of NHS patients, are experiencing the start or end of caring, and many millions are continuing to provide care.

There are two dimensions to consider; first to look at the health and well-being of carers – carers as patients. Put simply, if carers have the responsibility of providing most of the care and support in this country, how does the NHS help them to stay well, to have timely medical help and support when they need it, so that they can continue to care and live full and healthy lives of their own? Second, how should the NHS best work with carers and involve them so that their understanding, knowledge and expertise about the person they are caring for is valued by the NHS? This means understanding carers as partners in care – of their own health, and of the health and well-being of the person they are caring for.

Caring should come with a health warning; the evidence clearly shows that caring damages your health. The 2011 Census showed that full-time carers (caring for over 50 hours a week) are twice as likely to be in bad health as non-carers. Carers UK research¹ on over 5,000 carers (weighted towards those caring for 50 hours a week or more) showed the impact of caring, with half the respondents stating that they were affected by depression after taking on a caring role.

Carers run the individual risk of their own health suffering as a result of caring, but there is a risk for the NHS too. If a carer's health (mental and physical) deteriorates, or they put off getting medical treatment, then it stores up problems for the longer term. If their health suffers to the extent that they cannot continue providing care, then this potentially brings much greater costs for the NHS. For example, six in 10 carers responding to the

¹ Carers UK *State of Caring 2014* (2014)

Carers UK State of Caring survey said that they had been pushed to breaking point by caring without enough support. A quarter of these carers needed medical treatment as a result, and one in nine said the person they cared for had had to be rushed into hospital or else social services had had to step in to look after them while the carer recovered.² It is therefore imperative that the NHS identifies and supports carers, and works to prevent carers' health deteriorating. Part of this is understanding the range of caring relationships and commitments that a person may have. For example, the support needs of an 85-year-old man caring for his wife with dementia will be different from that of the couple caring for their disabled child.

As carers get older, they are more likely to provide more hours of care; a third (32 percent) of carers aged 65 to 74 are providing 50 or more hours of unpaid care a week, compared with 55 percent of carers aged 85 and over – despite these carers being more likely to be in bad health themselves.³ This cohort of carers is growing rapidly; they now number nearly 90,000 in England. The number of carers aged 65 and over has risen by 35 percent since 2001 to 1.2 million.

Over the last two years significant and welcome progress has been made, with the NHS beginning to recognise the role and experiences of carers. The NHS England *Commitment to Carers* published in May 2014⁴ includes no fewer than 37 commitments across eight priorities, including raising the profile of what a carer does and how they can be supported by healthcare staff, and developing a programme of work to support the health and well-being of carers through the community nursing strategy. The NHS *Five Year Forward View* builds on this with a clear statement that it recognises carers' contribution to the sustainability of the NHS, and commits to finding new ways to support carers and build on their rights in the Care Act.

The NHS *Five Year Forward View* pays particular attention to older carers – those aged over 85 – and to children and young people who are caring. It states that it will work with voluntary organisations and GP practices to identify them and provide better support. Encouragingly, it also recognises the needs of carers in its own workforce and the need for flexible working for those with “major unpaid caring responsibilities”, and NHS England has joined the Employers for Carers⁵ network.

It is crucial that the role of carers, and the issue of their health, are recognised at the national level in the *Forward View*, but it will take significant behavioural change to improve carers'

2 Carers UK *Carers at Breaking Point* (2014)

3 Census, 2011

4 Available at: england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf

5 www.employersforcarers.org

experiences day-to-day. Carers are at risk of putting their own health second, not finding the time for appointments or maybe not even wanting to consider that their own health may be fragile. A survey of 3,400 carers for Carers Week in 2012 found that 39 percent had put off medical treatment because of caring.⁶ So the NHS needs to be proactive: for example, it should introduce annual health checks for carers, and ensure that GP practices provide information and signposting for sources of help and support with caring.

For example, as part of a tri-borough initiative in London, Carers UK worked with GP surgeries to identify a carer lead in each practice who, with support, encouraged colleagues to be more carer-aware, to increase the number of carers identified and to refer those carers for support where appropriate. Carers also need access to regular breaks from caring, and although funding has been made available for this in the past few years, it is questionable whether this level of funding – £100 million in 2014/15 – has actually gone into the provision of breaks for carers.

At the system level, the NHS should monitor when carers are being admitted to hospital because of the impact of their caring role, and indeed when there are “double admissions” because the health of the carer has broken down, resulting in the person being cared for also needing to be admitted. Carers need to be closely involved in discharge planning too, not least to ensure that they are able to care for the patient after discharge and that the right health and social care support is in place to enable them to do this.

This brings us to the role of carers as partners and experts in the care of the person they are looking after. Carers can feel thrown in at the deep end when they begin caring or when there is a change in the condition of their loved one. Carers need support to help them cope with complex treatments, moving and handling, or administering medication, but they quickly become experts in their role. Do carers feel empowered, and do they feel they have a recognised role in decision making? In the State of Caring survey, 19 percent of carers who responded felt that their caring role was ignored and not recognised by health professionals.

It is imperative that this changes, because the NHS is missing out on valuable insights and knowledge about patients' health. Talking to carers about decisions affecting the person they look after makes life easier for everyone – the professional benefits from the carer's valuable knowledge and experience; the older or disabled person has their needs met more safely and fully, and the carer's life is made easier when they know what is going on. Great attention is being paid to the need for integration, but it is often carers who are bearing

6 Carers Week *In Sickness and in Health* (2012)

the responsibility and working to integrate services and support for the person for whom they are caring.

So, what needs to change? It is time for a "carer-friendly NHS" – to ensure that carers are respected and involved in decision making, and that they get the information and advice they need, both from hospitals and primary care services. There is a growing recognition that this is needed, and we are seeing more carers pushing successfully for change too. For example, "John's Campaign" is advocating for carers of people with dementia to be able to stay with their loved ones in hospital, and for hospital wards to have a "carers welcome" approach. This is being picked up by a number of hospitals, for example the Imperial College Healthcare NHS Trust. There are other examples too, of where hospitals have taken the lead in helping carers. The Ipswich Hospital NHS Foundation Trust has introduced a "family carers passport". Passport holders are given a special badge so that staff can see straight away that they are a carer. They have extended visiting hours and access to a kitchen, which they can use to rest or wait while tests are done. Importantly, the carers passport is also intended to encourage conversations between the carer and hospital staff.

