



SELECT COMMITTEE ON THE LONG-TERM SUSTAINABILITY OF THE NHS Collated Volume of Written Evidence

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AbbVie – Written evidence (NHS0035)

Summary

- Pressures brought about by demographic changes, increasing demand and rapid developments in innovative new medicines require new approaches to delivering healthcare to ensure continued sustainability of the NHS.
- The NHS has taken steps to progress a number of initiatives to develop, test and implement such new approaches. The Five Year Forward View places a key emphasis on prevention, service redesign and new models of care which are being further refined and implemented through programmes such as collaborative commissioning and the Right Care approach.
- AbbVie is committed to playing our part to support people living with illness to get better outcomes and make the resources of the NHS go further. It is for this reason we established and dedicate expertise and resources to our Sustainable Healthcare programme. The work of this programme has been guided by the Sustainable Healthcare Steering Group, a multidisciplinary group of independent experts, who have identified key opportunities to improve sustainability within the NHS.
- Through this programme, AbbVie is supporting three distinct pilot studies that have been designed to test new approaches to sustainable healthcare. These pilots, described in detail in this submission, support the goals of the NHS and cover many key aspects of interest to the Committee such as prevention, early intervention, patient empowerment, workforce development and service integration.
- AbbVie is supporting the NHS to introduce innovative medicines in a sustainable manner through our contribution to the Pharmaceutical Price Regulation Scheme, the agreement between Government and the pharmaceutical industry regarding the supply of branded medicines to the NHS. This ensures the NHS expenditure on such medicines is capped at agreed levels with any overspend above this level rebated by industry to Government. 93% of branded medicines are underwritten in this way and to date over £1.1 billion has been paid back to Government. However, the flow of these rebate payments does not yet operate fully effectively, reducing the positive prescriber impact, and highlights an example of funding arrangements within the NHS that is not structured optimally.
- The commissioning landscape is complex and misalignments of incentives exist within the health system that can act as a barrier to achieving the best value. Innovations in service delivery can be stymied as a result and approaches which can better reflect whole patient pathway benefit and reduce the existence of contradictory incentives should be encouraged.

Background

1. AbbVie is a global, research-based biopharmaceutical company formed in 2013 following separation from Abbott Laboratories. The company's mission is to use its expertise, dedicated people and unique approach to innovation to develop and market advanced therapies that address some of the world's most complex and serious diseases. For further information on the company and its people, portfolio and commitments, please visit www.abbvie.com.
2. The Committee has identified many of the key issues that challenge the sustainability of the NHS regarding the pace of change in healthcare, the rapid developments in innovative new medicines treating a wider range of conditions than hitherto and the rising demand placed upon the health service due to demographic changes. For example, a quarter of people in England – some 15 million – have a long-term condition¹ and this figure is set to rise². Around 70% of the NHS budget is spent on care for people with long-term conditions³.
3. The NHS has taken steps and progressed a number of initiatives to develop, test and implement new approaches to healthcare designed to improve sustainability and improve outcomes. The Five Year Forward View clearly articulated that prevention is a primary focus and, taken together with new models of care and innovative service delivery, seeks to place the NHS in a more stable financial position. It further articulated the need to break down barriers between different partners within the health service which is a key aim of the more recent developments of the 44 Sustainable Transformation Plan (STP) regions across England.
4. AbbVie is determined to play our part in identifying new, sustainable ways of supporting people living with illness to get better outcomes, contribute more to society and the economy, and to making the precious resources of our NHS go further. In this submission we highlight key examples of new approaches to healthcare and AbbVie initiatives which we believe closely support the aims of the NHS in delivering sustainable healthcare.
5. It is for this reason that we have established and dedicate expertise and resources to our **Sustainable Healthcare programme**. The Sustainable Healthcare Steering Group, a multidisciplinary group of independent experts supported by AbbVie, identified three key areas where there are opportunities to improve the sustainability of healthcare services:
 - Embedding a **person-centred approach**, which considers the individual rather than a siloed focus on their condition(s)

¹ The King's Fund, Long-term conditions and mental health: the cost of co-morbidities, February 2012

² Department of Health, Improving the health and well-being of people with long term conditions, January 2010

³ Department of Health, Long Term Conditions Compendium of Information – Third Edition, May 2012

- Using **technology** to improve the delivery of services and care closer to home and equipping individuals to self-manage with appropriate support
 - Helping individuals to **navigate the healthcare system** and manage their condition with confidence, therefore improving overall experience
6. In 2014, with our partner the College of Medicine, the *Roadmap to Sustainable Healthcare* report was published. The inaugural Sustainable Healthcare conference took place in December 2015 in London with over 100 representatives from patient organisations, the NHS, public health, professional societies, clinical bodies and other stakeholders to explore this issue further. In 2016, the second conference will be held in November with the addition of a September conference in Cardiff.
7. Through this programme, AbbVie has launched three pilot studies looking at how to build sustainability into the NHS:
- a. A three year partnership with The Hepatitis C Trust and Addaction, to help them develop a programme that provides peer-to-peer mentoring and support for people who are at risk of, or undergoing treatment for hepatitis C.
 - b. Creating the UK's first early intervention clinic (EIC) for people who have been signed off from work with musculoskeletal disorders so they can stay in or return to work as soon as they can. The EIC has recently begun accepting new patients in Leeds.
 - c. A new, shared decision-making tool to improve conversations and decisions about health and work between patients and their healthcare professionals.
8. The report, further information on these pilots and additional information is available online - <http://www.abbvie.co.uk/responsibility/sustainable-healthcare.html>

Areas of Committee interest

Resource issues, including funding, productivity, demand management and resource use

9. For the many reasons the Committee articulates, there are significant funding pressures placed on the NHS including an ageing population, increasing demand and the development of new medicines which hold the potential to provide options in disease areas which, until now, had no such treatments available.
10. Specifically in relation to the expenditure on medicines, AbbVie believes it is important for the Committee to understand how the industry is supporting the NHS to introduce such medicines in a sustainable manner. The Pharmaceutical Price Regulation Scheme (PPRS) is an agreement negotiated between Government and the pharmaceutical industry regarding the supply of branded medicines to the NHS and it ensures NHS spend on the vast majority of branded medicines is capped at agreed

levels. Any overspend above this cap is paid back by companies. Medicines spend is therefore effectively underwritten. 93% of branded medicines acquired by the NHS are underwritten in this way⁴ and to date over £1.1 billion has been paid back to Government by industry⁵ and £3 billion is expected over the course of the agreement (up until 2018)⁶.

11. AbbVie believes this should provide surety of access for all patients requiring treatment to appropriate medicines. However, the rebate payments flow back to UK Government but not directly to the NHS and AbbVie believes these rebates should be protected and specifically used to transparently support continued patient access to innovative medicines, as happens in Scotland through the Scottish New Medicines Fund. It is important to remember in this context that many of these medicines are reviewed by NICE to ensure they are a cost-effective use of NHS resources.
12. The PPRS provides an example of the steps industry is taking to support a sustainable NHS but also highlights the importance of ensuring the funding flows within and between the Department of Health and the NHS is carefully considered to ensure the benefits of such agreements are felt by prescribers and clinicians.
13. AbbVie also makes significant financial investment into the NHS in the research and development of new medicines. For example, clinical trials are an essential part of the pathway of developing new medicines which delivers benefits: a) to patients, who have the chance to receive promising, innovative treatments at an early stage of their development; b) to doctors, who are given the opportunity to be at the cutting edge of their experience to improve clinical practice; and, c) to the NHS, which receives investment and supports its ambition to be at the forefront of global innovation.
14. AbbVie has clinical trials in over 80 sites across the UK and since 2012 has invested over £11 million in R&D in the UK. Over 1,600 patients have participated in AbbVie UK trials since 2007. This activity demonstrably supports NHS sustainability and is a key focus of government investment through the National Institute for Health Research for example.
15. An additional area the Committee may also wish to consider is how the NHS defines and recognises the 'value' of medicines from a commissioning perspective. Commissioners across the NHS face a number of competing demands and pressures, while being tasked with improving quality. The need to achieve better value has been recognised by NHS England through, for example, the creation of the NHS Right

⁴ Department of Health and ABPI, The Pharmaceutical Price Regulation Scheme 2014, December 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/282523/Pharmaceutical_Price_Regulation.pdf (date accessed: September 2016)

⁵ Department of Health, 2014 Pharmaceutical Price Regulation Scheme (PPRS) Aggregate Net Sales and Payment Information — 17 February 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/502538/2015_Q4_PPRS.pdf (date accessed: September 2016)

⁶ Pharmaceutical industry announces financial agreement with the Department of Health to help fund NHS's 2016 medicines bill, ABPI. Available at: <http://www.abpi.org.uk/media-centre/newsreleases/2015/Pages/211215.aspx> (date accessed: September 2016)

Care programme. AbbVie understands and supports the desire to identify where savings can be achieved that deliver better overall value. However, in some cases financial pressures and structural limitations constrain commissioners' ability to make long-term decisions that may require upfront costs but which have potential to deliver savings in the long-term. In other cases, the benefits of investing in particular preventative strategies or investing in medicines or technologies may fall on the shoulders of one commissioner at a particular part of the patient pathway with the benefits of such investment, through reduced admissions and financial savings, accruing to other commissioners.

16. For example, in hepatitis C the screening and diagnosis of the virus might be the responsibility of different commissioners (local authorities, NHS England or CCGs for example) but the financial burden of managing the disease may impact other commissioner budgets. The cost of treatment sits with NHS England, but the significant health, social and financial benefits of early treatment, through reduced hepatitis C related hospital liver admissions for example, accrue to other commissioners. More integration of budgets, for example through collaborative commissioning arrangements, could help to ensure that the cost savings of earlier treatment are shared across the system.
17. Another example would be the management of long-term conditions such as rheumatoid arthritis or inflammatory bowel disease and the value that can be achieved across a whole patient pathway by patient support programmes that seek to provide bespoke support to patients receiving medicines in a way which is most impactful to them. As an illustration, just one aspect of AbbVie's patient support programme, AbbVie Care, includes providing the medicine at an individual's home and supporting them with the skills and confidence to self-administer at a time convenient to them. This can reduce the amount of hospital appointments required for routine medicine administration which, alongside patient benefits, frees up hospital resource. It can also support adherence to medication reducing complications and costs that can arise from a patient failing to take their medicine. However, these wider benefits and value points that occur across the patient pathway are not always easily accounted for by the prescribing commissioner. In addition, despite a recognised need to reduce demand on secondary care and free up hospital beds, as the approach described above would, there remain tariff based incentives in place which can be worth more to NHS Trusts based on the number of hospital procedures undertaken.
18. These examples from different therapy areas demonstrate, in AbbVie's view, the complexity of the commissioning environment and the misalignment of incentives that exist within the health system. NHS England is clearly seeking to address these issues through the Strategic Framework for specialised services and the creation of population based STPs for example. AbbVie believes that, in addition to these structural changes, tools that encourage a wider assessment of value may be beneficial.

19. Finally, the independent Accelerated Access Review (AAR) has examined a wide range of issues related to the provision of healthcare in the UK and may make relevant recommendations regarding the new, flexible and innovative funding models needed now and in the future for the NHS to make better use of the resources available to it. The publication of this review is anticipated and may be of interest to the Committee.

Workforce

20. It is AbbVie's view that supporting the provision of care in the community and closer to people's homes will be increasingly important for the NHS to respond to individuals' needs and make the most of its resources. This will give rise to different educational and professional needs encompassing a wider range of stakeholders such as pharmacists and third sector providers alongside healthcare professionals.
21. The Hepatitis C partnership, mentioned above, provides an illustrative example in this regard. The hepatitis C virus (HCV) is a potentially fatal infection that can cause serious liver disease and there are an estimated 214,000 individuals chronically infected with HCV in the UK. Currently the condition is both under-diagnosed and under-treated with less than 50% of people infected with HCV aware of their condition⁷.
22. Addaction and The Hepatitis C Trust, two charities, are partnering in a pilot initiative in the South West region, with AbbVie's support, which is designed to widen HCV testing and offer additional support to access appropriate treatment for people who use drugs or are in recovery. The pilot initiative comprises of three key interventions, two of which are particularly relevant to this question posed by the Committee:
 - a. Workforce development: Addaction staff are provided with training on HCV to improve their understanding of the disease, the benefits of testing, new treatment options and the importance of modifying individuals' behaviour. The training helps them to better understand the ways in which they can effectively support local drug service users. An ongoing programme to train frontline Addaction staff is currently underway, which is crucial to raising awareness of the virus and dispelling myths associated with it. Upskilling workers in this way will, it is hoped, provide a key route to engaging individuals in a new setting.
 - b. Peer-to-peer education: educators are trained to deliver a personal message to service users regarding the importance of testing and attending hospital appointments. Through talks at various sites, the peer educators use their personal story to encourage service users to get tested and receive treatment. So far, over 500 people who use drugs or are in recovery, have been reached by the peer-to-peer education programme.

⁷ Public Health England, Hepatitis C in the UK 2016 report, July 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541317/Hepatitis_C_in_the_UK_2016_report.pdf (date accessed: September 2016)

Models of service delivery and integration

23. AbbVie believes the UK's first Early Intervention Clinic (EIC) for people with musculoskeletal disorders (MSD) is a useful example of a new model of care aimed at integrating services for enhanced impact. The clinic, supported by AbbVie, is for people who have been signed off work with a MSD and has been rolled out by the Leeds Community Healthcare NHS Trust. MSDs consist of a wide range of conditions that place a major health burden on the UK population, greatly intensify pressures on finite NHS resources and represent the single largest cause of sickness absence in the UK, having a detrimental impact on the UK economy⁸. If provided with specialist help quickly, people with MSDs are often able to manage their conditions effectively, improving their quality of life and enabling them to remain in work. Indeed, early intervention for people with MSDs can reduce temporary work disability by 39% and permanent work disability by 50%⁹.
24. The EIC is being specifically designed to enable quick referrals from primary care, reducing the time from being signed off from work with a MSD to being able to access a specialist from several weeks to just 5 days. It is planned that there will be numerous dedicated clinics per week over two to three sites, which will be offering 45 minute initial appointments, serving a population of 750,000.
25. It is hoped that through early intervention the clinic will reduce work disability and improve patient outcomes and satisfaction. If successful in achieving its primary objectives, the clinic will demonstrate proof of concept that early intervention reduces temporary lost working days and absenteeism, delivers savings to the employer and wider economy, reduces hospital admissions and will be transferable to other therapy areas and geographies.
26. AbbVie is also seeking to support the NHS to deliver changes to services for people with inflammatory bowel disease to enable more individuals to receive treatment in their own homes, instead of attending hospital outpatient appointments. Providing the right support to assist individuals in managing their condition at home could bring benefits to patients, by providing them with greater control over their treatment, to hospitals as it could help to alleviate capacity pressures on outpatient treatment services and to commissioners as it could help to deliver cost savings.
27. Increasing access to home-based treatment is also aligned with the objectives for the NHS set by NHS England in the Five Year Forward View, to move care out of hospital so it is delivered closer to patients' homes and to deliver efficiencies. However, AbbVie has identified barriers that may prevent the wider adoption of different models of service provision for patients with IBD. These include incentives created by the NHS Tariff system, whereby hospitals may be opposed to changes that would

⁸ The Work Foundation, Self-management of chronic musculoskeletal disorders and employment, September 2014 (work was supported by a grant from AbbVie)

⁹ Abasolo L, Blanco M, Bachiller J, et al. A health system program to reduce work disability related to musculoskeletal disorders. *Ann Intern Med* 2005;143: 404–14

result in lower levels of outpatient activity as this would also result in reduced income.

Prevention and public engagement

28. There are multiple approaches that can be taken to prevention that have been described in AbbVie's responses to previous questions, for example, education, awareness raising and myth busting through peer-to-peer mentors in hepatitis C, prevention of complications due to poor medicine compliance through enhanced adherence support by patient support programmes, or prevention through early intervention such as with the EIC.
29. There are two additional relevant points AbbVie wishes to draw to the Committee's attention in relation to this topic. Firstly, the Patient Activation Measure (PAM), which is a patient-reported measure validated in the UK that describes the knowledge, skills and confidence a person has in managing their own health¹⁰.
30. PAM scores have been shown to predict a number of health behaviours and are closely linked to clinical outcomes, the costs of healthcare and patients' rating of their experience. People who have low levels of activation are less likely to play an active role in staying healthy versus those who have higher levels of activation. AbbVie is utilising the PAM through AbbVie Care to specifically tailor the range of services and support offered to an individual patient, based upon their levels of activation, so that those with lower levels are given the opportunity for enhanced support. Early data in the field of hepatitis C is encouraging.
31. Use of the PAM is increasing across the NHS. For example, NHS England has purchased a number of PAM licenses and announced a large expansion of its use across England with 37 organisations successfully applying to use the PAM, right across England, to measure levels of patient activation in their local areas, tailor interventions and support people to manage their own health¹¹.
32. Using the PAM to tailor support might make such support more relevant and impactful which, in turn, could raise an individual's activation and approach to their wider healthcare.
33. Shared decision-making is also relevant to this question. The UK is facing a growing challenge in terms of the health of its workforce and every year almost a million workers take sick leave of over a month in length¹². It is estimated that almost 21

¹⁰ The King's Fund, Supporting People to Manage their Health. Available at:

http://www.kingsfund.org.uk/sites/files/kf/field/publication_file/supporting-people-manage-health-patient-activation-may14.pdf (date accessed: September 2016)

¹¹ NHS England, Patient activation: at the heart of self-care support. Available at:

<https://www.england.nhs.uk/ourwork/patients/patient-participation/self-care/patient-activation/licences/> (date accessed: September 2016)

¹² Department for Work and Pensions, A million workers off sick for more than a month, February 2014, Available: <https://www.gov.uk/government/news/a-million-workers-off-sick-for-morethan-a-month> (date accessed: September 2016)

million people of working-age will have at least one long-term health condition by 2030¹³. A shift is needed that recognises the therapeutic benefits associated with employment and identifying work as an important health outcome and continuous engagement of patients is important in achieving this.

34. AbbVie is supporting the development of a new, shared decision-making (SDM) tool, led by Professor Debbie Cohen at Cardiff University. The SDM tool has been designed to aid and improve conversations and decisions about health and work between patients and their healthcare professionals. By facilitating better conversations, for example around the patient's wants, concerns and needs around their ability to work, this project aims to help optimise the management of their long-term condition and ultimately support people in achieving their goals.
35. The tool is now being piloted in both primary and secondary care settings with the results to be evaluated. It is hoped real world data will be created on the usefulness of the tool and that, if proven to be effective, AbbVie will work with NHS England to support its inclusion alongside the existing 36 therapy based SDM tools for long-term conditions and make it available for use by clinicians in multiple settings across the NHS to help guide conversations about health and work.

20 September 2016

¹³ H Vaughan-Jones, Healthy Work: Challenges and opportunities to 2030, 2009 Available at: <https://www.gov.uk/government/news/a-million-workers-off-sick-for-more-than-a-month> (date accessed: September 2016)

ABHI – Written evidence (NHS0068)

About ABHI and reason for submitting

- ABHI is the leading medical technology industry association in the UK. We are a community of over 250 members, from small UK businesses to large multi-national companies. We champion the use of safe and effective medical devices. The work of our members improves the health of the nation and the efficiency of the NHS.
- The medical technology industry makes a vital contribution to economic growth in our country. The industry employs 88,000 people in over 2,600 companies, mostly small and medium sized enterprises (SMEs)¹⁴. Many companies are working closely with universities and research institutions. The industry is generating a turnover of £17 billion and has achieved employment growth of greater than 11% in recent years. Our country also has the most highly regarded universal healthcare system in the world, the NHS. The NHS, in turn, is dependent on technology produced by the industry to enhance the efficiency of services, and drive continuous improvement in their delivery.
- Demographic changes are creating an ever increasing demand for the NHS, which threatens the long-term sustainability of healthcare services. The deficit of the provider sector for the year 2015 illustrates the pressures on the wider health and care system, which is over-reliant on the delivery of services in resource intensive settings. Innovations in medical technologies that support new models of care could provide a solution.
- ABHI's response to the consultation focusses on the role of medical technology and how innovation can help address the long-term sustainability challenge that faces the NHS.

Introduction

1. This response refers to the following three themes :
 - a. Models of service delivery and integration – How can the move be made to an integrated National Health and Care Service? How can organisations in health and social care be incentivised to work together?
 - b. Resourcing issues – including funding, productivity and demand management. Is the current funding model for the NHS realistic in the long-term? Should new models be considered? Is it time to review exactly what is provided free at the point of use?
 - c. Prevention and public engagement – How can people be motivated to take greater responsibility for their own health? How can people be kept healthier for longer?

¹⁴ UK Government Strength and Opportunity 2015 Annual Report, Department of Department of Business Innovation and Skills

2. The response does not explicitly address the committee's other two themes, though indirect implications do flow from ABHI's consideration of the three themes above.
 - a. Digitisation, big data and informatics.
 - b. Workforce – including supply, retention and skills.

1. Models of service and delivery integration

It is understood that a key goal for the current development of Sustainability and Transformation Plans (STPs) is to enable a reduction in the intensity of care, particularly to enable treatment in settings other than hospitals. This is being pursued through geographic 'footprints' across England and the intention is to bring together the budgets of NHS commissioners with the social care budgets of local authorities.

2. Resourcing issues

Demand management is among the stated intentions of STPs. However, it is worth noting that, in supporting treatment nearer home, there is also the potential to pursue greater *public engagement*, through encouraging individuals to take more responsibility for their own health. It seems reasonable to suggest that integration of service would be a strong facilitator for this and that, by contrast, the historic separation between health and social care in England has served to inhibit clear messages from the state, as funder of care (i.e. payer), to the individual citizen.

However, aspects of *resourcing and funding* cut across or offset the above intention and impact on *productivity*.

Unlike many other developed countries with public payers, the NHS in the UK has achieved a remarkably balanced budget over a very long period of time, recent challenges notwithstanding. A key in this has been the creation and maintenance of public corporations, in the form of NHS bodies which, whilst they have at intervals changed in both name and form, retain responsibility for their own individual financial viability and sufficiency. 'Balancing the books' is among the highest priorities for the boards of NHS organisations.

As a corollary to this it is arguable that leadership in the NHS has come to be associated with the idea of a strong organisation, often one which dominates its local or regional geography. It may do so negatively if it is not a financial success.

However, for new models of service delivery and integration to grow and prosper, this concept of the strong, standalone organisation might need to give way to an organisation that, whilst well-run and financially viable, works routinely in partnership with others and is 'place-based' rather than based on the historic NHS model of organisational self-sufficiency.

This may be key to addressing one of the main goals of healthcare, as stated in the Five Year Forward View, of getting the right care in the right place at the right time. In other words, to provide treatments for which there is good evidence, rather than perpetuating the historic mix of treatments with varied evidence, for otherwise identical patients in different

geographies. Progressing towards such consistency has proved difficult over time, partly as a result of the difficulty of changing service patterns which are linked to income streams. This difficulty predated the creation of the purchaser-provider split which was intended partially to address it, but has proved persistent.

The above considerations inform some tentative conclusions about future sustainability of health and social care delivery. They do not, in ABHI's view, point towards anything such as a 'National Health & Care Service'. The history of attempted central or national management of health care is not encouraging as regards continuous improvement in outcomes. Relatively good health outcomes *vis a vis* inputs must certainly be acknowledged. The NHS has delivered pretty good care for the UK population over the long term, by contrast with that in other OECD comparator countries. However, the reduction in inputs at the level of percentage of GDP must now threaten that. The existing NHS model, based as it is on large providers of very mixed financial viability, poorly established commissioners, together with local authorities which have different drivers, looks unlikely to be resilient with declining GDP input to the NHS.

However, health and social care is a very substantial sector within the overall economy. In that light, it seems fair to draw analogies from other sectors of the economy and especially from the service sector, with which there are strong parallels.

Other sectors of the economy have changed beyond recognition in the last two decades. Organisations have sought every opportunity to adopt new technologies which have offered the scope to improve services through innovation, whilst also reducing costs, usually through investment over time. It has been striking that these characteristics are not at all consistently apparent in the NHS over the same period. The financial viability imperative on the NHS has clearly ensured staying generally within budget. The scope for planning to secure a return on investment, in exchange for service improvement, has remained limited.

Recommendations

In this context ABHI makes several related suggestions:

- 1) Continue to pursue the current direction of travel as regards leadership of health and social care services. This would be linked strongly with STPs whilst taking into account the learning to date from the Academic Health Science Networks. There is now, as never before, the potential to create accountability for health and social care funding at this geographic level. This would mean a lower profile role for the centre. The existing national arrangements are cumbersome and difficult to manage in this context and will no doubt need to be streamlined in due course. None of this, however, need obstruct the objective of local and/or regional accountability, with financial viability (i.e. books balanced across geographies). One of the key gains from enhanced local accountability should be freedom to innovate – more details below – with a view to improving productivity and responsiveness, in keeping with other aspects of the modern world. Pursuit of a 'National Health & Care Service' is a distraction in this context. 'Free at the point of delivery' remains a key requirement but, as has always been the case, can be delivered in heterodox ways.

- 2) Pursue this geographic accountability by encouraging STPs etc. to use procurement as a lever: both for local innovation and for cost reduction in patient pathways, seen end to end.
 - This would mean rigorous identification of costs, including through length of stay and infection, across geographies. Furthermore, it will mean improved outcomes and consistency through procurement of innovative and appropriate evidence-based technologies.
 - This has already been trialled in Sweden, for example, and the methodologies are in place to make it work¹⁵.
 - The approach is counter to the current reductive trend of repeated focus on unit price in procurement, to the neglect of the total value chain in treatment. The STPs etc. would keep savings accrued, which would be an incentive to invest further in improvement.
- 3) Finally, changes in demographics are referred to in the Select Committee's terms of reference. These are a key reason for addressing the reduction in GDP dedicated to health. Whilst continuous improvement in productivity is a reasonable requirement on a public service, the reduction in GDP commitment, whilst retaining the same expectations, suggests policy without evidence in the context of the way the NHS has been run to date. The opportunity to address this, through a more devolved approach, should be taken.

23 September 2016

¹⁵ Boston Consulting Group, (2015). *Procurement: The Unexpected Driver of Value-Based Health Care*. [online] Available at: http://www.medtecheurope.org/sites/default/files/resource_items/files/BCG-Procurement-Dec-2015.pdf [Accessed 20 Sep. 2016].

Academy for Healthcare Science – Written evidence (NHS0131)

SUMMARY

We have explained who the Academy for Healthcare Science represent and what our key functions and roles are in the UK health care system. The specialist expertise of HCSs and their training in scientific methodology and research makes them crucial to the conduct and evaluation of research and implementation of effective evidence-based medicine. **AHCS regards this as a crucial element of the future sustainability of the NHS.** Specific topic areas for requested input have been outlined;

The future healthcare system

- *Implications of demographic changes, their implications and our contribution.*
- *Health and Care Systems: how these must become more integrated*
- *Technological innovation: how we can contribute to personalised medicine*

Resource issues, including funding, productivity, demand management and resource use

- *We outline the need to meet the demands of poor health and good health in the context of the shifting demographics challenging healthcare finances*

Workforce

- *HCS are about 7% of health workforce with a long lead-in training time.*
- *Long term workforce planning needs to be sustained*
- *We outline the challenges of Brexit and the other key retention issues*
- *We highlight how scientists lead in innovation and new technology.*

Models of service delivery and integration

- *We offer constructive suggestions on providing an integrated NHS.*
- *We recommend the removal of the purchaser-provider split to fund future integrated services*
- *We provide suggested barriers to improving healthy places to live including; economic inequality, social immobility, education and political short-termism in time of financial austerity*
- *We emphasise the need for a paradigm shift in the maturity of public understanding of health issues and the significance of healthcare research outcomes*

Digitisation of services, Big Data and informatics

- *As guardians of innovation and technology, healthcare scientists can offer practical solutions to implementing new technologies, maximising appropriateness of healthcare decisions and facilitating quality assurance.*
- *We outline some of the barriers to industrial roll out of new technology.*
- *We suggest more use of an enhanced NICE in assessing the cost effectiveness of interventions and improved do once and share practice.*
- *We believe the use of Big Data is key to focussing on the most cost-effective diagnostic and therapeutic services in the future.*

1.0 About the Academy for Healthcare Science

1.1 The Academy for Healthcare Science (AHCS) brings together the UK’s diverse and specialised scientific community, comprised of over 50 separate disciplines under the generic groupings of life sciences (pathology), physiological sciences and physical science & medical engineering. Healthcare scientists work across the health and care system including; NHS Trusts, NHS Blood and Transplant, Public Health England, independent healthcare organisations, and the academic sector across the UK.

1.2 The Academy’s functions are to:

- Provide a strong and coherent professional voice for the healthcare science workforce
- Ensure the profession has a high profile sufficient to influence and inform a range of stakeholders on healthcare science and scientific services in the health and social care systems across the UK
- Provide engagement and support for wider strategic scientific initiatives
- Act as the overarching body for issues related to education, training and development in the UK health system and beyond including standards and quality assurance of education and training

1.3 The AHCS was established as a joint initiative of the UK Health Departments and the professional bodies. The AHCS has been commissioned to undertake and support key projects including:

- Developing consistent regulation for the healthcare science workforce e.g. by establishing accredited voluntary registers where none exist.
- Implementing a system to assess and confer ‘equivalence’ of the existing qualifications and experience individuals have, mapped to the outcomes of formalised quality assured training programmes.
- Quality assuring education and training in partnership with other stakeholders.
- Developing common standards for healthcare science practice.

1.4 Further information about the work of AHCS can be found at its web site:

<https://www.ahcs.ac.uk/>

AHCS is responding to this request for evidence under its “One Voice for Healthcare Science” initiative.

For further information or detail about any of the issues we raise please contact:

Dr Brendan Cooper,
President, Academy for Health Care Sciences
Brendan.Cooper@uhb.nhs.uk

2.0 Role of Healthcare Scientists (HCSs) in UK healthcare

- 2.1 In summary Healthcare Scientists work in partnership with AHPs, doctors and nurses & midwives to deliver scientific technical diagnostic and therapeutic services directly or indirectly to patients. Staff span the range of level of practice from assistant grades to consultant and clinical director level leading networks of services.
- 2.2 The wide range of specific healthcare science disciplines with links to details is given on the Health Education England careers web pages:
<https://www.healthcareers.nhs.uk/explore-roles>
- 2.3 The specialist expertise of HCSs and their training in scientific methodology and research makes them crucial to the conduct and evaluation of research and implementation of effective evidence-based medicine. **AHCS regards this as a crucial element of the future sustainability of the NHS.**
- 2.4 HCSs are at the cutting edge of innovation and quality assessment, to ensure traditional disciplines continue to deliver the best, most clinically appropriate services, and in the development of new scientific areas. These are the staff delivering progress in bio-informatics and the UK, flagship, 100,000 Genomes project
<https://www.genomicsengland.co.uk/>.

3.0 Specific topic areas for requested input

- 3.1 In our response to the Select Committee's specific areas of interest below we have largely restricted ourselves to issues directly affecting healthcare sciences, the context in which healthcare science operates or where we feel that HCSs have a specific contribution to make to increase NHS sustainability. We have tried to keep our responses concise but AHCS officers would be pleased to expand on any of the themes mentioned on request.
- 3.2 Recurring themes underlying our responses are:
 - Appropriate healthcare professionals, including HCSs fulfilling all the tasks that they can do to contribute to healthcare;
 - Breaking down inappropriate professional (and organisational) silos without compromising on quality; Integration of the partners in health care delivery; develop cross-disciplinary models where these are beneficial;
 - Making sure that what is done is effective both clinically and in cost terms and that means it is based on high quality research, evaluation & good clinical science;
 - Tackling inappropriate public demand driven by lack of knowledge and misinformation - public education in the face of sensationalist press stories about health. This would include education about the nature and significance of medical research evidence. That supports the need for a cultural change to engage the population as partners in their own continued good health.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

- Implications of demographic changes:

We have been informed by the Government Office for Science Foresight report: “Future of an Ageing Population”,
<https://www.gov.uk/government/publications/future-of-an-ageing-population>

Key contextual implications are:

- Greater numbers of an aged population coping with multiple long-term conditions;
- Fewer (traditional) working-age population to deliver healthcare services;
- Fewer younger working age, economically active population to fund healthcare from taxation;
- Greater demands on the ageing population to provide informal carer services for children of the economically active workforce and their own, even more elderly relatives;
- A drive for the ageing population to remain in work and economically active themselves for longer.

All of these emphasise the importance of adopting strategies to move the NHS from a service mainly treating acute illness episodes to:

- One facilitating the population to cope itself with long-term conditions;
- One focussed on prevention of illness;
- One which the population regards as a partner in their own health maintenance rather than as consumers of healthcare as if it were a commercial service.

HCSs can contribute by:

- Developing, assuring and implementing technologies delivering self-monitoring of long-term conditions so that patients call upon the NHS only as and when they need higher level or more intensive intervention;
- Education and support of patients in understanding their diseases and the technologies there to help them;
- When professional intervention is necessary ensuring that it is based on high quality scientific evidence and that the research knowledge base is updated for new medical contexts: e.g. much of the existing research is based on diagnostic and therapeutic interventions in single condition scenarios rather than more complex multiple, acute on chronic conditions

- Health and Care Systems:

- The health and care system is currently designed around isolated provider units as separate business entities. This operates to fragment the delivery of health and social care services and inhibits healthcare professionals, including HCSs, delivering the most efficient and effective contribution that they can.

- This lack of integration of services wastes resources by providers delivering only what they are contracted to deliver rather than what is in the best interests of the patient at the time. It creates multiple avoidable interactions for piecemeal delivery of fragmented services.
- Healthcare professionals, including HCSs, have in the past contributed to protectionist “silo” thinking. We regard that the change in the nature of patients and their needs described above implies a need for HCSs with in-depth expertise in specialist areas operating at an academically high level to be supplemented with a new type of HCS professional with expertise across a wider-range of related health care activities operating close to the patient. This would put in scope a more patient focussed, one-stop approach to meeting their needs.
- Technological innovation:
 - Remote services and support facilitated by internet communications is well embedded in many areas of daily life. Apart from a limited number of exemplars healthcare has been slow to adopt these technologies e.g. to facilitate telemedicine and remote monitoring using “point of care” devices. HCSs have a distinct role in ensuring that such models are robust, operate to the necessary quality and that patients are well educated in their use and the interpretation of their results.
 - The UK’s 100000 Genomes project is a ground-breaking initiative of international importance. It has the scope to fundamentally change the impact and penetration of truly “personalised” medicine which itself is about ensuring that expensive drugs and therapies are used only where they are most effective. The NHS must take this potentially highly beneficial project to its conclusion and build the system of scientists and other professionals ready and able to capitalise on that investment.
 - Capital should be made out of the ability of newer technology, used within a robust evidence-based system, to give rapid diagnosis, as early as possible in the clinical course of disease, followed by rapid intervention. Failure to act at the right time prolongs patient suffering, wastes resource and possibly costs more to resolve compounded problems if they are left to develop.
 - A key role for HCSs is in assuring that technology is of quality fit for purpose and used effectively.

Resource issues, including funding, productivity, demand management and resource use

2. *To what extent is the current funding envelope for the NHS realistic?*

AHCS has limited specific expertise to comment. At face value it is self-evident that NHS funding is currently inadequate for the political and pseudo-commercial system within which it operates. We suspect that there is waste in funding the system itself rather than direct healthcare delivery.

a. *Does the wider societal value of the healthcare system exceed its monetary cost?*

- Poor health of the population has a high cost (financial and societal) way beyond direct costs of healthcare provision. Examples include reduced productivity, collateral effects, reduced economic activity of carers.
- Good health is a prerequisite of the “working longer”, retirement at later age, objective. We are still in process of this working through the system as State Pension Age increases over next few years. This demands research assessment as it happens.
- Wider consideration needs to be given to the change in roles of older workers and the context within which they are working to best meet both their own and employer’s needs. The NHS has a clear role in supporting them in this objective.
- Public and patients have little concept of the cost of their healthcare. This is a consequence of the “free at point of delivery” doctrine being perceived as just “free”. Long-term sustainability begs public and patients taking more responsibility for their own healthcare (the corollary of “with me” rather than “to me”) and the cost of waste they produce – missed appointments, non-compliance with prescriptions or therapy.

b. *What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?*

AHCS is not able to comment

c. *What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?*

AHCS is not able to comment authoritatively. However we would note that National Insurance as a funding mechanism was conceived in a very different age and under very different circumstances. It would now seem to be not fit for purpose and ready to be replaced.

d. *Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing-care be made means-tested with a Dilnot-style cap?*

- We in fact already do this in dental services, opticians. A problem is that it risks driving population into hands of un-evidenced “medicine” of questionable value representing a high risk of abuse of the public..
- There are real risks to the sustainability of NHS through needing to pick up the problems caused by alternative, non-NHS providers of parts of healthcare if this becomes common place.
- It potentially leaves the public open to un-validated (and potentially detrimental) commercial healthcare of no value. Fosters growth of the quack sector.
- These risks could possibly be mitigated by the public being much more aware of the significance of quality research and evidence base. The UK has been a world leader in quality medical evidence through the Cochrane initiative, <http://www.cochranelibrary.com/> and development of meta-analysis

methodology. The role of NICE in testing the cost effectiveness of interventions is well established. However the authority of such high quality evidence is undermined by neglecting to educate the public in how these functions work, leaving the initiative with the sensationalist press and alternative interest pressure groups. The debacle of the MMR vaccination scandal has cost the NHS considerable money and will continue to impact on avoidable suffering of patients for many years to come. Despite this the internet remains rife with the stories against vaccination.

- We note that the healthcare system is not itself free from self-generated problems such as the current serious concerns over anti-biotic resistance which is in part of its own making through inappropriate use. We must take care that such problems, which cost a great deal in financial terms and suffering, do not recur.