The commissioning of services also needs to recognise the needs and circumstances of carers. The NHS England *Commissioning for Carers* principles and resources published in December 2014 needs to gain traction and make an impact in the range, type and quality of services and support commissioned and provided.

Approaches like these have the potential, over the next five years, to change the culture and ways of working of the NHS, so that it becomes second nature for health professionals to recognise and engage with carers on a day-to-day basis. With pressure on NHS services increasing and budgets being squeezed, we cannot afford to overlook the benefits that being carer-friendly can bring – or the costs of ignoring carers' expertise and failing to provide the information and support they need. It is time for carers to be partners in care. Without these changes, the sustainability of caring relationships is at risk – but, more than this, so is the sustainability of the NHS itself.

Maximising the potential of CCGs

I have long been an advocate of locally determined, clinical-led commissioning. As a former primary care trust chief executive, I realised early on in my role how important it was to have an organisation leading the local NHS. But what was also striking at times was the lack of connection between those who needed to take the decisions about the changes to services and those who needed to implement those decisions. It therefore made complete sense to me to formalise those connections and develop organisations that, within an agreed national context, had local freedoms to do what was needed in the interest of patients and local people, but also had clinical leadership running through its DNA.

The solution lies in clinical commissioning groups (CCGs). These were created with one simple idea: to harness the expertise and local knowledge that clinicians could bring to commissioning. Led by local GPs and their clinical colleagues, using their clinical insight and unique front-line relationship with patients, CCGs have within them the expertise to lead a new local approach to healthcare that puts patients and local communities at the heart of the NHS.

The 211 new commissioning organisations that we now have across the English NHS are still very young in the life cycle of NHS organisations, yet have been expected to reach full maturity almost as soon as having taken their first breath. Sadly, time has not been on their side and they have been expected to deliver the sort of service transformation that primary care trusts, with their much greater longevity, largely struggled to deliver. They also need to maintain delivery on performance in the face of unprecedented demand levels, and all within the context of an increasingly challenged fiscal environment not only for the NHS, but also for those care services with which the NHS has to work ever more closely.

Every CCG has, to date, proven itself to be capable of delivering on the financial expectations, and all are beginning to take courageous decisions about how services must change if they are to be fit for the future. In October 2014 NHS Clinical Commissioners published the document *Leading Local Partnerships*, which showcases just a few of the many examples from around the country of how CCGs are driving integration right across health and social care to reduce fragmentation and ensure patients get the support they need. CCGs as membership organisations are different from what has gone before, and we must not underestimate the impact that they, with their USP of membership of their constituent practices, can have when taking population-wide clinical commissioning decisions based on local need.

Clinical commissioning is already making a positive difference in improving outcomes for

patients and empowering clinicians, but there is an urgent need to enable it to achieve much more, at scale and pace, to support the challenges currently facing the NHS.

Six key areas for decision makers to address

In order to maximise the potential for CCGs, I would highlight six key areas that need to be taken seriously by decision makers and politicians, both in the run-up to the 2015 general election and as the next government takes the reins.

1. Ensure stability in turbulent times.

The NHS is in a very fragile position, with demand rising beyond anything we have seen in recent years, flat term funding, and increasing pressure being felt across the whole system – in regard to both balancing the books and transforming care. In addition, the NHS has been through a very turbulent time reorganising, and – whatever you think of that and the previous three-year reform process that we have all very painfully experienced – our health and care system simply cannot be distracted by another process of reorganising deckchairs.

We absolutely must make the very best of the health and care system we now have. At NHS Clinical Commissioners we have plenty of examples of CCGs delivering what they need to, by working across their health and care system. They are pooling budgets where it makes sense to do so and working across boundaries in the interests of patients. We must ensure that, whatever happens at the next election, this progress is not halted, and indeed is accelerated.

2. Put faith in clinical leadership.

Having clinicians leading our new commissioning organisations, with the membership link to local general practices, has proven to be critical in bringing on board the population with the CCGs when taking difficult decisions. We know from research that people trust their doctors much more than they do politicians, and we now also know, from over 9,000 responses to the first major 360-degree assessment of CCGs, that over two-thirds of those 9,000 have confidence in the clinical leadership of the CCG to deliver its plans and priorities. We must therefore keep the faith and support our clinical leaders to take the courageous decisions that are needed to reshape services locally so that they meet patient needs.

This includes reshaping how primary care functions and its critical contribution to out-of-hospital care. For over a year, NHS Clinical Commissioners has argued that CCGs need to be more influential over the commissioning of primary care, and it is pleasing that so many have come forward and are embracing this now. The talk and concerns about how CCGs manage potential conflicts of interest in doing this must, however, be overcome. We must not let those concerns become our Achilles heel in the pursuit of doing the right thing in the interests of patients.

3. Free clinical commissioners to act in the best interests of patients.

CCGs have the responsibility but must also have the freedoms to become much more place-based commissioners and leaders, accountable to their local population for what they do. CCGs and their clinical leaders are driven by what works best for local patients and local people. The clinical legitimacy they provide, alongside experienced managerial counterparts, makes for a very powerful partnership. However, they must be able to take the decisions that are needed and to be held to account for the "what" while being free to determine the "how".

This was a key part of the new NHS but, as the system has unfolded, there are still too many examples of CCGs being pulled into detailed discussions and oversight such that they are spending precious time managing upwards, be it to NHS England, Monitor or the NHS Trust Development Authority, and too little time managing outwards, across their local health and care community on creating sustainable solutions to local problems.

4. Enable CCGs to work across the boundaries – between commissioning and provision and between health and care – in order to deliver change locally that meets today's needs.

The *Five Year Forward View* recently published by NHS England and the other national arm's-length bodies (ALBs) sets out a compelling narrative about the case for change, the need for increased investment to make that happen, and the enablers that need to be in place for that change to happen if we are to maintain a sustainable NHS for the future. We know from a recent Ipsos MORI global trends survey that the population still rate the quality of their healthcare very highly in comparison with 18 other developed countries, but it is worrying that such positivity significantly dips when people are asked about the years ahead.

Lack of resources and investment continues to be seen as the biggest problem facing the NHS, with most people wanting the health service to be protected from spending cuts, and in favour of increasing funding in order to maintain the current service rather than limiting those services. The decision about how much money the NHS has and how far it is to be protected from other public-sector budget cuts is of course a political one, and it is clear that the NHS will be a major election battleground.

Whatever happens as a result of the election, it is evident that the NHS today faces a very different challenge from that it faced when it was set up in 1948. Then it was infectious disease; now it is people with multiple long-term conditions, poor mental health, disabilities and frailty. This means we need a different pattern of care delivery than we have needed in the past. It is therefore incumbent upon those who lead organisations with the responsibility for commissioning and providing care to rise to the challenge of working

outside their organisational silos and come together around a sense of local "place" to determine the new models of care delivery that make the very best of the resources at our disposal, right across the local health and social care system.

5. Develop a more system-wide approach to regulation and inspection.

Just as the commissioning and provision elements of our health and care system need to work differently, we also urgently need a more joined-up and system-wide approach to regulation and inspection. Too often CCGs are still not aware when the Care & Quality Commission is inspecting the organisations from which they commission care. Therefore the intelligence that CCGs may have about the care being provided may be missed rather than being part of the process. In addition, with both Monitor and the Trust Development Authority fulfilling regulatory and oversight roles for foundation trusts and other trusts respectively, and with the Care & Quality Commission looking at an organisation's fitness to operate, we are still focusing effort around the "institutions" in which care is provided rather than taking a much more rounded and intelligent view about how well a local "place" is able to commission and deliver care.

A tri-partite system is emerging, comprising the oversight role that Monitor and the Trust Development Authority bring to the provision part of our system, together with that of NHS England in its role of overseeing and assuring the commissioning system. While consistency of message and approach is welcomed, it must not become an additional layer of top-down performance management for CCGs that takes them away from the assumed liberty that has been given to them through the mandate from government to the NHS.

6. Create a truly equal partnership of health and care, with health and well-being boards as the focus of joined-up commissioning.

Last of my areas for attention, but by no means least important, is the need to do something to bring together the clinical legitimacy of CCGs with the democratic legitimacy of local authorities. The 360-degree survey results following the first annual assessment of CCGs by NHS England show a lot of positive feedback from local authorities about engagement and joint working with CCGs, with almost nine in every 10 respondents reporting that they are working well or very well together to develop and deliver shared plans for integrated commissioning. One of the key tests of how far the positive feelings have translated into practical change is of course the implementation of the Better Care Fund plans to enable more care outside hospital in a more integrated way.

From a CCG perspective, while positive working with local government is reported, findings from the NHS Clinical Commissioners' review across health and well-being boards suggests that there is not yet a truly shared agenda between local government and the CCG, and the

partnership between them is not yet truly equal. *A Shared Agenda* details the findings from in-depth interviews with a range of CCG leaders from across the country and describes the current CCG role in HWBs, as well as the ambitions to make them function more effectively.

If HWBs are enabled and supported to be an equal partnership between health and care, they must not be steeped in local government systems and processes at the expense of the NHS, nor indeed should it be the other way around. These could then be THE places to join up commissioning for particular patient groups. This would mean that both health and local government would hold each other to account for their part in making local "place" based commissioning a reality.

In my role as director of NHS Clinical Commissioners I am privileged to meet and work with many CCG leaders from up and down the country. They still retain the passion and ambition that they first brought to their jobs as clinical chairs and accountable officers, whether with a clinical or managerial background, over two years ago.

CCGs can and do get very frustrated that the system does not always support them to act in the way they need to and at times reverts to the previous "NHS-type". They remain passionate and ambitious to get on and do what they need to for their patients and local people, but they need to do it with others, and in a different way. Is the system ready to let CCGs do the job they need to? I certainly hope so.

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Shifting from acute to primary and out-of-hospital care

At the time of writing, the UK is gearing up for what promises to be one of the least predictable of all general elections. In time-honoured tradition, the NHS provides a high-profile election platform and a rich source of political claim and counter-claim. The politicisation of the NHS before an election is inevitable, but what is indisputable is that our healthcare system faces the most serious threat to its existence since it came into being.

The reasons for the inexorable rise in demand for healthcare and the resulting pressure across the system are well documented: a growing and ageing population living with long-term conditions, more effective medicines and technologies that extend life, and a squeeze on finances. Added to this are the cuts in social care provision that inevitably result in increasing numbers of older, frail people being unable to return safely to their communities and therefore remaining in hospital beds, placing an additional burden on the system – and creating often entirely unnecessary distress for the already vulnerable. All these factors have combined to create a perfect storm. The future of healthcare over the next five years will depend on how well we navigate a course through increasingly choppy waters.

With threat, however, comes opportunity. In some ways, it is a good thing that this unprecedented pressure will force us all to think differently about how we go about delivering and using our national healthcare services. With the outcome of the election and the shape of the next five years' government being as yet uncertain, one thing in terms of healthcare over the next five years is very clear. There is simply no option to carry on as we are.

The overwhelming number of patient-to-practitioner contacts – more than 80 percent (some estimates are nearer 90 percent) – take place in primary care, by which we mean the multiplicity of services that provide care outside hospital: including general practice, community pharmacy, community eye and hearing care, dentistry, physiotherapy and podiatry. A pragmatic approach therefore is to turn our attention to provide the support and resources necessary to ensure that first contact, especially in general practice, is as easy, rapid and effective as possible.