Workforce

3. *What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?*

- Note that HCS are about 7% of health workforce.
- There is a long lead time for specialist professional training in context where NHS is often sole employment opportunity. (Training to higher specialist level takes a minimum of 8 years post first degree.)
- Therefore sustainability demands high quality, **long-term** workforce planning – history of this being notoriously poor in the NHS – and then sticking to and supporting the plan and workforce strategy.

a. *What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?*

- HCS has record of attracting good quality science graduates showing that internal development is sustainable BUT it demands long-term financial security for both trainees and the education system (which includes in-service training).
- As HCS roles change and the availability of young entrants reduces through the demographic impacts cited above there will be an increasing need for staff development and re-education of older staff in post.

b. *What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?*

- Brexit probably means UK will have to grow more of its own – either by competition for next entrant trainees or by developing those already within workforce.

c. *What are the retention issues for key groups of healthcare workers and how should these be addressed?*

- Tie-in clauses for those who have benefited from expensive training are superficially an attractive idea but implementation in practice is likely to be problematic.
- The demographic changes imply that the NHS will have to compete for the most talented entrants in an increasingly aggressive employment market.
- Competitive terms and conditions and remuneration are important for new entrants. Retention is more affected if there are negative changes to terms and conditions. In recent years these have been dominated by short-term actions by providers in economic distress.
- For entrants NHS HCS employment represent a long-term commitment. For retention these staff need good prospects of career progression. Short-term financial restrictions confound that aspiration.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

Positive engagement of the relevant professional bodies is essential to both the delivery of training – and re-training of the established professional population – and the assurance of continued quality. Appropriate professional regulation that is consistent, risk-related and equitable across all professional areas can contribute significantly. (There currently is unjustified variation between requirements for professional regulation. We acknowledge the work of the Professional Standards Authority to address this.)

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

- Key technological change is ready access to high quality information and support for those that need it wherever they need it. That means to both the patient's records – which must be regarded as a partnership issue shared with the patient themselves – and digestible relevant knowledge base for use by professionals and patients. Healthcare science in pathology has led in the area of authoritative patient targeted information through the "Lab Tests on Line" project: <http://labtestsonline.org.uk/>
- Point of Care Testing is technology for undertaking diagnostic and monitoring tests beside the patient in whatever geographical context they may be with results immediately available. They are particularly apposite for diagnosis in difficult to engage, at risk, populations such as the itinerant. Further developments are necessary in processes and quality systems to ensure clinical decisions are made using data that is fit for purpose.
- The UK biomedical science industry is world leading in the development of such devices but implementation is often inhibited by consideration only of immediate financial benefits rather than considering business cases holistically.

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

- AHCS would suggest regard this as an INVESTMENT not COST facilitating the more flexible, integrated model of healthcare mentioned above which we, in turn, maintain is essential for sustainability.
- Within healthcare science the Modernising Scientific Careers training model is good starting point
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215897/dh_123911.pdf. This initiative introduced a training programme combining a significant generic healthcare science component with specialist subject training. It is important that the generic component is at the right level to be professionally useful rather than superficial and endorsed by the relevant professional bodies.
- Training at graduate and post-graduate entry levels is now supplemented by a Higher Scientific Specialist Training scheme for those aspiring to be consultants and clinical leaders.
- Need also to include the Clinical Leadership development agenda.

c. *What investment model would most speedily enhance and stabilise the workforce?*

- For a workforce the size of many specialisms in HCS this must be done with a national perspective supported by nation (UK)-wide workforce planning .
- It is problematic where local employers demand direct return on training investment for such groups at the level of local training delivery
- Lots more scope to develop the existing workforce – conversion courses and equivalence assessment. AHCS has good record in this but could do more.

Models of service delivery and integration

5. *What are the practical changes required to provide the population with an integrated National Health and Care Service?*

- The key issue here is the integration of the disparate bodies, each with their own objectives and financial issues, and breaking down of protectionism. The situation of “bed-blocking” because of the lack of integration between social and health care is little short of a national scandal.
- Support those living with long-term conditions by more active prognosis / prediction healthcare element so that additional support / changes in therapy can occur at the most productive time.
- “Wellness testing” function to engage population more in ownership / responsibility for their own preserved good health. Specialist areas for this might be (simple) lung function monitoring in those with mild but potentially progressive chronic lung disease or in the investigation of reduced fertility.
- Scope for research in effective service delivery models.

a. *How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?*

AHCS is not in a position to answer this question however we would note that the purchaser – provider split and notions of the internal health market have been wasteful and undermine the collaborative, partnership integrated approach.

b. *How can local organisations be incentivised to work together?*

- Recognising the joint and mutual benefits and fair sharing of these.
- Shared information.

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

AHCS is not in a position to comment.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

- Good quality relevant research demonstrating outcomes and benefits.
- Public education with honest information – and acknowledgement of what we do not know – to counter the misinformation of the sensationalist press and pressure group propaganda. Thus fostering good public understanding of the nature of healthcare research evidence / healthcare science.
- Whilst there may be much scepticism, the most cost effective healthcare interventions through history have been preventive. This takes cultural change but the success of Finland in reducing cardiovascular disease demonstrates that the real life benefits are possible:
<https://www.ncbi.nlm.nih.gov/pubmed/9803593> .
- A further barrier is the vernacular claim that preventative medicine advice is always changing. This reveals an underlying lack of understanding about the nature of evidence. The public education must counter the resulting cynicism.

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

- Again, power of good evidence. Experience of where it has worked to the general good.
- Public understanding of what they really CAN do to help themselves, ideally with easily demonstrable personal benefit.

b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

- The State should provide the leadership, policy and infrastructure within which key, population-wide research and strategy development is conducted.
- We should not underestimate the power of central “nudge” in eliciting changed behaviour.
- Local and regional bodies have the role of translating central policy into the local context and implementation to the national standards. However this must avoid resulting in unjustified variance. We applaud the NHS Atlas of Variation initiatives: <http://www.rightcare.nhs.uk/index.php/nhs-atlas/>
- The individual has the responsibility for making a rational choice to engage or not. If they do engage then they are responsible for following the evidence-based system; if they do not engage then not to waste resource by sham engagement.

- The key change, as in so much of this response, is in developing a good, mature level of public understanding.
- c. *Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?***
- Yes, very much so.
 - Identification of the holistic cost benefits
- d. *Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?***
- There is potential for unexpected consequences from simplistic interventions of this nature.
- e. *By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?***
- This is a whole society issue not just provider issue. Needs a consistent message and engagement with all parties: Government, healthcare, public health, local government, industry.
- f. *What are the barriers to taking on received knowledge about healthy places to live and work?***
- Misinformation disseminated by sensationalist media
 - Economic inequality,
 - Social immobility,
 - Inadequate public education to generate a sophisticated level of understanding,
 - Short-termism in a time of financial austerity,
 - Lack of employer engagement in this agenda.
- g. *How could technology play a greater role in enhancing prevention and public health?***
- Validated, well researched evidence based self-monitoring,
 - Connectivity to professional support,
 - Strong evidence base supporting next-steps action,
 - Access to validated knowledge and decision-making support.
- 7. *What are the best ways to engage the public in talking about what they want from a health service?***
- Education without patronising,
 - Fostering real partnership in the individual's health maintenance,
 - Local, human scale engagement supported by an authoritative national structure.

Digitisation of services, Big Data and informatics

- 8. *How can new technologies be used to ensure the sustainability of the NHS***

- Fostering a truly joined up health (& social) care system with appropriate and secure information sharing.
- Avoid waste and duplication.
- Facilitating more rapid, robust decision-making early in pursuit of the “right things done on the right patient at the right time” principle.
- Facilitate interventions as close to the patient as possible without the need to use valuable specialist services.
- Where specialist centralised services are necessary to help ensure these are as effective as possible.
- Ensure the right information is available to those who need it when they need it.
- Need to consider the patient’s responsibility for care of the technology they are using.

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

- Powerful in helping make the patient (and carers) more responsible for their own healthcare
- Maximise appropriateness of healthcare decisions – facilitates “personalised medicine”
- Early warning and early intervention
- Facilitates quality assurance

b. What is the role of ‘Big Data’ in reducing costs and managing demand?

- Engaging the public in the nature and power of the (outcome) evidence derivable
- Integrated data available to all who need it to contribute to output.
- Power of large population data bases for “pragmatic” research supplementing more formal academic scientific research

c. What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

- Relating this to the profit bottom line for industry.
- MHRA regulatory processes unnecessarily rigorous for purpose.
- Short-termism in finances of healthcare providers.
- Public suspicion of centralised data records systems.

- Note that HCSs have a distinct role in providing scientific interpretative input and assessment of the validity and significance of conclusions

d. How can healthcare providers be incentivised to take up new technologies?

- Good evidence of benefits (including wider financial and holistic benefits).
- Enhance NICE with its strong scientific authority but make it more nimble than at present. More visible public involvement in NICE decisions when they are made – rather than reacting in protest in retrospect.
- Genuine “do once and share” of best practice with roll-out commitment.

e. Where is investment in technology and informatics most needed?

- Reaping and embedding the benefits of genomics.
- Identifying and rolling out high volume, low cost “quick fixes”.
- Translational research and development at the local level to reap the benefits of central academic research. The NHS is particularly poor at research implementation.

Dr Brendan Cooper

President, Academy for Health Care Sciences

on behalf of the AHCS

23 September 2016

Academy of Medical Royal Colleges – Written evidence (NHS0139)

About the Academy

The Academy of Medical Royal Colleges (the Academy) is the coordinating body for the UK and Ireland's 22 medical Royal Colleges and Faculties. They ensure patients are safely and properly cared for by setting standards for the way doctors are educated, trained and monitored throughout their careers.

Healthcare is complex and increasingly there are issues where a cross-specialty perspective is needed. It's the Academy's job to ensure this work is done effectively and then acted upon by policy makers, regulators and clinicians.

This unique position gives us a leading role in the areas of clinical quality, public health, education and training and doctors' revalidation.

The 22 medical Royal Colleges and Faculties are members of the Academy, bringing together the views of their individual specialties to collectively influence and shape healthcare across the four nations of the UK.

More information can be found at www.aomrc.org.uk

Executive Summary

The Academy welcomes the House of Lord's Select Committee on the long term sustainability of the NHS's inquiry and the opportunity to submit evidence. The Royal Colleges and Faculties which we represent have been concerned for some time about the unprecedented challenges the system faces and believe that these must be urgently addressed by government, the whole system and individual clinicians and healthcare. We hope this inquiry will be a first step in this process. A short summary of the key points in our submission is as follows:

Resources and funding

- The health and social care system needs more investment as current levels of funding are insufficient. We would like to see a real terms funding increase of £40 bn by 2030. This amounts to a rise from 7.4 per cent to 8.8 per cent of GDP over the next 14 years (at current levels)
- This should also be funded through increased taxation and restrictions on products where there is evidence that it improves people's health such as minimum alcohol pricing and further levies on sugar and tobacco products

- The government should reverse the recent cuts to public health budgets. They are already proving to be a false economy
- NHS staff can support a sustainable system by tackling the significant amount of waste seen in the NHS through changes in clinical practice.

Workforce

- Workforce shortages across the system should be addressed by creating more training posts
- The immigration system should remain flexible to allow employers to recruit from overseas
- The government must work to prevent the mass exodus of EU staff from NHS services following Brexit
- Royal Colleges and leaders must do more to retain NHS staff and create a culture where they feel valued
- Particular attention must be considered to the workforce issues faced by rural communities.

Models of service delivery and integration

- Integration and reconfiguration decisions must be evidence based
- Implement the *General Practice Forward View* and properly fund it
- Genuine co-production must be at the heart of all reconfiguration. Without it, any changes are difficult to implement at a local level
- Ensure parity by investing more in mental health.

Prevention and Public Engagement

- The government must show real commitment to tackling obesity, smoking and alcohol consumption. The first step towards this should be the reversal of the cuts to local authorities public health budgets
- Legislation should be used to further regulate industry, where there is evidence that this is effective, for example, maximum sugar content, minimum alcohol pricing and further tobacco levies
- Co-production is essential to the successful delivery of any reconfigured service
- Clinicians must also engage with local patients and the public to make the clinical case for sustainability and reconfiguration.

Digitalisation

- New technology will be most effective when there is strong clinical input, and steps are taken to evaluate evidence of efficacy. Procurement should be clinically led

- Digitalisation will require investment, not just in capital outlay but also maintenance, updates and integration solutions
- Managing demand is complex, while there may be a reduction in demand for certain services, there may be other unforeseen demands which will need consideration before wholesale introduction.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

The Academy shares the vision set out in NHS England's the Five Year Forward View (5YFV)¹⁶, published in October 2014. This vision for health and social care accurately describes the challenges we face and the solutions required to overcome them to ensure a truly sustainable system. The success of the NHS over many decades, as well as medical progress has resulted in people living longer, which both bring a new and different set of challenges to the system. We have an increasing number of patients with complex healthcare needs and multiple long term conditions. FYFV recognises that to address this we need to move away from treatment, towards prevention, move more care into the community, fully integrate health with social care as well combining physical and mental health care. This is vision shared by Academy and its members.

Almost two years after the publication of the 5YFV, there appears to have been little meaningful development; the 'radical upgrade in prevention' has failed to materialise. Instead, we have witnessed cuts to local authorities' public health and social care budgets. This will further compound the challenges of a sustainable healthcare system.

It is clear that some fundamental changes must take place in order for the NHS to become sustainable. It will take commitment from government, local leaders and individual clinicians. We all must play our part.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

The Academy does not believe the current funding envelope for the NHS is realistic. The growth in demand without a relative increase in the necessary funding has left providers with unprecedented deficits and crucial targets missed. In 2009/2010 less than 10% of trusts

¹⁶ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

were in deficit; this increased to 65% in the last financial year. 80% of acute trusts are in deficit, compared with 5% three years ago¹⁷. This cannot continue.

While integration and efficiency will result in savings, it will not provide the system with the resources necessary to operate safely and effectively. The UK spends less of its GDP (around 7.4%) on healthcare than most other developed nations and so it is entirely sensible to argue that there is scope to increase overall spending. The Academy agrees with the OBR's recent projections, which suggest that UK health services require a real terms increase of £40 bn by 2030.¹⁸ This amounts to a rise from 7.4% to 8.8% of GDP over the next 14 years.

a. Does the wider societal value of the healthcare system exceed its monetary cost?

The evidence is clear that the societal value of the healthcare system, particularly one which includes public health and the care system, exceeds its monetary cost. The Faculty of Sexual and Reproductive Health uses the case of the societal value in preventing unintended pregnancy brings through the relatively low cost of investment in contraception. If the estimated current levels of provision and access to contraception are maintained, unintended pregnancy is expected to cost the UK's social welfare system between £113 bn and £203 bn between 2015-2010.¹⁹ There are many more examples of this kind, particularly in public health.

b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

Outcomes and prevention would be properly recognised and rewarded in any sustainable funding model. The current tariff system creates perverse incentives by rewarding activity alone.

The Academy recognises that our colleagues in social care face an even greater challenge than in the NHS. The sustainability of either system cannot be considered separately. Serious thought should be given to a funding model that integrates their budgets to support the delivery of integrated local services, providing a truly 'cradle to grave' service. Kate Barker's report for the King's Fund addresses this in detail.²⁰

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

¹⁷http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Deficits_in_the_NHS_Kings_Fund_July_2016_1.pdf

¹⁸ http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf

¹⁹ <http://www.fpa.org.uk/sites/default/files/unprotected-nation-sexual-health-full-report.pdf>

²⁰http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf

The Academy strongly believes in a healthcare system which is free at the point of use; although this is ultimately a political decision, it is best funded through general taxation. This method also avoids additional costs related to transaction charges – a model used elsewhere in the world. Indeed, in 2011 the US based Commonwealth fund, outlined how the UK healthcare system was one of the most efficient and cost effective in the world. That does not, however, mean that the NHS cannot be made more efficient and effective.

Royal Colleges and Faculties are particularly supportive of the implementation of industry levies, where there is evidence that it improves people's health, for example in minimum unit pricing on alcohol²¹, maximum sugar levels and further levies on tobacco products. This generates immediate tax returns but is also an effective prevention strategy, reducing future financial pressures.

d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

The Academy believes that the principle of healthcare being free at the point of use should be protected. That said, given that extent of the financial pressure the system is facing the Academy believes there should be a national conversation about how the funding gap can be met. It should genuinely engage the public as well as those working in health and social care. Both government and those working within the health system have a duty to do this.

We also recognise that there is more the NHS and its staff can do to support a sustainable NHS. There are still significant amounts of waste in the system, which can be tackled through changes in clinical practice. It is estimated that around 20% of mainstream clinical practice brings no benefit to the patient as there is widespread overuse of tests and interventions.²² The Academy published seven key recommendations which outlined how clinicians can reduce waste and deliver higher value care.²³

Choosing Wisely, a global initiative which works with both patients and clinicians to reduce unnecessary tests, treatments and procedures is led by the Academy in the UK. This attempts to create a shift in culture where patients are more involved in decisions about their care. The Academy is poised to launch a national campaign on this issue, by publicising a list of 50 treatments and procedures of questionable value. These have been compiled collectively by the medical royal colleges and faculties and include such examples as prescribing exercise for mild-depression as well as more technical alternatives.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

²¹ http://www.fph.org.uk/uploads/050110_FPH_Alcohol_Bill.pdf

²² Berwick DM, Hackbarth AD. Eliminating waste in US health care. JAMA. 2012 Apr 11;307(14):1513–6

²³ http://www.aomrc.org.uk/wp-content/uploads/2016/05/Protecting_Resources_Promoting_Value_1114.pdf

There are currently significant workforce shortages, which must be addressed. All specialities in medicine face staff shortages, the exact number of which changes from year to year; the current problem is particularly prevalent in general practice and acute medicine. This problem is exacerbated by a general lack of ‘boots on the ground’, such as nurses and other healthcare professionals. Recent research by The Royal College of Physicians of London shows that 65% of trainee doctors reported permanent gaps in their training rotas. A further 95% reported that that gap is impacting on patient care, while 96% also reported gaps in nursing rotas.²⁴ In radiology an estimated 230,000 patients have been waiting more than a month for their imaging reports due to a shortage of diagnostic radiologists; this has impacts across the system.

These shortages coupled with increasing demand across primary and secondary care are unabated and puts patient safety and quality of care at risk. The UK must train more doctors and healthcare staff.

Given that around 70% of NHS provider costs relate to staffing²⁵, it is imperative that there is detailed workforce planning across the system to ensure that the NHS is sustainable and delivers the care patients will need.

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

Recruitment from overseas should not be used as an alternative to training an adequate number of doctors and health care staff in the UK. However, the recruitment of doctors and other healthcare staff from overseas provides a good solution where posts cannot be filled. The UK immigration system must remain open and flexible enough to allow employers to recruit from outside the UK.

The Academy runs the Medical Training Initiative (MTI)²⁶, which is a national scheme allowing a small number of trainee doctors to enter the UK from outside the European Union. It enables them to benefit from training and devolvement in the NHS before returning to their home countries.

More can be done to encourage doctors from outside the UK to train in the UK, such as providing appropriate salary and job opportunities. Health Education England is currently developing a commercial scheme entitled the *International Fellowship Programme*, which will allow international trainees who are not eligible to train as EU students or through the MTI scheme, to train in the NHS.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

The impact Brexit will have on the supply of NHS staff is potentially catastrophic. With an estimated 135,000 EU nationals working in health and social care system²⁷, it is self-evident that the levels of care currently provided could not be sustained if that workforce was lost.

²⁴ <https://www.rcplondon.ac.uk/guidelines-policy/underfunded-underdoctored-overstretched-nhs-2016>

²⁵ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf

²⁶ <http://www.aomrc.org.uk/medical-training-initiative/>

²⁷ <http://www.nuffieldtrust.org.uk/blog/fact-check-migration-and-nhs-staff>

How Brexit will play out is unclear, but the Academy believes this should be at the forefront of the UK Government's mind during the exit negotiations. Early action is vital to reassure EU staff of their employment in the NHS to prevent significant departure of staff.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

There are a large number of unfilled consultant posts across medicine, with some specialities particularly understaffed, 40% of new consultant posts in geriatric and acute medicine, for example, are unfilled. There is also a gap of 6.7% in the recruitment of consultant psychiatrists.²⁸ More can be done by Royal Colleges and the NHS to address retention issues.

Industrial action by junior doctors has shed light on the pressures in which NHS staff operate. The success and sustainability of the NHS will in part be dependent on the productivity and commitment of its workforce. It cannot be assumed that staff will remain resilient and resourceful under continued pressure. More must be done to create a supportive and enabling environment for NHS employees. This need not cost a large amount of money, but rather is more dependent upon good leadership and a change in culture.

Part of that change must be the provision of high quality occupational health services to NHS staff (SEQOHS accredited). It is an essential element of the supportive environment for NHS staff, protecting them against workplace health risks, supporting their health and well-being which enables them to provide the best care for patients.

There is a particularly acute challenge for the recruitment and retention of NHS staff in remote settings, which demands its own set of solutions. The Academy and Nuffield Trust published a document in July 2016 which sets out some of the unique challenges and potential solutions for remote services, such new approaches to staffing and delivery models.²⁹

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

There is consensus that there should be greater flexibility in training to support moving across specialties and the opportunity for greater generalism, in order to meet the changing needs of patients. Anaesthetists' delivery of perioperative care is a good example of this flexible approach.³⁰ Royal Colleges are concerned about the lack of progress since the Shape of Training report was first published in 2013 and feel that Government must re-focus its attention on this if a truly sustainable NHS is to be achieved.

Models of service delivery and integration

²⁸ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf

²⁹ http://www.aomrc.org.uk/wp-content/uploads/2016/08/Acute_care_remote-settings_100816-2.pdf

³⁰ <https://www.rcoa.ac.uk/perioperativemedicine>

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

There is widespread consensus that greater integration between all parts of the system; health and social care, primary and secondary care, public health and mental health is urgently required. There is also a consensus that the whole system should shift its focus from internal competition to genuine collaboration.

NHS England's New Models of Care – Vanguard Sites, supports the development and implementation of integrated models in certain areas across the country. It is clear that the exact new care model required in a particular area will differ across the country and will depend entirely on the needs of any given local population. The Academy is concerned that as new models of care develop through the Sustainability and Transformation Plans or other programmes, strategic decisions are not being made based on robust evidence and data. It is imperative that any fundamental change, such as reconfiguration of services, is based on clear evidence of what works best for the population it serves. Furthermore, major changes must be co-produced with the local population, or they run the risk of failing due to local opposition (more detail on this can be found in our response under the section on public engagement). The Academy's members recognise the need for clinicians to be part of the process of change and service redesign where there is evidence of a clinical case for it. Although, any new models of care or reconfiguration should be uniquely developed to suit the needs of a local population, it is clear that general practice will be heart of most proposals in order to support moving care away from acute settings and into the community. The sustainability of the wider NHS depends on sufficient investment and work force planning for general practice. For this reason the Academy supports the delivery of the *General Practice Forward View*.³¹

a. How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

We would draw the Committee's attention to the report published by the King's Fund, which outlines in detail how an integrated budget of the NHS and social care could work in practice.

An efficient and effective integrated health and social care system will require more than integrated budgets. The right culture is also an essential component and this will only be created if effective local and clinical leaders are allowed to work collaboratively across a local area. It will require staff and leaders to think out outside their organisational silos and priorities and work in a truly patient centred way. The New Local Government Network published a report which outlines the enablers to support truly integrated and collaborate working across a local area; these suggestions range from soft enablers such as good communication to pooled budgets. We commend this to the committee.

b. How can local organisations be incentivised to work together?

³¹ <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfov.pdf>

As outlined above good leadership at a local level is key to collaborative working. However, there are a range of barriers which stop this from happening. The first, is that health and social care providers work to very different set of organisational and financial drivers. There is also no powerful incentive to work together.

The way in which we inspect and regulate the system must also change. The Care Quality Commission (CQC) inspects institutions rather than systems or pathways, and therefore does not reflect a patient's journey and does not support collaborative and integrated working. There must be a shift from service silos to system outcomes. There are, however, pockets of good practice which the CQC should recognise as part of their inspections and assessment of quality, for example the accreditation and registration schemes available for specific services, many of which are supported and run by medical Royal colleges and faculties, which support integrated and collaborative working in their inspections.

A single capitated budget would support integration and collaboration between health and social care by joining all resources and care for a local population. This would support a move away from a disease specific approach to care and put the patient at the centre of provision of care. This does require the cooperation of all providers and organisation in a local area and some local STPs are looking at ways at how this may work.

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

As already stated there is widespread consensus that care should shift from hospitals and into communities, not just in order to make the system more sustainable but also to meet the needs of patients and improve their outcomes. One barrier to delivering this which Royal Colleges have been highlighting to government for many years is the perverse incentives of payments by results. The government must eventually address this, if we are to deliver a sustainable system.

The single greatest initiative which can readdress the imbalance between mental and physical health is further investment in mental health. Mental health has been underfunded for decades and continues to be affected by the Government's austerity programme, particularly in the provision of child mental health and prevention paid for by local authority budgets. Spending on mental health services equate to 11% of the total NHS budget; this must be rebalanced. Also, roles such as psychiatric liaison services play a vital part in bridging the gap between mental and physical health but are in woefully short supply across the system.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

Prevention strategies must take a whole system approach. The range of public services which patients and the public access in a local area should collaborate to deliver the best

outcomes for that population. For example, if local authorities and health services provide innovative prevention programmes, but local housing is sub-standard, then impact and outcomes for that particular population will be limited. A report published by the New Local Government Network outlines the way in which all institutions in a local area, which currently work in a separate and fragmented way can work together sustainably including NHS, local government, housing providers, schools, community pharmacies and charities.³²

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

The future sustainability of the NHS will be predicated on tackling three key public health issues: obesity, particularly in children, smoking and alcohol consumption.

First, the Government should reverse the cuts to local authority public health budgets, which have created a clear danger to the future sustainability of the NHS. Between 2015 and 2016, 39% of local authorities in England made cuts to their local smoking cessation services and we know more will follow. This is truly a false economy.

The determinants which affect an individual's health are also environmental and social and any truly preventative system must take these into consideration. The Marmot Review published in 2010 outlines a range of practical policies which will support people to stay healthy throughout the course of their life.³³

Despite the rhetoric around parity between physical and mental health, mental health prevention and treatment services continue to be cut. Good mental health should include a range of excellent perinatal services for mothers affected by moderate and severe mental health problems, as an important foundation for building resilience, and helping to give every child a mentally healthy start in life. Measures to tackle child poverty are important, as are programmes such as Sure Start, targeted mental health interventions in schools and supporting obese and often bullied children with their self-esteem challenges at the earliest opportunity. Systems and services to tackle these issues have all been cut by local authorities across the country. The substantial evidence of the benefits of commissioning public mental health programmes is contained in the Joint Commissioning Panel for Mental Health Guidance on Commissioning Public Mental Health services.³⁴

d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

Royal Colleges and Faculties support the use of legalisation to regulate industry, where there is evidence that this is effective, for example, maximum sugar level, minimum unit pricing for alcohol and further tobacco levies. The Academy was extremely disappointed that the UK Government did not heed the advice of clinicians and its own public health

³² http://www.nlgn.org.uk/public/wp-content/uploads/Get-Well-Soon_FINAL.pdf

³³ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

³⁴ <http://jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf>

advisors and instead implemented a voluntary target on sugar content. If we do not tackle childhood obesity with the seriousness it deserves, the will NHS face an existential crisis. The decision to water down the childhood obesity strategy suggests that the Government does not take prevention and the sustainability of the NHS seriously.

What are the best ways to engage the public in talking about what they want from a health service?

In light of the extreme financial pressures the health and care system in the UK are under and the fundamental changes required to create a sustainable system, there should be a 'national conversation' to determine how the shortfall should be funded and what reconfigured services should look like.

Co-production is essential to the successful delivery of any reconfigured service. There must be meaningful engagement with patients and public throughout a process, rather than formal consultation on an already designed proposal. The absence of genuine engagement and transparency creates suspicion among communities and often leads to opposition, which makes any change difficult to deliver. The Academy is concerned that failure of NHS England to publish the local STPs plans, demonstrates a lack of any genuine desire for co-production. There are already palpable suspicions around these plans at a local level which may have a negative impact on their development and delivery. Generally, the Government and the NHS must improve its public and patient engagement.

Clinicians must also engage with local patients and the public to make the clinical case for sustainability and reconfiguration; this will make any changes to the system to be palatable. Clinicians bring credibility to decision about health services and are seen as being motivated by a desire to improve outcomes for patients.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

By any measure, data and digital offer significant opportunities to transform and improve the health and social care systems. The NHS is too far from where it should be when it comes to making use of information and improving access to care for patients. Online consultations are a rarity, patient records remain largely paper based and IT systems that should be seamlessly integrated can vary not just between regions but within Trusts. Simply put, the NHS is not only way behind the curve when it comes to make use of the digital world the lack of investment is now costing the taxpayers money. The Academy set out the case for the need to redouble its efforts on making effective use of information, communication and technology in it's report i-care published in October 2013.³⁵

³⁵ <http://www.aomrc.org.uk/publications/reports-guidance/icare-ict-in-the-nhs-1013/>

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

The thoughtful use of technology has the potential to improve the way we deliver healthcare. Technological developments such as tele-medicine, wearable technologies and genomic medicine can help patients and clinicians work together to improve the quality of care delivered, especially for those patients with complex needs. The Academy and Colleges have supported the production of the “Clinical Requirements 2020” document produced by the Strategic Clinical Reference Group (SCRG) which sets out the expectation from the clinical community of the digital environment in which we expect to work in by 2020. We are expecting this to be adopted by the National Information Board (NIB) and would commend it to the Review. If the requirements in the document are delivered we believe it will contribute to a transformation in the delivery of care.

b. What is the role of ‘Big Data’ in reducing costs and managing demand?

The use of big data is potentially life-saving. However, costs related to technology can be high and analysis can be complex. Although there may be potential long-term cost-savings from prevention and early diagnosis, a large amount of investment and on-going expenditure is required. Costs will not only include capital outlay, but also involve maintenance, updates and integration solutions. Tele-health initiatives will still require strong clinical support and staff training whilst wearables will require strategies around equipment calibration and maintenance. Understanding healthcare demand in relation to technology will also require a nuanced approach. Whilst there may be a reduction in demand for certain services, other unforeseen demands may arise. For example, wearables may record incidental or unexpected findings that will require clinical support.

c. What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

Big data in healthcare has the potential to identify trends and predict future demand. Comprehensive large datasets can be used in a number of areas, including research, pathway design and population health measurement. Data is unlikely to manage patient demand, but can ensure that services are optimised to meet that demand effectively and efficiently.

The biggest barriers to the use of big data include quality, accuracy, integration and real-time rather than retrospective use of information. Data ownership and consent issues related to the use of data remain significant issues. Institutions should not own patient data, rather it is important that patients own their own data and that the NHS is the guardian of that data.

d. How can healthcare providers be incentivised to take up new technologies?

It is important that there is buy-in from key organisational decision makers in order for healthcare providers to take up new technologies. It is vital that the executive board of an institution understands the long-term benefits of technological investment and that this is

not sacrificed for short-term cost-savings. It is also important that there is strong communication between board members, clinicians and information technology stakeholders to ensure that solutions are user friendly and tackle real problems on the ground. Current IT investment and procurement is centred around institutions rather than patient pathways. As the sustainability and transformation plans grow, future procurement models should focus on integrated solutions.

e. Where is investment in technology and informatics most needed?

There are a number of areas of investment with regards to informatics and technology. The most important of these relate to data infrastructure and workforce. Developing a strong data infrastructure through developing information models and interoperability initiatives can ensure long-term sustainability across the health system and ensure minimal vendor lock-in. Investment in workforce is also a key step in developing effective technology and information systems within the NHS. Well-qualified clinicians, who lead a clinical-IT workforce, are an important step in ensuring the quality and sustainability of these initiatives. It is also vital that the workforce is engaged to understand and improve processes within institutions. Investment in technology to improve processes will only have a small benefit if the underlying flaws within these processes are not addressed. Health technology and information will be most effective when clinicians are engaged in its development, procurement and use.

23 September 2016

Action on Hearing Loss – Written evidence (NHS0082)

1. About us

1.1 Action on Hearing Loss, formerly RNID, is the UK's largest charity working for people with deafness, hearing loss and tinnitus. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose, enabling them to take control of their lives and removing the barriers in their way. We give people support and care; develop technology and treatments and campaign for equality.

1.2 We welcome the Lords Select Committee investigation into the sustainability of the NHS, and think it is important to consider the pressures the current system is under and the impact an aging population will have.

2. Summary

2.1 Hearing Loss is a major public health issue that currently affects over 11 million people in the UK, about one in six of the population. As the population ages hearing loss will affect a growing number of people. By 2035 there will be an estimated 15.6 million people with hearing loss, about one in five of the population³⁶.

2.2 National governments have recognised hearing loss as a major public health issue³⁷, yet this has often not impacted on practice by commissioners or providers. This may be partly a result of short term budgeting and prioritisation that doesn't demonstrate regard for long term costs or sustainability of the system.

2.3 Currently, over 71.1% of over-70-year-olds and 41.7% of over-50-year-olds have some kind of hearing loss³⁸, and if hearing loss is not identified and addressed it has a serious impact on the person's ability to communicate, their physical and mental health and their ability to access services, stay safe and remain independent³⁹. Evidence

³⁶ Action on Hearing Loss (2015) Hearing matters. Available at: www.actiononhearingloss.org.uk/hearingmatters

³⁷ NHS England and the Department of Health published an Action Plan on Hearing Loss in March 2015 (available at <https://www.england.nhs.uk/wp-content/uploads/2015/03/act-plan-hearing-loss-upd.pdf>), NHS England published a Commissioning Framework for adult hearing loss services in July 2016 (available at <https://www.england.nhs.uk/wp-content/uploads/2016/07/HLCF.pdf>)

³⁸ Action on Hearing Loss (2015) Hearing Matters (available at: www.hearingmatters.org.uk)

³⁹ Action on Hearing Loss (2015) Hearing matters, Available at: www.actiononhearingloss.org.uk/hearingmatters; Ringham (2012) Access All Areas. Available at: www.actiononhearingloss.org.uk/accessallareas; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. *Acta Otorhinolaryngologica Italica*. 28(2): 61-6; Arlinger (2003) Negative consequences of uncorrected hearing loss – a review. *International Journal of Audiology* 42(2): 17-20; Gopinath et al (2012) Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. *Age and Ageing* 41(5): 618–623; Action on Hearing Loss (2013) Joining Up (available at www.actiononhearingloss.org.uk/joiningup); Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. *Journal of the American Geriatrics Society* 58(1): 93-7; Mulrow et al (1992) Sustained benefits of hearing aids. *Journal of Speech & Hearing Research* 35(6): 1402-5; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. *Head & Neck Nursing*. 18(1): 12-6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly

demonstrates that hearing aids are a cost-effective treatment option⁴⁰, and recent data shows that across the UK 9 out of 10 people use their hearing aids regularly and 81% of people think their hearing aid works better than or as expected⁴¹. Yet, only approximately two fifths of people who could benefit from hearing aids in the UK have them⁴², and in some areas hearing aids are being included in proposals for rationing services. Insufficient resource is allocated to treatments and support and there is not enough active encouragement of people with potential hearing loss to seek help.

2.4 The level of unmet need amongst people with hearing loss, the lack of awareness of its impacts and the lack of a sustainable approach to tackling its rising prevalence mean that hearing loss services can provide good case studies for why and how the health and care system should change in order to be sustainable. A summary of the conclusions our evidence points to is below:

2.4.1 There needs to be a shift in priorities within the health and social care system, with resource behind developing sustainable and preventative approaches to health care. Commissioners and providers need to be able to test and fund preventative approaches or pilots that promote early intervention and integration, as well as continue to support people who need acute treatment.

2.4.2 Not having treatments free to all at the point of access, or restricting access to treatments does not incentivise people to access treatments in a timely way, often resulting in worse health outcomes and greater spending. Forcing people to pay for certain treatments also creates inequalities because some people may not be able to afford the healthcare they need, and this will also result in greater spending when people's condition deteriorates and they require more complex, costly interventions.

people, *Archives of Gerontology and Geriatrics*, 52(3): 250-2; Lin et al (2011) Hearing loss and incident dementia. *Archives of Neurology* 68(2): 214-220; Lin et al (2013) Hearing loss and cognitive decline in older adults. *Internal Medicine* 173(4): 293-299; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. *Otology & Neurotology* 35(5): 775-81; Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. *Alzheimer's and Dementia Journal*, 11 (1), 70-98; Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. *Archives of Ophthalmology* 124(10): 1465-70; McKee et al (2011) Perceptions of cardiovascular health in an underserved community of deaf adults using American Sign Language. *Disability and Health* 4(3): 192-197; Margellos-Anast et al (2006) Cardiovascular disease knowledge among culturally Deaf patients in Chicago. *Preventive Medicine* 42(3): 235-9; Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. *Otology and Neurotology* 24(3): 382-386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. *Diabetic Medicine* 26(5): 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. *Diabetes Education* 36(6): 956-64; Formby et al (1987) Hearing loss among stroke patients. *Ear and Hearing* 8(6): 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. *Stroke* 40(4): 1496-1498; Office for National Statistics (ONS) (2015). Labour Force Survey January – March 2015 - Analysis cited in House of Commons debate 9 June 2015 c 1723W; Matthews (2011) Unlimited potential (available at: www.actiononhearingloss.org.uk/unlimitedpotential); RNID (2008) Opportunity blocked: The employment experiences of deaf and hard of hearing people (available at: <https://www.actiononhearingloss.org.uk/~media/Documents/Policy%20research%20and%20influencing/Research/Previous%20research%20reports/2007/Opportunity%20Blocked.aspx>)

⁴⁰ Abrams et al (2002) A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? *Journal of Rehabilitation Research and Development* 39(5): 549-558

⁴¹ European Hearing Instrument Manufacturers Association (2015). *Eurotrak 2015*; Perez E and Edmonds BA, 2012. A Systematic Review of Studies Measuring and Reporting Hearing Aid Usage in Older Adults since 1999: A Descriptive Summary of Measurement Tools. *PLoS ONE* 7 (3), e31831

⁴² European Hearing Instrument Manufacturers Association (2015). *Eurotrak 2015*; Perez E and Edmonds BA, 2012. A Systematic Review of Studies Measuring and Reporting Hearing Aid Usage in Older Adults since 1999: A Descriptive Summary of Measurement Tools. *PLoS ONE* 7 (3), e31831

- 2.4.3 Coordinating between statutory, voluntary and private services can make the health and care system more efficient and sustainable, through signposting between services more effectively, sharing knowledge about local need, or passing on information about individuals who may be accessing or needing support from a variety of organisations. Incentivising commissioners to commission a wider variety of organisations as part of patient pathways is a way to encourage this.
- 2.4.4 Key to people having their needs met early is ensuring that the health and social care workforce are alert to the wider needs of individuals in their care, and are able to signpost to other health professionals or local services that can support them. There needs to be national guidance and better networks and processes to ensure health and social care professionals are updated on developments in best practice and local services that are available.
- 2.4.5 Health and social care services need to be accessible to all in order for them to meet the needs of the population effectively – this will ensure cost-effectiveness across the system.
- 2.4.6 The health and social care workforce should be supported to manage their own health conditions in a way that allows them to remain in work as long as possible – this will help people remain in employment and ensure that skilled staff are not lost.
- 2.4.7 There is technology that patients can use that encourages people to check their health status, self-manage or seek further help, and apps that are a good standard should be endorsed and promoted by the NHS . The NHS should also look to ensure that patients are able to access the technology as part of their care that improves the treatment outcomes and supports them to manage their condition well.