As the only independent leadership body for providers of health and social care outside hospital, NHS Alliance brings together general practice, community pharmacy, community eye care and community services, as well as emergency services and providers of housing, which is often crucial in determining the causes of good or ill health.

We recognise that change will be inevitable whether it is wanted or not. However, we take the view that change by design is preferable to design by default, and we believe that

changes should be led by those working within the service, who best understand the issues they and the communities around them face.

It is with some optimism that we consider that there is a way through the current constrained times, but to effect the necessary paradigm shift will take big thinking and bold decision making. Most of all, the sort of change we envisage will rely on a fundamental shift in thinking by all who interact with the health service.

We think the healthiest future for people and the NHS is based on creating what we describe as "communities of care". The "community of care" concept places general practice at the centre of a cohesive primary care team of multi-disciplinary health professionals and community leaders, such as community pharmacy, community eye care, housing and emergency services; professionals in the acute sector are also worked with closely.

The solution to creating a stronger, re-energised primary care workforce – and it is absolutely vital that we do this – lies within the workforce itself and within the communities served. We must bring an end to the historic tribalism that is one of the greatest barriers to true progress, and make a start on true collaboration. Only then will we have the potential to make an immediate difference to a system that has become overly complex and fragmented, and is considered by many to be near breaking point.

We believe that a new integrated and collaborative model of care, our communities of care – which is in alignment with NHS England's *Five Year Forward View* and the multi-speciality community providers it describes – is a crucial step in the evolution of the NHS and is the only viable future for delivering sustainable healthcare.

It will take a shift in how we think about delivering health – from being transactional and process-driven to being a system of delivery that relies on relationships. Our description of a responsive and responsible service is built on the key principles of having a responsive and responsible system, responsive and responsible health professionals and responsive and responsible patients.

If we are serious about building effective care outside hospital, we clearly need to look at investment in primary care. However, we also need to look well beyond formal health services, because only by working more closely with partners in housing and a wide range of community resources can we turn talk of out-of-hospital care into a reality.

If you ask the question, "How will we work better together?", the answers can often appear counterintuitive. For example, as recent news coverage has illustrated only too vividly,

while the NHS pressure points may well show up in A&E, the solutions may in fact be found outside hospital. Recognising this, the issue can be tackled only by long-term investment and better joint working across the system.

We also need to stop looking for grand designs and trust front-line staff to work together to find solutions. Commissioning in the NHS may be nearly 25 years old but, with a few honourable exceptions, it lacks sophistication – all too often, it is a blunt tool used for beating down costs rather than for visionary leadership or for transforming care. The current focus on commissioning risks reinforcing a culture in which people wait for permission and look to the centre for answers. The big opportunities in the next five years are likely to be where confident and competent providers, across both primary and secondary care, stop looking to others and create new models of care that make sense for their local communities.

If all this is to work, we need to create an environment where people are encouraged to support and challenge each other. Some areas, such as most community services, remain largely absent of real comparative information about the quality of care they provide. In general practice, more data is available, but there is still not enough emphasis on peer review to allow us to ask more searching questions about the striking variations in clinical care and how we use resources.

Generally, when you show clinicians how they compare with others, they start to question what it means and look to make improvements. All of this needs real investment in effective and intuitive information systems that let staff not just measure what they do but make sense of what it means and design changes that will improve the effectiveness of care.

We can also significantly enhance opportunities for shifting care if we look seriously at the often contradictory roles played by different organisations and professions within the NHS. Within most people who work in the NHS, there remains a high degree of passionate loyalty to both the patient and the values of the service, which is as it should be. All too often, however, especially at times of financial pressure, other targets and demands take priority. This can lead to moral dilemmas for managers and clinicians forced to align care with costs. Of course, there has to be accountability, but difficult as it is, we need to make rapid progress in the overall incentive framework so that we are all rewarded for working together rather than surviving apart.

The danger is that we all work harder and longer but have less impact on improving health. An increasing workforce crisis in general practice means that many GPs are working impossibly long hours, and yet there is increasing evidence of a link between practices offering fewer consultations and better patient satisfaction.

Working hard and being effective are not the same thing; as in all other areas of healthcare, general practitioners are partly responsible for creating some of their own demand. A drive for same-day care tends to compromise our ability to book two or three days ahead to see the clinician who knows us well, leading to multiple visits rather than addressing the problem first time round.

Similarly, the increasingly "heroic" behaviour of GPs makes it harder to let go and share responsibility with others who could provide appropriate support in the community. Unless we address these cultural issues, they are likely to undermine all our other plans for shifting care out of hospital.

If services are really to change, we need to avoid being constrained by the shape of the buildings we work in. In the end, it is all about relationships. If we are going to transfer care, hospital staff need confidence that the services are really in place to pick up the strain. We need to stop pretending that it will be cheaper – there is little evidence of this – or that it is automatically better, as for many people hospital is the right place and offers a sense of security at a time when they are anxious and frightened.

For too long, shifting care into the community has been an article of faith rather than an evidence-based approach to health policy and practice. It is time to make the investment and build the bridges that will enable the necessary shift to happen – and, crucially, work with us all as patients to build the individual support and care that makes sense to us, based on the things we want in our lives, rather than fitting in with a system that has yet to embrace the shift to personalised care.

A workforce fit for the future

The NHS is made of people. To respond to the opportunities and challenges facing the health and care system over the next five years, we need a workforce that is both effective now and fit for the future.

Health and social care organisations spend most of their money on staff (around 70 percent for the average provider). The fact that the delivery of services is inherently dependent on human labour, with its limited capacity for productivity gains, is one of the reasons why spending on these services is generally increasing as a proportion of GDP.¹

In a context where budgets are stretched to the limits and placed under intense political scrutiny, such observations can lead to consideration of the workforce as the most significant cost to the system. This fundamentally misses the point: the health and care workforce, alongside service users and "informal" care and support providers, *is* the system. Put simply, the NHS is made of people, and people bring the greatest *value*.