3. Full response

- 3.1 Our response answers specific questions in each of the five areas of the consultation. We have divided our response by the five consultation areas and also listed the question each section of our response relates to.

4. The future of the healthcare system

4.1 Question 1: Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

- 2.5 In order to cope with an aging population the healthcare system will need to invest in early intervention programmes and take a more holistic approach to managing conditions. Not addressing conditions before they are at a critical stage can have a major impact on health, wellbeing and the management of any other conditions, and place unnecessary extra burden on the health and social care system.

- 4.2 Hearing loss is a good example of this. Hearing Loss is a major public health issue that currently affects over 11 million people in the UK, about one in six of the population. As the population ages hearing loss will affect a growing number of people. By 2035 there

will be an estimated 15.6 million people with hearing loss, about one in five of the population⁴³. Currently, over 71.1% of over-70-year-olds and 41.7% of over-50-year-olds have some kind of hearing loss⁴⁴.

4.3 Research shows that people wait on average ten years before seeking help for their hearing loss⁴⁵, yet unaddressed hearing loss has serious consequences: hearing loss leads to communication difficulties and is shown to lead to social isolation, which poses significant risks to mental health⁴⁶. According to research, unaddressed hearing loss significantly increases the risk of developing depression, anxiety and other mental health issues, but hearing aids reduce these risks⁴⁷, and there is also strong evidence that mild hearing loss doubles the risk of developing dementia, with moderate hearing loss leading to three times the risk and severe hearing loss five times the risk, but there is some evidence suggesting that hearing aids may reduce the risk of developing dementia⁴⁸.

4.4 Not addressing hearing loss has been independently associated with increased health care use and burden of disease among older adults⁴⁹. Studies have also found hearing loss to be independently associated with more frequent falls⁵⁰, and an increased risk of mortality⁵¹, and there is evidence to suggest that there are associations between hearing loss and conditions such as diabetes⁵², sight loss⁵³ and strokes⁵⁴.

⁴³ Action on Hearing Loss (2015) Hearing matters. Available at: www.actiononhearingloss.org.uk/hearingmatters

⁴⁴ Action on Hearing Loss (2015) Hearing Matters (available at: www.hearingmatters.org.uk)

⁴⁵ Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. *Health Technology Assessment*, 11, 1–294.

⁴⁶ Gopinath et al (2012) Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. *Age and Ageing* 41(5): 618–623; Pronk et al (2011) Prospective effects of hearing status on loneliness and depression in older persons: identification of subgroups. *International Journal of Audiology*, 50 (12), 887–96; Héту et al (1993) The impact of acquired hearing loss on intimate relationships: implications for rehabilitation. *Audiology*, 32 (3), 363–81; Arlinger (2003) 'Negative consequences of uncorrected hearing loss – a review'. *International Journal of Audiology*, 42 (2), 17–20; Monzani et al (2008) 'Psychological profile and social behaviour of working adults with mild or moderate hearing loss'. *Acta Otorhinolaryngologica Italica*, 28 (2), 61–6.

⁴⁷ Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. *Journal of the American Geriatrics Society*, 58 (1), 93–7; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. *Head and Neck Nursing* 18(1): 12–6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, *Archives of Gerontology and Geriatrics*, 52(3): 250–2; Mulrow et al (1992) Sustained benefits of hearing aids. *Journal of Speech & Hearing Research* 35(6): 1402–5

⁴⁸ Lin et al (2011) Hearing loss and incident dementia. *Archives of Neurology* 68(2): 214–220; Lin et al (2013) Hearing loss and cognitive decline in older adults. *Internal Medicine* 173(4): 293–299; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. *Otology & Neurotology* 35(5): 775–81; Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. *Alzheimer's and Dementia Journal*, 11 (1), 70–98; Amieva et al (2015) Self-reported hearing loss, hearing aids, and cognitive decline in elderly adults: A 25 year study. *Journal of the American Geriatrics Society* 63 (2), 2099–2104; Deal et al (2015) Hearing impairment and cognitive decline: A pilot study conducted within the atherosclerosis risk in communities neurocognitive study. *American Journal of Epidemiology*, 181 (9), 680–90

⁴⁹ Genther et al (2013) Association of hearing loss with hospitalization and burden of disease in older adults. *Journal of the American Medical Association* 309(22): 2322

⁵⁰ Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States.

Archives of Internal Medicine 172(4): 369–371; Viljanen et al (2009) Hearing as a predictor of falls and postural balance in older female twins. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences* 64(2): 312–7

⁵¹ Appollonio et al (1996) Effects of sensory aids on the quality of life and mortality of elderly people: A multivariate analysis. *Age and Ageing* 25: 89–96; Karpa et al (2010) Associations between hearing impairment and mortality risk in older persons: the Blue Mountains Hearing Study. *Annals of Epidemiology* 20(6): 452–9

⁵² Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. *Otology and Neurotology* 24(3): 382–386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing

4.5 Hearing loss not only contributes to the development of other conditions, it also prevents people being able to manage their hearing loss and wider health, with evidence demonstrating this leads to greater spending on more costly health and social care interventions, missed appointments, extra consultations and unnecessary prescriptions that are costly for the health and social care system⁵⁵.

4.6 Health professionals need to be better aware of the consequences of leaving conditions until they are critical for individuals and the wider system, and commissioners and providers need to be encouraged to identify and address people's needs as early as possible. Currently, research shows that GPs fail to refer 45% of those reporting hearing loss to hearing services⁵⁶. A far more effective proactive approach to addressing hearing loss, and other conditions where stigma or lack of awareness is preventing people from being diagnosed, needs to be taken.

4.7 There also needs to be more integration between health and social care and better ongoing management of conditions to prevent or delay the need for more expensive health and social care interventions. If this practice improves across the health and social care system, there will be significant savings that can help ensure the sustainability of the NHS. For example, research by DCAL and Action on Hearing Loss estimated that at least £28 million per year could be saved in England by properly managing hearing loss in people with dementia and thus delaying their admission to residential care⁵⁷. Often at the moment commissioners and providers are having to prioritise according to short term budgeting decisions, and this does not support a sustainable system.

5. Resource issues, including funding, productivity, demand management and resource use

5.1 Question 2d: Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

5.2 Not having treatments free to all at the point of access, or placing higher eligibility criteria on access to treatments does not incentivise people to access treatments in a timely way, often resulting in worse health outcomes and greater spending. For

loss. *Diabetic Medicine* 26(5): 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. *Diabetes Education* 36(6): 956-64

⁵³ Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. *Archives of Ophthalmology* 124(10): 1465-70

⁵⁴ Formby et al (1987) Hearing loss among stroke patients. *Ear and Hearing* 8(6): 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. *Stroke* 40(4): 1496-1498

⁵⁵ Action on Hearing Loss (2013) *Joining Up: Why people with hearing loss or deafness would benefit from an integrated response to long-term conditions*. Available at: www.actiononhearingloss.org.uk/joiningup; The Ear Foundation (2014) *The real cost of adult hearing loss: reducing its impact by increasing access to the latest hearing technologies*. Available at: <http://www.earfoundation.org.uk/news/articles/438>

⁵⁶ Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. *Health Technology Assessment*, 11, 1-294.

⁵⁷ DCAL and Action on Hearing Loss (2013) *Joining Up: Why people with hearing loss or deafness would benefit from an integrated response to long-term conditions* (available at www.actiononhearingloss.org.uk/joiningup)

example, not treating hearing loss can contribute to the development of a wide range of other conditions⁵⁸, but hearing aids reduce this risk⁵⁹. Research also shows that patients whose hearing is deteriorating with age find it easier to adapt to hearing aids and gain greater benefits the earlier they are fitted⁶⁰, so it is beneficial to the healthcare system for these treatments to be free at the point of access and available to anyone as soon as they would benefit from them. Unaddressed hearing loss has been independently associated with increased health care use and burden of disease among older adults⁶¹. Reducing the availability of services, through removing them from the NHS or introducing more stringent eligibility criteria, is not a sustainable approach for the health system to take at a national or local level because people would be less able to communicate and manage their health and this would result in greater costs.

5.3 CCGs are already making decisions that are not sustainable in this regard. In October 2015 North Staffordshire CCG stopped providing hearing aids for people with mild hearing loss on the NHS. We are awaiting a report one year on from the implementation of this restrictive policy, but our analysis of data from Freedom of Information requests indicates that there have been very low savings for the CCG compared with costs that will occur as a result of people not having their hearing loss addressed in terms of quality of life, impacts on employment, and on their health. Action on Hearing Loss and other organisations have worked closely with many CCGs to support them to look at other ways to make services cost efficient without negatively impacting service quality or accessibility, but the pressure that CCGs are already under to meet the needs of their local population within the budgets they are allocated is not sustainable with a growing aging population, and the structure of the system needs reviewing to more actively

⁵⁸ Lin et al (2011) Hearing loss and incident dementia. *Archives of Neurology* 68(2): 214-220; Lin et al (2013) Hearing loss and cognitive decline in older adults. *Internal Medicine* 173(4): 293-299; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. *Otology & Neurotology* 35(5): 775-81; Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. *Alzheimer's and Dementia Journal*, 11 (1), 70-98; Amieva et al (2015) Self-reported hearing loss, hearing aids, and cognitive decline in elderly adults: A 25 year study. *Journal of the American Geriatrics Society* 63 (2), 2099-2104; Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. *Journal of the American Geriatrics Society*, 58 (1), 93-7; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. *Head and Neck Nursing* 18(1): 12-6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, *Archives of Gerontology and Geriatrics*, 52(3): 250-2; Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. *Otology and Neurotology* 24(3): 382-386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. *Diabetic Medicine* 26(5): 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. *Diabetes Education* 36(6): 956-64; Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. *Archives of Ophthalmology* 124(10): 1465-70; Formby et al (1987) Hearing loss among stroke patients. *Ear and Hearing* 8(6): 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. *Stroke* 40(4): 1496-1498

⁵⁹ Pronk et al (2011) Prospective effects of hearing status on loneliness and depression in older persons: identification of subgroups. *International Journal of Audiology*, 50 (12), 887-96; Mulrow et al (1992) Sustained benefits of hearing aids. *Journal of Speech & Hearing Research* 35(6): 1402-5; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. *Head & Neck Nursing*. 18(1): 12-6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, *Archives of Gerontology and Geriatrics*, 52(3): 250-2; Deal et al (2015) Hearing impairment and cognitive decline: A pilot study conducted within the atherosclerosis risk in communities neurocognitive study. *American Journal of Epidemiology*, 181 (9), 680-90

⁶⁰ Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. *Health Technology Assessment* 11: 1-294

⁶¹ Genter et al (2013) Association of hearing loss with hospitalization and burden of disease in older adults. *Journal of the American Medical Association* 309(22): 2322; The Ear Foundation (2014) The Real Cost of Adult Hearing Loss: Reducing its impact by increasing access to the latest hearing technologies

support prevention, early intervention and integration to reduce costs further along patient pathways.

5.4 Forcing people to pay for certain treatments also creates inequalities because some people may not be able to afford healthcare they need privately. Evidence shows that given good support, follow up and rehabilitation, high levels of hearing aid use and satisfaction can be achieved at low costs⁶², and it is highly cost-effective to provide hearing aids on the NHS: it costs the NHS on average £390 for all a person's appointments, two hearing aids and repairs for three years, which evidence shows is very cost effective⁶³, however it costs on average £3,000 privately, a figure which is beyond the savings of 55% of households⁶⁴.

5.5 Evidence demonstrates that people with lower socioeconomic status have worse health outcomes, and strong evidence suggests that hearing loss is independently associated with low socioeconomic status⁶⁵. Those in certain non white ethnic groups (particularly Bangladeshi, Black African, Pakistani, Black Other, and Asian Other groups) have higher risks of developing hearing loss than the general population⁶⁶. Making treatments unaffordable for these groups who are already more at risk of having health problems, or introducing eligibility criteria, means-tested systems, or other complications that could deter people from approaching the healthcare system, will exacerbate health inequalities and result in greater spending across health and social care⁶⁷. Rather than adopting these approaches, the system should be designed to address inequalities and health needs in a sustainable way.

6. Workforce

6.1 *Question 3c: What are the retention issues for key groups of healthcare workers and how should these be addressed?*

6.2 As the population ages, it is likely that people will be working and needing to manage their own health conditions. We know at the moment that people with hearing loss face significant barriers gaining and keeping employment, and there needs to be a significant

⁶² Abrams et al (2002) A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? *Journal of Rehabilitation Research and Development* 39(5): 549-558

⁶³ Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. *Health Technology Assessment* 11: 1–294

⁶⁴ Which? website (2014) <http://www.which.co.uk/home-and-garden/staying-independent-at-home/reviews-ns/best-hearing-aid-providers/best-hearing-aid-providers-overview/>; Department for Work and Pensions (2015), Family Resources Survey: financial year 2013/14, Savings and investments: data tables, Table SI.9: Households by amount of savings and investments, and composition. Available at: <https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201314>

⁶⁵ Dawes et al (2014) Hearing in middle age: a population snapshot of 40- to 69-year olds in the United Kingdom. *Ear and Hearing* 35(3): 44-51; Davis et al (2008) The relationships between work based noise over the adult life course and hearing in middle age. *International Journal of Audiology* 47: 100-108; Sixt and Rosenhall (1997) Presbycusis related to socioeconomic factors and state of health. *Scandinavian Audiology* 26(3): 133–140

⁶⁶ Dawes et al (2014) Hearing in middle age: a population snapshot of 40- to 69-year olds in the United Kingdom. *Ear and Hearing* 35(3): 44-51

⁶⁷ Action on Hearing Loss (2013) *Joining Up: Why people with hearing loss or deafness would benefit from an integrated response to long-term conditions*. Available at: www.actiononhearingloss.org.uk/joiningup; The Ear Foundation (2014) *The real cost of adult hearing loss: reducing its impact by increasing access to the latest hearing technologies*. Available at: <http://www.earfoundation.org.uk/news/articles/438>

shift in employer attitudes and increased support available to support those with health conditions remain in the workplace.

6.3 Given that over 41% of over-50-year-olds have some form of hearing loss, it will be highly likely that there will be staff working in health and social care with this condition, who may struggle without adequate support or be forced to leave work early. People with hearing loss are less likely to be employed (65% are in employment) compared with people with no long-term health issue or disability (79%)⁶⁸. Developing hearing loss can also lead to a loss of employment⁶⁹ and difficulties gaining employment⁷⁰. Action on Hearing Loss's Hidden Disadvantage⁷¹ report found that around two thirds (70%) survey respondents felt their hearing loss sometimes prevented them from fulfilling their potential at work and a similar proportion (68%) said that hearing loss left them feeling isolated at work. Two fifths (41%) of survey respondents who retired early said this was related to their hearing loss.

6.4 The health and social care system should set a good example in supporting staff to remain in work for as long as possible, particularly as the demands being placed on the workforce are significant and there are often staff shortages – in order for the NHS to be sustainable staff with important skills must be supported to work. Under the Equality Act 2010, employers have a legal duty to make reasonable adjustments if people face substantial difficulties in the workplace due to physical or mental impairments – including hearing loss.

6.5 Examples of support and simple adjustments employers could make to help people with hearing loss remain in the workplace include:

6.5.1 Deaf awareness training for staff - to make sure employees are able to communicate with colleagues and members of the public with hearing loss.

6.5.2 Communication support - if an employee with hearing loss needs support to communicate in meetings or take notes at work, such as a British Sign Language (BSL) interpreter or speech-to-text-reporter (STTR).

6.5.3 Technology such as hearing loops or personal listeners that can help people hear more clearly over background noise.

6.5.4 Adjusting the layout of the meeting room to make sure employees with hearing loss can see everyone clearly – this is important for people who lipread.

6.5.5 Moving the employee to a quiet area of the office with good acoustics (where sound is transmitted well).

⁶⁸ Office for National Statistics (ONS) (2015). Labour Force Survey January – March 2015 - Analysis cited in House of Commons debate 9 June 2015 c 1723W.

⁶⁹ Matthews (2011) Unlimited potential (available at: www.actiononhearingloss.org.uk/unlimitedpotential)

⁷⁰ RNID (2008) Opportunity blocked: The employment experiences of deaf and hard of hearing people (available at: <https://www.actiononhearingloss.org.uk/~media/Documents/Policy%20research%20and%20influencing/Research/Previous%20research%20reports/2007/Opportunity%20Blocked.aspx>)

⁷¹ Arrowsmith (2014) Hidden disadvantage; why people with hearing loss are still losing out at work (available at: www.actiononhearingloss.org.uk/hiddendisadvantage)

6.6 The government's Access to Work scheme⁷² provides grants to help fund practical support and specialist equipment that can help people with hearing loss communicate well, but the scheme must be better promoted and used in order to keep skilled individuals in employment and support the NHS to manage the increasing demand for its services. The scheme offers grants when an individual's support needs or adaptations are beyond the reasonable adjustments that an employer is legally obliged to provide under the Equality Act. However, in a YouGov poll of business leaders Action on Hearing Loss commissioned in April 2016⁷³, nearly two-thirds (63%) of business leaders had not heard of Access to Work.

6.7 Question 4: How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

6.8 It is essential that the health and social care workforce are alert to the wider needs of individuals in their care, and are able to signpost to other health professionals or local services that can support them. With a growing aging population, more people will be living with comorbidities and a more integrated approach is important to ensure needs are met earlier and a more preventative approach to support is taken.

6.9 Evidence demonstrates that often professionals are not referring people to support they need. For example, our World of Silence⁷⁴ research revealed that there was a worrying level of unaddressed hearing loss amongst care home residents, with care home staff not identifying hearing loss amongst residents or encouraging it to be addressed.

6.10 Health and social care professionals should undertake training throughout their career, to ensure they are up to date on developments in evidence-based best practice concerning their area of care and the wider needs of patients, and there should be adequate systems in place for educating professionals on local services on offer to those in their care and robust signposting mechanisms to ensure people are supported in the best way possible. At the moment the approach to training and updating health and social care professionals, particularly about the importance of identifying and addressing other conditions, is adhoc and is often reliant on the voluntary sector. There needs to be national guidance and better processes and networks to ensure effective updates, training and sharing of good practice.

7 Models of service delivery and integration

7.1 Question 5: What are the practical changes required to provide the population with an integrated National Health and Care Service?

7.2 In order to have a truly integrated National Health and Care Service, there needs to be more resource put into trialling integrated care models and rolling out successful pilots

⁷² <https://www.gov.uk/access-to-work>

⁷³ Total sample size was 618 adults (aged 18+). Fieldwork was undertaken between 4th - 8th April 2016. The survey was carried out online. The figures have been weighted and are representative of all senior decision makers in GB businesses

⁷⁴ Action on Hearing Loss (2012) World of Silence: the case for tackling hearing loss in care home (available at: https://www.actiononhearingloss.org.uk/~/_media/Documents/Policy%20research%20and%20influencing/Research/A%20World%20of%20Silence/A0408%20Care%20Home%20report_final.ashx)

as standard practice. It is not possible for services to become integrated without resource funding this change in approach, and collaborative approaches between health and social care should be incentivised, to encourage integrated working at a local level.

7.3 Question 5b: How can local organisations be incentivised to work together?

7.4 Coordinating between the statutory, voluntary and other services people receive support from can make the health and care system more efficient and sustainable, through signposting between services more effectively, sharing knowledge about local need, or passing on information about individuals who may be accessing or needing support from a variety of organisations.

7.5 A good way they can be incentivised is through more flexible and open commissioning, to encourage a wider variety of organisations to be part of health or care pathways. In many cases, the voluntary sector can bring expertise in a particular area or deliver services using a different model, for example in community settings or through volunteers.

7.6 Action on Hearing Loss provides its Hear to Help hearing aid aftercare service as part of NHS pathways in some areas of the country, commissioned by CCGs or sub-contracted by providers. Aftercare is a key component in the hearing aid pathway, and this model uses volunteers and offers the service in community-based locations, as opposed to requiring people to return to audiology. The service provides basic hearing aid maintenance, information and advice through drop-in services and home visits, as well as engaging people through local events and producing communications raising awareness of local services on offer and the importance of recognising and addressing hearing loss. This service offers holistic aftercare that is more accessible, cheaper to deliver and frees up audiologists' time. A range of local organisations should be commissioned to deliver services where they improve patient outcomes, encourage people to manage their health better, and are cost-efficient, sustainable ways of working.

8. Prevention and public engagement

8.1 Question 6: What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

8.2 Commissioners and providers need to have enough resource to test and fund preventative approaches as well as continue to support people who need acute treatment.

8.3 Currently budget constraints are resulting in cuts to services that are leaving people without support until their needs have escalated, and with an aging population this is not a sustainable approach. Non-critical treatments maybe seen as the easiest thing to cut, even if they help delay or prevent the need for further more costly interventions. For example, many CCGs have considered cutting hearing aids for people with hearing

loss⁷⁵ even though evidence clearly demonstrates that hearing aids are a cost-effective intervention⁷⁶ and unaddressed hearing loss can lead to a wide range of physical and mental health conditions⁷⁷. There needs to be significantly more resource to allow commissioners to work with local providers to proactively develop preventative approaches to care intervening early at a lower cost, which will in the longer term reduce costs by moving people away from more costly acute care.

8.4 *Question 6a: What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?*

8.5 It is very important that health services are accessible. People who are deaf or have a hearing loss face serious barriers when accessing healthcare, which leads to worse care, poor health and increased costs for the NHS.

8.6 Our Access All Areas⁷⁸ report showed that most of the people with hearing loss we surveyed had to struggle with the phone or go in person to book an appointment with the GP, because of a lack of other options such as online booking, SMS or text relay. One in seven (14%) had missed an appointment because they didn't hear their name being called in the waiting room. When they did get to see their GP, alarmingly, more than a quarter (28%) said that they didn't understand their diagnosis, and one in five (19%) were unsure about their medication.

8.7 The diagnosis and management of all types of health conditions are often inaccessible for people with hearing loss. This can all too easily lead to poor care, a lack of diagnosis or even misdiagnosis particularly when people have conditions that are linked to hearing loss, such as mental health problems, dementia, learning disabilities, sight loss, cardiovascular disease and diabetes⁷⁹.

⁷⁵ www.actiononhearingloss.org.uk/hearingaidcuts

⁷⁶ Abrams et al (2002) A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? *Journal of Rehabilitation Research and Development* 39(5): 549-558

⁷⁷ Lin et al (2011) Hearing loss and incident dementia. *Archives of Neurology* 68(2): 214-220; Lin et al (2013) Hearing loss and cognitive decline in older adults. *Internal Medicine* 173(4): 293-299; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. *Otology & Neurotology* 35(5): 775-81; Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. *Alzheimer's and Dementia Journal*, 11 (1), 70-98; Amieva et al (2015) Self-reported hearing loss, hearing aids, and cognitive decline in elderly adults: A 25 year study. *Journal of the American Geriatrics Society* 63 (2), 2099-2104; Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. *Journal of the American Geriatrics Society*, 58 (1), 93-7; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. *Head and Neck Nursing* 18(1): 12-6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, *Archives of Gerontology and Geriatrics*, 52(3): 250-2; Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. *Otology and Neurotology* 24(3): 382-386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. *Diabetic Medicine* 26(5): 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. *Diabetes Education* 36(6): 956-64; Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. *Archives of Ophthalmology* 124(10): 1465-70; Formby et al (1987) Hearing loss among stroke patients. *Ear and Hearing* 8(6): 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. *Stroke* 40(4): 1496-1498

⁷⁸ Action on Hearing Loss (2012) Access All Areas (available at www.actiononhearingloss.org.uk/accessallareas)

⁷⁹ Action on Hearing Loss (2013) Joining Up: Why people with hearing loss or deafness would benefit from an integrated response to long-term conditions (available at www.actiononhearingloss.org.uk/joiningup); Foundation for People with Learning Disabilities (2015) Hearing Loss (available at: <http://www.learningdisabilities.org.uk/help-information/learningdisability-a-z/h/hearing-loss/>)

8.8 There are often serious problems for profoundly deaf people accessing health care, many of whom use British Sign Language (BSL) and need a properly qualified BSL interpreter (registered with the National Registers of Communication Professionals for the Deaf) at their medical appointments. Research by SignHealth found that 70% of deaf people who haven't been to their GP recently wanted to but didn't go mainly because there was no interpreter. Even when an interpreter is asked for, around two-thirds of BSL users (68%) don't get one; and almost half of those who do find the quality of interpretation isn't good enough⁸⁰. BSL users may have problems accessing public health information – putting them at greater risk of health problems and worse care⁸¹, and research by SignHealth also suggests that people who are deaf are more likely to have undiagnosed high blood pressure and receive less effective treatment due to confusion about their medication and health information being provided in written English rather than BSL⁸².

8.9 Putting simple measures in place to ensure people's communication and information needs are met is now a legal requirement, under NHS England's Accessible Information Standard⁸³, and can save significant amounts of money. NHS and social care services waste millions of pounds each year by not making services accessible for people with hearing loss. NHS England has estimated that £14 million is wasted because of missed appointments, and The Ear Foundation suggested that, because of communication difficulties, people with hearing loss cost the NHS £76 million in extra GP visits and £60 million in increased use of social care⁸⁴. Accessible services and messages at all levels, from GP appointments to national public health campaigns, would benefit individuals and the system.

8.10 Question 6g: How could technology play a greater role in enhancing prevention and public health?

8.11 NHS England's Patient Online Programme⁸⁵ is a good example of an initiative that can improve prevention and public health. It encourages GPs to increase online access to health records, booking appointments and ordering repeat prescriptions. There are many benefits of online accessibility, including for people who are deaf or have a hearing loss who may find it difficult or impossible to use the telephone. Online information can also be helpful because it can be presented in a variety of formats, including BSL videos for people with hearing loss.

⁸⁰ Action on Hearing Loss (2012) Our Health in Your Hands: Survey of BSL users about access to communication support in healthcare. (available at: <http://www.actiononhearingloss.org.uk/get-involved/campaign/equal-treatment/the-problem/survey-of-bsl-users.aspx>); SignHealth (2014) Sick of it; how the health service is failing deaf people (available at: <http://www.signhealth.org.uk/wp-content/uploads/2016/09/Sick-Of-It-Report.pdf>)

⁸¹ Action on Hearing Loss (2013) Joining Up: Why people with hearing loss or deafness would benefit from an integrated response to long-term conditions (available at www.actiononhearingloss.org.uk/joiningup);

⁸² SignHealth (2014) Sick of it; how the health service is failing deaf people (available at: <http://www.signhealth.org.uk/wp-content/uploads/2016/09/Sick-Of-It-Report.pdf>)

⁸³ NHS England Accessible Information Standard, available at: <https://www.england.nhs.uk/ourwork/accessibleinfo/>

⁸⁴ The Ear Foundation (2014) The Real Cost of Adult Hearing Loss: Reducing its impact by increasing access to the latest hearing technologies

⁸⁵ NHS England's Patient Online programme: <https://www.england.nhs.uk/ourwork/pe/patient-online/>

8.12 There is also technology that patients can use that encourages people to check their health status, self-manage or seek further help, and apps that are a good standard should be endorsed and promoted by the NHS. For example, there are many apps on the market that enable someone to check their hearing, such as Action on Hearing Loss's hearing screening test, which can be undertaken online or over the phone⁸⁶. These are not alternatives to a full hearing assessment, but can prompt someone to seek further help and support the early identification of health conditions.

8.13 *Question 7: What are the best ways to engage the public in talking about what they want from a health service?*

8.14 In order to ensure the views of the whole local population are represented, patient engagement exercises must be accessible and meet the requirements of the Equality Act. There should always be a variety of engagement methods available, and information should be produced in a variety of formats and languages.

9. Technology/ digitalisation

9.1 *Question 8: How can new technologies be used to ensure the sustainability of the NHS?*

9.2 Technology that patients can use can be very helpful in encouraging self-management and also to help diagnosis. Apps, for example, can help people check their health status and can encourage people to be formally diagnosed and access treatment at an earlier stage.

9.3 Specifically, for hearing loss there are many apps on the market now that enable someone to get their hearing tested⁸⁷. These are not alternatives to a full hearing assessment, but can prompt someone to seek further help, and apps and wider technology that are a good standard and encourage prevention, self-management or early intervention should be endorsed and promoted by the NHS.

9.4 When someone does receive support for a health condition, technology can lead to increased satisfaction with treatments, which can help people manage their health better and not require more costly interventions. It is important that the health and care system invest in good technological solutions in order to best meet the needs of patients and encourage people to remain independent and self-manage their conditions. For example, lots of hearing aids now have better connection to other devices such as mobile phones and tablets - some need a secondary streaming device which is paired to hearing aid and other device, whereas others connect wirelessly and don't need this, and all hearing aids will have a bluetooth connection on the next NHS supply chain contract for hearing aids.

9.5 All potential impacts of technology should be considered however, if new solutions are going to be introduced across an area of the health system. Technology could lead to an

⁸⁶ Action on Hearing Loss hearing check: <https://www.actiononhearingloss.org.uk/your-hearing/look-after-your-hearing/check-your-hearing/take-the-check.aspx>

⁸⁷ For example, Action on Hearing Loss's Hearing Check, which can be undertaken online or over the phone: <https://www.actiononhearingloss.org.uk/your-hearing/look-after-your-hearing/check-your-hearing/take-the-check.aspx>

increase in demand that could have an impact on capacity, and new processes may need to be established or staff may need to be retrained.

9.6 What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

9.7 Telecare and telehealth can have a very positive impact on reducing costs and managing demand. Innovative ways to use phones or tablets and computers to help with healthcare (often in the form of apps) have several advantages. For example, they can be used in remote settings, including in developing countries where there is limited access to healthcare and highly trained medical professionals, and lower trained staff can be trained to use devices and report back to higher trained medical professionals remotely, many doing this in real time. For hearing loss this can be useful in many situations: for example, if someone was doing video otoscopy, medical professionals can see what the person doing video otoscopy was seeing. Some devices go beyond this and can even help with diagnoses – for example algorithms have been developed to recognise signs and symptoms of particular ear conditions, one of the most common being otitis media (infection – glue ear)⁸⁸.

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⁸⁸

https://www.researchgate.net/publication/223987869_Development_of_an_Algorithm_for_the_Diagnosis_of_Otitis_Media; <http://umu.diva-portal.org/smash/get/diva2:705007/FULLTEXT01.pdf>

Action on Smoking and Health – Written evidence (NHS0146)

Note: ASH grants permission for this submission to be published with the exception of the information included in paragraphs 20 and 36 which is currently unpublished and confidential. Therefore we would request that information contained in these two paragraphs be withheld prior to publishing this response.

About ASH

1. ASH is a health charity working towards the elimination of harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK. It has also received project funding from the Department of Health to support tobacco control. ASH does not have any direct or indirect links to, or receive funding from, the tobacco industry. ASH provides the secretariat for the APPG on Smoking and Health.
2. ASH welcomes the opportunity to provide evidence to the Select Committee, and would be pleased to provide further written information or give oral evidence if asked.

Answers to Consultation Questions (those relevant to ASH)

Question 1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

3. The NHS England Five Year Forward (FYFV) view forecast a £30 billion shortfall in funding for the NHS by 2020.⁸⁹ Even after the £8 billion in additional funding committed by the Government, there remains a predicted shortfall of £22 billion.⁹⁰ This funding gap is highly unlikely to be closed through increased efficiency alone, since this would require efficiency savings of about 3% per year, a higher level of efficiency saving annually than the NHS has achieved since its foundation.
4. Therefore, some of the funding gap will have to be met through cuts in NHS services, longer waits for treatment, or through reductions in demand for NHS services, which is obviously the best option of the three. To reduce demand requires a sustained effort to improve public health, and to tackle the major causes of illness, in particular smoking.
5. This is why the FYFV stated that: *“The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a*

⁸⁹ [NHS England Five Year Forward View](#)

⁹⁰ [Five Year Forward View](#). NHS October 2014

radical upgrade in prevention and public health.” The report notes that this has been long called for: *“Twelve years ago, Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.”*⁹¹

6. Smoking remains the major cause of preventable premature death in England, causing about 80,000 premature deaths every year. This is more than the next five causes put together, including obesity, alcohol and illegal drugs.⁹²
7. The Rt Hon Theresa May, in her first statement as Prime Minister on 13th July 2016, said that: *“if you’re born poor, you will die on average 9 years earlier than others”*.⁹³ In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review on reducing health inequalities in England. His report stated that: *“Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups”*.⁹⁴ The highest smoking prevalence rates are found in the poorest communities, and these communities need to be made a principal focus of tobacco control activity. Smoking has a major impact on the household incomes of poorer families. If the poorest smokers were to quit, over half a million households would be lifted out of poverty.⁹⁵
8. The majority of smokers take up smoking when they are still children, and over 80% do so before the age of 20.⁹⁶ Children who grow up in households where people smoke are much more likely to become smokers themselves, so there is an inter-generational impact of smoking. Uptake of smoking appears to be falling progressively while quit rates appear to be remaining relatively constant across successive cohorts.⁹⁷ So while preventative action to stop people taking up smoking is important, it is essential that more is done to help addicted smokers quit.
9. Mental health conditions affect almost a quarter of the adult population, who die on average 10-20 years earlier than the general population.⁹⁸ Smoking is the single largest cause of this health inequality. Adults with mental health conditions are more heavily addicted to smoking and around one third of adult tobacco consumption is by people with a mental health condition. As such they experience much greater smoking related harm.⁹⁹

⁹¹ Ibid page 9

⁹² [Statistics on Smoking, England 2015](#). HSCIC, 2015

⁹³ [Statement from the new Prime Minister, Theresa May](#) 13 July 2016

⁹⁴ [Fairer Society, Healthy Lives](#): report of the Marmot Review, February 2010, main report page 145

⁹⁵ [Smoking Still Kills](#), ASH, 2015

⁹⁶ [General Lifestyle Survey](#) 2008, ONS

⁹⁷ Royal College of Physicians. [Nicotine without smoke: Tobacco harm reduction](#). London: RCP, 2016.

⁹⁸ [The Stolen Years](#). The mental health and smoking action report. ASH, April 2016

⁹⁹ [The Stolen Years](#). The mental health and smoking action report. ASH, April 2016

10. The UK is rightly regarded as a global leader in tobacco control, and there has been a steady fall in smoking rates over several decades. However, international evidence shows that where tobacco control work is not properly funded, the rate of decline slows, or even goes into reverse. In New York, for example, sustained investment in tobacco control led to a sharp fall in prevalence between 2002 and 2010. But when funding was cut in 2010 this decline ceased. Following new investment from 2014, smoking rates began to decline again.¹⁰⁰ To be effective, tobacco control policy and activity has to be both sustained and progressive, one reason being that people who continue to smoke when a particular policy or control action is introduced can be said to have “discounted” it and therefore will require new incentives to quit. To plan sustained and progressive action of this kind requires a considerable degree of certainty about future funding.
11. ASH believes that changes are needed to ensure the sustainability of the health and care systems, and ensure an integrated tobacco control (and wider public health) strategy at local, regional and national level. These changes include:
- Long-term secure (and probably ring-fenced) budgets for the public health function in local government
 - A stronger requirement on NHS bodies and local authorities to co-operate in improving public health and reducing long-term demands on the health and social care system
 - Consideration of how financial incentives can be aligned so that those organisations delivering services that reduce demand on the health and social care system are adequately rewarded.

Question 2. To what extent is the current funding envelope for the NHS realistic?

- Does the wider societal value of the healthcare system exceed its monetary cost?**
- What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?**
- What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?**
- Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?**

12. As well as the considerable human cost, smoking also places an enormous financial burden on society. The costs of this were estimated at £12.9 billion in HM Treasury’s consultation document on a possible Tobacco Levy.¹⁰¹ This figure was made up of:

¹⁰⁰ Politico New York, [NYC smoking rate drops to lowest on record](#), September 2015

¹⁰¹ HM Treasury, [Tobacco Levy: consultation document](#), December 2014.

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- £2 billion cost to the NHS of treating diseases caused by smoking
- £3 billion loss in productivity due to premature death
- £5 billion cost to businesses of smoking breaks
- £1 billion cost of smoking-related sick days
- £1.1 billion of social care costs of older smokers
- £391 million cost of fires caused by smokers' materials

These figures have been updated by ASH and now total an estimated £13.9 billion ¹⁰²

13. Tobacco control, encouraging smokers to quit and dissuading others from taking up smoking, is extremely cost-effective. An inquiry by the APPG on Smoking and Health concluded that: *'Government expenditure on tobacco control is excellent value for money and provides a net annual revenue benefit of £1.7 billion'*.¹⁰³
14. Further investment in tobacco control could bring greater financial rewards. The APPG on Smoking and Health's Representation to the 2015 Spending Review, argued for the Government to invest a further £100 million a year in tobacco control. This additional funding could bring a return on investment of £11 for every £1 invested over five years and increase the rate of decline in smoking prevalence by an additional 0.57 percentage points each year.¹⁰⁴
15. The greatest return on investment in tobacco control comes when there is a comprehensive approach, which must include appropriately funded action at a national, regional and local level.¹⁰⁵ However, as shown in the answers below, spending on tobacco control is falling, not rising. This will simply increase costs to the NHS in future years, and threatens the long-term sustainability of both the health and social care system.
16. ASH therefore strongly supports the introduction of a levy on the major tobacco companies, to raise additional funds for tobacco control work. This is justified on the "polluter pays" principle: the tobacco industry is the only legal commercial activity in the world based on the sale of a product that first addicts consumers and then kills half of all lifetime users. The principle is the same as that behind the Soft Drinks Industry Levy, known colloquially as the "sugar tax", which the Government has committed to implement.¹⁰⁶
17. We suggest that the levy should be calculated and allocated nationally, regionally and locally to support tobacco control measures. At local level it should be allocated to local authorities, the NHS and other public and voluntary organisations providing relevant

¹⁰² ASH factsheet. [The economics of tobacco](#). December 2015.