This is why supporting and challenging our people – the staff and leaders of health and care organisations – has always been a priority for the NHS Confederation, and is a focus as we enter a new phase of healthcare reform.

Last May the confederation, as part of a coalition of national organisations representing patients, professionals, local government and NHS leaders, published the 2015 Challenge declaration.² The declaration was a call to action – one year ahead of the 2015 general election – for politicians, policy makers and system leaders to engage in an honest debate about how and why things need to change. It used the best evidence in describing what we all know. Change is essential.

The challenges of managing demand for care, designing more effective services, making better use of technology and funding the system adequately are well rehearsed and come to the fore in most debates. Yet at the heart of the declaration are three essential challenges which recognise that the change can only be delivered by people: we need a new, value-based leadership style that supports working in a system, not just a single organisation; we need to deliver an open culture where staff feel engaged in their own organisation and patients are seen as assets, not issues; and we must create and support a 21st-century workforce that can deliver care in new ways.

¹ Baumol, WJ *The Cost Disease: Why Computers Get Cheaper and Health Care Doesn't* (Yale University Press, 2012)

² NHS Confederation *The 2015 Challenge Declaration* (2014)

These messages resonated, and by September we had assembled 21 national organisations in the biggest ever coalition of royal colleges, charities and trade associations assembled across health and care. Together we set out the 2015 Challenge manifesto³ to create a burning ambition for the NHS: a vision including the essential components of a new health and care system and how it would be experienced by the public, and people using and working in health and care.

In terms of the workforce, our shared vision was for a system in which all staff at every level would be valued and supported to deliver high-quality, compassionate, joined-up care, in partnership with service users. For this to become a reality, the experience and insight of staff must be used to influence how care is provided and help to prevent failures, and staff must be supported to maintain their own well-being. Leaders of health and care organisations must engage with staff to build trust and demonstrate they are valued, which will in turn enhance the reputation of health and social care organisations as great places to work and aid recruitment and retention. Crucially, staff must be helped to make the transition to different types of jobs as new models of service delivery evolve, and as we make a reality of the expectation that a professional's role is to support and respond to expert patients and service users, their carers, and their communities.

This shared vision attempts to build on the work of Michael West⁴ and Don Berwick⁵ to redefine our relationships and culture. It is both liberating and challenging to staff – asking them to take control and engage differently with their patients, their organisations and each other. If successful, it will drive a revolution on health and care and begin the process of removing the stain of the Mid Staffordshire poor care scandal and other failings on the NHS.

We were pleased that the *Five Year Forward View* (FYFV), published a month after the 2015 Challenge declaration, called for change that is driven by our workforce. It commits national bodies to work with the system to address gaps and imbalances in the training and deployment of staff to better reflect changing patterns of demand. This will include identifying the education and training needs of our current workforce and equipping them with the skills to deliver new models of care, as well as expanding new health and care roles, to ensure we are future-proofing the system. There are also initiatives promised to ensure that the NHS as an employer supports its 1.3 million staff to stay healthy, with progress here contributing to improved productivity and satisfaction across the health and care workforce, as well as improvements in overall population health and well-being.

3 NHS Confederation *The 2015 Challenge Manifesto: A Time for Action* (2014)

4 Selected work from Professor Michael West for the King's Fund in 2014

5 National Advisory Group of the Safety of Patients in England *A Promise to Learn – a Commitment to Act: Improving the Safety of Patients in England* (Department of Health, 2013)

This is welcome and begins to respond to our call in the 2015 Challenge manifesto for government and national policy makers to help build consensus around the expectations on the health and care workforce in a modern, 24/7 service.

But recommendations – however laudable – are not enough. We urgently need to see a strategy that can command wide support, given the scale of change that is needed in how and where people work.

All this is easy to say and hard to do. What helps is the consensus around the direction of travel set out in the FYFV and the chink of optimism that penetrates the difficult operational environment. There remains a significant risk that the FYFV, and our own 2015 Challenge manifesto, will suffer the fate of strategies that have come before them: warm, even inspiring, words will achieve nothing without concerted action.

Whatever happens in the election in May, health and care leaders must stay firm in their commitment to the vision we have worked so hard to build together. It is vital that the next government recognises the importance of valuing, developing and supporting our staff, and understands where the real priorities lie.

Alongside an acceleration of strategic workforce planning, high on our list of priorities will be how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support service redesign, and encourage recruitment and retention. The current workforce *are* in many ways the future workforce, and we need to take them with us.

The numbers needed for the future are important here. The analysis and effort on getting this right must extend to embrace the whole health and care workforce – from volunteers and carers, to occupational therapists, midwives, GPs and doctors. As debates about the accreditation of healthcare assistants and the time available for home visits show, getting these numbers right is just as important to the dignity and experience of people who use our services, and the motivation and well-being of those who support them, as is understanding how many cardiothoracic surgeons we need. The Shape of Training review⁶ will emerge into this world.

And looking further beyond this still, investing in people with the right skills elsewhere in the system – in schools and nurseries; in housing, leisure and employment services; in the criminal justice system – is all-important too, if we are serious about improving health and well-being and reducing health inequalities.

⁶ Shape of Training *Securing the Future of Excellent Patient Care: Final Report of the Independent Review Led by Professor David Greenaway* (2013)

This is complex, and meaningful workforce planning is an easy target for the cynics. It feels as though it is increasingly necessary across the NHS and wider sectors to get this right. As leaders we must improve outcomes for individuals and communities and be willing to grapple with the complexity that brings.

Workforce planning, professional education and training, working conditions and rewards are important factors in securing the workforce we need. There are also other important priorities to address. If we truly see the future role of health and care workers as being to facilitate personalised care and planning, shared decision making and self-management, we still have some way to go to embed the right attitudes, values and behaviours consistently across the sector. Staff need to be better equipped and supported to work in partnership with the public, people who use services, and their families and carers.

For the existing workforce, this may require enhanced communication skills, greater knowledge of resources in their local community, or the ability to work with group and family dynamics. It might also mean embracing new technologies and media so that they can engage with people in ways that are most convenient and meaningful to them. We live in an age where technology can enhance and shorten the distance between us, and we desperately need to bring the NHS into the 21st century.

There are some areas of professional practice where co-production with patients may be less familiar due to the episodic nature of the service; and others where it may feel more complex because of the greater risks involved. Rather than put these in the "too difficult" box, it is important that we listen carefully to staff working in these areas to identify what support they need to support the people they care for.

This is why the 2015 Challenge calls for the resourcing of a sector-led programme to equip our existing workforce for the challenges of working in new ways – including with different sectors and professions – engaging service users and supporting personalised care, shared decision making and self-management. Alongside this, we must see the emergence of patient leaders who can help bring their voice and expertise into the clinic, service improvement programmes and every boardroom in country.

In terms of new staff, the introduction of values-based recruitment for those joining the NHS is an important development. This will help to ensure that people enter the health and care workforce with a commitment to the values set out in the NHS Constitution, including putting patients at the heart of everything.

We need to go further. World-class HR and organisation development saves lives – you can

believe it in your heart or check out the evidence linking engaged staff to better outcomes.⁷ The "soft stuff is the hard stuff" in terms of people management. National leaders, local boards and everyone in between should demonstrate the right values and a commitment to the right culture. This will include a golden thread of organisational vision to team and personal objectives, with every member of staff being able to see how they contribute to their team and the purpose of their organisation. There must be zero tolerance of bullying or failing to act on concerns by genuine whistleblowers.

In this way, we can embed values-based individual, team and organisational development throughout the system. We must support our staff to cope with the continuous change that comes with striving for continuous improvement. And create working environments that distinguish between the inherent constraints of human psychology and behaviour, and personal or professional "failure"; that treat errors as learning opportunities; that genuinely encourage staff to speak up when things are not as they should be.

Which is why securing a workforce that is fit for the future is a leadership task. The leaders who supported the 2015 Challenge signed up to play their part in ensuring the health and care system benefits fully from the value that staff bring. We signed up to help inspire a new generation of leaders to deliver a burning ambition for a better future. Because the future for health and social care *is* its people – some of the finest people doing the toughest and most rewarding jobs in the country. We have a workforce that can be fit for the future. The NHS will survive only if we work together to ensure that it is.

⁷ King's Fund *Leadership and Engagement for Improvement in the NHS: Together We Can* (2012)

Being honest about the pressures on the NHS

When compared with the austerity applied to the rest of the public sector in recent years, to many it might seem that the NHS got off relatively lightly. It is true that protection for health spending meant the government's 2010 spending review set aside 0.1 percent real-terms growth in expenditure each year, and from the perspective of 2015 this has actually translated into an average 0.8 percent a year as inflation stayed low.

Yet the voices calling for more money for the NHS have got steadily louder, and politicians have begun to respond, whether by setting out higher spending plans for 2015/16 or by making promises of additional money later in the next parliament. How has this happened, given the undoubted relative protection for health spending and the continued austerity in the rest of the public sector?

Perhaps the first and most obvious point to note is that the NHS has only been protected relative to spending in other parts of the public sector. When compared with the historic real-terms growth in health spending – whether the 5.7 percent a year under Labour from 1997 to 2010 or the 3.2 percent a year under the Conservatives from 1979 to 1997 – the sustained slowdown in spending looks remarkable. In the face of this slowdown, until relatively recently the NHS appeared to hold up remarkably well. This meant that the iconic national targets that include A&E, non-urgent treatment (the 18-weeks target) and cancer all performed well, and the Coalition even added a few extra of its own – of which some, like the end of mixed-sex accommodation, were quickly delivered.

Previous, far less ambitious, attempts to restrain NHS spending had always led to unacceptable deteriorations in performance and been reversed. From this perspective it is not the more recent decline in performance that is exceptional. Rather the oddity was the success with which the NHS handled the early years of austerity.

This success came partly because the previous chief executive of the NHS, Sir David Nicholson, launched the Quality, Innovation, Productivity and Prevention challenge (QIPP), which tried to prepare the NHS for the downturn and led to a savings plan that included a pay freeze along with a range of efficiency initiatives. The success of QIPP in releasing efficiencies lay behind the relatively smooth path for these early years, a path that has now become very bumpy indeed.

The current difficulties in the NHS have arisen for a number of reasons. Firstly, QIPP was only ever a plan to get the NHS to 2014/15, after which it was hoped that restored public finances would allow the health service to revert to its historic 3-4 percent annual growth.

Though the 2010 spending review was indeed built upon a plan to remove the deficit by 2015, from our current perspective we now know that instead of 2015 being the end of austerity, it is only the mid-point. Yet for the NHS the low-hanging fruit of efficiency savings were reaped by QIPP, leaving only hard choices for the future.

Secondly, the NHS faces rising demand for its services. This is partly the straightforward impact of a growing population. More importantly, it is also driven by an ageing population, as on average older people need far more support from the NHS than do the young. At the same time, new technologies (particularly in medicine) and the roll-out of older medical technology across the population adds a further twist to demand. However, it is very well known that demand tends to rise over time in health, so none of this could come as a surprise to anyone. To manage rising demand, QIPP aimed to "bend the curve" by slowing the growth in demand and by generating other savings to allow the system to absorb what was left. However, in 2014 in particular, the number of patients needing emergency admission to hospital rose quickly, to well above the long-term average. Equally, referrals from GPs into hospital also began to rise quickly, as did the number needing cancer treatment. There is no definitive evidence on what lay behind this accelerated growth, but whatever the cause, we all expect the NHS to meet it and to do so without compromising the quality of care. Looking forward, whether the recent upsurge in growth abates to more normal levels, it still remains the case that demand for healthcare in all developed (ageing) countries is on the rise.