¹⁰³ [Inquiry into the effectiveness and cost-effectiveness of tobacco control](#), All Party Parliamentary Group on Smoking and Health, 2010

¹⁰⁴ APPG on Smoking and Health [Representation to the 2015 Spending Review](#).

¹⁰⁵ [Smoking Still Kills](#). ASH, June 2015

¹⁰⁶ [Soft Drinks Industry Levy: 12 things you should know](#). Gov.uk. Accessed 13th September.

services, on the basis of local sales data, or (our less favoured option) local smoking prevalence rates.

18. In the 2015 Autumn Statement,¹⁰⁷ the then Chancellor proposed that a future funding solution for public health could come through returning more of business rates to local authorities. ASH is concerned that far from addressing variation in funding between local authorities, a solution based on local business rates could entrench inequalities even further. Councils' income from business rates vary widely, with richer areas raising more income than poorer ones, and since richer local authority areas generally have lower smoking rates than poorer ones, this form of funding would be unlikely to be allocated to areas with the highest need.

Question 3: What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

- a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?**
- b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?**
- c. What are the retention issues for key groups of healthcare workers and how should these be addressed?**

19. Stop smoking specialists, who provide highly skilled specialist support to tobacco dependant people across the health and social care system, are highly cost effective. Stop smoking services are estimated to quadruple the success rate of quit attempts, but cost under £1,000 for each additional Quality Adjusted Life Year ("QALY").¹⁰⁸ This compares with, for example, up to £57,000 per QALY for statins to prevent coronary heart disease,¹⁰⁹ up to £130,000 per QALY for treatments for COPD, and as much as £100,000 for a course of treatment of the lung cancer treatment opdivo.¹¹⁰

20. However, research by ASH (unpublished at time of writing) carried out in Summer 2016, shows that for the 2016-17 financial year, 59% of local authorities have reported a cut in their smoking cessation budget (including almost half who reported a cut of more than 5%) and 45% reported a cut in their wider tobacco control budget.¹¹¹ The NHS has not replaced the decommissioned stop smoking specialists to treat smokers accessing health care. Between April 2015 and March 2016, 68,082 fewer smokers set a quit date with

¹⁰⁷ [2015 Autumn Statement](#)

¹⁰⁸ Flack S. Taylor M. Trueman P. [Cost-Effectiveness of Interventions for Smoking Cessation](#). York Health Consortium for NICE 2007.

¹⁰⁹ Ward S et al. [A systematic review and economic evaluation of statins for the prevention of coronary events](#), Health Technology Assessment 2007; Vol. 11: No. 14

¹¹⁰ Gapper J. [The unhealthy high price of cancer drugs](#). Financial Times, 3 June 2015

¹¹¹ ASH/CRUK. 2016 Annual survey of tobacco control leads (unpublished).

the Stop Smoking Services in England, compared with the previous year. This is the 4th consecutive year to show a fall in the number of people using the services.¹¹²

21. This small segment of the NHS workforce requires significant, sustained and closely monitored expansion to deliver the comprehensive treatment of tobacco related health and social care burden, paid for by the proposed tobacco levy and in partnership between the NHS and Public health budgets.

Question 4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

- a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?**
 - b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?**
 - c. What investment model would most speedily enhance and stabilise the workforce?**
22. Currently there is no requirement that health and social care workers are trained to treat or to refer people who are tobacco dependant, despite tobacco being the largest preventable cause of morbidity and mortality in the UK.
23. Training in treating tobacco dependency is low cost and could easily be integrated into the curriculum of all health and social care workers at both undergraduate and postgraduate levels. Mandatory training in treating tobacco dependence should be introduced for all health and social care professionals as part of continuous professional development. The National Centre for Smoking Cessation Training (NCSCT) provides high quality free online distance learning that should be adopted across the health and social care professions.¹¹³
24. Workforce regulatory authorities such as the GMC and NMC can introduce and monitor clear standards of training for health care professionals in tobacco control.

Question 5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

- a. How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?**
- b. How can local organisations be incentivised to work together?**

²⁷ [Stop Smoking Services in England: April 2015 to March 2016](#), NHS, 2016

¹¹³ See http://www.ncsct.co.uk/pub_training.php

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

25. The structure of the current health and social care system can militate against investment in tobacco control.
26. Reductions in smoking prevalence, and other changes in smoking behaviour, are known to lead to clear and measurable benefits to the NHS. Reductions in smoking can have an in-year benefit to NHS outcomes for example through reducing incidence of CVD, poor birth outcomes, surgical complications and complications from asthma and diabetes. Specific tobacco control policies can also have a measurable benefits, for example the latest Cochrane review on the impact of smokefree legislation confirmed that there is *“robust support for the previous conclusions that the introduction of a legislative smoking ban does lead to improved health outcomes through reduction in SHS for countries and their populations. The clearest evidence is observed in reduced admissions for acute coronary syndrome”*.¹¹⁴
27. Local authorities also recoup medium and long-term benefits from investing in reductions in smoking, through a reduced burden on social care services and improved productivity in the local economy. Other local authority activities, such as trading standards officers’ enforcement action against the illicit tobacco trade, protect state revenues and improve public health, but the immediate financial benefits accrue to central government rather than to the local authority concerned.
28. However, ASH is not aware of any systematic effort to measure the aggregate financial benefits of integrated tobacco control policies: the best estimates probably remain those commissioned by ASH and by the All Party Parliamentary Group on Smoking and Health. At local and sub-national levels NICE has produced a return on investment tool to help decision making in tobacco control in local authorities and the NHS. The tool evaluates a portfolio of tobacco control interventions and models the economic returns that can be expected in different payback timescales. Disappointingly, despite the positive returns from tobacco control shown by the tool, this does not seem to be preventing disinvestment by local authorities from tobacco control (see point 29).
29. As suggested above, a funding structure for tobacco control which included an industry levy, using local sales data, with the proceeds allocated both nationally and at regional and local level to local authorities, NHS bodies and other service providers (e.g. in the voluntary sector) could help address this problem of maladjusted incentives.
30. ASH understands that although CCGs have been provided with guidance on their responsibilities in relation to health inequalities,¹¹⁵ at present NHS Trusts do not have a

¹¹⁴ [Does legislation to ban smoking reduce exposure to secondhand smoke and smoking behaviour?](#): Cochrane review web pages, accessed 2 September 2016

¹¹⁵ [Guidance for NHS commissioners on equality and health inequalities](#): NHS England 14 December 2015

direct responsibility to reduce health inequalities. Data analysed by researchers at the University of York for NHS England also shows that the performance of individual CCGs in tackling the social divide in preventable hospital admissions is not always linked to how rich or poor the CCG's patient population is.¹¹⁶

31. Inadequate statutory duties and a poorly allocated set of incentives to reduce health inequalities result in obvious failures in public health provision. For example, it appears that many NHS Trusts have no means of getting real time information on the number of smokers in their care, nor measuring and assessing any interventions designed to promote quitting, nor measuring the proportion of previous smokers who quit while they are being treated. NHS England advocates the principle of *'Making Every Contact Count'*, stating that *"Opportunities exist to promote the benefits of healthy lifestyles through routine contacts that people have with health services, by engaging individuals in conversations which support them in the steps they wish to take towards a healthier lifestyle. This includes provision of information, signposting or referral for individual support, and encouragement for behaviour change"*. However, this principle is not systematically applied and there appears to be no reliable means of aggregating information on the actual practice of NHS organisations.
32. A minimum standard of public health protection should require that smokers are given appropriate advice on the risks of their behaviour, including information about available support for quitting, at all points of contact with the NHS and social care system. ASH would also like to see this extended to all relevant public services. All public bodies should ensure that their grounds as well as their buildings are smokefree, and should provide readily accessible information about stop smoking services. Occupational health services in NHS trusts and other relevant public bodies should ensure that they make regular contact with employees who smoke to advise them of the availability of support for quitting.
33. NHS planning guidance, which sets out the operating framework that will support the delivery of the 44 place-based sustainability and transformation plans (STPs) was published on 22nd September provides some opportunities. We have not had the opportunity for a detailed analysis but we did note a shift to upscaling prevention through commitment to the national prevention transformation programme and two-year prevention-focused Commissioning for Quality and Innovation (CQUIN) schemes, including brief advice for tobacco and alcohol use. In order to be able to measure the impact of CQUIN schemes NHS Trusts should be required to measure smoking behaviour among patients, stop smoking interventions provided, and outcomes.

Question 6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

¹¹⁶ [CCG inequality indicators](#): Centre of Health Economics, University of York

- a. **What are the key elements of a public health policy that would enhance a population’s health and wellbeing and increase years of good health?**
 - b. **What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?**
 - c. **Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?**
 - d. **Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?**
 - e. **By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?**
 - f. **What are the barriers to taking on received knowledge about healthy places to live and work?**
 - g. **How could technology play a greater role in enhancing prevention and public health?**
 - h. **What are the best ways to engage the public in talking about what they want from a health service?**
34. In 2013/14, local authorities received £2.7 billion as a ring-fenced grant for public health services, in 2014/15 the grant was £2.79 billion, and the original grant for 2015/16 was also £2.79 billion (a reduction of 2% in real terms)^{117 118} However, in his 2015 Budget statement, then Chancellor George Osborne announced a further in year reduction in the 2015/16 grant of £200 million. In the 2015 Autumn Statement further progressive reductions in real terms of 3.9% annually over the next five years.¹¹⁹ This translates into a further cash reduction of 9.6%. From the baseline of £3,461m (after the £200 million grant reduction), the additional reductions savings will be phased in at 2.2% in 2016/17, 2.5% in 2017/18, 2.6% in each of the two following years, and flat cash in 2020/21.
35. The Kings Fund has described the cuts to the public health budget as the ‘falsest of false economies’¹²⁰ a criticism also made by local authorities¹²¹ and those working in the NHS.¹²² The King’s Fund has also pointed out that: *“The most significant local authority-funded public health services - including sexual health, substance misuse, smoking cessation - and “NHS” health checks services are either intimately entwined with NHS pathways or are directly commissioned from the NHS.”*¹²³
36. There are already wide variations in local spending on reducing smoking. Using local authority revenue expenditure and financing for 2016 to 2017, ASH has calculated the

¹¹⁷ [Public Health England's grant to local authorities](#): National Audit Office, 17 Dec 2014

¹¹⁸ [LGA Briefing on Public Health Settlement for 2015/16](#) Local Government Association, 3 Oct 2014

¹¹⁹ HM Treasury. [Budget](#) 8 Jul 2015. HM Treasury. [Autumn Statement](#) 25 Nov 2015

¹²⁰ Buck D. [Cuts to public health spending: the falsest of false economies](#). The Kings Fund, 6 Aug 2015

¹²¹ Gill, K. [£200 million cuts to public health for 2015/16. Our response to the £200m in-year cuts](#). London Councils, 2015.

¹²² [Nurses condemn ‘false economy’ of public health spending cuts](#). Royal College of Nursing, 28 Oct 2015

¹²³ Buck D. [Cutting the public health budget will cost the NHS](#). Local Government Chronicle, 10 June 2015

intended spend per smoker by each local authority for this financial year.¹²⁴ The average intended spend is £14.99 per smoker and the range is from £3.52 per smoker to £29.48 per smoker. There is a correlation between smoking prevalence and spending: areas with higher prevalence spend more per head of population (but not more per smoker) than areas with lower smoking prevalence.

37. England currently has two regional offices of tobacco control operating at a subnational level, funded by local authorities in the northeast and northwest. These have been shown to be highly effective and cost-effective in increasing the rate of decline in smoking prevalence above the national average, and they are included in the NICE return on investment tool for tobacco control as a good return on investment. The work they do is highly innovative, for example they have run successful paid for mass media campaigns backed up by intensive media advocacy, and campaigns to reduce the supply of, and demand for, illicit tobacco. Until this year there was also a regional office in the southwest but it had its funding terminated in January with six months' notice. Funding for the offices in the northeast and northwest, both areas of deprivation with high smoking rates, is also under threat.

38. Research has shown that mass media campaigns are highly effective and cost-effective in motivating quit attempts and discouraging uptake of smoking.¹²⁵ However, the UK is currently falling far below best practice spending on mass media campaigns. In 2009 funding for anti-smoking mass media campaigns in England was just under £25 million: by 2015 this figure had been cut to only £5.3 million, with further cuts expected this year. If England were to fund mass media campaigns at levels recommended by the US Centers for Disease Control and Prevention, it should be spending around £60 million; more than ten times the amount spent in 2015.¹²⁶

39. Studies carried out in England in the past few years have found that mass media campaigns have been effective in triggering quit attempts and have been responsible for a significant proportion of the reduction in smoking prevalence,¹²⁷ and that the freeze on mass media campaigns at the time of the 2010 election was associated with a reduction in quitting activity.¹²⁸ A systematic review of economic evaluations of mass media campaigns noted that all of these found mass media campaigns to be cost

¹²⁴ ASH/CRUK. 2016 Annual survey of tobacco control leads (unpublished).

¹²⁵ Langley T. et al. [The impact of media campaigns on smoking cessation activity: a structural vector autoregression analysis](#), *Addiction* 2012, 107(11):2043-50.

¹²⁶ Hopkinson NS, Millett C, Glantz S, Arnott D, and McNeill A (2016) UK government should fund stop smoking media campaigns not give tax breaks to films with smoking imagery. *Addiction*. doi: [10.1111/add.13511](#)

¹²⁷ Sims M, Salway R, Langley T. et al. [Effectiveness of tobacco control television advertising in changing tobacco use in England: a population-based cross-sectional study](#) *Addiction*. 2014 109 (6): 986-94

¹²⁸ Langley T, Szatkowski L, Lewis S et al. [The freeze on mass media campaigns in England: a natural experiment of the impact of tobacco control campaigns on quitting behaviour](#). *Addiction* 2014: 109: 995-1002

effective¹²⁹, but these campaigns need to have sufficient intensity and be sustained in order to have a meaningful effect.¹³⁰

40. A 2016 regional mass media campaign conducted by Fresh North East and Smokefree Yorkshire and Humber illustrates the value of mass media in promoting quit attempts. The campaign which focused on 16 cancers caused by smoking, reached approximately 333,000 people via TV, radio, print and online. Of those who saw the campaign 16% (around 55,300 people) cut down on their smoking. A further 8.4% (around 28,000 people) made a quit attempt as a result of the campaign while 4% switched to electronic cigarettes. This shows the clear impact mass media campaigns have on triggering quit attempts and changes in behaviour.
41. This is why ASH, together with other organisations concerned with public health, has called for urgent Government action to establish a **sustainable funding model for tobacco control**.¹³¹ As advocated in the answers to previous question, ASH believes that this funding should be secured through a levy on the tobacco manufacturers, allocated to local areas on the basis of local sales data, ring-fenced for tobacco control purposes and tied to specific performance targets based on measurable outcomes for the organisations and services it funds (including NHS organisations, local authorities, other public bodies contributing to tobacco control work and the voluntary sector).

Question 8. How can new technologies be used to ensure the sustainability of the NHS?

- a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?**
 - b. What is the role of ‘Big Data’ in reducing costs and managing demand?**
 - c. What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?**
 - d. How can healthcare providers be incentivised to take up new technologies?**
 - e. Where is investment in technology and informatics most needed?**
42. Current NHS IT and data collection systems are often a mixture of electronic and paper records. Often, this means that a hospital trust may not be able to aggregate real-time data on the number of smokers in its care at any particular time.¹³² Even if there is a working and comprehensive Electronic Patient Record (EPR) system in operation, data on smoking may still not be collected and aggregated. A hospital is likely to know precisely how many patients it has with c-difficile at any particular time, but not how many patients are smokers. This in turn means that it cannot track their progress through the hospital and specifically cannot accurately assess the impact of the

¹²⁹ Atusingwize E, Lewis S, Langley T. [Economic evaluations of tobacco control mass media campaigns: a systematic review](#) Tobacco Control 2015; 24: 320-327

¹³⁰ Durkin S & Wakefield M. [Commentary on Sims et al. \(2014\) and Langley et al. \(2014\) Mass media campaigns require adequate and sustained funding to change population health behaviours.](#) Addiction 2014; 109: 1003-1004.

¹³¹ Smoking Still Kills. ASH 2015.

¹³² Examples from private communication to ASH

repeated interventions advocated above. This is despite the fact that international evidence shows that systematic hospital wide anti-smoking interventions work well.¹³³

43. It should be a requirement of future procurements of EPR and related systems in the NHS that it include the capacity to record and aggregate information on patients' smoking behaviour, and to assess how this behaviour changes as patients move through the system. It should be a requirement for existing hospital patient information systems (whether fully digital, or a combination of digital and paper) that they are developed in order to provide this information.

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¹³³ See for example a Canadian study: [Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes](#): K A Mullen et al, Tobacco Control Online May 2015

The AHSN Network – Written evidence (NHS0031)

Introduction

The AHSN Network is a national network of 15 Academic Health Science Networks (AHSNs), set up by NHS England in May 2013.¹³⁴

There are 15 AHSNs across England with the purpose to accelerate the adoption and spread of innovation. Each AHSN works across a distinct geography serving a different population in each region.¹³⁵

In order to spread innovation at pace and scale - improving health and generating economic growth - AHSNs connect academics, NHS providers and commissioners, patients and industry.

We achieve our mission through delivering the four objectives as set by NHS England for AHSNs and our local partner organisations:

1. Focusing on the needs of patients and local populations
2. Building a culture of partnership and collaboration
3. Speeding up adoption of innovation into practice to improve clinical outcomes and patient experience
4. Creating wealth

Through delivering against these objectives, we aim to address the three healthcare gaps as identified in the *NHS Five Year Forward View* – health and wellbeing, care and quality and funding and efficiency.

We are grateful for the opportunity to comment on this select committee consultation.

As the only national and regional network of academia, the NHS, social care, patients and industry, we are able to give a unique perspective on the long term sustainability of the NHS.

Since we were established, we have amassed a great deal of learning on the enablers and barriers to the uptake of innovation across the NHS, and the part these play in ensuring the NHS remains sustainable and fit for purpose in the future. Much of this learning is set out in our 2016 *AHSN Network Impact Report*¹³⁶, and we will be including lessons learned and case studies in this response.

We have not attempted to answer all questions, but instead make contributions in areas where we have unique insight, such as the uptake of innovation. Given our unique role within the NHS, we would be delighted to provide oral evidence to the committee, in order to explore these issues in further detail.

¹³⁴ NHS England website, *New Academic Health Science Networks announced*, 21 May 2013

<https://www.england.nhs.uk/2013/05/acc-health-sci-ntwrk/>

¹³⁵ The AHSN Network website, *Regional map of 15 AHSNs*, <http://www.ahsnnetwork.com/about-academic-health-science-networks/>

¹³⁶ *The AHSN Network Impact report: Improving Health and Promoting Economic Growth*, June 2016
<http://www.ahsnnetwork.com/wp-content/uploads/2014/12/AHSN-Impact-Report-2016.pdf>

The future healthcare system

QS: Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must health and care systems change to cope by 2030?

Long-term sustainability of the NHS depends on at least two key dimensions – i) our ability to reduce in unwarranted variation in the quality, safety and efficiency of care (doing more of the same but better); and ii) our ability to transform how care is provided in the first place (doing things in new ways).

The NHS needs to adopt more consistently best practice everywhere to reduce the unacceptable level of variation, helping to significantly improve safety, quality and efficiency. The NHS Right Care programme¹³⁷ has exposed the scale of this challenge through the publication of its NHS Atlas of Variation in Healthcare data reports, which expose the widespread variation in the quality, cost, activity and health outcomes of healthcare across the NHS in England.¹³⁸ The programme has also started to signpost potential solutions, providing CCGs with practical support in gathering data, evidence and tools to help them transform the way care is delivered for their patients and populations.

AHSNs also have a strong focus on the reduction of variation. For example, East Midlands, North East and North Cumbria and West Midlands AHSNs are working collaboratively to spread best practice and reduce the amount of variation in how patients are supported to self-manage their long term conditions, through the roll-out of the Flo telehealth system. So far over 70 health and social care organisations are now using the system, with 33,000 patients registered for a wide range of conditions.¹³⁹

While such programmes will make a difference, on their own they are unlikely to be sufficient to respond to the magnitude of the sustainability challenge, which requires more fundamental changes in the NHS structure, culture and capability rather than just do more of the same better and more consistently.

The past two decades have seen a level of technological innovation that can shift the NHS from analogue to a digital care model, putting the patient at the centre as a co-producer of their health and healthcare. Such innovation has the potential to democratise the existing medical model in a way never seen before.

However, unlike other industries, the NHS has still not sufficiently integrated these technologies at pace and scale to turn potential into reality. The reasons for this are complex and there are no silver bullets. AHSNs have developed a deep understanding of these issues over the past three years. In our joint policy briefing with NHS Confederation in

¹³⁷ Introduction to the NHS Right Care programme, <http://www.rightcare.nhs.uk/index.php/programme/>

¹³⁸ The NHS Atlas of Variation in Healthcare, <http://www.rightcare.nhs.uk/index.php/atlas/nhs-atlas-of-variation-in-healthcare-2015/>

¹³⁹ *The AHSN Network Impact report: Improving Health and Promoting Economic Growth*, June 2016 <http://www.ahsnnetwork.com/wp-content/uploads/2014/12/AHSN-Impact-Report-2016.pdf>, p.7

June last year¹⁴⁰, we identified several barriers which are currently preventing this from happening.

Annual NHS budgeting infrastructure preventing commitment to invest-to-save programmes

Most organisations in the NHS are required to plan on an annual basis and, more importantly, commissioners have to balance the books in-year. While there is some flexibility, this is a commonly cited barrier to long-term commitment to invest-to-save programmes. Short-term accounting rules militate against long-term investment and require finding alternative routes locally, such as social impact bonds or new contracts with industry. For example, the three London AHSNs have developed a strong business case for the treatment of patients with atrial fibrillation that would prevent 500 deaths and 2000 strokes in London over five years by simply applying NICE best practice systematically. Over five years, this would also generate significant net savings. However, this would require upfront investment from CCGs while the savings mainly occur to social care. Given annual budgeting and separate funding streams for the NHS and social care, change will happen despite - not because - of the system, and at a much slower pace.

We therefore would like to see multi-year budgets for providers and commissioners, incentivising invest-to-save schemes, should be introduced. Ideally, there should be ring-fenced NHS spending for long-term investment in preventative or truly transformative innovations.

Limited contestability amongst existing services

A lack of contestability of most existing services, most notably in primary care, provides incumbent providers with very little impetus to change radically, unlike in other industries. The most radical improvements have often come from outside the NHS, for example from SMEs or wider industry.

We therefore would like to see more options to non-NHS providers to provide services under the NHS branding and in accordance with NHS values, as is the case with self-employed GPs. This would offer providers currently outside the NHS – e.g. from the voluntary sector – with the mechanisms to provide their services and contest the market, proving the extent to which it is open to new ways of delivering services. This model has already worked successfully elsewhere. For example, in Finland the market entry of Meedoc, an online doctor consultation service, was able to contest existing analogue providers and offer a radically different digital solution reducing system costs, improving convenience for patients and attracting women back into the GP workforce.¹⁴¹ This is not to be confused with more competition or privatisation but open the mostly closed NHS market to a greater variety of skills and capabilities while maintaining the principles of the NHS.

Misalignment of national and regional innovation needs

¹⁴⁰ The AHSN Network and NHS Confed, *Cracking the innovation nut: Diffusing healthcare innovation at pace and scale*, June 2015 <http://www.nhsconfed.org/resources/2015/06/cracking-the-innovation-nut-diffusing-healthcare-innovation-at-pace-and-scale>

¹⁴¹ Meedoc <https://uk.meedoc.com/>. This is currently receiving support and funding from Digital Health.London Accelerator, which is jointly run by the three London AHSNs, MedCity and NHSE London. There are other examples of digital primary care services including [Babylon Health](#),

The NHS has a world-class research infrastructure. With such a strong focus on research through National Institute of Health Research (NIHR) funding, there is a bias towards the 'new' rather than the 'existing'. The NIHR impact factor required to be demonstrated is welcome but in practice insufficient to accelerate the adoption of research at scale.

Equally, there is little reward and recognition in the NHS for organisations which adopt systematically what others have already developed. This is most obvious in the very many national rewards for research and innovation. Related to this is the risk that the evidence generated by innovators is driven by the requirements of often academic funders, rather than clients such as procurement departments, clinical leaders and patients. Other sectors, such as education, have found better ways of making best practice and evidence available to professionals. For example, the Education Endowment Foundation offers innovation in knowledge mobilisation from which the NHS in particular NICE and even Cochrane Reviews could learn.¹⁴²

We therefore suggest that NHS organisations and staff should be more strongly supported (see below for examples of how) and rewarded for the systematic uptake of existing innovation. We would also been keen to see a review from NICE on how best practice is presented and shared with clinicians, learning from other organisations such as the Education Endowment Foundation.

Lack of willingness to experiment

There is currently an expectation that all nationally driven change programmes will be successful, such as the recently launched Vanguards programme. True innovation and transformation requires experimentation, failure and learning from these failures. Such an approach also requires reviewing the scale of and political investment in pilot programmes and moving towards smaller, quicker and cheaper methods of experimenting which are more akin industry standards in other sectors, such as engineering.

We therefore would like to see AHSNs are better utilised nationally and locally as unique environments in which innovation experiments can happen, working in partnership with their NHS, industry, commissioner and patient networks.

Lack of transformation capacity and capability within the NHS

Too often, the role of transformation is given to clinicians on top of their already busy day jobs. Furthermore, we know that there are also often skills gaps in several transformation areas which are often overlooked, such as business intelligence, procurement for innovation, or actuary training for those working in the new Accountable Care Organisations (ACOs).

Again, cross sector learning may help the NHS develop the necessary organisational infrastructure and culture to systematically scout for and adopt both existing and emerging innovations. There are plenty of examples from industry which demonstrate that only deliberate investment and CEO focus on this issue delivers results. The systematic adoption of existing innovation may seem straightforward but it clearly is not, and unless it is hard wired into an organisation and driven by senior executive management, it rarely happens.

¹⁴² The Education Endowment Foundation, <https://educationendowmentfoundation.org.uk/>

It can be argued that private sector organisations have a different set of incentives and harder budget constraints, which is a key driver to their desire to copy innovations from elsewhere more systematically.

Some AHSNs have started to develop joint programmes with non-NHS organisations to offer this capacity building to their member organisation. For example, Eastern AHSN is working in partnership with the Advancing Quality Alliance (AQuA) to develop a quality improvement infrastructure supporting continued service improvement and innovation. This is based on a successful programme already rolled out in the North West by the Innovation Agency and Greater Manchester AHSNs. Imperial College Health Partners, the AHSN for North West London, is running an “Intrapreneur” programme in partnership with ?What If! an organisation that has worked with hundreds of companies to improve their ability to utilise innovation, upskilling both executive and frontline staff to scout and adopt innovation as part of their everyday roles. These programmes are starting to show benefits but would benefit greatly from mainstreaming as part of general medical training. In fact, the NHS may not need Chief Innovation Officers, which are prevalent in other industries, but more Chief Imitation Officers.¹⁴³

What we would like to see

To summarise, the future sustainability of the NHS depends on its ability to support i) reduction in variation through adopting best practice and ii) transformation through innovating. To address the challenges currently faced in these two areas, we make the following suggestions:

1. Multi-year budgets for providers and commissioners, incentivising invest-to-save schemes, should be introduced;
2. More opportunity to should be given to non-NHS providers to contest the current market by offering them mechanisms to provide services under the NHS branding and values;
3. NHS organisations and staff should be more strongly supported and rewarded for the systematic uptake of existing innovation;
4. NICE should review how best practice is presented and shared with clinicians, learning from other organisations such as Education Endowment Foundation;
5. AHSNs should be better utilised as unique environments in which innovation experiments can happen, working in partnership with their NHS, industry, commissioner and patient networks;
6. NHS staff should be trained in developing skills and capability to scout for and adopt innovation as part of their core medical training;
7. NHS staff should be given capacity to focus on the implementation of best practice and innovation, rather than as an “add-on” to already busy day roles.

Resource issues, including funding, productivity, demand management and resource use

¹⁴³ Roth, A.M and Lee, T.H, *Health Care Needs Less Innovation and More Imitation*, Harvard Business Review, 19 November 2014

QS: To what extent is the current funding envelope for the NHS realistic?

Does the wider societal value of the healthcare system exceed its monetary cost?

What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

There is surprisingly little systematic evidence on the true economic costs and benefits of the NHS that take into consideration the wider societal value of healthcare.¹⁴⁴ In principle, there are five ways in which healthcare interacts with wider economic growth: creating jobs, consuming goods and services, improving the health and therefore productivity of the population, exporting health related goods and services and, finally and most importantly, it is also a source of innovation which is the only determinant of permanent economic growth in the economy.

To date it has been incredibly difficult to quantify these factors. However, without at least attempting to establish a more robust evidence base, the NHS will mainly be seen as a spending line in the Government's budget, when in fact there are good reasons to argue that it is more akin to an investment.

Taking the investment funding model, the question is therefore who is best placed to make this investment, Government through general taxation or individuals through an insurance market? The international evidence on different funding models is inclusive and depends on what aspects or outcomes are being considered.

For example, it was believed that increasing the competition amongst Dutch healthcare insurance companies would drive better health outcomes and efficiency. The emerging evidence suggests otherwise, with no link established between insurer competition and improved health system performance.¹⁴⁵

At the same time, the US insurance systems offers employers incentives to foster health amongst their workforce to reduce their insurance premium. Again, the evidence is not conclusive as to whether individual incentives for employees will have long-term health benefits. Finally, Germany recently abandoned co-payments as they did not deliver the anticipated reduction in healthcare utilisation.¹⁴⁶

¹⁴⁴ For a brief summary of the issues see e.g. <http://imperialcollegehealthpartners.com/blog/beyond-the-headline-wealth-creation/>

¹⁴⁵ Thomason, S, Busseb, R, Crivellio, L, Vvan de Vend, W and Van de Voordee, C, *Can insurer competition improve health system performance? Evidence from Western Europe* <http://www.ire.eco.usi.ch/paper-crivelli-182414.pdf>

¹⁴⁶ Augurzky, B, Bauer, T.K, Schaffner, S, *Co-payments in the German Health System: Does It Work?* <http://ftp.iza.org/dp2290.pdf>

As a recent Organisation for Economic Co-operation and Development (OECD) report stated, *“there is no healthcare system that performs systematically better in delivering cost-effective health care. It may thus be less the type of system that matters but rather how it is managed. Both market-based and more centralised command-and-control systems show strengths and weaknesses.”*¹⁴⁷

The NHS is clearly at the lower end of health spend as a percentage of Gross Domestic Product (GDP) in comparison to other countries and while further efficiency gains are possible, it is questionable as to whether the current funding is sufficient for the medium to long-term. However according to a recent poll by Ipsos MORI commissioned by the Health Foundation¹⁴⁸, around 85% of the public believe there should be more investment in the NHS through taxation, which suggests that its wider societal value exceeds its monetary cost.

Adopting new models of funding, such as means-testing, would need to be tested through high quality public engagement and debate and consider the best available evidence from elsewhere. It should also follow a thorough discussion about the primary and secondary objectives of any change (e.g. sustainability, behaviour change etc).

What we would like to see

- International evidence be considered carefully and any policy change should be informed by evidence;
- To take the heat out of the public debate, some clear principles should be developed including a clear distinction between services which are “needed” and “wanted”;
- The outcomes of current policy experiments, such as the Vanguard, should be first considered to see how far outcome based payments or capitation (moving away from fee for service) can deliver transformation and further efficiencies.

Digitisation of services, Big Data and informatics

QS: How can new technologies be used to ensure the sustainability of the NHS?

What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

What is the role of ‘Big Data’ in reducing costs and managing demand?

What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

How can healthcare providers be incentivised to take up new technologies?

Where is investment in technology and informatics most needed?

The role of new technologies

¹⁴⁷ OECD 2010, “Health care systems: Getting more value for money”, OECD Economics Department Policy Notes, No. 2. <https://www.oecd.org/eco/growth/46508904.pdf>

¹⁴⁸ Ipsos MORI, Polling for the Health Foundation, 7 April 2015, <https://www.ipsos-mori.com/researchpublications/researcharchive/3546/Polling-for-The-Health-Foundation.aspx>

The global market for digital health was worth £23 billion in 2014 and is expected to almost double to £43 billion by 2018, although investors are increasingly getting worried about monetisation. As we have noted above, digital technologies have the potential to democratise healthcare by creating patients as co-producers of both their health and healthcare. In this way, technology has a huge part to play in ensuring the sustainability of the NHS, supporting patients to better self-manage their conditions, reducing costs and managing demand on GPs and out-of-hours services.

Currently, the impact on healthcare has mainly been theoretical, with more publications highlighting the potential of digital health rather than demonstrating impact. However in our Impact Report for 2016, The AHSN Network sets out the impact we are starting to have in supporting the use of new technologies across England, reducing costs and managing demand. For example, as a national network, we have supported over 500 new products or services to be developed and/or supported into the NHS. These include innovations such as AliveCor - a highly effective mobile heart monitor that detects heart arrhythmias, including instantly highlighting Atrial Fibrillation in electrocardiograms – which is currently being implemented in five AHSN sites across the country in London, Oxford, North East and North Cumbria and the North West, helping to reduce treatment costs and reduce hospital admissions.¹⁴⁹ Our network also hosts the NHS Innovation Accelerator programme, supporting 17 fellows to scale their tried and tested innovations through the programme, which involves mentorship from seasoned healthcare innovators. The programme has generated almost £8 million in investment (primarily through the private sector and charities) and the innovations are now being implemented in 345 NHS organisations across the country.

There are currently several national pieces of work looking at the role new technologies have to play in ensuring the sustainability of the NHS, most notably the Department of Health's Accelerated Access Review (AAR), supported by The Wellcome Trust.¹⁵⁰ Collectively, AHSNs are supporting the AAR, which aims to speed up access to transformative health technology that can change the lives of NHS patients, service users and citizens. In the Review's interim report, AHSNs have been identified as one of the factors which will drive and enable the increased uptake of new technologies.

The role of data

We know interoperability of patient records at the point of care, will play a huge part in transforming the sustainability and particularly the safety of the NHS. Nationally, this has been challenging in the past. However, more progress has been made locally.

For example, Wessex AHSN has been working in partnership with PharmOutcomes to improve the discharge and transfer of care process for patients when moving between settings. Traditionally, inconsistency of patient records between settings can lead to readmissions, poorer outcomes and poor patient experience. Good referral of care regarding medicines from hospital to community pharmacy is helping to change this, and

¹⁴⁹ *The AHSN Network Impact report: Improving Health and Promoting Economic Growth*, June 2016

<http://www.ahsnnetwork.com/wp-content/uploads/2014/12/AHSN-Impact-Report-2016.pdf>, p.7

¹⁵⁰ The Accelerated Access Review, <https://www.gov.uk/government/organisations/accelerated-access-review>

new discharge pathways are now being implemented across Wessex, North East and North Cumbria and the South West AHSNs.

In North East and North Cumbria so far, six acute trusts are now making referrals to 700 community pharmacies for follow up support with their medication after discharge from hospital and more than 750 patients have now received follow-up support.¹⁵¹ This work won two HSJ awards in 2015 – “Enhancing Care by Sharing Data and Information” and “Most effective adoption and diffusion of best practice”.

In North West London, Imperial College Health Partner AHSN has been involved in the first sector wide contract for the online patient record platform Patients Know Best enabling patients to control and share their data. The sector has also one of the largest linked data sets in the country enabling care planning at patient level.

In the North the four AHSNs are part of/ leading the Connecting Health Cities programme. This programme matches data from health and social care to front line services, enabling services to be planned to meet service user needs and prevent ill health.

We have provided our learning from case studies such as these to the Wachter Review, led by Professor Rob Wachter, which is looking at the use of information technology in the NHS across England, with a particular focus on electronic records.¹⁵²

Despite successes in some areas, we know there are still several barriers to the uptake of both new technologies and the utilisation of data:

Many digital solutions – whether apps or wearables – exist in isolation from mainstream healthcare record systems.

Solutions may offer promising interventions to increase medicine adherence or improve sleep, but few are connected to electronic patient record or primary care systems. Furthermore, the plethora of data is rarely turned into insights that directly benefit patients. Without closing that loop, the impact of digital health application and technology will always stay limited. Recent developments, including Apple’s ResearchKit which effectively allows anyone to write apps that access patient recorded data on their phones with their consent, have the potential to change this. However, maintaining privacy and trust remains a key issue for interoperability between systems, with programmes in areas such as North West London proving slow to get off the ground due to this issue. The NHS is still overly risk averse to data sharing, which means it is hard to assess the full potential of digital solutions. This is a particular issue for the secondary use of data for research even in anonymised form making the NHS a less attractive place to conduct research or deploy novel analytical tool.

We would like to see more sophisticated public engagement on this issue, perhaps following the “deliberative democracy” model adopted in the NHS, where the public were engaged

¹⁵¹ *The AHSN Network Impact report: Improving Health and Promoting Economic Growth*, June 2016

<http://www.ahsnnetwork.com/wp-content/uploads/2014/12/AHSN-Impact-Report-2016.pdf>, p.16

¹⁵² The Wachter Review, <https://www.england.nhs.uk/digitaltechnology/info-revolution/wachter-review/>

with debates on ethical questions raised by the increased use of large data sets to fuel decision making across Government.¹⁵³

Showing efficacy for most of the digital health market remains a challenge

This is a particular issue for mobile applications of which there are around 165,000 at the last count, but only 300 trials with varying levels of robustness according to a report by the IMS Institute.¹⁵⁴ There is very little agreement on what constitutes a sufficient level of evidence in digital and what an appropriate pathway into healthcare might look like. We believe the National Information Board and the Accelerated Access Review need to address these issues rapidly. There is also an urgent need for further evidence to be developed on how digital health solutions can support prevention and self-care, if digital health is to be taken seriously as a lever to make the NHS sustainable for the future. Again, there are potential solutions in the market already¹⁵⁵ and the National Information Board may want to consider these first before developing their own provision.

Incentives to use digital health solutions are not aligned

It is often unclear which organisation should be the main commissioner/payer for interventions. For example, with sleep interventions employers benefit, as do wider society and healthcare systems, but the benefits are only medium to long term, making return to investment models difficult. However, aligning incentives is possible, as a discussion between a large pharma company and one of the few fully integrated insurance and provider organisations in the US at a recent HealthXL global gathering has demonstrated. The aim of the project was to find a bio-marker to more accurately which predict patients are risk of readmission, and a solution was quickly found to make the necessary changes in funding to incentivise interventions. We need NHS providers and commissioners to work together to make these funding decisions, if interventions are to make a real impact on the future sustainability of the NHS. We have already previously referred to the challenges of annual budgeting in the context of invest to save decisions.