Behind these demographic pressures lies a wider challenge for the NHS. As the population ages the NHS must adapt to a world where many of its users have multiple long-term conditions, often combined with on-going frailty. This requires a joined-up response from across all parts of the NHS, and often from social care too. Adjusting the model of care to meet these needs is clearly required, but it is not always easy to do when trying to manage business-as-usual under difficult circumstances. Further, many of the diseases of the modern world come from our lifestyles, and the longer-term challenge remains finding the right way to help people to healthier lives. Without making progress on both of these fronts, the future will be even more challenging.

The third factor behind the NHS's current difficulties is linked to the fact that the costs of healthcare are predominately the salaries of the staff it employs. Along with a wage freeze, the NHS slowly reduced the number of staff it employed after 2010, thereby making savings. However, the Francis report into the dreadful lapses in care in Mid Staffordshire NHS Foundation Trust quickly led to a recruitment round (mainly of hospital nurses), as a lack of staff had been identified as a key cause of poor care. The problem with this recruitment round was twofold: firstly, many organisations did not have the money to pay

for extra staff and so began to run deficits; secondly, many could not find the permanent staff they wanted and so turned to (very expensive) agency staff instead. While with hindsight it may be just as well that NHS hospitals did recruit extra staff, given the subsequent rise in demand, it is also the case that overspends in NHS hospitals turned from a trickle into a flood.

The challenge to the NHS on workforce will only intensify. The wider economy is now recovering, and the NHS will need to compete for staff. At the same time, UK-trained health workers often have options to work in other countries. Taken together, these two factors mean the NHS will struggle to maintain the control on pay it has achieved since the recession began. Indeed, we are already beginning to see upward pressure on pay deals.

The challenges of rising demand, worker recruitment and managing budgets are not limited to hospitals, even if they are easily the most visible part of the health service. Anecdotal stories of problems in mental health have been increasing, and difficulties in recruitment were flagged in community health services in a recent survey from the King's Fund. Just as loudly have come concerns from both the public and the medical profession over difficulties in getting appointments with GPs, which have all added to the sense of rising and widespread difficulties across the NHS.

Some of these difficulties may have arisen as the side effect of austerity in other parts of the public sector. In particular, local government has borne the brunt of the reductions in public spending, and it is responsible for funding social care. Facing similar demographic pressures to the NHS, many local authorities have been forced to reduce access to social care as a consequence. For elderly or vulnerable people, the separation between healthcare and social care is not always easy to make. Many hospitals are experiencing a rise in the number of frail elderly people arriving in A&E, and some point the finger at these cuts as a key cause. Certainly the case has been well made for better integration of healthcare and social care, to meet the needs of an elderly population more successfully. If, as many suspect, declining social care has been part of the reason behind rising demand in the NHS, then that case becomes more urgent.

At least until recently, it was not clear that the public recognised the challenges faced by the NHS, as long as these were limited to rising hospital deficits without much impact on commonly used services. However, as 2014 progressed the iconic standards that had been maintained so well (with only the occasional hiccup) began to look more vulnerable. Through spring and autumn, A&E performance lagged below that in previous years, and it lapsed further and faster as winter approached. The 18-week target was placed in a "managed breach" that allowed the service to miss the target while trying to treat those

who had waited the longest. Despite this, performance has remained worryingly weak. Some of the cancer waiting-times targets were also broken, and the noise around cancer was soon amplified as NHS England tried to rein back the increasingly expensive Cancer Drugs Fund, which has been picking up the bill for new cancer drugs not otherwise paid for by the NHS.

Meanwhile, in the search for efficiency savings, the very public protection provided to the NHS has arguably made its life more difficult. Making radical changes to services is not popular, and given its "protection" it is not always easy to persuade voters or clinicians of the need for change. Equally, being protected, the NHS has been expected to maintain performance across the board and has indeed also been asked to deliver more – with new targets on, for example, dementia. This is in sharp contrast to other parts of the public sector that have been allowed much greater freedoms to redraw services as required. Hence, while numbers of police have fallen, social care is in retreat and libraries close, the NHS is expected to treat everyone that crosses its threshold to consistent or better standards without changing the model of care it has inherited from the past.

So where does this leave the NHS in 2015?

Unless something is done, at best we are left facing the rising demand that has historically required the NHS to spend at ever-increasing levels. At worst, the current upsurge in demand will continue and add to this pressure, and it is likely that continued cuts to social care will only make this worse. At the same time, many parts of the NHS are facing recruitment problems that will mean, at the very least, that the pay freeze which has reduced cost pressures so far is again in retreat. At worst (from a finance perspective), the NHS will be forced to offer staff a better deal on terms and conditions or face growing recruitment problems. Rising deficits across the NHS this year may also mean any new administration must inject more money just to pay off an overspend inherited from 2014/15.

Public support for the NHS remains very high, and there is no sign yet that people are prepared for, or willing to accept, significant cutbacks in service. Already, NHS England and its partner organisations have asked for an additional £8 billion by 2020 to help meet this challenge, alongside delivering a very ambitious efficiency programme. Assuming this money is forthcoming, it is the possibilities behind this efficiency programme that offer hope for the future. There certainly are still substantial efficiencies the NHS could make to unlock savings. More fundamentally, delivering these efficiencies through transforming its services so that they meet the needs of an older population at the same time as encouraging us all to look after our own health offers a way to improve health while making best use of

taxpayers' money. The challenge is that these changes will take some time to bring about, and whether on finance or on performance, time is now in short supply.

Sustainable healthcare systems – an international outlook

Delivering efficient and effective healthcare systems will continue to be of major public interest around the world over the next five years and beyond. Most recently, interest has been heightened by the impact of austerity and the demographic, technological and economic challenges placed on healthcare services. For many countries, maintaining the status quo is untenable. Yet change is likely to be fiercely resisted and difficult to implement politically.

The scale of the changing demographic alone is likely to place considerable pressure of healthcare. The World Health Organization's (WHO) health statistics for 2014 highlight that around the world we are witnessing major gains in life expectancy.¹ According to these figures, a baby girl born in 2012 can expect to live to an average age of 72.7 years, and a baby boy to 68.1 years, which is six years longer than the average global life expectancy for a child born in 1990. Low-income countries are making the largest gains, although they are starting from a lower base.