Lack of open source technologies

The NHS is a significant market for IT related services. Many of these are still closed rather than open source and therefore make sharing across systems and the plugging in of user generated data very difficult. We would like to see the NHS using its purchaser power to move to open source and APIs over time as a key requirement.

However, we do acknowledge progress is being made to incentivise the uptake of digital technologies:

- NHS England's recently announced Technology and Innovation Tariff¹⁵⁶ will have a large part to play in standardising the use of new technologies across the NHS, and the AHSN Network has already supported the roll-out of several new technologies

¹⁵³ <http://www.ischool.berkeley.edu/newsandevents/events/2014bigdataworkshop>

¹⁵⁴ IMS Institute, *Patient Adoption of mHealth*, October 2015 <http://www.imshealth.com/en/thought-leadership/ims-institute/reports/patient-adoption-of-mhealth>

¹⁵⁵ See e.g. <http://www.orcha.co.uk/>

¹⁵⁶ NHS England website, *NHS Chief launches new fast track funding so NHS patients get treatment innovations faster*, 17 June 2016 <https://www.england.nhs.uk/2016/06/treatment-innovations/>

included in the digital tariff announcement – MyCoptd, AliveCor and PenuX – and will continue to work with our partners to support the implementation of the tariff.

- We also welcome the announcement that 26 of the most digitally advanced Trusts have been invited by NHS England to apply for a £100+m funding pot to become centres of digital excellence. Again, the AHSNs have supported their local Trusts in their bids for funding to invest digital infrastructure and specialist training.

What we would like to see

Based on our learning to date, our suggestions are as follows:

1. Higher quality of public engagement needed on the sharing of electronic patient records for patient benefits, and the use of this data in anonymised form- Big Data - to inform local commissioning decisions and national healthcare policy development;
2. National agreement urgently needed on what constitutes a sufficient level of evidence in digital healthcare innovations and what an appropriate pathway into healthcare might look like utilising solutions already in the market;
3. Further evidence to be developed on how digital health solutions can support prevention and self-care, to help support take-up across the country;
4. Stronger incentives for NHS providers and commissioners to work collaboratively to make invest-to-save decisions on commissioning new digital health solutions, supported by a multi-year budgeting process.

19 September 2016

Mr Tom Allison – Written evidence (NHS0024)

As a normal person may I suggest that the best way to maintain long term sustainability for the NHS is to increase income tax by 1p in the pound and let it be known that will on go to the NHS. As a member of the General public earning on average approx £1600 I would have no problem of paying a little bit more if I knew it would be used exclusively for the NHS. I am confident that the majority of citizens would also have no problem with the above proposal it has to a better solution to improve the current situation in our NHS.

8 September 2016

Arthritis and Musculoskeletal Alliance – Written evidence (NHS0087)

About ARMA

ARMA is the alliance representing the arthritis and musculoskeletal community in the UK. Our [members](#) include major national patient-led charities, professional bodies and research organisations active in this area, as well as patient-led charities focusing on rare and complex musculoskeletal disorders.

ARMA has a strategic partnership with NHS England to support the **Musculoskeletal Clinical Network**. Clinical networks have been increasingly turned to in order to improve health and health services with the overarching aim of ensuring people are enabled to live longer and better.

About Arthritis and Musculoskeletal (MSK) conditions

Musculoskeletal conditions are conditions of the joints, bones and muscles, which also include rarer autoimmune diseases and back pain. There are more than 200 MSK conditions.¹⁵⁷

MSK conditions represent an area where many of the biggest wins lie for both health and social care. Their cost, impact, prevalence and degree of co-morbidity makes these conditions an important gateway for effectively tackling wider priorities with regard to public health such as prevention of health problems, health promotion, keeping people in work, and maintaining independence.

The Global Burden of Disease study (2015) shows that MSK disorders collectively are the single biggest cause of pain and disability in the UK. MSK conditions currently account for one in five visits to the GP¹⁵⁸, over £5 billion NHS spending every year and 30.6 million working days lost each year. Much of this is avoidable through prevention and early intervention.

As the UK population ages and the number of people of people living with multiple long-term conditions grows, the burden of MSK conditions is set to increase. Due to the cost, impact, prevalence and degree of co-morbidity of musculoskeletal conditions, investing in quality improvement can greatly benefit patients. Thus MSK conditions represent an area where many of the biggest wins lie for both health and social care.

Historically, health policy has not focussed on MSK conditions that affect so many people with the same emphasis and priority that has been targeted at other areas, such as high mortality diseases.

Effectively tackling musculoskeletal conditions requires:

¹⁵⁷ Department of Health (2006). *The Musculoskeletal Services Framework, A Joint Responsibility: doing it differently*. Available at:

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138413

¹⁵⁸ Arthritis Research UK (2016). *Working with arthritis*.

- Musculoskeletal conditions to be highlighted in all national strategies or frameworks for long-term conditions.
- Equitable access to the best available treatment with comprehensive, co-ordinated care pathways
- Government and employers to provide meaningful support for people with musculoskeletal conditions to remain or return to work. Work needs to be seen as a health outcome by health professionals.
- People living with musculoskeletal conditions to be empowered to take control of their health.

ARMA also supports NHS England's [Declaration for Long-Term Conditions](#)

The future healthcare system

- 1.1. "Sustainability", particularly in the NHS, is often understood fundamentally in terms of financial sustainability, and specifically in terms of reducing costs. However, it is essential that the NHS take a broad understanding of "sustainability" in terms of delivering high-value, [person-centred care](#), reducing unwarranted variation and improving patient outcomes. This would enable the NHS to become more sustainable by integrating and streamlining services around population needs, and enable patients to remain healthier and independent for longer, thereby reducing the demand on the NHS.
- 1.2. All the evidence demonstrates that *bad care costs more*: by redesigning services around patient and population needs, the NHS can both improve outcomes and increase sustainability. Nowhere is this more important than in the area of MSK conditions, nor is there a set of conditions which is more amenable to such an approach.
- 1.3. It's possible to identify two main ways in which the NHS of the future can both deliver better outcomes and improve sustainability: coordinated, person-centred care; and delivering care through a networks approach.
- 1.4. Coordinated, person-centred care can be summed up as the *right care, in the right place and at the right time*.
- 1.5. Doing so includes, among other things:
 - Providing care closer to home, as outlined in [this report](#) by the King's Fund (including a case study from the [Haywood Rheumatology Centre](#))
 - Early supported discharge, as outlined in [this document](#) by the Royal College of Surgeons
 - Supported self-management, including signposting to [voluntary sector organisations](#) which provide information, support and in some cases courses for MSK conditions.
 - Support from health professionals to help people [remain in or return to work](#)
 - Interventions aimed at improving health and wellbeing and preventing potentially debilitating conditions such as MSK conditions from causing unnecessary pain and hardship, such as around [physical activity](#).

- Effective [care planning](#) for all those who need it, particularly those with one or more long-term conditions
 - [Shared decision-making](#) to ensure that patients are able to make informed decisions about their care and take ownership of their care, thereby also improving “compliance” and avoiding unnecessary interventions or interventions which may inadvertently lead to negative outcomes or reduce a patient’s quality of life.
- 1.6 In a decentralised NHS where the key driver for service design and delivery is population-based commissioning, it is impossible to deliver high-value, person-centred care through an exclusively top-down or hierarchical structure. NHS structures and mechanisms are also subject to change, sometimes at short notice, which means that the systems which design, commission and deliver care need to be sufficiently flexible to allow for and withstand organisational change. Research has shown that networks contribute to healthcare improvement by providing a forum for experimentation and creating knowledge, exchanging information and spreading good practice. [Multidisciplinary networks of care](#), organised locally or regionally around key condition areas such as MSK, and involving key stakeholders from public health and social care as well as from the NHS, represent the future of healthcare.
- 1.7 Over the past few years, the MSK community, through ARMA, has been working in partnership with NHS England and other stakeholders to develop MSK clinical networks in England. This [resource pack](#) produced by ARMA and the NHS Confederation clearly outlines the importance of adopting a networks approach for effectively tackling broad and complex condition areas like MSK, and provides a practical guide on setting up effective MSK networks. Our [MSK Knowledge Network](#) provides a national “hub” for supporting the development of effective MSK networks and the dissemination of key evidence and resources. The project has been described by many as a template for other long-term conditions.

Resource issues, including funding, productivity, demand management and resource use.

2.1 ARMA believes that

- Health is a human right, and that therefore the NHS must remain at all times free at the point of need, delivering high-quality and coordinated, patient-centred care for all, in line with the [NHS Constitution](#).
- This requires, among other things:
 - The progressive reduction of health inequalities and social isolation
 - Investing in integrated, patient-centred care
 - Providing [real-terms increase in funding for the NHS](#): Health and social care need sufficient resourcing to be able to meet the needs of

today and tomorrow, and to deliver genuinely integrated, patient-centred care. Current levels of resourcing are inadequate and the funding gap in the NHS in particular will not be filled via “efficiency savings” alone.

- The **full integration of health and social care** as a longer-term objective.
- 2.2. Sustainability and Transformation Plans (STPs) have the potential for delivering a more sustainably and person-centred NHS in England, in the manner outlined above. To do so, however, they must be transparent and they must effectively [involve all key stakeholders from the communities they serve](#).
 - 2.3. ARMA fully supports and was a signatory to National Voices’ letter to the Chief Secretary to the Treasury ahead of last year’s Spending Review, which is included in full in the Appendix.

Workforce

- 3.1. In order to effectively stem the rise in musculoskeletal conditions, it is essential for there to be a workforce trained in musculoskeletal conditions and early intervention, which is able to identify, treat and/or refer MSK conditions promptly and accurately as required.
- 3.2. This needs to be accompanied by a culture change and change methods of working between healthcare professions, to ensure that they are able to collectively deliver a joined-up, person-centred service, as outlined in [Health Education England’s Strategic Framework](#).
- 3.3. ARMA also supports the points raised by the Chartered Society for Physiotherapy in this section, particularly around the need to re-enable all parts of the health workforce to work to the height of their capabilities.

Prevention and public engagement

- 4.1. A preventive approach to care is essential to improving outcomes and increasing the sustainability of the NHS. This needs to include measures aimed at primary prevention as well as secondary prevention. The latter is particularly important for all people with an existing long-term conditions, many of which cannot be completely prevented but all of which can be prevented from causing undue harm or having an unnecessarily large impact on a person’s quality of life and ability to remain independent, as we have previously described in [this article](#).
- 4.2. Certain forms of MSK conditions, particularly inflammatory forms of arthritis such as rheumatoid arthritis and ankylosing spondylitis, require early intervention and access to specialist treatment. The [National Audit Report on Services for people with rheumatoid arthritis](#) in particular highlighted the cost-effectiveness as well as

the importance of early intervention for people living with this condition, for whom access to specialist treatment within 3 months from the onset of symptoms is critical. A recent [audit by HQIP and the British Society for Rheumatology](#) highlighted the gaps and unwarranted variation in service provision in England for this area.

- 4.3. Certain models provide a very good and cost-effective way of identifying risks early in order to provide the necessary interventions before problems arise or become compounded. One of these is in the area of falls prevention, particularly around fragility fractures, and [Fracture Liaison Services](#) in particular represent a very effective model which ARMA feels should be commissioned by all CCGs and made available in every locality in England.
- 4.4. In relation to public engagement and specifically in relation to physical activity, it is important that messaging for people with long-term conditions (including musculoskeletal conditions) is positive, encouraging and inclusive.
- 4.5. Research conducted on behalf of the Richmond Group in April 2016¹⁵⁹ by Britain Thinks gives insights into messaging that resonated with people with long-term conditions in helping them overcome barriers to physical activity.¹⁶⁰ The research included both a qualitative and quantitative sample that included people with multiple long term conditions who had differing levels of physical activity.¹⁶¹ The research revealed that “people with long term conditions often have the attitude that both exercise and physical activity are seen as ‘not for people like me.’ However, whilst the broad understanding of both are similar, the negative

¹⁵⁹ People with long-term conditions and attitudes towards physical activity. Research conducted on behalf of the Richmond Group by Britain Thinks. March 2016

¹⁶⁰ ¹⁶⁰ The research included: 8 depth interviews (6 with people with multiple LTCs who never / rarely exercise, 2 with people who are close to someone with multiple LTCs). 5 focus groups (4 groups with people with LTCs who never / rarely exercise, 1 group with people close to someone with an LTC) & an online poll with 323 respondents

¹⁶⁰ Full list of conditions listed below. Many of these conditions were present in multiple participants.

- Heart disease
- Arthritis
- Calcific tendonitis
- Overactive thyroid
- Asthma
- Diabetes
- CVID
- Kidney disease
- Osteoporosis
- Chronic back pain
- Depression
- Essential benign tremors
- Eczema
- Cancer
- Bulimia
- Anxiety
- Psychosis
- Multiple sclerosis
- Cerebral palsy
- Crohn’s disease

¹⁶¹ The research included: 8 depth interviews (6 with people with multiple long term conditions (LTCs) who never / rarely exercise, 2 with people who are close to someone with multiple LTCs). 5 focus groups (4 groups with people with LTCs who never / rarely exercise, 1 group with people close to someone with an LTC) & an online poll with 323 respondents.

connotations (e.g. pain) of ‘exercise’ are slightly more dominant.” Public health messages that are overly prescriptive, instructive, make assumptions about people’s conditions or set unrealistic expectations (such as getting fit) will not cut through.

- 4.6. It is essential, nonetheless, that the promotion of healthy practices is not used to set arbitrary thresholds for access to medical treatment, such as BMI thresholds for access to surgery for patients with MSK conditions, or to covertly ration access to treatment.
- 4.7. When developing health promotion messages, the benefits of physical activity to people with musculoskeletal conditions should be emphasised. Common misunderstandings should be challenged, including that nothing can be done if you have arthritis or back pain that rest is beneficial for painful musculoskeletal conditions, or that physical activity is inherently harmful for people living with these conditions.
- 4.1. Everyone can do something to improve and maintain the health of their bones, joint muscles and spine, at every age. It is never too late to start taking up physical activity and there should be no fear of participation.¹⁶²

¹⁶² Arthritis Research UK (2014) Musculoskeletal Health, *A Public Health Approach*

Appendix:

Letter from National Voices to Rt Hon Greg Hands MP, Chief Secretary to the Treasury, 19 October 2015

Dear Chief Secretary,

HEALTH AND SOCIAL CARE IN THE SPENDING REVIEW

We, members of National Voices, are writing with our recommendations on the Spending Review outcome for health, social care and the voluntary sector.

National Voices, an independent charity, is the leading coalition of health and social care charities in England, we have a deep understanding of the experiences and needs of millions of patients, service-users, carers and families. We work closely with the Department of Health and the NHS and have a key role in the implementation of the NHS Five Year Forward View and supporting other priorities in health policy.

With the NHS under huge pressure and increasingly in deficit, we are seeing a direct impact on the accessibility and quality of services. We welcome the Government's commitment to increasing the NHS budget by £8 billion in real terms by 2020. We see this as the very minimum necessary and would support calls for these increases to be front-loaded.

The challenge of achieving £22 billion of NHS productivity savings is daunting. Key to this will be seeing through the Five Year Forward View reforms that are meant to give priority to preventing ill-health and promoting people's physical and mental health, wellbeing and independence at home and in the community.

The evidence is clear: joined up, proactive, preventative services, developed in collaboration with citizens and communities, result in better health outcomes and a better patient experience.¹ Such services enable a higher proportion of care to be provided in and close to people's homes in the short term, reducing demand for high cost acute services in the medium to long term.

National Voices has published a set of systemic reviews of the evidence for person centred care. These are available at <http://www.nationalvoices.org.uk/evidenceterm>. They also make a vital contribution to economic growth by improving the employability of working age people with disabilities and long term conditions, and family carers.

For these reforms to achieve the Government's goals, we see a number of key conditions that must be met as part of the Spending Review outcome.

Funding for health and care services

Local government plays a critical role in the provision of health and care services, and in prevention. This role will become more important with the passing of the Cities and Devolution Bill. However, while direct NHS funding has been protected, substantial cuts to

local government funding risk health outcomes and are likely to lead to growing demand for acute NHS care.

Real-terms increases in funding are needed for social care.

The progressive squeeze on local authority social care spending has left a growing number of older and disabled people with un-met needs. Disabled children, along with their families, are also being affected by cuts to social care funding. A decent society should not tolerate this.

The squeeze on social care adds extra costs to the NHS as it risks people's health deteriorating to the point where expensive and unplanned medical services become necessary. A lack of social care resource also creates pressure on Accident and Emergency services, and costly delays in discharge from hospital. Further, while we welcome the move to introduce a National Living Wage in principle, we are concerned that unless additional funding is made available for social care, this will lead to further restrictions on services.

In-year reductions to the public health allocations to local government announced in the summer Budget will put NHS services such as sexual health clinics and drug and alcohol services at risk, as well as undermining the potential for NHS savings through primary prevention. **The cuts to allocations made this year should be reversed, and the Government's commitment to prevention should be demonstrated by a real terms increase in public health spending.**

The NHS budget itself must be re-aligned so that a greater proportion of total spend is geared towards promoting health and supporting people's independence and supported self-management in the community. In particular, we believe moving away from payment for episodes of care to, for example, year of care tariffs, will be important in bringing this about for those with complex and long term conditions. We are also concerned about the decline in spending on both GP services and on support for people with mental health, creating significant pressure including growing waiting times. Allocations to services should reflect the importance of these services in preventing ill health.

The current system of prescription charge exemptions is inequitable and reinforces health inequalities for some groups of patients with long term conditions. We recommend that this is reviewed.

Together, these recommendations will support a shift of demand away from costly acute care, to that provided closer to home, with a greater role for supported self-management, community support and the voluntary sector.

The role of the voluntary sector in health and care

As is fully recognised in the Five Year Forward View vision, **the voluntary and community sector is an integral part of the health and care infrastructure** and key to the development and delivery of preventative, holistic, person-centred approaches that keep people out of hospital and help them back into work. Our sector fills gaps in provision and reaches people

not otherwise reached or adequately served by statutory services, as a result often offering better value for money. Our contributions to achieving the Government's goals span:

- system resilience and demand management, for example in the recent winter pressures work
- preventing diabetes, obesity, and cancer
- supporting people with dementia and mental illness
- supporting children and young people (and their families) with life-limiting and life-shortening conditions
- integrating health and social care and reforming out of hospital care
- helping to develop and then implement the Care Act, and promoting personalisation, choice and control and supported self-management
- supporting compliance with legal duties relating to equality, health inequalities, safety and public involvement
- innovating, for example in developing social prescribing, peer support and other new models of service delivery
- promoting a patient and citizen voice in accelerating access to new technologies and treatments
- promoting social action and the Big Society
- providing support, and a voice, for people with rare, overlooked or stigmatised conditions, for example HIV, rare cancers, or conditions leading to incontinence, or disfigurement.

Looking forward, we see an important role for our sector in supporting the success of devolution in Greater Manchester and subsequent areas and in helping to ensure that the move to 7 day working does not create unsustainable demand pressures on the NHS.

The strategic importance of our sector in health and wellbeing has not been reflected in the funding environment. The voluntary sector has experienced no real terms growth in income since 2006/07 and overall spending on the sector from both central and local government has declined by more than 10 per cent since 2009 in real terms.

Smaller voluntary organisations, representing the majority of the sector, have experienced much sharper reductions in income. Such organisations are typically those best connected to individual neighbourhoods, and to particularly excluded communities, including those living with overlooked health conditions. While voluntary organisations must avoid the trap of over-dependence, statutory funding is vital for building their capacity to diversify funding streams and for ensuring that their voices continue to be heard.

It is in this context that we call for the **protection of the Department of Health's central grant programmes for the voluntary sector**, currently worth a little under £25 million (and which have had no inflation uplift in their history). These programmes are subject to the current DH-led VCSE review, which is expected to recommend reforms to improve the targeting of funds and their alignment with the Government's objectives. We support this review and believe that it should inform the Department's decisions following the Spending Review.

While grant funding plays a vital role in supporting the sustainability of the voluntary sector, it is also important that our sector is able to experience a level playing field in commissioning, so that our full potential to support better health and care can be realised.

A better overall relationship between commissioners and the voluntary sector is a goal of the Five Year Forward View and one key strand of the VCSE review. We think that the Spending Review could helpfully reinforce the changes required.

Finally, please do not ignore the **wider impact on health and wellbeing of changes in the funding and organisation of public services, of reforms to benefits and of other economic policy changes**. Our members have direct experience of the effects of austerity in recent years. There has been a negative impact on the physical and mental health of parts of the population, which if not addressed, will increase demand for NHS services. The Spending Review offers an opportunity to take a holistic approach. We think that patients would benefit greatly if during this Administration you and your ministerial colleagues would engage a forum of voluntary sector and civil society leaders to help you consider such matters on a cross-departmental basis, building on the excellent example of the Department of Health's voluntary sector strategic partners.

I am copying this letter to the Prime Minister, Chancellor, Chancellor of the Duchy of Lancaster, Secretary of State for Health, Secretary of State for Work and Pensions, and Secretary of State for Communities and Local Government.

I am also copying this letter to the chief executives of NHS England and Public Health England.

Yours sincerely,

Jeremy Taylor, Chief Executive, *National Voices*
Robert Johnstone FRSA, Chair, *Access Matters*
Jeremy Hughes, Chief Executive, *Alzheimer's Society*
Federico Moscogiuri, Chief Executive, *ARMA*
Judi Rhys, Chief Executive, *Arthritis Care*
Dr Liam O'Toole, Chief Executive, *Arthritis Research UK*
Sue Millman, Chief Executive, *Ataxia*
Professor Frank Chinegwundoh MBE, Chair, *Black Cancer Care*
Robert Dixon, Chief Executive, *Bladder and Bowel Foundation*
Caroline Davey, Chief Executive, *BLISS*
Joy Warmington, Chief Executive, *BRAP*
Mike Hobday, Director of Policy, *British Heart Foundation*
Fiona Loud, Policy Director, *British Kidney Patient Association*
Andrew Langford, Chief Executive, *British Liver Trust*
Jane Lyons, Chief Executive, *Cancer52*
Alison Cook, Director of Policy and Press, *Cancer Research UK*
Dr James Partridge OBE, Chief Executive, *Changing Faces*
Amanda Batten, Chief Executive, *Contact a Family*
David Barker, Chief Executive, *Crohn's and Colitis UK*
Sue Bott CBE, Deputy Chief Executive, *Disability Rights UK*
Diana Perry, Chief Executive, *Ectodermal Dysplasia Society*

Arthritis and Musculoskeletal Alliance – Written evidence (NHS0087)

Jane Hudson Jones, Chief Executive, *Endometriosis UK*
Paul Declé, Coordinator, *Forum Link*
Chris Whitwell, Director, *Friends, Families and Travellers*
Caroline Morrie, Chief Executive, *GAIN*
Malcolm Alexander, Chair, *HAPIA*
Heidi Wilson, Chair, *I Have IHH Foundation*
Nick Turkentine, Chief Executive, *James Whale Fund for Kidney Cancer*
Jane Dunnage, Chair, *Lupus UK*
Jane Collins, Chief Executive, *Marie Curie*
Jenny Edwards CBE, Chief Executive, *Mental Health Foundation*
Wendy Thomas, Chief Executive, *Migraine Trust*
Sophie Corlett, Director of External Affairs, *Mind*
Michelle Mitchell, Chief Executive, *MS Society*
Debbie Cook, Chief Executive, *National Ankylosing Spondylitis Society*
Amanda Allard, Assistant Director, *NCB*
Claire Henry, Chief Executive, *NCPC*
Ailsa Bosworth, Chief Executive, *NRAS*
Kath Parson, Chief Executive, *Older People's Advocacy Alliance*
Steve Ford, Chief Executive, *Parkinsons UK*
Sue Farringdon, Chair/Chief Executive, *PiF/SRUK*
Tess Harris, Chief Executive, *Polycystic Kidney Disease Charity*
Mark Winstanley, Chief Executive, *Rethink Mental Illness*
Alex Fox, Chief Executive, *Shared Lives Plus*
John Murray, Director, *SHCA*
Wendy Hughes, Founder and Hon President, *Stickler Syndrome Support Group*
Jon Barrick, Chief Executive, *Stroke Association*
Preth Rao, Assistant Director Policy and Campaigns, *Sue Ryder*
Barbara Gelb, Chief Executive, *Together for Short Lives*
Liz Felton, Chief Executive, *Together UK*
Barbara Babcock, Chair, *Transverse Myelitis Society*
Silvia Petretti, Chair, *UK CAB*
Jasmijn De Boo, Chief Executive, *Vegan Society*

23 September 2016

Association of Anaesthetists of Great Britain and Ireland – Written evidence (NHS0114)

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) is the professional membership organisation representing almost 11,000 anaesthetists, the largest speciality group of doctors in the NHS.

This response is submitted on behalf of the Board of the AAGBI as an overview. A separate and complementary response has been submitted by the GAT (Group of Anaesthetists in Training) Committee which represents over 3,500 anaesthetic trainees within our membership.

In preparing the responses, we have used both our professional experience and knowledge of relevant processes and data, our insight as members of NHS staff and also our experience as members of the public. We believe that all these perspectives are relevant.

Questions

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

1.1. Medical innovation will continue both at home and abroad. Expectations from the public and patients will rise. Demographic changes will continue to impact on patients and the medical workforce.

1.2. The single biggest challenge facing the NHS is to respond to the vastly increased demands of an ageing patient population and workforce. Two thirds of patients staying in hospital have contact with anaesthetists, the specialist doctors who make up the largest group of hospital doctors (16% of NHS consultants). As well as anaesthesia for elective surgery, these doctors also deliver acute and emergency care to patients, particularly at night and weekends. A 28% increase in the number of consultants aged over 50 years is forecast. Adjustments in working patterns will be needed by an ageing NHS workforce. [see *Anaesthesia News* special issue: *Age and the Anaesthetist* August 2016 <http://www.aagbi.org/AgeandtheAnaesthetist>].

1.3. Life expectancy is continuing to rise resulting in an increase in the elderly population. With this the burden of long-term conditions will rise, such as diabetes, obesity and heart disease: there will be more older patients with multiple co-morbidities. It is unrealistic to expect to fund this within the current budget and without change and innovation in the way services are delivered.

1.4. These demographic changes will make a significant difference to the number of patients requiring the services of an anaesthetist. Healthcare systems should ensure that there are

sufficient fully qualified specialists in anaesthesia and intensive care to deliver the amount of care needed. Pre-operative preparation, including exercise training, less invasive surgery, early postoperative mobilisation, and rapid return to the familiar environment of home all make positive differences to patient outcomes.

1.5. As well as demographic changes, generational attitudes will have a significant impact. The baby boomer generation will soon become the 'old'. They will expect high quality care to be delivered quickly and efficiently and be less prepared to wait than are the current 'old' who were born before the inception of the NHS. In short they will be much more demanding as patients.

1.6. At the same time, within the medical workforce generation x and generation y are less likely to show the same level of loyalty to the service, more likely to work part time or to leave the service, and unlikely to stay on in organisations that value their contributions.

1.7. The ageing population will need better 'joined up' services, 'one stop' centres for the elderly, easily accessible, parking etc. Many large hospitals are difficult for elderly and infirm people to negotiate and should be re-designed to be easily accessible.

1.8. Integration of primary and tertiary care would remove many of the practical barriers encountered in providing sufficient beds for those needing tertiary care. For instance, patients who need social care services cannot be discharged at the weekend when there is no access to social care. If a general practitioner looked after a patient in their last few days of a hospital stay and in the first few days in the community, the patient's needs would be better managed. Currently, there are some intermediate care hospitals looked after by primary care physicians, which provide good quality care for those no longer needing the resources of the tertiary care environment, but these are by no means universally provided.

1.9. Another aspect of care in need of attention is the use of Accident and Emergency departments. Co-location of a GP surgery, fully staffed with a mixture of nurses and general practitioners might go a long way to reducing the almost overwhelming numbers of patients that A & E services are expected to manage.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

2.1. The current funding is not realistic to meet the challenges outlined above. In order to continue the current scope of work of the NHS, and meet societal expectations, huge investment is needed. The NHS cannot continue to provide the service it does without this. The service is already under pressure from staff shortages and under-recruitment.

a. Does the wider societal value of the healthcare system exceed its monetary cost?

2.2. Yes, society places a high value on a healthcare system based on the principle that it should be free at the point of need and not dependent on an individual's ability to pay. There are wider economic and social benefits of investing in the nation's health; for instance, a healthier and more productive and economically active workforce.

b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

2.3. The status quo is not financially sustainable. There is a requirement for greater funding for both infrastructure and staffing. There is a choice to be made: dramatically increase funding of the NHS, invest in infrastructure and staffing and continue to provide all the services the NHS does or cut services to make the NHS more affordable. We need honest conversations with the public about this choice and what is affordable, and what options are available to fund our national healthcare services. A long-term financial strategy for a sustainable healthcare system should be created with cross party support. The NHS needs to be safeguarded from continual changes in government policy and incessant re-organisation with its associated costs.

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

2.4. Co-funding could allow patients and the public to value the treatment and engage better with it. An example would be better weight loss in bariatric patients with a gastric band performed privately rather than on the NHS.

2.5. Any increases in taxes would have to be met with a clear picture of how the money would be spent, and measurable, publicised outcomes demonstrating that the aims are being met or it will be seen as an underhand method by the government to fund other expenditure. Locally raised taxes for specific regional problems may be more acceptable to the population.

d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

2.6. Yes. High quality emergency care, free at the point of delivery, must remain at the heart of the NHS – something we are rightly proud of. But it is time for a rational, well conducted and researched public debate about other non emergency healthcare services. We need to challenge unrealistic expectations of what can be done, especially for the old and infirm, and about the extent and scope of what can be provided freely for all patients. Should we, for instance, be providing the more elective and to some extent cosmetic procedures for patients when we have long waits in emergency departments? Should we restrict cosmetic surgery on the NHS? Might we look for at least co payment for more elective procedures?

2.7. From our clinical experiences these sorts of questions must be asked if the scope of what is provided is to be limited. Overall, we would favour consideration of patient need rather than financial means testing of individuals.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

3.1. The recent [RCoAs' Workforce Census](#) indicated insufficient new consultant anaesthetists joining the NHS anaesthetic workforce to meet the future patient demand predicated by the Centre for Workforce Intelligence. Unless this is addressed by 2033, there could be a shortfall of 33% in the consultant anaesthetist numbers required to maintain expected levels of safe and effective healthcare.

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

3.2. Entry into medical school remains fiercely competitive. Many UK students who do not meet the stringent UK entry requirements undertake courses abroad, and yet make good UK doctors. A 10% increase in medical student places would broaden opportunity.

3.3. Recently, a medical school has opened in the UK which will only take non UK entrants due to the way that UK medical school places are funded. What is the scope for introducing 'private' medical schools for those who can afford to pay?

3.4. Overseas recruitment is likely to become increasingly problematic. Many more medical graduates from the Indian subcontinent and South East Asia elect to remain there – indeed several UK universities have campuses in South East Asia. What is needed is a much better understanding of the true future need for healthcare professionals – worked out on a sessional basis and not on a 'full time equivalent headcount'. It is likely that many more of generation X and Y will work what is now regarded as 'part time'.

3.5. The NHS will need to retain older workers in order to have sufficient staff to meet ever-increasing demands.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

3.6. With 'Brexit', working in the UK may become more difficult. About 10% of doctors come from the EU. Furthermore, some who do not get into medical school in the UK do their primary degree in English, but in an EU country. If fees go up to a point where this becomes prohibitive [they are currently in the range of 1,500 – 9,000 Euros], this supply of doctors will dry up. In the event of leaving the EU we may be able to attract back doctors from the Indian sub continent who left when EU workers gained priority over them regardless of qualifications. Many will now be working in other countries with similar health care systems.

3.7. Visa restrictions have made it more difficult for non-EU staff to work in the NHS, resulting in problems; overseas staff may wish to work for short periods in good, well regulated jobs, with appropriate supervision and training, to enhance their skills and career opportunities at home. In the past, this both helped our workforce and enhanced our knowledge of overseas practice. With so many gaps in rotas throughout NHS, this supply of overseas, often temporary, workers has been lost. The alternative is to train more staff: doctors, nurses etc in the UK, which may cost money, but is a more permanent solution.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

3.8. Retention is crucial, associated with this is maintaining good staff morale. Recent

contract disputes, and the increasing workload with no extra resource have impacted on morale. This will make it more difficult to recruit and retain staff: junior doctors may go abroad and senior doctors may retire early. Being valued at work and having a sensible work-life balance are key issues for doctors, particularly from generations x and y.

3.9. Current workforce planning is largely done by the ‘baby boomer’ generation, for whom hard work, ambition and loyalty were key career drivers. Yet the people involved in delivering these plans are generations x and y, for whom loyalty is not important. This generation does not stay long in bad jobs, want a good working atmosphere & a family friendly environment and value co-operation, communication and encouragement. Consultant jobs as they are currently arranged may not, in the long term, be attractive to the next generation of doctors. What is needed is a review of the amount of healthcare likely to be required not in terms of ‘whole time’ jobs, but in terms of ‘days worked’.

3.10. Training 10-20% more doctors, more of whom work part time, is more likely to provide the quality of life that generations x & y expect.

3.11. For more senior doctors, there is expected to be a significant impact from the lowering of the lifetime pension allowance to £1million. With the current contract, many people will reach this level of contribution in their mid to late 50s. Some may stay on and just leave the pension scheme; others may elect to retire at this point and yet others may move to working part time. Depending on the outcome of contract negotiations, the combined impact of the lowering of the lifetime allowance and of the annual allowance could lead to a significant diminution in the number of sessions worked [see Pandit, J.J. ‘Pensions, tax and the anaesthetist: significant implications for workforce planning’. In *Anaesthesia* 2016,71,883-891].

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

c. What investment model would most speedily enhance and stabilise the workforce?

4.1. A mix of pay and benefits, which should include training packages, would be effective. Reward clinical work above managerial to keep experienced staff working in clinical areas. It would help if the Government were more respectful of NHS workers; at present ministers seem quick to criticise, slow to praise. A feeling of being valued would mean more staff stay in the UK.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a. What are the key elements of a public health policy that would enhance a population’s health and wellbeing and increase years of good health?

6.1. Better engagement in management of obesity, the importance of exercise and of a healthy diet. Incentives that encourage employees to take time out of their working day to

do exercise, even if only for those working in healthcare settings and in the civil service, would be one way of demonstrating the government's commitment to this agenda. In the UK public health measures are sometimes criticised as the behaviour of a 'nanny state'. This attitude may have to be challenged. Health inequality is a reality. Some families have problems raising children in a way that offers them reasonable opportunities in life. Directing more resource to disadvantaged families, particularly in the early years from birth, is crucial for lifetime health.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

b. What is the role of 'Big Data' in reducing costs and managing demand?

8.1. 'Big data' in terms of national audits has been very effective in informing a more consistent and more effective approach to management of patients undergoing emergency laparotomy and those with fractured neck of femur. Attention to detail, good technique and facilities and resources to promote rapid mobilisation and recovery will, over time, lead to a reduction in costs from longer term care and rehabilitation.

c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

8.2. The NHS is a professional bureaucracy, where frontline staff has control over work content, and more influence than those in authority on day to day decisions such as how to treat a particular patient. In this context, leaders have to negotiate changes rather than impose them, hierarchical directives have little impact. Factors influencing change are:

- Positional power is not always followed or respected
- Influence is more significant in achieving change
- Professional networks & peer pressure are important
- Professional credibility is important

23 September 2016

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT) – Written evidence (NHS0115)

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) is the professional membership organisation representing almost 11,000 anaesthetists, with the GAT (Group of Anaesthetists in Training) Committee being the directly elected representative body for over 3,500 anaesthetic trainees. This response has been prepared by the elected members of the GAT Committee. We have used both our professional experience and knowledge of relevant processes and data, our insight as members of NHS staff and also our experience as members of the public. We believe that all these perspectives are relevant.

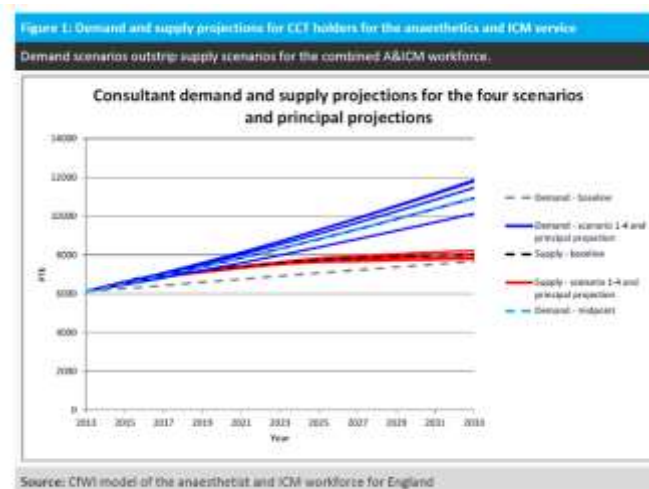
Submitted by Dr Emma Plunkett, GAT Chair

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

1.1. The NHS is constantly adapting to meet the needs of the population. New technologies and therapies are regularly introduced and staff adapt to these changes. We can predict some “knowns” about the future needs of the population – increased longevity and increased co-morbidities, such as obesity for example. However, there are likely to be “unknowns” that appear and we need to encourage innovation, recognise and value the expertise and diligence of NHS staff, and empower them to be able to do their best and adapt to changing conditions. Well-trained, resilient staff with appropriate resources will ensure sustainability of our world-class healthcare system.

1.2. In terms of the specialty of anaesthesia and intensive care, the Committee Centre for Workforce Intelligence (CfWI) predicted that an increasing demand for healthcare indicated a need to expand numbers of anaesthetists to meet this.



1.3. As staff working in anaesthesia in the NHS, it feels like theatre efficiency is hampered by lack of available hospital beds. Despite efforts to focus on this, there remain a proportion of patients within each hospital who are awaiting discharge due to lack of social care packages

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or placements. Efforts to reduce this bottle-neck will become more important in the future with increased longevity of the population.

1.4. We also need better communication between all aspects of health and social care. This will be helped by the introduction of electronic records, available at all times but more work needs to be done to link primary, secondary and social care.

1.5. Increasing involvement of patients in decisions affecting their health has to be central to the future NHS. This should be on both a population basis, with continued work on public health and primary prevention initiatives, and also on an individual basis. We need to make it easy for the population to make sensible health choices.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

a. Does the wider societal value of the healthcare system exceed its monetary cost?

2.1. Yes. One of the defining characteristics of our nation is how we care for sick and vulnerable members of society. Accessible, high quality healthcare is a key priority for everyone and the NHS provides us with an unrivalled system that gives universal access to healthcare. We firmly believe that the value of the NHS lies in removing personal finance from any decision regarding the healthcare of one's family. The importance of a healthcare service that is free at the point of delivery should not be underestimated. GAT holds the view that the value of this certainly outweighs the cost.

b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

2.2. Our current NHS funding sources comprise general tax, National Insurance and a much smaller proportion from patient payments (<http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/how-nhs-funded>). A funding system that is consistent and protected from macroeconomic fluctuations would be ideal.

2.3. Governments are under constant pressure from increasing health expenditure. There are 3 options: containing costs (by reducing services or creating efficiency savings), increasing expenditure or a combination of both. If expenditure is going to increase, the Government will have to raise available revenues.

2.4. Revenues can be sourced from taxation, compulsory insurance contributions, voluntary insurance premiums, individual savings and out-of-pocket payments. Quite often the source of revenue is a combination of the above. We realise the challenges for the Government but we believe that the public healthcare system funded principally via taxation should continue.

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

2.5. Hypothecated health tax: Overall, we think that a hypothecated health tax is a good idea, specifically as a way of reconnecting taxes and services. We agree with the benefits as outlined by the World Health Organisation:

2.6. Accountability and trust: Rather than paying taxes into a perceived black hole, hypothecated taxes provide taxpayers with in-built accountability for public spending. At times when a government is suspected of following its own agenda, this can help to restore trust between it and its citizens.

2.7. Transparency: Hypothecated taxes can educate people about the cost of particular services, such as healthcare. Taxpayers can then make better-informed decisions about the balance between tax burden and level of services provided. Health spending, in particular, has grown faster than GDP in many countries and the decision whether to go on spending ever more on health or whether to cut back on these services can be a tricky one for politicians. Paying for health through hypothecation allows governments to explicitly hand back that choice to the electorate and escape a potential political fallout.

2.8. Public support: In some cases, hypothecation can generate public support for tax increases. This is highly dependent on whether the service set to benefit from the earmarked tax is perceived to merit it. Education and health have consistently, and internationally, shown this potential and we believe that the public would likely respond to general tax increased more favourably if they had a guarantee that tax was being direct towards the NHS.

2.9. Protecting resources: Because of the relative public support for such spending, ministries of health are often in favour of hypothecated taxes for health. They see it as a way to ring-fence their resources from competing political interests and a way to by-pass budgetary constraints mandated by ministries of finance.

2.10. We also appreciate there are disadvantages, which include:

Exemption from review: Unsurprisingly, ministries of finance rarely endorse hypothecation as it undermines their mandate to allocate budgets as they see appropriate. It exempts the tax revenues in question from scrutiny and potential cuts that others are subjected to. There is also no obvious answer as to who should set rules on the level of hypothecation. Furthermore, when the hypothecation affects a large amount of public expenditure, as is typical for health, it can severely impact on other public spending should cuts be necessary.

2.11. Undermining solidarity: Financing from tax revenue is one of the major mechanisms allowing governments to achieve a fair distribution of the cost of healthcare. Some fear that specifying each individual's share of the cost vis-à-vis services received could undermine this solidarity.

2.12. Inappropriate funding levels: Hypothecated taxes are accused of linking spending not to the requirements of the services but to unrelated macroeconomic circumstances. Rather than determining health spending by how much a tax raises, it should be based on the health needs of the population. Severing this link between need and provision risks wasteful spending when the tax base is buoyant and insufficient budgets when it is depressed.

2.13. Tying the hands of government: By taking decisions on spending levels out of government discretion, hypothecating tax revenues constrains its ability to deal with

economic cycles.

2.14. Sin taxes: The continuing decline in smoking has been in part attributed to the effect of the tax on tobacco. There have also been calls to increase the taxation on alcohol to go some way to cover the estimated social cost of £21 billion. Sin taxation has also recently been extended to drinks with high sugar content. Whilst the idea of sin taxation is appealing with the dual effect of generating revenue and discouraging harmful behaviour, care has to be used, as they can be regressive. In addition, other activities which are deemed to be 'healthy' can also lead to increased healthcare resource use. For example, road running can lead to osteoarthritis necessitating a total knee replacement, or road cycling accidents leading to broken bones. Should these habits also be taxed? Overall, we think sin taxes are a good idea and could be extended within reason.

2.15. Inheritance taxes: Whilst the public might be willing to give up more of their inheritance if they knew it was going towards healthcare, it would be very difficult to create an accurate budget around this due to the fluctuating nature of inheritance.

2.16. Co-payments: Co-payments are a useful way of limiting inappropriate overuse of healthcare systems. However, if set too high they may also discourage people from accessing healthcare when genuinely necessary. As such, increasing co-payments would be an appropriate way of raising more revenue, but the targets for co-payment would have to be very carefully selected.

d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

2.18. A King's Fund report from 2013 suggests that the public still value the key NHS principles of high quality comprehensive care free at the point of use and would be somewhat resistant to limitation of services and means testing.

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/how-should-we-pay-for-health-care-in-future-kingsfund-apr13.pdf. However, limiting the services that the NHS offers is one way to continue to fund the NHS.

2.19. Consideration has been given in the past to restricting access to services where a patient's lifestyle choice has been implicated in their disease (e.g. smokers, obesity, and illicit drug use). However, delineating causation and denying care makes for uncomfortable denial of services for healthcare professionals within the NHS as it seems contrary to the fundamental principle of universality. Ethical debate about new treatments as they become available must continue and the threshold used by the National Institute of Health and Care Excellence to assess cost effectiveness of services could be increased to achieve this.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long-term needs of the NHS?

3.1. Please see the graph above (Q1) from the CfWI report regarding future requirements for anaesthesia and intensive care medicine. The full report can be found here: <http://www.cfwi.org.uk/cfwi-work/medical-and-dental-workforce-reviews/medical-specialties/anaesthetics-and-intensive-care-medicine-in-depth-review>. We need adequate numbers of junior doctors to meet this need and we also need adequate numbers to staff on call rotas and provide 24-hour care. The optimum situation would be a reduced reliance on locums, which are not cost effective, but are being used more frequently to meet gaps on rotas.

3.2. We also need to consider the implications of increased longevity on the workforce itself. This is discussed in depth in the latest edition of Anaesthesia News; “Age and the Anaesthetist”.

3.3. <http://www.aagbi.org/sites/default/files/AUG%20Anaesthesia%20News%20web.pdf>

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

3.4. Removing the pre-conditions for trainees applying to core training. (e.g. trainees who have ‘too much’ experience to apply to be a core trainee).

3.5. Increasing the number of trainees taken at core training level to account for the poor attrition rate at specialty training.

3.6. Improving morale amongst the junior staff already in the workforce, which will attract people into the profession as well as decrease the numbers of junior staff leaving the NHS.

3.7. Removing the barriers for less than full time training.

3.8. Given the large number of rota gaps, offering an attractive fee for additional hours may help bridge the gaps’.

3.9. Removing minimum salary requirement for overseas workers, as those in the nursing profession/LTFT doctors may not earn above the threshold to remain in the UK.

c. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

3.10. Whilst there are some overseas EU trainees, the main supply of overseas workers are for locum provision, nursing and Healthcare Assistant (HCA) posts. The supply of overseas doctors will be affected by decreasing locum rates as current rates may be unappealing, which will be compounded by the fall in value of sterling against the Euro. The nursing and HCA supply may decrease due to minimum salary requirements for immigrants.

d. What are the retention issues for key groups of healthcare workers and how should these be addressed?

3.11. The **attrition rate** from Core Trainee year 2 (CT2) to Specialty Trainee year 3 (ST3) in anaesthetics is of major concern.

3.12.

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http://www.aagbi.org/sites/default/files/Anaesthesia%20News%20JAN%202016web_0.pdf

(page 12-13) According to Royal College of Anaesthetists figures, there is around a 37% difference between trainees being appointed to core training posts in 2013 and those taking up ST3 posts in 2015. As to how this should be addressed, would depend on why we are failing to retain these trainees in Anaesthesia. It is currently unclear why these trainees are not taking up ST3 posts, whether they have gone abroad, doing a non-recognised training post due to lack of primary FRCA (an essential requirement) or whether they have decided to change specialty. The only accurate way to track this would be through the GMC database. Clearly, currently all trainees are under stress due to rota gaps throughout the UK and this may influence a trainee's decision to work abroad. At least part of the reason for the poor CT2-ST3 progression is likely to be exam failure, as this is a necessary component. So, increasing study leave budget and deanery support may help. Improving the terms and conditions for medical staff will help with retention, for e.g. providing workable rotas well in advance and honouring rota requests.

3.13. The increased **feminisation** of the medical workforce but the lack of support for and availability of flexible or part time working options is another key concern. The new junior doctors' contract is known to disadvantage this group of doctors and this is likely to hamper future recruitment and retention.

3.14. Finally, we need to address the issue of an **ageing** workforce and how we can support older consultants to continue to work, whilst protecting them from the effects of fatigue. Changes to the NHS pension scheme, with limits on the tax free lifetime allowance, will impact on the financial viability of people working later in life and have significant implications for the NHS consultant workforce. This editorial in Anaesthesia explains the issue: <http://onlinelibrary.wiley.com/doi/10.1111/anae.13579/full>

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

4.1. With regard to anaesthesia, there are clear training objectives to be met at each stage of training, including Royal College of Anaesthetist examinations that are required to be passed. The curriculum provides a broad training with flexibility to produce both general and specialist anaesthetists. We believe that it is fit for purpose. Increasing amounts of education and training could be delivered remotely, via webinar or webcast. However, many departments have inadequate IT support available to trainees and the availability of computers and printing facilities can be extremely variable.

4.2. There are various online tools available to help with rota planning, potentially these could be used to identify rota gaps early and help the workforce by providing early information about on call requirements.

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT) – Written evidence (NHS0115)

4.3. According to data recently published by the Royal College of Anaesthetists this year, for the first time, Anaesthesia had a 90% fill rate. This means that 10% of posts were not filled. These rota gaps will have to be filled by locum doctors. By making the training posts more attractive to trainees, the rota gaps created by this lack in recruitment would not exist. As locum doctors cost more than those in a training post the NHS would be better to invest money in recruitment of trainees, and making the NHS an attractive place to work, which may make emigration a less attractive option.

c. What investment model would most speedily enhance and stabilise the workforce?

4.4. Investing in a stable junior doctor workforce in order to ensure supply of consultants in the future both costs less than reliance on locums to fill rota gaps and ensures future sustainability. This means expansion of the numbers of anaesthetic training posts.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

5.1. A high quality, integrated and efficient health and care service will improve care for patients. Organisations will work better together if they understand each other's perspective and roles and see that working together provides mutual benefits.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a .What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

6.1. Engage with schools and do more to tackle obesity, prevent smoking and stress the dangers of drugs and alcohol.

6.2. More programmes such as vaccinations for babies and children and dispel myths regarding the dangers of vaccines which have since been disproven.

6.3. Increase taxation on cigarettes, alcohol and unhealthy food.

6.4. learner labels on packages regarding the salt, sugar and fat content – penalties for company who fail to engage with this and rewards such as tax relief for companies that show willingness to engage.

6.5. Less appealing packaging for cigarettes, alcohol and unhealthy foods, with more stringent rules for advertising on posters/TV.

6.6. More emphasis on screening – both encouraging public to engage with screening programmes and more money to develop more screening programmes.

6.7. Contacting patients regarding screening programmes etc with different methods of

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT) – Written evidence (NHS0115)

communication e.g. post, text and email.

6.8. Emphasis on allowing local authorities to use money from government to develop health schemes that are more relevant to the local population e.g. if high population of diabetic patients, use local money to focus on management of diabetic patients.

6.9. Subsidise gym memberships for those overweight and obese; continue to subsidise in those who engage.

6.10. Companies having to provide information to new employees regarding the health benefits they provide

6.11. Provide patients when discharged from hospital and A&E or when seeing GP, a bill with how much the visit costs so patients have a better idea/understanding of how much healthcare costs.

6.12. More advertising and use of social media to increase public awareness regarding important health issues and health websites approved by NHS e.g. Change4Life etc.

6.13. Organising local discussion groups to see what patients in the local community want from their local health care services.

6.14. Funding for and emphasis on looking after patients with chronic illness in the community and within primary health care e.g. using COPD nurses, diabetic nurses etc. so there is less pressure on the OPA within the hospitals – regular follow ups will help to prevent disease progression.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

8.1. Telecare (network devices to monitor patients in their own home, connected to centre via call system)

- Reminders for patient medication administration, for example pre-operative medication or fasting guidelines may prevent cancellations of surgery, and post-operative analgesia reminders may help patients to get home more quickly after surgery. This would improve efficiency.
- Telecare systems may allow patients to remain in their home and reduce the cost and demand for social care provision. If social care is required, it can be more efficiently tailored to individual patients.

8.2. Telehealth (ability to measure patient vital parameters whilst at home)

- The use of telehealth devices may allow earlier assessment/triage prior to admission including early assessment at home and prevention of the need for admission.
- If hospital admission is required, potential for early treatment and avoidance of higher levels of care.
- Earlier discharge may also be possible, if remote follow up using telecare is possible.

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8.3. Wearable tech (any wearable piece of technology inc. fitness trackers)

- Increase in availability of activity trackers may lead to increased activity levels and reduced burden of obesity related issues
- Ability to non-invasively measure health parameters such as blood glucose may improve stability and efficacy of chronic illness therapies, thus improving general health.
- Devices may be instrumental in habitual activities e.g. smoking cessation, diet control, physical activity – this may help with pre-optimisation for surgery and reduce postoperative morbidity.

8.4. Genetic medicine

- Potential for early identification of disease risk and preventative management in a targeted manner
- Potential for reduction in cost of disease treatment due to prevention
- Ability to plan services around specific requirements of local population, many years in advance.

b. What is the role of ‘Big Data’ in reducing costs and managing demand?

8.5. There is an incredible volume of data (patient vitals, disease progression, surgical procedures, and consumable usage) collected in the NHS on a daily basis, which has the potential to be used to shape the future care of individual patients. At present, we lack structure for much of the data collected, which can be problematic. Data use is mostly restricted to within the institution it is collected and increasing data sharing within the NHS (not with private entities) on a national scale may allow more efficient treatment of rare, but expensive, conditions.

8.6. Integration of data collection and display systems throughout the NHS will allow development of specific services in particular areas relative to demand. Clinical risk intervention and predictive analytics will allow individualised treatments and more rapid assessment/resolution of chronic disease.

8.7. Electronic data collection and storage, including in the cloud, will reduce the environmental burden of the NHS, reducing paper and stationary usage

c. What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

8.7. Cost; information governance / law; data quality, inaccuracies are magnified as dataset size increases; structure of datasets, intelligent tools are required for verification of data accuracy and believability.

d. How can healthcare providers be incentivised to take up new technologies?

8.8. Increased funding for new technologies

8.9. Positive publicity if provider uses technology

8.10. Internationally recognised research to show benefit

8.11. Grass roots action – get junior doctors/nurses on side with new technology

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8.12. Streamline processes, increase availability of new tech vs old tech

8.13. Remove barriers to using/applying new technology

e. Where is investment in technology and informatics most needed?

8.14. Social care / care in the community

8.15. Hospital / GP record keeping

8.16. Anaesthetic / Peri-operative record keeping including pre-op assessments

8.17. Making this information easily accessible to the staff who needs it (who may work in different organisations) and yet maintaining security is crucial.

23 September 2016

The Association of the British Pharmaceutical Industry – Written evidence (NHS0167)

The Association of the British Pharmaceutical Industry (ABPI) represents some 200 innovative research-based biopharmaceutical companies, large, medium and small, leading an exciting new era of biosciences in the UK. These companies, along with the wider life sciences sector, make a major contribution to the UK economy. The sector:

- Invested £4bn in research and development in 2014, more than any other sector¹⁶³;
- Has a turnover of more than £60bn a year¹⁶⁴, generating exports worth £30bn and a trade surplus worth £3bn¹⁶⁵;
- Employs 220,000 people, two thirds of who live outside of London and the South East.

Our industry brings life-saving and life-enhancing medicines to patients. We represent companies supplying the majority of branded medicines used by the NHS, and are researching and developing the majority of the current medicines pipeline, ensuring that the UK remains at the forefront of helping patients prevent and overcome diseases.

In this capacity we are acutely aware of the need to sustain a well-funded, efficient and outcome based NHS that delivers for patients in the UK. We are pleased to have the opportunity to provide evidence to the Select Committee. We have chosen to answer most but not all of the questions outlined in the Call for Evidence paper.

Industry is very aware of the challenging financial position facing the NHS, and wishes to continue to play a role in supporting the NHS to improve patient access to innovative treatments. We recognise the value of a negotiated and collaborative approach between industry and Government on medicines policy.

Key points

- Recognising the financial challenges facing the NHS, the ABPI negotiated a five year agreement with Government to cap and underwrite growth in the branded medicines bill and to refund NHS spend in excess of the agreement. This should allow clinicians to prescribe new medicines to patients on basis of clinical need alone, rather than cost, but access remains low and slow.
- The medicines assessment system must evolve to be able to effectively assess medicines with smaller patient populations and to take into account the wider societal benefits of

¹⁶³ Office for Life Sciences, "Life Sciences Competitiveness Indicators" (May 2016), p. 25

¹⁶⁴ House of Commons Science and Technology Committee, "EU regulation of the Life Sciences", 11 June 2016, p.3.

¹⁶⁵ ONS Balance of Payments data, (2015), provided by Office for Life Sciences in "Overview of the Life Sciences Sector", August 2016, p. 2.

those medicines.

- More flexible reimbursement models, such as outcomes based models, for medicines would allow the NHS to improve patient access to those medicines while ensuring costs remain sustainable.
- The primacy of licensed medicines must be respected in order to ensure patient safety and the efficacy of treatment.
- Vaccinations are an important public health intervention and investment must be maintained.
- Better use of health data is welcome and would allow for more innovative reimbursement models along with a better understanding of existing treatments, improving outcomes for patients.

1. How must health and care systems change to cope by 2030?

The aging population, with increased life expectancy due to healthier living and innovative treatments, means that the UK health and care systems face increasing pressure.

Medicines are becoming more ‘specialised’ and increasingly targeted at smaller groups of patients. The aim is to improve patient outcomes, but a consequence of smaller patient numbers is that it becomes increasingly challenging to conduct clinical trials which demonstrate the cost effectiveness or clinical effectiveness of the medicine. As targeted treatments, including gene therapies and immunotherapies, become more common, the medicines assessment system will need to adapt in order to make them available to patients.

The UK lags behind comparably developed countries in allowing early patient access to the latest medicines, with UK use of the newest medicines only 15% of the average use in comparable countries in the first year after launch¹⁶⁶. If we want the UK health system to remain one of the best in the world, then this disparity must be addressed. Both the Five Year Forward View and the Accelerated Access Review seek to accelerate patient access to cost-effective innovative medicines.

It is important to view medicines as an investment, not simply a cost. Investing in new medicines has wider benefits for UK growth and productivity through improving the quality of life of patients and supporting them back to work.

It also creates a virtuous circle, supporting and encouraging the life sciences sector in the UK where 25% of the world’s current top prescription medicines were discovered and developed¹⁶⁷.

¹⁶⁶ Office for Life Sciences, *Life Science Competitiveness Indicators* May 2016

¹⁶⁷ BMI Research, “United Kingdom Pharmaceuticals & Healthcare Report, Q1 2016”, p. 61

To remain sustainable in the future, the NHS will need to consider the contribution it can make to the wider UK economy through this virtuous circle. By creating a seamless pathway from the lab bench to the patient bedside, pharmaceutical companies will be more willing to invest and patients will benefit from increased access to medicines. Supporting research, innovation and growth in this way is one of the seven objectives in the Government's Mandate to the NHS.

The NHS must also address the issue of decommissioning: it is widely recognised that there needs to be more rapid decommissioning of cost-inefficient interventions and pathways. In our members' experience there is often the lack of a strong project management skill set locally to enable change at pace and scale so that the benefits of decommissioning and development of new pathways and services that are more efficient and better meet patients' needs can be maximised.

2. To what extent is the current funding envelope for the NHS realistic?

UK spend on healthcare as a share of GDP is lower than most developed countries, and within this the UK also spends a relatively low share of healthcare spend on medicines¹⁶⁸. Inevitably this has led to a challenge in the uptake of and patient access to new medicines.

The UK is generally slow to adopt newer medicines, even those with a positive NICE recommendation¹⁶⁹, and budget constraints at a local level in the NHS can lead to a 'postcode lottery' in the use of medicines across different NHS organisations¹⁷⁰.

Recognising the financial challenges facing the NHS, the ABPI negotiated a five year agreement with Government. Under the 2014 PPRS (Pharmaceutical Price Regulation Scheme), industry committed to underwriting growth in the branded medicines bill and to refund the difference in spend back to the Department of Health.

This scheme has given Government a more predictable branded medicines bill and should have allowed NHS commissioners and clinicians to make prescribing decisions on the basis of clinical need rather than cost. However, the agreement has not been utilised as effectively as the industry hoped, with patient access to new medicines remaining low and slow.

In answer to specific questions in the consultation document:

- a. The wider societal value of the healthcare system must be taken into account in determining the right investment in healthcare and the NHS. This is especially true for medicines, where cost effectiveness is determined by the Quality Adjusted Life Year (QALY) but does not take into account additional benefits such as supporting the individual to return to work, the impact on carers or the time and resources

¹⁶⁸ OECD (2016), Pharmaceutical spending (indicator). Accessed on 20 September 201

¹⁶⁹ Office for Life Sciences, *Life Science Competitiveness Indicators* May 2016

¹⁷⁰ Health and Social Care Information Centre/NHS Digital, *Innovation Scorecard* May 2016

saved by treatments administered in the home or community rather than in hospitals.

- b. The NHS and the pharmaceutical industry both recognise the need for more innovative and flexible funding and reimbursement arrangements. It is likely that simple purchasing arrangements and the buyer/supplier relationship will not be adequate in future. ABPI proposes that discussions be opened on the compatibility of current patient access scheme (PAS), PASLU operations, and the desire for more flexibility in commercial arrangements being driven by NHS England. For example: Multi-indication Pricing (MIP) is one area that is being adopted by most other advanced health systems around the world and will be necessary to support the introduction of many new cancer treatments.

- b. It is important to take a whole system approach to ensuring that money is being spent effectively. Medicines spending is visible and easy to separate out from wider health spending, which can make it a tempting and easy target for short term cost savings. However some of the bigger challenges the NHS faces are in restructuring or reforming patient pathways and services, which are harder to target short term.

In exploring potential solutions it is also important to respect the primacy of licensed medicines, which ensures that unlicensed or off-label medicines are only prescribed on the basis of clinical need. Prescribing off-label medicines without a medical rationale but rather for economic reasons and where licensed alternatives exist, puts patients at risk, undermines the integrity of the regulatory approval system, and is in contradiction to EU law.

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

Vaccination has saved more lives and prevented more serious diseases than any advance in recent medical history¹⁷¹. As part of ensuring the NHS is a preventative treatment service, we must ensure that investment in vaccinations is maintained.

The Government commissioned the Cost-Effectiveness Methodology for Immunisation Programmes and Procurements (CEMIPP) Review is looking into whether the methods that NICE uses are appropriate for vaccination and immunisation.

To maintain access to vaccinations it is imperative that the threshold value at which vaccines are considered cost-effective should remain the same as that which is currently applied to both vaccines and medicines. To improve the assessment of vaccinations, the

¹⁷¹ NHS Choices. <http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-saves-lives.aspx>

ABPI recommends that the wider societal value of vaccinations is taken into account and the long-term benefits of vaccination programmes are more highly valued.

A longer-term vision of healthcare is also needed across the whole health system. In a tight fiscal setting, inevitably, the NHS is taking a short term budget focus, yet the health of the nation will require a more long term outcome based focused, which may require investment to realise long-term savings.

8. How can new technologies be used to ensure the sustainability of the NHS?

The Accelerated Access Review calls for “better use of existing data assets”. The NHS should capitalise on its potential to act as a ‘single healthcare system’ to make it a global leader in using real world data.

Better use of real world evidence would allow for more innovative patient pathways to be created, facilitate the creation of more complicated reimbursement models and improve patient outcomes by increasing our understanding of treatments. Progress is already being made with data registries, like the Cancer Registry for the Cancer Drugs Fund, which can help to improve early access and accelerated access to new medicines.

There are already examples where the pharmaceutical industry is working with the NHS to invest in the technological infrastructure needed to realise improvements in patient outcomes. One way to improve NHS sustainability is to reduce the cost burden on the NHS through this kind of innovative collaboration.

NHS England could use a competitive advantage in data, to encourage increased company investment in the UK health sector. Better data makes the UK a more attractive environment for investment, clinical trials and this will lead to innovative treatments being available faster in the UK. This would help NHS England to meet its NHS Mandate objective and there are opportunities to trial this through health and social care devolution and the vanguards.

The UK also has an opportunity to lead in medical technologies of the future, e.g. genomics, digital health and cell and gene therapies (ATMPs). To realise these opportunities, the UK should invest in new technology capabilities to enable research breakthroughs to develop into commercial successes that benefit the UK and UK patients.

This would support newer, better and more efficient treatment within the NHS and support the wider economy to grow, contributing to potential Government investment in the NHS.

The UK should build upon the successes of schemes such as the Biomedical Catalyst, Cell and Gene Therapy Catapult and Precision Medicine Catapult to ensure the UK benefits from its discoveries.

27 September 2016

The Association of Child Psychotherapists (ACP) – Written evidence (NHS0066)

Long term Sustainability of the NHS: How can we ensure a sustainable future for the NHS?

About the ACP

The Association of Child Psychotherapists is the main professional body for psychoanalytic child and adolescent psychotherapists in the UK. It is responsible for regulating the training and practice standards of child and adolescent psychotherapy, provides information to the public about child psychotherapy and is working to increase its availability to children and young people within the public sector, including the NHS, schools and social services.

Members of the ACP work with children and young people, as well as their parents, families and wider networks. They work with some of the most vulnerable children and young people in society such as those who are looked after and adopted, which means they have the knowledge and experience as well as insight, to enable them to make informed decisions about effective treatment and support. They also play an important role supporting other professionals who work with children and young people, including teachers, social workers, youth workers and other mental health professionals. They do this through training, supervision and consultation.

Established in 1949, the ACP has over 900 members working in the UK and abroad. Child and adolescent psychotherapists who have qualified at one of our five recognised training schools are eligible for full membership of the ACP, which enables them to work with children in a range of settings and give expert advice and responses regarding child and family mental health related issues.

About this Response

The response was jointly led on behalf of the ACP by:

Heather Stewart

ACP Chair

Isobel Pick

Chair of the Training Council

Alison Roy

Media, Policy and Communications Lead

We hope you find our comments useful.

The Association of Child Psychotherapists response to the House of Lords Select Committee

Long term Sustainability of the NHS: How can we ensure a sustainable future for the NHS?

	<p><u>The future healthcare system</u></p> <p>Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?</p>
1.	
	<p><u>Resource issues, including funding, productivity, demand management and resource use</u></p> <p>To what extent is the current funding envelope for the NHS realistic?</p> <ul style="list-style-type: none"> a) Does the wider societal value of the healthcare system exceed its monetary cost? b) What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent? c) What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)? d) Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?
2.	<p>We would like to comment on mental health in particular but with a link to health care in general within the NHS.</p>

	<p>a) In short – Yes.</p> <p>The economic and societal costs of individuals being unable to access effective, timely treatment are huge. This is especially the case for mental health, which currently receives a fraction of health funding overall. It is hard to put an exact figure on what resources will be required going forward, but we would emphasise the need to invest in building services so that there is a provision for the right treatment to be available at the right time, this means having specialists as well as generic workers available to provide a choice of quality and evidenced treatments (as highlighted in the MH taskforce report, Future in Mind). This will save significant costs in the long run.</p> <ul style="list-style-type: none"> • The cost of mental health to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.¹ • Mental illness results in 70 million sick days per year, making it the leading cause of sickness absence in the United Kingdom.² • 44% of Employment and Support Allowance benefit claimants report a mental health and/or behavioural problem as their primary diagnosis.³ <p>b) We are concerned that mental health provision, despite recent promises of funding for CAMHS, does not seem to have had the positive and desired effect of increasing access to services and treatment for some of the most complex and enduring difficulties. Our members who are well trained and many of whom, occupy senior clinical posts, report that they are spending more than twice as much time as they were five years ago, completing administrative tasks and inputting data such as lengthy tick box risk assessments. Meeting the demands of “time hungry” IT systems is not a good use of a specialist staffing resources - already in scarce supply.</p> <p>We would also recommend a fairer system of funding across health and mental health. In terms parity of esteem, access to good and recommended treatments for mental health is key to recovery as with physical health. We would argue that mind and body could be better treated using a more integrated model of care and allocation of funds.</p> <p>c) The ACP has no comment to make here.</p> <p>d) We would recommend that services for those who need them are accessible and of the highest quality. We cannot comment on medical procedures but our members work in a range of settings such as community CAMHS, hospitals, cancer units, perinatal services, local authority projects and voluntary of private enterprises and we would advocate the provision of services to meet needs rather than the best service only being available to those with the ability to pay.</p>
	<p><u>Workforce</u></p> <p>What are the requirements of the future workforce going to be, and how can the</p>

	<p>supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?</p> <p>a) What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?</p> <p>b) What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?</p> <p>c) What are the retention issues for key groups of healthcare workers and how should these be addressed?</p>
3.	<p>The ACP would like to comment on mental health in children and young people more specifically but provision for this group affects future and more general healthcare costs.</p> <p>a) Not providing an adequate workforce now and going forward into the future, would have significant cost implications. In order save money in the long run, the workforce needs to have a good skill and experience base. Keeping current specialists in place, to provide training and supervision for more junior and less qualified practitioners. Career progression and learning from senior and experienced staff, is vital in order to maintain quality of care.</p> <p>Think Tank the Education Policy Institute (formerly Centre Forum) published its second report into children and young people’s mental health which looks into the progress made since the publication of <i>Future in Mind</i> and identified key barriers to the delivery of the transformation programme which relates to staff retention and how these should be addressed. ⁴</p> <p>Key findings include:</p> <ul style="list-style-type: none"> • 83% of trusts who responded said they had experienced recruitment difficulties. 80% of trusts had had to advertise posts on multiple occasions to fill roles, with mental health nurses being the most difficult profession to recruit, followed by consultant psychiatrists. • Recruitment challenges had led to an 82% increase in expenditure on temporary staffing in the last two years. In 15/16 nearly £50m was spent on agency staff by 32 trusts, an expensive solution which undermines continuity of care. However, there were significant regional variations in recruitment difficulties, with six areas (15 per cent) not experiencing any problems, in particular trusts in the Midlands and some Northern trusts. • Of the 122 published Local Transformation Plans, only 18 areas (15%) have ‘good’ plans. 85% required improvement. 58 (48%) plans ‘require improvement’ and 45 (37%) ‘require substantial improvement’. The report judged published plans on transparency; involvement of children and young people; level of ambition; early intervention, including links with schools and GPs, and governance. • For 2016/17 £119m has been allocated to local areas, but this has not been

	<p>ring-fenced, instead, it has been included in their total baseline allocation—specialist services also sit within a wider network of support from youth services to local authority funded charities and social care, meaning there is a risk that the overall budget for children and young people’s mental health may not increase or may even be reduced due to wider austerity measures.</p> <p>b) The ACP cannot comment on this.</p> <p>c) Retention issues for ACP members are affected by the demands on practitioners within the NHS as opposed to working in private practice or independently. We are aware that more members are reporting more difficult working conditions, with less opportunity for development and career progression. These could be addressed through better working conditions, more multi-disciplinary team support and approach to cases, with shared decision making and greater access to good supervision.</p> <p>On recruitment difficulties, the following passage from the report mentioned above states:</p> <p><i>“There are signs that recruitment difficulties will continue for the foreseeable future. Statistics from Health Education England show that in the August 2015 intake over half (51%) of ST4 (specialist training post) trainee Child and Adolescent psychiatry posts were unfilled. This means that there will continue to be significant shortages of consultant psychiatrists in future. According to Health Education England, providers’ plans for the mental health workforce “do not appear to represent the additional focus and resources we might anticipate in light of the policy around parity of esteem”. This may reflect concerns over commissioning plans over the period.</i></p> <p><i>“Planned changes to the training of health professionals could impact on the numbers coming into the workforce and therefore make matters worse.”</i></p> <p>After outlining the proposed reforms to funding for training and their stated purpose, the report notes:</p> <p><i>“The risk, however, is that the change from a grant to a loan will lead to a reduction in applications for these posts, further undermining the ability of providers to recruit for mental health nursing and allied health professional posts.”</i></p>
	<p>How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?</p> <p>a) What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?</p>

	<p>b) What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?</p> <p>c) What investment model would most speedily enhance and stabilise the workforce?</p>
<p>4.</p>	<p>Our overall statement in response to wider question is:</p> <p>The health and social care workforce appear to have ever demanding caseloads, thus making the training of specialists more important, in order to hold and manage high levels of risk and anxiety. This is especially the case within NHS CAMHS teams, where the are reported higher levels of stress and post retention difficulties. Specialists are needed in order that they can continue to train, support and supervise others both in health and social care. Many of our members provide support and consultation to social work staff in children’s homes, specialist LAC and adoption services and help social care staff manage the high level of complexity and vicarious trauma.</p> <p>We would therefore recommend greater clarity around protecting specialist NHS postgraduate trainings in order to maintain the quality of treatment on offer in health and mental health services. This would have a cost implication negatively if this training was removed. In the long run, this would create greater risk to staff and patients, and generate more complexities and costs around managing privately contracted specialists or consortiums who in our experience, can have a limited understanding of the specifics of the national legal framework and the local priorities.</p> <p>Helping social care practitioners understand their role in safeguarding through establishing relationships with families in need, rather than only with regards to reporting, is important. This also links to implementing the legal framework with regards to Section 47 and Section 17, helping social care workers understand their role in protecting children, not only the legal requirements but how to build a broader range of safeguarding skills, is key going forward.</p> <p>Our members report that fewer social workers appear to focus on core relationships with families and carers and work less in partnership with mental health professionals. Social work therefore appears to have become more focused on reporting risk and signposting, rather than building information through observation skills and completing good needs assessments. Many appear to not have the time or resources to understand the complexities of the families they work with.</p> <p>a) With regards to new technologies - these need to take on board the challenge of current technologies – our members report that many social workers use email as a therapeutic and social care tool, to inform others of risk, to update professionals and families but this creates its own demands and risks, but on time, but also means that detail can be lost. More safe, online supervision portals, questions and answer forums and access to senior staff on-line would be helpful for social care practitioners out in the community and support lone workers.</p> <p>b) With regard to cost implications and skill mix within the workforce, we are of the opinion that having the expertise of experienced or mental health specialists such as</p>

	<p>child psychotherapists, to support junior social care staff members, is needed, in order to decrease risk to children in the long run through a greater understanding of the underlying issues and prove to be more cost effective overall. This would also enable workers to adapt and respond to areas of difficulty which may be out of their area of knowledge and expertise, with access to specialist consultation when needed.</p> <p>We would also recommend more multi-professional training about the interpretation and implementation of legal frameworks to fit local areas and priorities, whilst learning from the approach and experience of others.</p> <p>In our opinion, inductions need to be better, with more information about local demographics and particular areas of need, to ensure that workers understand these and services operating in the area. Social workers are often expected to ‘hit the ground running’. The cost implications would mean more resources would need to be available to set systems up and provide the support infrastructure, but once these were in place, the cost would reduce and the cost saving effect of professionals working more closely together and training together, could be significant. Our members have reported some confusion though about the closure of family centres and the limited opportunities for early intervention, available in the community which once supported the role of social care staff and ultimately helped to free up more resources for higher risk and complex cases.</p> <p>d)The ACP advocates for investing in relationships as early as possible with families, making relationship focused practice a priority, integrating this approach into the training of staff, in order to build stronger and more meaningful connections with those in the greatest need. This would enable staff to gain a more in-depth understanding of the needs but also risk and what would be the best support/treatment package to implement.</p>
	<p><u>Models of service delivery and integration</u></p> <p>What are the practical changes required to provide the population with an integrated National Health and Care Service?</p> <ul style="list-style-type: none"> a) How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly? b) How can local organisations be incentivised to work together? c) How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?
<p>5.</p>	<p>a) The ACP is aware of members who have developed partnership working projects with social care, where they not only deliver therapy services in partnership with the Local Authority, but they share responsibility in terms of finances and budget planning. Our members work with networks and organisations to encourage shared decision making and reflective practice. This requires managers and commissioners to</p>

	<p>work together and agree shared goals and allocate resources together. This would be a recommendation going forward in delivering more cost effective but better integrated services where a deeper understanding of care and support can be achieved. We would be happy to provide details of these innovative projects if requested.</p> <p>b) National commitment and funding for good partnership models between health and social care would be an added incentive to encourage services to work together.</p> <p>c) As above.</p>
	<p><u>Prevention and public engagement</u></p> <p>What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?</p> <ul style="list-style-type: none"> a) What are the key elements of a public health policy that would enhance a population’s health and wellbeing and increase years of good health? b) What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this? c) Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing? d) Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how? e) By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care? f) What are the barriers to taking on received knowledge about healthy places to live and work? g) How could technology play a greater role in enhancing prevention and public health?
<p>6.</p>	<p>a –f) The ACP has no specific comment to make here, other than to highlight the importance of early intervention and the usefulness of combined assessments. Connected to this, is the importance involving children and young people (and their parents, where possible) to create environments where they can learn together and along-side each other, about health and mental health, with the support of specialists.</p> <p>g) Young people know how to use and make the most of technology but also find it hard to control and regulate their use of it. We would therefore recommend a</p>

	combined technology and face to face approach. Our members have reported that on-line treatments without additional input from a clinician, appear to have little impact.
	What are the best ways to engage the public in talking about what they want from a health service?
7.	In our experience, the best way to engage with the public is to ensure that people are listened to and have the opportunity to explain in their own way, what they think they need and what the main difficulties are – this requires time but can also save time in the long run. Providing good and detailed information about possible treatments will also enhance informed decision making, make waiting for treatments more bearable and empower those who currently feel let down and ignored by services.
	<p><u>Digitisation of services, Big Data and informatics</u> How can new technologies be used to ensure the sustainability of the NHS?</p> <ul style="list-style-type: none"> a) What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand? b) What is the role of ‘Big Data’ in reducing costs and managing demand? c) What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’? d) How can healthcare providers be incentivised to take up new technologies? e) Where is investment in technology and informatics most needed?
8.	The ACP has no comment to make here, but we do have members who are doing more research in this area and may be able to provide evidence at a later date.
	References

	<ol style="list-style-type: none">1. Green H, McGinnity A, Meltzer H <i>et al.</i> 2005 <i>Mental Health of Children and Young People in Great Britain</i>, 2004. Basingstoke: Palgrave Macmillan.)2. The Mental Health Policy Group – General Election 2015, <i>A Manifesto for better mental health</i>, August 2014. Available at: http://www.mind.org.uk/media/1113989/a-manifesto-for-better-mental-health.pdf3. Murphy M and Fonagy P (2012). <i>Mental health problems in children and young people</i>. In: Annual Report of the Chief Medical Officer 2012. London: Department of Health.4. The Think Tank report: http://epi.org.uk/report/progress-challenges-in-transformation-of-young-peoples-mental-health/
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23 September 2016

Association of Directors of Adult Social Services – Written evidence (NHS0072)

Association of Directors of Adult Social Services (ADASS) is a charity. Our members are current and former directors of adult care and social services and their senior staff. Our objectives include:

- Furthering comprehensive, equitable, social policies and plans which reflect and shape the economic and social environment of the time
- Furthering the interests of those who need social care services regardless of their backgrounds and status and
- Promoting high standards of social care services

Overview

1. The long-term sustainability of the NHS can only be ensured if there is an improvement in the status, recognition and funding of adult social services. Adult social care is vital to health and wellbeing of a population with an increasing average age, life expectancy and more long-term and multiple conditions and illnesses. A good system of health and social care should provide support for people who are older, disabled or have mental health problems. It should also provide support for their families and carers: these are the people who are increasingly under pressure to provide good care due to a major lack of funding and support. This is not without cost: to their own employment, their health and their future pensions.