The WHO also reports, however, that our children are getting fatter. In 2012, around 44 million (6.7 percent) of the world's children aged less than five years were overweight or obese, it says. In the WHO African region alone, the number of overweight children increased from 4 million to 10 million.

A recent report commissioned by the Association of Chartered Certified Accountants (ACCA) and undertaken by Nottingham Trent Business School, *Sustainable Healthcare Systems: An International Study*,² reviewed healthcare systems across 11 countries (Australia, Abu Dhabi, Canada, England, France, Germany, Ghana, India, Malawi, New Zealand and the US) to assess how healthcare systems were coping with the challenges such as those outlined by the WHO. It found that although healthcare systems vary enormously between countries in the way they are configured and financed, most face medical, demographic, technological and economic challenges as highlighted by the WHO. Additional demands are being placed on healthcare services in these countries at a time when financial austerity continues to bite and when public expectations are rising about both the quality of services provided and the scope of treatments being made available.

The ACCA report identified that in both low-income and high-income countries societal changes and behaviours are taking place that include the adoption by many individuals of lifestyles that can negatively affect health over time, such as through obesity or alcoholism.

¹ World Health Organization *World Health Statistics 2014* (2014)

² Nottingham Trent Business School *Sustainable Healthcare Systems: An International Study* (ACCA, 2015)

Limits on resources have meant that progressive governments have typically sought to further improve efficiency and productivity. The requirement to deliver continuous improvement has removed all the "easy options" and therefore new and innovative approaches need to be found if further efficiency gains are to be achieved. All these pressures come at a time when, in most countries, patient expectations are growing alongside greater accountability, as more information comes into the public domain.

Worldwide economic contraction has impacted healthcare policy and delivery. While previous recessions have been relatively short-lived, the current situation is expected to continue into the medium term. There are particular concerns for a number of low-income countries that face the problems of poor physical infrastructure, low standards of literacy and high levels of poverty, affecting the health of parts of the population. War and other societal conflicts have also led to the dispersal of populations, disruption and restrictions to existing services. New diseases also pose new problems because of the lack of treatments and additional costs. The recent ebola outbreak is evidence of potential problems from new diseases, particularly in the developing world.

In the more affluent countries there are often high levels of morbidity and mortality linked to lifestyle. Politicians and policy makers frequently talk about the need to transfer resources from caring and curative services towards prevention services. While preventive services are more cost-effective in the longer term, it would require an injection of funding to pump-prime such initiatives. Changing the emphasis from cure to prevention would require promoting better health education. But, even with this change, discrepancies might still remain between different social and regional groupings within a population in the future. Many of the interviewees contributing to the ACCA report placed great emphasis on the importance of preventive measures as a means of reducing the incidence and prevalence of avoidable diseases, but they had seen little evidence of significant investment.

The biggest barriers to implementing change highlighted in the report were both technical and political. The technical factor concerns the organisation of the change process itself. One of the biggest problems is that change has not always been done well, and the public has a long memory when it comes to badly run projects and/or restructurings within their beloved healthcare system. Arguably, this accounts for why 82 percent of respondents identified public opinion as highly resistant to change.

The lack of political consensus in most countries over healthcare reform is also a major barrier. Interviewees expressed a strongly held view that politicians use health as a political football for scoring points against their political opponents, rather than focusing on what needs to be done. The report identified that over 90 percent of respondents anticipated some

form of reconfiguration of healthcare systems. In terms of the form of reconfiguration, 63 percent of respondents predicted administrative restructuring as being most likely, while 54 percent saw greater decentralisation as unlikely, and 73 percent felt there would be more involvement of the private sector in the provision of public healthcare in the future. A key message is that politicians must devise ways of communicating the essential need for major reformation of the way healthcare is provided across the world.

The report also compared healthcare systems of each country against a series of criteria, which included the quality of services provided, efficiency of the sector, public acceptability of the system operated, and equity of access to services. Most countries met some but not all of the criteria, and the emphasis varied. For example, the US healthcare system scored high on quality but did less well on equity and efficiency. However, new legislation introduced in 2014 requiring all Americans to have health insurance or pay a monthly fee for a minimum level of medical cover may help to address some aspects of inequality in the future. In comparison, low-income countries such as Malawi might have limitations on the quality of care and equity between different parts of the population, but appeared to do quite well on efficiency, given the limited resources available.

In most of the 11 countries surveyed, the report highlighted some form of private-sector involvement. They provided services to individuals in return for payment either directly or through a private health insurance scheme, or supported publicly led services by either providing facilities or running areas of service provision. The political debate often focused on the appropriate size of the private healthcare sector, but of more interest to policy makers is the role of that sector in providing healthcare to non-private patients.

While in some countries, such as England, there is a significant involvement of the private sector, elsewhere such an approach is strongly resisted, possibly on ideological grounds. The report suggests that it is important to consider the balance of involvement between the two sectors on their merits rather than based on ideology; otherwise, potential collaborative opportunities that are available might be overlooked. In addition, some commentators identified that there might be further potential for growing the involvement of both the charity and the voluntary sectors, given their historical involvement in healthcare in many countries. This would be particularly pertinent in those countries that are currently moving towards closer alignment of traditional hospital and local social care services. The balance between sector providers of services now requires a broader perspective, given the growing need for better social care, which arises in part from an ageing population.

The report concludes that there needs to be a better consensus between political parties on healthcare policy, as this would have the added value of replacing a short-term view with

longer-term vision, thereby providing greater sustainability. In the future it will also be important for politicians, healthcare system managers and professionals to devise ways of communicating the essential need for change and how this might be implemented. It will require more openness on both the cost and scope of healthcare treatments available, in order to inform a meaningful debate on the types and levels of services to be provided. Innovative approaches to healthcare service provision will be required to achieve an outcome that is politically acceptable, sustainable and offers value for money.