2. Social services provide care and support for the oldest and most vulnerable members of our communities. They enable disabled people to be in control of their lives and be fully included and part of society. They safeguard people's rights when they are at risk of abuse or neglect, when they lack capacity to make decisions and may be deprived of their liberty and where compulsory admission to hospital or for treatment is being considered. ADASS emphasises that no consideration of the long-term sustainability of the NHS is complete without consideration of adult social care.

Demographic changes

The potential impact on the NHS and adult social care in the years ahead

3. We know that people are living longer, but with more complex and long-term conditions. This is leading to greater demands on the NHS to provide vital care, support and treatment. 62% of hospital bed days were occupied by older people (those aged 65 and over) in 2014-15. Between 2010-11 and 2014-15 there was an 18% increase in emergency admissions of older people. The National Audit Office estimates that the gross cost to the NHS of older

patients in hospital beds who are no longer in need of acute treatment is around £820 million¹⁷².

4. An increase in life expectancy does not only concern older people: it also concerns younger people with disabilities and health conditions who are now enjoying much longer lives. The number of people with learning disabilities who will need social care services is likely to rise 25% by 2030.¹⁷³

5. Providing care in the right place is vital to health and wellbeing for all of us. If there aren't sufficient social, primary, community and mental health services in the community to keep people as well as they can be then hospital becomes the only answer. There have been ongoing reductions to the funding of social and community services. Keeping people in hospital for longer than is necessary is detrimental to both their health and wellbeing– *it can in fact increase long-term healthcare needs* – and creates added pressure on the financial stability of the NHS and social care systems. Given that it is now generally accepted that reducing the unnecessary use of hospital beds would be one of the most effective routes towards cutting NHS costs in the future, the government must acknowledge that this cannot happen unless patients have adequate care awaiting them at home.

Delayed Transfer of Care (DToC)

6. One of the most visible indication that failures in adult social care are having a negative impact on the NHS are the ongoing issues with delayed transfer of care (DToC). The two most significant reasons for delayed transfers are those waiting for a package of care at home and those waiting for non-acute NHS care. The latest figures - at the time of writing - for July 2016 showed the highest totals on record for total individual delayed days (184,200) and for social care (61,035)¹⁷⁴.

7. The proportion of delays attributable to social care has increased over the last year to 33.1% in July 2016, compared to 25.3% in July 2014¹⁷⁵. Unless measures are taken to reduce the number of patients awaiting social care it is unlikely that we will see any changes in this trend.

8. If a positive step towards ensuring the long-term sustainability of the NHS would be to reduce hospital bed days, additional steps must be taken to resource social care to address the issue of DToCs.

Resourcing Issues

9. In order to build a successful partnership between social care and health for years to come, both partners need to be sustainable and have stable foundations. While funding for health increased in real terms in each year of the previous Parliament, adult social care faced significant cuts despite councils diverting money from other budgets to protect essential services and increasing demand.

¹⁷² National Audit Office (2016). *Discharging older patients from hospital*. National Audit Office Website. Available at: <https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital.pdf>

¹⁷³ ADASS. *Distinctive, Valued and Personal*. April 2015

¹⁷⁴ NHS England. *Statistical press notice for monthly delayed transfers of care, England, 2016*. Available at <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2016/06/July-16-DTOC-SPN.pdf>

¹⁷⁵ *Ibid*.

10. Local authorities will always balance their books, but in the process services and the people who need them will be affected. Many providers are at marginal viability and others are only able to accept local authority price rates by cross subsidising from paying clients to local authority ones. Some providers may withdraw from the public sector market to concentrate on services to self-funders. The likelihood is that costs will have to rise more than planned if failure in supply is to be avoided.

11. The care market is becoming increasingly fragile, and this adds a further risk to the system. These risks are illustrated by high turnover of staff, suppliers leaving the market, and increasingly slim margins for those that remain, particularly in domiciliary care. These pressures are well evidenced and recognised among independent experts including the National Audit Office¹⁷⁶. Funding for adult social care must keep pace with these growing demands and costs if we are to avert widespread market failure and the consequent impact on the lives of some of the most vulnerable members of our society.

Lack of funding

12. *The rise in DToCs and long-term term illnesses is evidence that current arguments which overemphasise NHS funding are missing the point.* The long-term sustainability of the NHS can only be ensured if social care funding is addressed. NHS as well as social services leaders advocate this.

13. Sustainability involves taking into account a changing demography. So far this has not been the case for adult social care. To maintain care this year at the same level as last year would require more than an extra £1.1 billion¹⁷⁷. As a result, 90% of councils are now only able to respond to people with critical and substantial needs, whereas in 2005 it was 47%¹⁷⁸, and despite preventative services being seen as necessary to address this, spend on prevention is reducing. ADASS estimate the minimum funding gap between needs and resources is set to reach £4.3 billion by 2020. This is a similar figure quoted to one by the King's Fund and Nuffield Trust in a joint study which estimates that the gap is set to reach £2.8 billion by 2019¹⁷⁹. Furthermore, we estimate that during the last Parliament funding for adult social care funding decreased by 31% in real terms.

14. Whilst satisfaction rates for those who accessed care have been sustained, we would argue due to increased personalisation, at least 400,000 fewer disabled and older people are getting publicly funded help and people's needs are growing more complex (including the need for safeguarding from abuse and neglect).¹⁸⁰

Social care council tax precept and Improved Better Care Fund

15. The 2015 Spending Review announcements for a social care council tax precept and additional funding allocated through an improved BCF were welcome and a recognition from Government of the challenges facing adult social care. However, the value of the

¹⁷⁶ NAO, report March 2015 Adult social care in England: overview.

¹⁷⁷ ADASS. Budget Survey 2016.

¹⁷⁸ ADASS. Distinctive, Valued and Personal. April 2015

¹⁷⁹ The King's Fund & Nuffield Trust (2016). *Social Care for Older People: Home Truths*. King's Fund Website. Available at: <http://www.kingsfund.org.uk/publications/social-care-older-people>

¹⁸⁰ Nuffield Trust, The Health Foundation and the Kings Fund, *The Spending Review: what does it mean for health and social care?* December 2015.

council tax precept – which, according to the Government’s own analysis is worth £1.8 billion by 2019/20, not £2 billion¹⁸¹ – is based on a number of important assumptions that cannot be guaranteed. These assumptions are that:

- **All councils will use the precept to the maximum amount.** Last year - 144 out of 152 councils implemented it, generating £382 million income. It is difficult to predict how many will use the option in future years, but it would be impossible to say that it will become easier for councils do to this. Assuming they all do pursue this, most of this extra resource (£1.8 billion) will be swallowed up funding the costs of the implications of the National Living Wage (£1.6 billion).
- **Core council tax will increase by CPI each year.** It is difficult to say at what level councils will set their council tax at in future years.

16. There is, however, a significant issue relating to the inverse relationship between councils ability to raise council tax and needs for social care. Those councils least able to raise tax are those with the highest levels of people with social care needs. The Local Government Finance Settlement last year went some way to addressing this, through the introduction of a profiled Improved Better Care Fund, but it did not fully address this issue. ADASS argues strongly for social care funding to be allocated based on need and risk.

17. Whilst the additional money through the Improved Better Care Fund is welcomed we have already publically stated that it is too little and comes too late. It is heavily back-loaded to arrive late in this Parliament. There is no extra money arriving in 2016/17, and only reaches £1.5 billion in 2019/20. Additional money is needed now as social care has huge pressures on it impacting on the care that people receive today. This is why we continue to call on the Government, at the very least to bring forward this funding to help tackle immediate challenges.

18. We acknowledge that new funding will make a partial contribution to addressing the growing gap between funding and need in the future, but services supporting older and disabled people to get safely home after hospital are at breaking point right now in many areas.

19. Whilst different parts of the UK have varying needs, requirements and challenges. It would be useful to learn and share experiences with the devolved nations to see how they are addressing these, such as with Scotland’s Set Aside Fund.

National Living Wage

20. In addition to this lack of funding, the welcome introduction of the National Living Wage has, and will further, increase cost pressure on councils and providers. The LGA estimates that implementing the NLW may add at least an extra £1 billion to council social care costs by 2020 to pay the increased wages for residential and homecare staff.

21. 2016/17 saw the introduction of the Adult Social Care Precept, the estimated national total raised from which, according to the ADASS Budget Survey, is around £380 million¹⁸².

¹⁸² ADASS (2016). *ADASS Budget Survey*. ADASS website. Available at: <https://www.adass.org.uk/media/5379/adass-budget-survey-report-2016.pdf>

However, this is less than two thirds of the costs of the National Living Wage. So this year, Directors of Adult Social Services have to find more savings of £941m, 7% of the total net budget.

22. To add extra concern, directors of adult social services are becoming increasingly unclear about how budgets will be met. This year's ADASS Budget Survey found that only 31% of directors were fully confident that planned savings for 2016/17 would be met and this already brittle confidence falls sharply away for future years, to a point where only 2% are fully confident that savings targets will be met in 2019/20¹⁸³.

23. There are other additional burdens on already stretched social care budgets:

- the widened scope of Deprivation of Liberty Safeguards (DoLS) which is well beyond anything assumed in the Department of Health's impact assessment.
- the costs of further demographic pressures over that period which we estimate to be £1.5 billion.

The care market

24. We have seen a rise in care providers becoming insolvent. Four out of five Directors say that providers are facing financial difficulty now, there is continued evidence from of actual failure within the provider market in the last 6 months, affecting at least 65% of councils and thousands of individuals as a consequence. Providers are increasingly selling up, closing homes or handing back the contract for the care they deliver for older and disabled people.

25. This disruption significantly impacts on wellbeing. When care homes close there is an impact on mortality when it involves someone moving home in an unplanned way¹⁸⁴.

26. Staff turnover is some 20-22 per cent across the sector (32 per cent for nurses working in nursing homes), the regulatory regime is identifying increasing numbers of serious concerns. This has created more uncertainty following the UK's referendum to leave the EU. Around 1 in 20 (6%) of England's growing social care workforce are EEA migrants, equating to around 84,000 people. Further, more than 90% of those EEA migrants (78,000) do not have British citizenship – meaning they could be at risk of changes to their immigration status following Brexit¹⁸⁵.

27. Given the many challenges facing social care - providers making strategic decisions to exit the market, high staff turnover, issues of poor quality, wage pressures and the need to find up to a million more care workers by 2025 - maintaining a caring, compassionate and trained workforce in a sustainable provider market should be a matter of national concern.

Staffing Issues

28. Social care employs more staff than the NHS. Councils and care home providers are finding it more difficult to find social workers and carers. Up to a million more care workers

¹⁸³ Ibid

¹⁸⁴ ADASS (2016). *ADASS Budget Survey*.

¹⁸⁵ Independent Age (September 2016). *Brexit and the future of migrants in the social care workforce*

will be required by 2025¹⁸⁶ at a time when the social care labour market is growing increasingly complex.

29. Those who feel they are underpaid for difficult and often emotionally draining work are liable to seek alternative employment. Major supermarkets can offer their employees more for less, and without reward and recognition it is understandable that many social care workers would find these offers attractive. This situation is compounded by a shortage of nurses in health and care and high staff turnover.

Confusion in the system

30. Due to six years of local authority cuts 26% fewer people are receiving the help they need¹⁸⁷, so those who are dependent on local authority contracts are more at risk of finding themselves ‘outside the system’ with no means of support. As a result, *the most vulnerable people, socially, emotionally, financially and medically, are the ones at risk*. If the most vulnerable people struggle to find care this will inevitably lead to more misery, loneliness, more family members having to give up their employment and more hospital admissions, putting even more pressure on the NHS.

31. People are relying more on their ability to pay for care. A study by LaingBuisson suggests that around £1 billion of public expenditure is spent by people on care in their own home¹⁸⁸.

Strategy

Address the growing gap between needs and resources in social care

32. The government must ensure that social care funding is protected and aligned with the NHS to give it a secure footing for the future. It must make provisions for the growing gap between needs and resources in social care. If these provisions are not made, the NHS will indeed become unsustainable: it will not be able to cope with the growing demands and expectations of a changing demography without a good system of social care in place to support it. The ADASS budget survey demonstrates, while demographic pressures, such as people living longer, is increasing costs by 3 per cent per year, the number of people actually receiving services has not increased, suggesting growing unmet need. England now spends less than 1% of its GDP on social care.

A global approach

33. ADASS’s proposed model for care and support is based on four key elements:

- A. Good information and advice to enable us to look after ourselves and each other, and get the right help at the right time as our needs change.
- B. The recognition that we are all interdependent and we need to build supportive relationships and resilient communities.

¹⁸⁶ Skills for Care Workforce Report 2015 <http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/State-of-2014-ENGLAND-WEB-FINAL.pdf>

¹⁸⁷ The King’s Fund & Nuffield Trust (2016). *Social Care for Older People: Home Truths*.

¹⁸⁸ LaingBuisson (2016). *Homecare, supported living and allied services: UK market report*. London: LaingBuisson. Cited in: The King’s Fund & Nuffield Trust (2016). *Social Care for Older People: Home Truths*

- C. Services that help us get back on track after illness or support disabled people to be independent.
- D. When we do need care and support, we need services that are personalised, of good quality, that address our mental, physical, and other forms of wellbeing and are much better joined-up around our individual needs and those of our carers. Personal budgets are central to this approach.

The overarching theme of this model is that any consideration of adult social care needs to be global, not just focusing on individual treatment.

34. (A) Good information is needed so that people are able to make wise choices and stay well, safe and engaged with their families and communities.

35. Points (B), (C) and (D) emphasise the importance of a global approach to social care. Social care touches the lives of millions of people – almost one fifth of the adult population of England has experience of social care – which means it is everyone’s concern; it is not simply the concern of people who are in need of it. This includes families, carers, and doctors. The long-term sustainability of the NHS depends upon a sustainable model of social care. The model we propose serves as a guide.

36. To this end, health and social care must work in conjunction with other areas, such as housing. Research by BRE Trust suggests that improving housing could be of significant benefit to the NHS in the long-term. The cost of direct medical treatment resulting from leaving people in the poorest housing is around £600 million a year, and the additional costs of medical treatment resulting from poor energy efficiency and fuel poverty is around £700 million¹⁸⁹. Investment in good quality housing for the elderly and the disabled could therefore bring about major savings to the NHS.

37. We welcome the Government’s commitment to integrate health and social care across England by 2020 and the acknowledgement that it will be up to local areas to agree how best to integrate health and care services, in order to better co-ordinate care on a partnership basis and with the aim of increasing the proportion of investment outside of hospitals. However, we urge caution that a mere integration of health and social services should not be seen as the long-term solution. Taking a global approach also means seeking to offer a more personalised service. Coordinated care is crucial for offering good quality, personalised services, increasing public confidence in the social care system and reducing the pressure on the NHS to provide additional services where social care is failing.

38. ADASS has consistently argued that there is a need for a separate transformation fund with the aim of implementing a new prevention strategy to drive real change. This would, in the short-term, enable local areas to spend money on new investment in preventative services alongside ‘business as usual’ in the current system, until savings can be realised and new ways of working become commonplace.

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¹⁸⁹ [http://www.local.gov.uk/documents/10180/5902366/P11+Health+costs+of+poor+housing+-+Simon+Nicol,%20BRE+\(21+pages\).pdf/fca1e053-7e5d-4334-9766-a0edb9f9d531](http://www.local.gov.uk/documents/10180/5902366/P11+Health+costs+of+poor+housing+-+Simon+Nicol,%20BRE+(21+pages).pdf/fca1e053-7e5d-4334-9766-a0edb9f9d531)

Association of Independent Healthcare Organisations – Written evidence (NHS0083)

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

b) What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

1. Independent hospitals can support the NHS through the provision of NHS procedures through spare capacity at no additional cost to the taxpayer. Only 1 per cent of independent hospital capacity was utilised to increase NHS operational resilience in 2013/14¹⁹⁰. Referral to treatment times show that patients are treated earlier by independent sector providers compared with those treated by NHS organisations. Waiting times are an important indicator of organisational efficiency.
2. Policymakers and local decision makers should develop a strategic vision which effectively utilises the capacity and capability of independent hospitals within the NHS. New research commissioned by AIHO shows that the independent sector carried out approximately 21 per cent of NHS funded hip replacements and 23 per cent of NHS funded knee replacements at a cost set by the NHS in 2014/2015, helping to alleviate NHS capacity demands and providing greater choice to NHS funded patients. Rather than an ad hoc approach at times of intense demand, the capacity available in independent hospitals should be part of a longer term plan to meet the growing needs of the ageing population.
3. Better use of self-pay and personal or corporate insurance is also vital to ensuring the financial sustainability of the NHS. As the population's healthcare needs increase and become more complex, we must consider how to moderate demand for NHS care in order for the service to continue to deliver care to a high standard. Demand for frontline services can be reduced by harnessing healthcare provided outside of the NHS. To improve NHS sustainability, we should use capacity in the independent sector through self-pay and insurance. The sector is actively exploring ways to make private medical insurance (PMI) more accessible and attractive to corporates and individuals.
4. The government should also encourage the public to use PMI more effectively. A reformed and incentivised PMI market could support demand moderation for the NHS and boost innovation, efficiency and productivity in the UK economy. In 2012, 10.9 percent of the UK population had private voluntary health insurance. The bulk of it was

¹⁹⁰ NHS Partners Network, Letter to Jeremy Hunt, February 2016

provided through employers (3.97 million policies) versus individual policies (0.97 million)¹⁹¹.

5. Policymakers should develop mechanisms that encourage people with PMI to use it, such as a more formalised GP referral system. In addition, the government should better inform patients, GPs and support staff on PMI. This would help consumers to understand about the scope of their cover alongside the NHS and how the claims process works. This in turn will help increase the likelihood of patients being asked whether they have it, and consequently, the likelihood of them using it. Spire Healthcare surveyed GPs in 2013 and found that less than two thirds of GPs asked their patients whether they have PMI¹⁹². Research from HCA International also found that of those patients who go down a private treatment route, only 22% had the option raised by their GP. 78% of the time it is the patient that brings it up.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

a) What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

6. Immigration and registration processes for nurses should be made faster and easier to ensure hospitals are able to meet safe staffing levels. Furthermore, the new Immigration Skills Charge must exempt health skilled workers. This is set to be introduced in April 2017 and will place an additional levy of £1,000 per year, every year for skilled workers on Tier 2 visas. This will have a huge impact on the NHS as well as all independent healthcare providers.
7. Nurse shortages in the UK is a prevalent issue across both the NHS and independent sector and explains why there is an increasing need to look abroad for qualified staff. Greater emphasis should be placed on increasing training places to enable a long-term pipeline of available staff. Workforce calculations should always take account of the independent sector. Many staff move across the independent and public sectors throughout their careers, with some working in both sectors simultaneously. Without accounting for this, projections will be inaccurate and cause over or undersupply of healthcare professionals.
8. Furthermore, in order to mitigate the risks as a result of Brexit, the Government needs to reassure EU staff in particular about the importance of their current and future contribution to the UK healthcare system and confirm that they will be able to remain once the UK leaves the EU. There have also been discussions about a potential

¹⁹¹ The Commonwealth Fund, International Health Care System Profiles, Who is covered and how is insurance financed? Accessed here: http://international.commonwealthfund.org/features/who_covered/

¹⁹² Laing & Buisson, Private Acute Medical Care Report, February 2015

immigration ‘emergency brake’ for the UK in an effort to meet concerns on free movement in the short-term. It is anticipated that the political discourse on immigration will force the Government to take measures on a form of immigration it can control in the short-term, i.e. non-EU immigration. This is of real concern as a significant number of nurses come to the UK from outside the EU.

b) What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

9. Maintaining sufficient staffing levels in the healthcare sector is dependent on importing expertise from the EU and elsewhere. If the EU exit disrupts freedom of movement it may become much harder to attract workers, particularly nurses and social care workers. It is vital that nursing remains on the shortage occupations list in order that UK demand continues to be met. However, the government must realise that healthcare services do not just depend on 'skilled labour' such as doctors and nurses. They also rely on critical team members such as cleaners, porters and other administrative staff from the EU. Uncertainty around visas may mean that some EU workers currently employed in the health service return home.
10. Clarity in terms of employment law, for example agency workers' rights, holiday entitlement, working time and TUPE is also a priority for the sector. The sector would be keen to ensure the retention of the EHC (European Health Insurance Card) reciprocal arrangements with the rest of Europe.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

11. Pathways and assessment processes that bridge acute care and the community are vital to achieve this shift. Illustrative examples of this have been developed and provided by AIHO members. For example, one organisation takes the view that health and fitness are fundamentally interrelated and approaches the two within an integrated setting, connecting its hospitals and fitness & wellbeing centres with its wider health care network.
12. This provider offers comprehensive health assessments to members, workplace wellbeing customers and patients. Health assessments are the gateway to a seamless care pathway which includes fitness and wellbeing, nutrition, physiotherapy and primary and secondary care services. Recent research shows that those who undertake regular health check-ups are more likely to make improvements to their own health and fitness.
13. An AIHO member has also developed a pre- and post-operative care programme for orthopaedic patients. Their holistic approach employs physiotherapy and training services to fully rehabilitate patients who have completed standard post-operative

treatment. Current evidence demonstrates patients who proactively engage with the programme recover to a satisfactory level more readily.

a) What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

14. In order to deliver a more preventative public health strategy we need to consider how to better harness care delivered outside of the NHS. The average waiting time for NHS-funded treatment in independent sector providers is less than in NHS providers, with patients seen in outpatient departments of independent hospitals waiting 10 days less than the national average.¹⁹³ This means more people can get back to work sooner, welfare costs are avoided and there is less demand placed on the NHS.

15. The NHS calls on employers to incentivise improvements in health and wellbeing through workplace initiatives. This aligns with policy objectives for individuals to adopt a more preventative, self-care approach to their own health.

16. If employers were to incentivise improvements in health and wellbeing through the workplace, it would also reduce staff sickness, provide swift access to rehabilitative care when needed, and maintain or improve staff well-being and productivity. AIHO also supports the NHS's agenda for greater personal responsibility in healthcare. It is not only the job of the NHS to help us stay healthy; it is down to each citizen to take an interest in their own health and wellbeing and plan for their healthcare needs in the future.

17. Incentivising uptake of SMEs and corporate PMI membership schemes aligns with policy objectives for individuals to take more of a proactive interest in their own health and wellbeing. AIHO is working with the wider industry to encourage personal and employer responsibility over health and wellbeing.

b) What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

18. Individuals must be encouraged to take an interest in their health and wellbeing. This can mean using smartphone apps and devices to monitor health, taking more exercise, stopping unhealthy habits or through greater health planning such as the use of PMI. The UK government and local and regional bodies should encourage this behaviour through incentivising and highlighting the means of improving, monitoring and planning for health.

19. For example, some PMI schemes have the ability to reward individuals for positive personal health decisions, e.g. tracking their exercise levels through smart phone apps and gym memberships and providing relevant discounts.

¹⁹³ NHS Partners Network, Independent sector providers: Our contribution to NHS Services, 2016

c) Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

20. The UK government should encourage employers to take a greater interest in their employees' health. Employers benefit when their employees are healthy and productive and this should be reflected in the workplace. The UK government could encourage this behaviour through a number of measures, including:
- making large employers publish employee healthcare plans;
 - rating employers based on the measures in place;
 - incentivising behaviours through the tax system.

7. What are the best ways to engage the public in talking about what they want from a health service?

21. Patients are better informed and engaged with their healthcare when they are offered meaningful choice. Choice empowers patients to take control of their healthcare and promotes improvements in quality, efficiency and health outcomes.
22. Independent hospitals coexist alongside NHS trusts providing patients with greater choice over their healthcare. GPs should be encouraged to offer patients choice of provider. Recent surveys have shown that the number of patients being offered choice over where they are treated has reduced since 2010. In 2015, only 40 per cent of patients were offered a choice of hospital or clinic by their GP, compared to 50 per cent in 2010. In 2014, only 51 per cent of patients were aware of their legal right to choose a hospital or clinic for an outpatient appointment¹⁹⁴.
23. Furthermore, 64 per cent of people agree that it is fine for the NHS to use private companies to provide services to patients as long as they meet NHS standards, the cost to the NHS is the same or lower, and services remain free at the point of use¹⁹⁵. This shows that the public's overriding concern is ensuring excellent NHS care rather than who provides such care.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

a) What is the role of 'Big Data' in reducing costs and managing demand?

24. A partnership between the independent sector and the NHS could be hugely beneficial to UK patients in terms of harnessing 'big data' globally. For example, one AIHO multi-national member hospital has 26 million patient interactions each year and is using that data for ground breaking research into MRSA, antimicrobial resistance and early sepsis

¹⁹⁴ The Times, Doctors refusing patients the right to choose hospital, January 2016

¹⁹⁵ NHS Partners Network poll, November 2015

diagnosis. The sector is willing to work much more strategically with the NHS, including by sharing data sources and best practice.

b) Where is investment in technology and informatics most needed?

25. Technology and informatics must be invested in to support the NHS's transition from a reactive service to a proactive, preventative model. Independent hospitals' capital assets and investment must be harnessed to drive this innovation in UK healthcare.
26. Independent hospitals are the source of many innovative practices and products that the NHS can benefit from. For example, Babylon is a subscription health service with origins that lets patients book virtual GP consultations with professional physicians, monitor symptoms and receive prescriptions. It is the first service of its kind to be registered with the Care Quality Commission and have designated body status from NHS London.
27. Clinical support technology can also enable the consultant (or clinical staff) to deliver care more efficiently to the patient. For example, this might be achieved by providing technology that offers consultants remote, real-time access to the patient's current status as well as instant access to all diagnostic and test results. Another example might be technology that enables nursing staff to better monitor the patient's condition and accurately record the patient's drug intake.

23 September 2016

Association of Medical Research Charities – Written evidence (NHS0059)

AMRC and our response

1. The Association of Medical Research Charities (AMRC) represents 133 of the leading health and medical research charities funding research in the UK.¹⁹⁶ Our members fund research focussed on the needs of patients for better treatments, therapies and interventions designed to improve the quality of life and ultimately prevent or cure their condition. As such, a focus on the patient perspective and patient voice is central to all of our work.
2. In 2015, AMRC member charities:
 - Invested over £1.4 billion of research funding in the UK; more than other public funders of medical research in the UK including the Medical Research Council (MRC) and the National Institute for Health Research (NIHR);
 - Funded around 25% of non-commercial research in the NHS;
 - Funded the salaries of over 15,000 researchers in the UK.
3. AMRC's response will focus on the topic of ***'Digitisation, big data and informatics. How can new technology be used to ensure sustainability of the NHS?'***

Medical research and the future sustainability of the NHS

4. **Research is vital to the future sustainability of the NHS** for a number of reasons:
 - it generates the evidence which enables the NHS to improve outcomes, save lives, improve quality of services, reduce costs and improve productivity
 - research active hospitals deliver better health outcomes¹⁹⁷
 - it enables basic science discoveries to be pulled through so full benefit to patients, the NHS and the economy can be realised
 - helps anchor life sciences industries in the UK enabling patients to have access to innovative new drugs, devices and techniques and attracting inward investment
5. **Research funded by medical research charities does – or, could if implemented - generate savings for the NHS as illustrated by the case studies in the annex, this includes:**
 - Research funded by Arthritis Research UK to develop the STarT Back Screening Tool. This tool has resulted in a significant reduction in patient-reported disability, an average saving to the health service of £34.39 per patient and wider societal cost savings of over £400 per patient due to reduced time off work.

¹⁹⁶ For a list of our members see: <http://www.amrc.org.uk/our-members/member-directory>

¹⁹⁷ Baris A. Ozdemir, Alan Karthikesalingam, Sidhartha Sinha, Jan D. Poloniecki, Robert J. Honchcliffe, Matt M. Thompson, Jonathan D. Gower, Annette Boaz, Peter J. E. Holt (2015) *Research Activity and The Association with Mortality*. <http://www.ncbi.nlm.nih.gov/pubmed/25719608>

- Anthony Nolan is the world's first stem cell registry to invest in Third Generation Sequencing (TGS) technology, which allows to type and match the genes of donors and patients to the highest possible level of accuracy. By lowering the risk of mismatches between patient and donor, the risk of post-transplant complications is also lowered, thereby saving the NHS money through reduced demand for specialist services.
6. **Medical research charities fund studies which provide vital evidence for clinical guidelines. This saves the NHS money.** In 2013, the Wellcome Trust conducted an analysis which found that 54 NICE guidelines cited Wellcome Trust associated papers, with 123 papers cited.
 7. It should also be noted that the use of digital health, with access to real time data monitoring, is already empowering patients to manage their health more actively or to live independently and therefore could support a more sustainable NHS. Also, access to linked genotypic and phenotypic data is having a huge impact in reducing the diagnostic odyssey suffered by patients with rare diseases.
 8. It is important that the legal and regulatory framework governing data access keeps up with the pace of discovery and that a balance is maintained between sharing data and maintaining privacy. New initiatives must be planned carefully, with robust and transparent governance.

Opportunities of health information (data) in medical research

9. The use of health information, also commonly referred to as data or medical records, is crucial in medical research. Researchers use health information to develop understanding of disease and ill-health, discover new cures and treatments for patients; and improve the care provided by the NHS and provide efficiency and cost savings.
10. With the NHS as a single provider, and with a large, socially and ethnically diverse population, **the UK has the potential to become a world-leading centre for innovative digital healthcare.** If successful, this could improve patient experience, increase efficiency, attract investment and create jobs.
11. Our members are funders and/or users of disease registries; patient/volunteer registers; biobanks; cohorts; medical “apps”; and funders of studies which deploy patient data, including genomic information and tissues; as well as users of data to inform their non-research charitable activities.

Challenges in realising the potential of health information to support a sustainable NHS

12. To realise the potential of the use of health information (including big data and informatics) for the future sustainability of the NHS, **Government must ensure that researchers are able to continue to access health information for the purposes of research. Without access to health information, the advancement of medical research will be hampered and with it the benefits to the NHS's future sustainability.**

13. Failure to record, link and share data for care and research is compromising the safety of today's NHS patients; opportunities for efficiency gains in delivery of NHS services; and research which could transform our ability to predict, diagnose and treat disease.
14. A number of challenges must be addressed in relation to the potential of health information:

The introduction of an England-wide opt-out question

15. As part of the National Data Guardian for Health and Care's review of data security, consent and opt-outs Dame Fiona Caldicott has proposed a new opt-out model for data sharing in relation to personal confidential information.
16. AMRC supports the right to opt-out; we believe that the public and patients must have the option to choose whether their identifiable health information is used for purposes beyond their direct care.
17. However, careful and considered implementation of the opt-out question is vital and **we urge the Government to produce a comprehensive plan for implementation, which should be communicated transparently with an appropriate timescale.** It is important going forward that lessons are learnt from the implementation of the care.data programme which led to mistrust and concern amongst the public about the use of health data. Please find our full response to the consultation on the National Data Guardian's review of data security, consent and opt-outs [here](#).
18. The accidental publication of NHS Digital's business plan, suggests that the opt-out question could be implemented as early as March 2017.¹⁹⁸ We have serious concerns with this timeline and its potential impact on public trust and confidence in the system.
19. Making the case to the public for sharing personal health information (choosing not to opt-out) is critical for the future of medical research. AMRC and our members are extremely concerned that an opt-out system will be introduced without the public really understanding the value of data sharing and the consequences of opting-out.
20. This echoes the Wachter review findings and recommendations. The review found the Government's target of a paperless NHS by 2020 to be unrealistic and recommended it should be disregarded. The review proposes 2023 to be a more reasonable goal.

Improving data security standards

¹⁹⁸HSJ (September 2016) *Patient data consent model 'to be launched in March'* <https://www.hsj.co.uk/topics/technology-and-innovation/patient-data-consent-model-to-be-launched-in-march/7010328.article>

21. We will only be able to realise the benefit of data, informatics and other technologies in creating a more sustainable NHS if patients and the public trust and have confidence in the health and social care system to handle their data with care and confidence. If the public do not trust the system, they will be unwilling to share health information and the benefits of big data and informatics may not be realised.
22. Dame Fiona's review proposes robust security standards that should be applicable to every organisation handling health and social care information. Implementing these measures will be a significant, but important undertaking for health and care organisations. Adequate staff training is essential to support and develop understanding of data security; building confidence and consistency amongst the workforce. The Government must ensure that NHS and social care organisations have adequate support and resource to ensure these improvements take place. We note the Wachter review found that the £4.2 billion the Treasury made available in 2016 to promote digitisation is not enough to enable digital implementation and optimisation at all NHS trusts.
23. In conclusion, research is vital for future NHS sustainability. Health data and research can save the NHS money- but it is key that researchers are able to continue to access and work with health information.

ANNEX: Examples of research outputs with cost-saving benefits to the NHS

Arthritis Research UK case study - STarTBack Tool

This is a back pain stratification tool developed by the Arthritis Research UK's Primary Care Centre in Keele. The tool stratifies people with back pain into three groups: those needing routine care, those needing physiotherapy and those needing physiotherapy and psychological support. This tool enables clinicians to deliver more targeted interventions to help improve outcomes for patients. The new model has been demonstrated to result in: a reduction in patient-reported disability, 50% fewer days off work, cost savings to the NHS of £34.39 per patient and wider societal cost savings of over £400 per patient due to reduced time off work.

Anthony Nolan case study - Stem cell registry

Anthony Nolan carries out pioneering research into stem cell transplantation techniques and the genetic matching process in order to improve patient outcomes. The charity is the world's first stem cell registry to invest in Third Generation Sequencing (TGS) technology, which allows to type and match the genes of donors and patients to the highest possible level of accuracy. By lowering the risk of mismatches between patient and donor, the risk of post-transplant complications is also lowered, thereby saving the NHS money through reduced demand for specialist services.

22 September 2016

Association of UK University Hospitals (NHS0150)

On behalf of the Association of UK University Hospitals (AUKUH), we write to you in response to the committee's call for evidence on the long-term sustainability of the NHS. The AUKUH represents the 47 leading research and teaching hospital trusts across the UK.

Healthcare services in the UK are second to none. The UK is an international leader, driving forward standards of patient care through innovation and advances in research and education. Our staff are caring, compassionate, and driven by improving the lives of others. Life expectancy, quality of life, and the overall patient experience continue to improve and increase. The UK has much of which to be proud.

The UK, as with other developed countries, is facing increasing demands for health and social care provision. As advances in medicine and technology have furthered our understanding of medicine and our ability to provide targeted treatments, expectations have grown. We must acknowledge that funding has not been increased proportionately. Very little (if any) of the recent increase in Treasury funding has been made available to providers through an increase in the prices paid for services. The number of provider trusts that ended the year in deficit has gone up from 8% in 2009/10 to 65% in 2015/16¹⁹⁹; and the provider deficit in 2015/16 was over twenty times larger than the deficit in 2013/14.²⁰⁰ This is not owing to poor financial management. Trusts are in a financial crisis because they have been required to deliver a greater volume of healthcare services alongside increasingly expensive complex care, within a funding envelope which has not kept pace. The burden of increased regulation is not part of a solution.

The current model is not sustainable. Either funding must increase in the long term or the level of healthcare provided must be restricted. We know that the UK spends a smaller percentage of its GDP on healthcare than almost any other advanced economy; and that UK total healthcare spending as a proportion of GDP has declined since 2009 (see appendix 1). We also know that an NHS that is free at the point of use is something we absolutely must retain if we are to continue striving towards an equal society. On average, people living the poorest neighbourhoods in England die seven years earlier than those in the richest neighbourhoods.²⁰¹ We cannot risk worsening inequalities. In order to protect the NHS, difficult decisions must be taken.

The workforce is our biggest asset. We must ensure that our staff - clinical, non-clinical, support and management – are equipped to deliver the highest standards of care of which they are capable. Moving to a full seven-day service model would require a substantial increase in workforce numbers. We are already at risk of losing staff who feel demoralised by the unprecedented demand faced by the NHS, a risk that will only be worsened by the impact of leaving the EU. Expanding the workforce needs to be fully costed and fully funded,

¹⁹⁹ The King's Fund (2016), *Trusts in deficit* [online] available [here](#). [Accessed 13 Sep 2016]

²⁰⁰ Campbell, D. (2016), NHS hospitals in England reveal £2.45bn record deficit, *The Guardian*, [online] available [here](#). [Accessed 20 Sep 2016]

²⁰¹ NHS Future Forum (2012), *The NHS's role in public health*, [online] available [here](#). [Accessed 13 Sep 2016]

or we shall damage the very services we are aspiring to improve. This needs to be addressed immediately, with upfront investment for long term gains.

Health research is vital, across medicine, nursing & midwifery, the allied health professions and health services management. It is vital not only in continuing to advance the interventions and understanding of care, but also in ensuring efficiencies, and targeted, effective interventions.

At the same time, steps must be taken to ensure that tertiary services are of the highest quality. The funding models must recognise variation in the complexity of care, and accept that some variability is warranted – not in the standards, but in the complexity and therefore cost.

Direct government legislative interventions in public health have, in the past, delivered the biggest gains in terms of health outcomes – for example, mandating seat belts and preventing smoking in public places. Incentives for the population to maintain its own health is crucial if we are to reduce demand and pressure on our healthcare service.

The five-year Sustainability and Transformation Plans proposed in last year have real potential to offer step changes towards a truly integrated healthcare system. The boundaries between social and health care, and between primary and secondary care need to be far better and more efficiently integrated than is the case at present. There need to be both structural and workforce changes. New investment should be introduced in a controlled and sustainable way – with some upfront funding to cover the backlog, and then to restructure and to invest in research and training to heighten productivity and increase the volume of care.

A world-leading national health and social care system that delivers all this cannot be sustained without increased funding. The AUKUH believes that there needs to be a public debate around how best to bring healthcare provision in line with expenditure: whether to increase government health and social care spending to a level that is in line with OECD averages, or to restrict the services provided freely on the NHS. This is not a decision to be taken by an individual government; it is fundamentally a ‘values’ question to be decided by the nation.

The NHS is widely viewed as the UK’s crown jewel. The AUKUH calls on the House of Lords to open the debate to the public so that we can continue to provide a national health service of which we can all be proud.

Appendix 1

In 2009, the UK spent 9.8% of GDP on healthcare. It ranked 13/34 in the OECD health spending league (see figure 1). Since 2009, the UK's healthcare expenditure as a proportion of GDP has declined each year. In 2014, it was 9.1% of GDP, placing the UK in the bottom half of the OECD health spending league, at 19/34 (see figure 2).

Figure 1: Healthcare expenditure as a proportion of GDP for OECD member countries, 2009

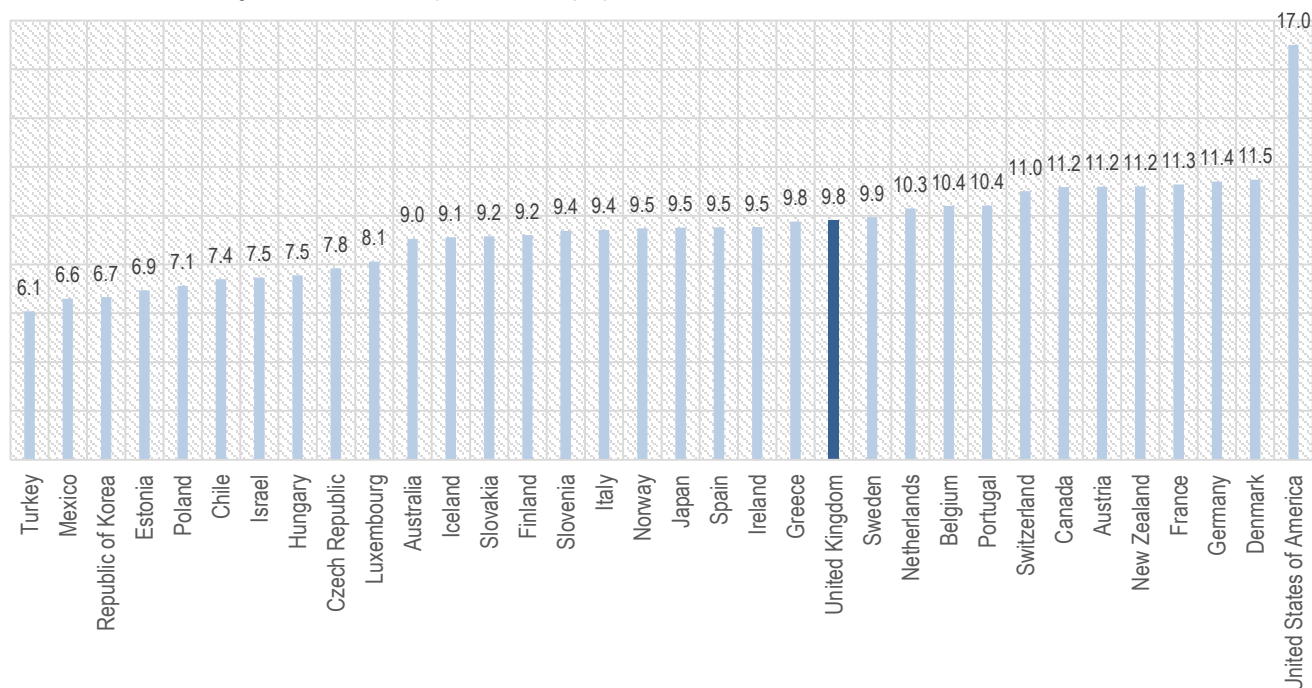
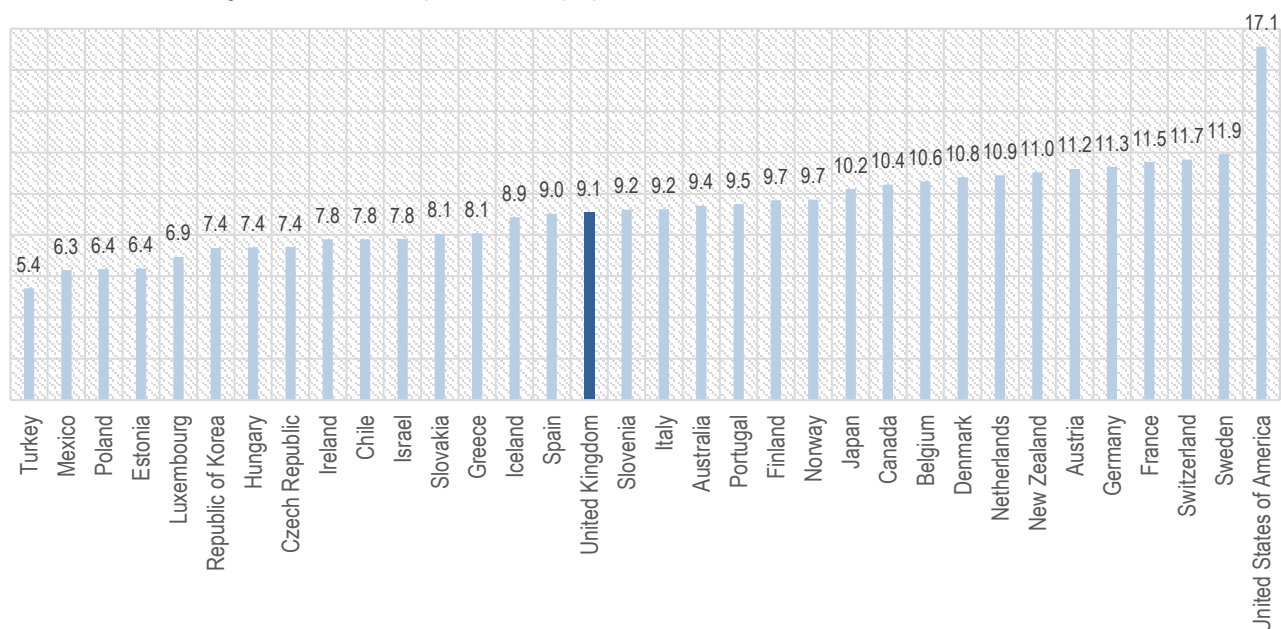


Figure 2: Healthcare expenditure as a proportion of GDP for OECD member countries, 2014



Data source: World Health Organization, [Global Health Expenditure Database](#)

23 September 2016

Baroness Altmann – Written evidence (NHS0184)

You asked me to write you a note about the issues surrounding social care and the impact on the long-term future of the NHS. Here are some of my thoughts.

The first and vital point to note is that this really is an issue that needs to be addressed urgently. The impact of the aging population on the NHS is likely to be catastrophic and could also cause significant social and economic distress. This crisis has been left far too long already.

Of course, the problems stem from what would normally be considered good news – i.e. that more of us are living longer and staying healthier in the early stages of retirement than ever before. However, this trend of rising longevity has been in place and been recognised for quite some time, yet policy has not really addressed the implications adequately thus far. Social care is artificially distinguished from healthcare and left to councils. The local authority responsibility for social care actually dates back to the Poor Laws – yet the NHS is much more recent. However, the NHS was designed as a ‘make you better’ service, not as a ‘look after you for ever’ service. It cannot cope with the latter – and neither can councils. Social care for older people is already pushing the NHS to breaking point – and that is before the huge numbers of baby boomers start reaching older ages.

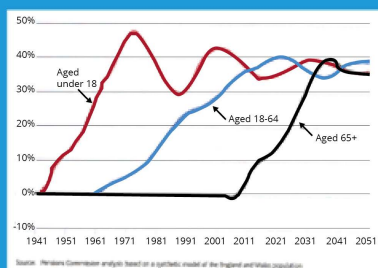
Demographics of the care crisis

There are two major demographic aspects to the problem:

- Firstly, people are living much longer than was previously predicted, so the current cohorts of older people who end up needing social care (rather than having passed away before reaching that point) are much larger than expected.
- Secondly, the proportion of the population who are likely to need care is set to soar in coming years. The baby boomers are only just now reaching their 60s. They generally will not yet need long-term care (although they may now be dealing with parents or loved ones who do). However, if you look at the chart below, you will see just what a massive rise in numbers of people in their 80s we will be facing in 20 years or so. This means an enormous jump in the numbers who may require social care.

DEMOGRAPHICS DEMAND ACTION NOW!

- Life expectancy has risen significantly
- Baby boomers currently hitting 65
- Huge rise in numbers aged 85+ coming in 20 years' time



Financial aspects of the care crisis

Unfortunately, the financial aspects of this crisis are possibly even more alarming than the demographics. There has been no real planning for these demographic realities. No money has been set aside – in either the public or private sector – to fund social care if or when the needs arise.

Care funding falling while demand has been increasing

The Welfare State did not cover the care costs of an ageing population or cater for rising longevity. But even worse than this, funding for social care has actually been falling in recent years, even as the needs have been rising. Beveridge's National Insurance system covered pensions and health, but not social care. In fact, social care was always the 'poor relation' of health services, left to local councils to pick up responsibility. The NHS was really designed as a 'make you better' service, and it does that very well, but was not intended as a service to cater for people who simply won't recover, but will have to live – possibly for many years – with chronic long-term conditions that may even worsen.

Inadequate social care puts extra burdens on NHS

There has been successful integration of health and social care in places such as Torbay and South Devon but such examples are rare. When done properly, this integration has almost completely eliminated emergency hospital admissions for the over 65s. With councils continually cutting care provision, fewer people are receiving early-stage help, they don't get preventative interventions and then end up in hospital or care homes.

Many Government reviews but little action

We are already very late in trying to tackle the lack of funding for social care. Previous Governments have undertaken reviews, but little action has followed. Indeed, in recent years as council budgets have been cut and their populations have aged, the funding for care has been falling and the quality of social care has declined. Social care has one of the most stringent means-tests of all our welfare benefits, so that most people do not get council help until they have used up virtually all their savings – and if they need to go into residential care and have no partner then they must use their home to pay the care bills.

Potentially worse than pensions crisis – political risks of continued inaction

This social care crisis is potentially worse than a pensions crisis. Firstly, with pensions, at least there has been substantial provision over the years, even if it is not sufficient for all. Billions of pounds are set aside to pay pensions in future. In contrast, there is no money set aside for social care spending by individuals or by local authorities – needs have to be

funded as they arise and if the money is not there, the quality and availability of care is compromised, causing scandals and misery that could potentially rebound on policymakers at some point. Secondly, with pensions, it is also possible to ask people to wait longer before they receive their money. Raising the state pension age has been possible but this option is not available to deal with care funding. Once someone needs care we cannot tell them to wait. So if there is no money for them, the social care won't be delivered. Of course, ultimately, this rebounds onto the NHS, which picks up the pieces and may end up costing taxpayers significantly more than would otherwise be required, while also leaving the elderly people in need of care with much worse outcomes.

Responsible Government needs to prepare for care funding. This will require changes to the NHS and also, in the long-term, a national insurance solution would make sense. This could ultimately be built into the current system.

Artificial distinction between healthcare and social care.

Under the existing arrangements, there is an artificial and somewhat arbitrary distinction that appears unfair to the public once it is understood. As more and more families have to engage with the social care system, there is likely to be increasing dissatisfaction with the status quo and more pressure for change. It would be good to have plans to start addressing this as soon as possible, since the issue is unlikely to resolve itself.

From the point of view of the person who is ill, or their family, the situation seems arbitrary and unfair. If someone is ill but considered to have a health need (perhaps cancer) then the taxpayer is most likely to pick up all the cost of the treatment they need. However, if someone is ill but their illness is considered a social care need (such as dementia) then the state may pick up none of the costs until they have spent most of their money (they must spend their savings down to about £23,250 of assets to qualify for council support). When families find this out, they are indeed unhappy about it.

Most people think the NHS will pay if they are ill. The unpredictability of the current system and the perceived unfairness comes as a shock to most families. Of course, the Government really should have explained how the system works many years ago, but then if most people actually did understand it, there would have been far more pressure for change long ago. The system has resulted in a national failure to plan ahead for social care costs, that are inevitably coming.

No incentives for NHS to save money on social care and vice versa

For now, though, we need to address the fact that there is almost no money earmarked to pay for care in advance. Some money has already been moved over from the NHS budget to try to integrate health and social care. This is likely to be increasingly required but would involve a significant change in health practices as well as social care. Currently, for example, there are no real incentives to those operating the social care system to save money to the NHS. The longer someone is looked after in an extremely expensive hospital bed, the less money the council has to spend on them. Equally, there is no incentive in the NHS for doctors to save money to social care services. For example ensuring their older patients have a little bit of homecare at an early stage to prevent them from deteriorating much more. Prescribing minor social care interventions can improve outcomes for many people. Such incentives for each service to be conscious and incentivised to save money to the other could also help reduce care needs and improve long-term care quality.

No single solution

In the meantime, money must be found to pay for care. I do not believe there is one single solution to this – we have left it so late that we are likely to need a combination of

approaches. It is clear that an insurance option has not yet been forthcoming to help people fund up to the £72,000 care cap. Any insurance solution would only be a partial one. We also, in my view, need to find a way to help people with savings to set that money aside for care, instead of spending it before care needs arise. We should help families recognise that they should consider having some savings in case they need to pay for care.

Changing the terms of the debate.

I think it would be helpful for us to consider trying to change the terms of the debate. Care is currently considered an issue about elderly people. None of us really wants to think about ourselves in that light. However, for many people, care affects their nearest and dearest, not themselves. So we can start to think of care as being about our families and loved ones, rather than about us in a frail physical state. Once we focus on our families, not just ourselves, we may start to find a better solution.

What can Government do?

I believe a vital step is for Government to help families prepare for care in advance. Just carrying on with the current system, which leaves so many people deeply dissatisfied, is not easily politically defensible.

Insurance-style solutions:

Ideally, the issue of paying for social care would be predominantly addressed by using a wide scale insurance solution. If Beveridge were designing a welfare state in the 21st Century, it would include provision for social care. However, for the older members of society now, it is probably rather too late for this to function adequately. Therefore, we could think of a national insurance type solution for younger generations, to address long-term care funding needs, while recognising that an insurance solution will be more limited for the shorter-term needs of those already retired.

However, some insurance may be possible for those who are in their 50s now, who still have perhaps 20 or more years left before they are likely to need care. There has been no interest in such a market so far, and it may need a national scheme. A particular benefit of an insurance solution is that it could encourage preventive measures to be taken as people get older, which will help drive prevention and early intervention that is urgently required but currently under-used. Just as house insurance now normally requires that the insured takes preventive measures to lower their premiums, or indeed to achieve cover at all, a similar principle might apply for social care. Home insurance usually demands that houses have burglar alarms, secure locks and windows, smoke alarms and so on. Similarly, care insurance might demand that the person's house is adapted as much as possible to avoid more expensive interventions and possibly require regular telehealth checks or even modest domiciliary help.

INSURANCE?

- Care cap too high for realistic insurance
- Most will spend far more than the cap before getting state help
- Could national insurance be adapted?
- Insurers will not insure unlimited payout
- Could help with prevention – e.g. house insurer demands locks, smoke alarm, burglar alarm

10 failings of social care:

1. **Lack of integration between health and social care services leaves the NHS paying for those who develop health needs due to lack of care** - In Torbay and South Devon, the integration of health and social care has seen emergency hospital admissions for the over-65s almost eliminated. But in most other areas, failure to fund social care, often results in older people ending in the NHS – the most expensive care setting.
2. **No incentives for councils to save money to NHS** – The current system actually incentivises councils to push extra costs onto the NHS. The longer councils can delay hospital discharge, the less they will have to pay for an elderly person’s care. This ends up costing the taxpayer far more, as well as being worse for older people. This failure is leaving NHS resources stretched to breaking point, a lose-lose situation for us all.
3. **No incentives for NHS to save money to councils e.g. GPs could help patients by recommending preventative measures** – currently GPs are not incentivised to prevent care needs, rather than waiting to treat them after problems arise. It could save money and improve people’s lives if GPs could recommend personal alarms, handrails or a bit of home care.
4. **Lack of cross-Departmental approach** – addressing the care crisis will require several Government Departments to work together - Department of Health, DCLG, Treasury and Housing. The NHS should work with DCLG to properly integrate funding for health and care needs of rising numbers of older people. Treasury must urgently introduce incentives to help families save for care. Housing Ministers must ensure building of suitable homes for ‘last time buyers’ to downsize to. If people stay in unsuitable homes, rather than being able to move to good quality, smaller, user-friendly housing, they are more likely to need social care.
5. **Health lottery** – depending on what’s wrong with you, taxpayers may pay all your costs via the NHS, or none if your care needs come under council control. Most people assume the NHS looks after elderly people but they are often left to pay for care themselves.
6. **Triple cutbacks in publicly funded care is betrayal of British families** - It is estimated that 150,000 fewer people are receiving help at home than five years ago as councils impose triple cutbacks: (a) only paying for those whose care needs are already

substantial; (b) cutting the amount of care provided per person (such as 15 minute visits); (c) failing to pay the full costs.

7. **Postcode lottery** – Many councils are cutting back care spending, leaving care homes or domiciliary care companies unable to cover their costs.
8. **No financial or tax incentives to help families prepare for care costs in advance:** There are significant incentives to help people build up private pensions, but no Government incentives for care savings. There is employer help for pensions and also the state pension to provide a base, but there is nothing for later life care needs.
9. **Social care is the meanest of all means tests, and families with savings face a double hit** – councils will only pay for care if people have less than £23,250. This could include the value of their house, unless they or their partner is still living there. While those with no assets get care costs covered by council taxpayers those people who have to pay for their own care are hit twice. Councils are not paying enough to cover the costs of care for those who do get public funding, so those who get no public money must not only cover their own cost, they also have to pay extra for other people's care too, to make up for council underfunding.
10. **Government hasn't told the public about the need to prepare for care costs** Government has tried to pretend it is sorting out the problem when in fact the crisis is getting worse. Families are being left to find funds when needs suddenly arise rather than having to prepare for care in advance. Political spin is does not help those in dire need.

Conclusion:

Ultimately, good social care is in the interests of society as a whole, but it cannot be delivered without funding. Indeed, the distinction between healthcare and social care for an increasingly aging population is unhelpful. Good quality, timely social care can often save older people's lives and improve their quality of life better than conventional medical care received later on. Most individuals are better off in their homes than in hospitals, remaining independent and in familiar surroundings. Having a small amount of early homecare can keep people healthier for longer. The aging population should be great news but we have not prepared for it. The next crisis after pensions is already beginning and this poses significant challenges. We know the NHS will not be able to cope and that change is required. We also know that no money has been earmarked privately or publicly to pay for social care. There is no single solution to this. We will, in my view, need a combination of short-term measures based around savings (with a little insurance as well) and longer term measures based more on insurance at a national scale.

Tax incentives to help people save for social care are urgently required. Time is of the essence. Such incentives are important both because they have the potential to help private individuals pre-fund potential care needs they currently do not appreciate they will have to cover and also because announcing such new incentives will, in itself, help educate the public of the need to consider this kind of saving. It is a brand new concept.

In the context of our ageing society, attention has been focussed on financing pensions, but later life income needs are not covered by pension incomes. Annuitisation of Defined Contribution pension savings resulted in ongoing incomes, but left no leeway for the sudden significant extra costs that could arise in later life to cover care. Inevitably, at this late stage, pre-funding social care will have to start with those who already have some money put by. If they are the kind of people who would take out life insurance when younger, to save their

family worry if they were to die young, and if they have long-term savings, they are likely to be the kind of people who would want to consider making provision for care in advance, if they know they need to. This can help address the shorter term crisis.

In the coming years, however, considering how to extend national insurance to help fund social care, not just the NHS and pensions, will be an important debate to prepare for the future costs of increasing numbers of citizens requiring long-term care. After 65 years, the Welfare State needs to be reconsidered, to encompass the realities of life in today's world. We really need a new Beveridge for the 21st Century.

24 November 2016

Association for Clinical Biochemistry and Laboratory Medicine – Written evidence (NHS0043)

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

There will be an increasingly aging population with growing health needs and expectations. Technical and medical innovation will progress at pace and needs to be translated into patient care, meaning that resources need to be allocated based on research evidence demonstrating value.

There should be a focus on prevention and self-management and monitoring especially in terms of long-term conditions.

The barriers between primary, secondary and social care (especially financial) must be removed so patients are cared for in the most appropriate surroundings.

Issues of confidentiality and patient choice as well as standardisation of communications and reporting mechanisms must be addressed and resolved quickly to enable information and communication technologies to be deployed to make records and data available across the board to authorised healthcare professionals so that the fullest level of care can be offered in all circumstances and locations.

Resource issues, including funding, productivity, demand management and resource use

7. To what extent is the current funding envelope for the NHS realistic?

The current funding envelope is not realistic for the future of the NHS

- a. Does the wider societal value of the healthcare system exceed its monetary cost?

Poor health places a large burden on society and the NHS. Patients have little idea of the cost of NHS treatments and the wastage due to non-compliance with medications or therapies etc. There needs to be a shared responsibility for health of the nation

- b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

A single source of funding across the whole health economy

- c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

- d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

This already happens for a range of procedures as CCGs have been removing procedures from scope eg gastric bypass surgery, tonsillectomy and varicose veins.

Workforce

8. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

Workforce planning for most healthcare staff is not good and results in periods of under and over supply. The NHS needs a robust system for workforce planning as it takes a long time to train the professionals who work in the NHS

The disaffection of NHS staff resulting from long term pressures on salaries, grading structures and general working conditions needs to be addressed. Clearly this is difficult at times of austerity and in the context of public sector consistency but a demoralised workforce is not an efficient one. An unfortunate side effect of the increased pressure on employees' time is that they are less able to contribute constructively to reforms and developments that might improve efficiency and this, too needs to be addressed. Having some involvement and being able to contribute one's experience as a professional helps make one more receptive to change. Unilaterally imposed changes generate resentment and disaffection.

- d. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

'Grow your own' seems to be the best option for increasing supply and there is uncertainty around overseas staff in the light of the EU referendum

A clear commitment to improving rather than attenuating ("dumbing down") of health care professionals and qualifications would encourage recruitment and retention. Stronger efforts should be made to ensure that training and involvement in management of the service by healthcare professionals does not require them to neglect or reduce their health professional skills.

- e. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

Leaving the EU has already had an effect on healthcare scientists (HCS) as the European discussions around mutual recognition of qualification across Europe have been abandoned. Many HCS staff in the UK are EU citizens and there is uncertainty around qualifications, professional registration and future rights to practise in the UK.

- f. What are the retention issues for key groups of healthcare workers and how should these be addressed?

Healthcare Scientist retention is difficult in the shortage specialties and changes to training, resulting in a decrease in training numbers, have not made this any easier. The recent Health Education England (HEE) consultation around funding for training posts will make the situation much worse.

Remarks under 3a. above are relevant here also

9. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

- c. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

Information Technology (IT) is the lynchpin to increased agility with improved connectivity and ensuring harmonisation of data including diagnostic results which will contribute to patient safety.

Issues relating to standardisation, confidentiality, and so on mentioned under 1 above are also relevant here. Clear and straightforward standards for communication protocols would make it easy and affordable to incorporate commercial technological advances (such as smart phones, watches, etc.) into the healthcare environment.

- d. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

Training costs would be the main implication

There may also be an implication for salary costs in order to attract and retain appropriately qualified staff.

- c. What investment model would most speedily enhance and stabilise the workforce?

Training needs to be co-ordinated across the entire country so a national funding model is required

Models of service delivery and integration

10. What are the practical changes required to provide the population with an integrated National Health and Care Service?

- d. How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

Integration of budgets would work best if the individual Trusts are merged into single Trusts with single budgets

- e. How can local organisations be incentivised to work together?

Removal of the competition caused by the internal market in the NHS

- c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

Integration into single Trusts to avoid silo working

Prevention and public engagement

11. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

Healthcare education for the public and incentivise healthy living and wellbeing

Greater (though modest) investment in public health information, especially on-line, with full attention to evidence base and consistency of advice could reap great rewards in avoiding GP surgery visits, for example. This needs to include consistency in provision of direct access for patients to diagnostic investigation and results where it is appropriate coupled with interpretative professional advice. Peer reviewed and objective websites such as Lab Tests Online should be incorporated in and supported by central provision.

- h. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

Public awareness

- i. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?
- j. Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?
- k. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

No, it's better to provide education to the public

- l. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

It is not necessarily the sole responsibility of providers and needs all parties engaged

- m. What are the barriers to taking on received knowledge about healthy places to live and work?

The public becomes jaded with the array of conflicting information in the media especially around health and wellbeing

- n. How could technology play a greater role in enhancing prevention and public health?

Tele-health and wearable devices can assist in public health. This requires robust standards and protocols for confidentiality and communications as well as integration with healthcare records and quality assurance arrangements.

7. What are the best ways to engage the public in talking about what they want from a health service?

Patients and public are always keen to discuss health services and issues so social media may be a good route

Digitisation of services, Big Data and informatics

9. How can new technologies be used to ensure the sustainability of the NHS

- f. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

Technology will allow patient empowerment, informing choice and personal responsibility. In addition to the developments mentioned in the question, it may be anticipated that diagnostic technologies once only available in laboratories or radiology centres may become available in the GP surgery or even in wearable devices. This may drastically reduce the face-to-face time required between patient and professional but must be supported by relevant, robust and workable standards as well as the availability of professional interpretative advice through the same technologies.

- g. What is the role of 'Big Data' in reducing costs and managing demand?

Access to big data will provide evidence around patient outcomes and inform decision making

- h. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

Cost of the technologies may be prohibitive and there may be concerns over confidentiality and consistency (eg units and reference ranges for diagnostic tests) that will need to be addressed.

- i. How can healthcare providers be incentivised to take up new technologies?

Understanding the benefits that technology provides and ensuring cost effective options. Making examples of best practise readily available and supported by robust evidence.

- j. Where is investment in technology and informatics most needed?

Investment is required at local level to ensure local delivery. Some of the investment will be required in the development of robust standards and provision of technical expertise for deployment and ongoing quality assurance of the "devolved" technologies.

21 September 2016

Sir David Bell and Professor Jonathan Cohen – Written evidence (NHS0020)

A PUBLIC COMMISSION ON FINANCIAL SUSTAINABILITY OF HEALTH SERVICES

SUMMARY

There is broad acceptance of the fact that the NHS faces a considerable financial challenge. Failure to confront this challenge and to make decisions about the long term funding of healthcare risks a significant breakdown of services, but there is reluctance to even consider what options may exist because politicians regard the subject as too toxic and the public are antagonistic to any move which they perceive as risking the future of a service which they see as a national treasure.

Here, we propose the creation of a Public Commission that will carry out an evidence-based, forensic examination of national and international experience and make recommendations that would allow for the development of a sustainable funding model for the provision of NHS services. Critically, the Commission will be broadly based, will include members of the public in its membership and will actively engage the public in its deliberations.

This submission focuses on the “prevention and public engagement” theme of the enquiry.

1. Principles.

1.1 Four recent authoritative reports¹⁻⁴ have concluded that the next five years will be a period of considerable difficulty for the NHS. Three of these reports believe that the current financial model is unsustainable (the fourth, Simon Stevens’ 5 year forward view, concedes that the challenge will be considerable). At the same time, there is a very broad consensus, both politically and among the general public, that the fundamental model of the NHS providing the vast majority of its services free at the point of delivery, should remain.

1.2 Given anticipated demographic changes, the rising costs of goods and services, technological innovation and ever-increasing expectations there is a pressing need to review the current funding model and explore whether there are viable alternatives which merit consideration. Achieving this will not be easy, in part because of the undoubted complexity of the question but also because of the politicisation of health provision in the UK. If the solutions arrived at are to have traction across the spectrum and have a real chance of bringing about change, it is essential that the process is inclusive, rigorously evidence based, and emphatically apolitical. We believe that the best way to achieve this will be by the formation of a Public Commission with a broadly based membership commanding wide respect and the resources necessary to carry out the work to the highest standard.

1.3 But this alone will not be enough. Others have also seen the need to address the problem and have produced authoritative analyses and recommendations⁵ but their findings have failed to persuade politicians of the need for change. A very considerable part of the challenge is that the general public have shown no appetite to engage meaningfully in the debate. Despite the financial problems of the NHS appearing regularly in news reports, there appears to be a reluctance to recognise that this represents what is potentially an

existential threat to the service in its current form. It is for this reason that we believe that the crucial “missing piece” is the need to develop a process that allows the general public to play a full part, to be able to see, review and comment on the process, to understand the core challenges and to participate in the development of possible solutions.

1.4 We understand that this is not straightforward. But the alternative to not trying to address this is to wait until there is a crisis of sufficient magnitude that it forces short-term, ill thought-through solutions.

2. Challenges.

2.1. Ensuring political independence

It is self-evident that no political party would want to be associated with what would inevitably be characterised as an attempt to diminish or privatise the NHS. For these reasons, it is critical that the Commission we propose is explicitly independent of government, albeit it will have been established and perhaps funded by government. In fact, we have considered an alternative model, in many ways preferable, in which the Commission is paid for by a crowd funding model. Given the strength of feeling in the country it is not implausible that several million pounds could be raised in this way. Such an approach, of course, would provide very significant face validity to the findings as well as insulating the project from accusations of political interference. One of the strengths of this approach is that the government of the day will be able to say honestly that they were not involved in any way in generating the proposals. If the ideas are sufficiently authoritative and cogent, government will be able to consider them with a clear political conscience.

2.2. Scope

A key consideration is whether the Commission should include social care in its brief or limit itself to health. This will require careful thought. At present we are minded to suggest that a limited review would be more tractable, albeit with the disadvantage that it might miss the opportunities offered by the interconnections between health and social care.

2.3. Output

We do not believe that the purpose of the Commission is to produce a single, “recommended” solution. Rather, it would be to carry out what in simple terms might be described as an option appraisal. It will construct a series of plausible scenarios for long term funding and then test them, economically, technically (in terms of deliverability but also quality of healthcare provided), and socially, i.e. in respect of public acceptability. The purpose will be to expose, in an objective and transparent fashion, the tension between 100% tax funded healthcare and a mixed model of public/private funding in order to try and arrive at a consensus that would have broad public support. But beyond this central question, it would also ask whether *structural* changes in healthcare funding, e.g. adopting or modifying some of the models used in other developed economies, would offer any benefits to the UK.

2.4. Securing active public engagement

It is very unlikely that the nuances of health service funding will grip the public imagination in the same way as some of the more lurid revelations of the Leveson enquiry. Nevertheless, experience from Leveson suggests that the transparency of the proceedings and the opportunities to stream live feeds from the committee played a large part in ensuring a high impact for the committee's work. And even if discussions of funding models do not make good copy, cancer statistics or perinatal mortality rates certainly do: there is no lack of patient interest groups who would undoubtedly wish to give evidence. The appointment of some non-specialist commissioners (that is, members of the public without specific expertise in health or economics) will help to secure public engagement. We are under no illusions: much of the detailed work of the Commission will be dry and technical. But by proactively seeking the advice of those from the field of public communications and information technology it will be possible to demonstrate to the press and public the potential *implications* of the work and hence its relevance.

3. Outline proposal

3.1 Any significant change to funding of the health service is very likely to fail without strong public engagement and commitment, irrespective of which political party is in government at the time. We propose the establishment of a Public Commission that would undertake a detailed, forensic examination of models of healthcare funding and make recommendations on how the NHS should be funded over the next 10 – 15 years.

3.2. Membership will be inclusive, international, ensure user representation, and drawn from a wide range of disciplines. Our initial view is that there would be a core group of 6-8 commissioners who would draw upon other expertise on an ad hoc basis, as required.

3.3. Sessions will be open to the public and live streamed. Other social media communication methods will be used as appropriate. Public /"town hall" style meetings, regionally based, will help in raising public awareness.

3.4. The Commission would be apolitical, and ideally, crowd funded.

4. Conclusion

4.1. The general public recognise that the current situation is unsustainable; it is also extremely demotivating for those who work in the NHS, at all levels.

4.2 We believe that there is an appetite for genuine, open political discourse that will help frame policy. Such a fundamental question as funding of the NHS is very unlikely to find public acceptance unless the public is actively engaged in the process.

Sir David Bell

Prof Jonathan Cohen F Med Sci

Notes on the authors

This submission is the result of a series of conversations we have had with a number of experts about the future funding of the NHS and also springs from our own strong

conviction that there has to be a public debate about the future funding of the NHS which draws in as many members of the public as possible.

We are approaching this on a totally non party-political basis.

Sir David Bell is a former Chairman of the Financial Times and is on the board of the Economist. A former chairman of Crisis, the homeless charity, he was one of the Assessors in the Leveson enquiry into the British press. He is a trustee of the Esmée Fairbairn Foundation and Chair and President of Coram, the oldest children’s charity in Britain. He is also Chair of Governors of the University of Roehampton and Chairman of Cambridge University Press. He also chaired the organization that built the Millennium Bridge across the Thames – before and thankfully, after it wobbled !

Prof Jonathan Cohen is Emeritus Professor of Infectious Diseases and was the Foundation Dean of the Brighton & Sussex Medical School. He has worked in the NHS for more than 35 years. He is currently President of the International Society for Infectious Diseases. In addition to his clinical roles, he served as Vice Chair of the Medical Schools Council and served/currently serves as a non-executive director of several NHS trusts and foundation trusts, and as a trustee of several health-related charities including Arthritis Research UK. He has advised government in a number of roles including membership of the Joint Committee on Vaccination and Immunisation and the National Expert Panel on New and Emerging Infections. He has written this paper in a personal capacity.

¹ Dalton D. Examining new options and opportunities for providers of NHS care. Nov 2014

² National Audit Office. The financial sustainability of NHS bodies. Nov 2014

³ Murray R et al. Financial failure in the NHS. What causes it and how best to manage it. The Kings Fund. Oct 2014

⁴ Stevens S. Five year forward view. NHS. Oct 2014

⁵ Barker report, Kings Fund 2015

10 September 2016

Mrs Win Betts – Written evidence (NHS0166)

Mrs Win Betts – Written evidence (NHS0166)

Please do not let our NHS go, it is the lifeline of the infirmed and ill.

Even if it means everyone in the Country pays a small amount to keep it going and not selling it off

for a quick bob !! and tell them no rises for a year (Good luck on that one).

No more pay them the earth like we did Bankers.

Forget the TTIP, we can do this if as a Country we all pull together.

We are the envy of all countries So keep Britain Great Please via the NHS as everything is being sold off and we do not want that to happen to our NHS.

You hear horror stories but Kings College saved my life after having an

SAH/Ventriculitis/Sepsis. I do not do things by half xx

So please save our NHS

Regards

1 Grateful Patient who was able to cuddle my Daughter again and sing xxxx

23 September 2016

John Boyd – Written evidence (NHS0129)

Having worked in the NHS from 1966 and played an active part in hospital management as well as enjoying a busy clinical life can I make the following pleas:

1. Integrate wherever possible instead of separating; every separate sphere of responsibility creates duplication and bureaucracy.
2. Create a fixed formula for funding linked to an appropriate measure of the national wealth and the increasing health care needs of the population thereby removing it from political ideology.
3. This funding should be essentially tax based. Consider tax relief for private health care (it was never given a long enough trial) and consider specifically linking innovative tax raising measures specifically to the NHS. At present the older members of society are the best off financially and the justification for giving large sums of un-earned money to their inheritors is questionable.
4. My firm belief is that the role of the private sector in the NHS is rarely beneficial in the long term, but by all means test different approaches to health care on a measured and trial based basis.

22 September 2016

Juliet Boyd – Written evidence (NHS0126)

I am a retired doctor who qualified in 1964 and spent all my working life in the NHS. It is the envy of the world and must be preserved. I realise that the demands are ever-increasing and there is a chronic shortage of funds.

My suggestions are as follows:

1. Levy a tax specifically for the NHS and Social Care. Most people would rather pay such a tax than see the privatisation of the NHS. Consider a Lottery as a money-raising idea.
2. Fund public health better to prevent the problems of obesity etc.
3. Fund social care adequately to prevent patients having to stay in hospital unnecessarily.

22 September 2016

Dr Brian Boughton – Written evidence (NHS0012)

The growing funding gap in the NHS cannot be closed again and again by efficiency savings without affecting the staff morale on which the whole ethos of the NHS depends.

New funding is becoming urgent and if ideas from other countries are to be examined, the Canadian Ontario Health Insurance Plan is a good example.

28 August 2016

British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) – Written evidence (NHS0015)

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

There must be an urgent review of what the NHS should, and can, afford. It is not possible for politicians or the medical, para-medical and nursing professions to decide on this and a Royal Commission is required to look at the question to remove it from the political sphere. There are no efficiency savings left in the NHS, privatisation is not an option and so the only options that remain are patient contributions for care, which will be political unacceptable, or a proper debate about what we can afford as a country. (As an individual, I feel this strongly enough, to have set up a .gov poll asking for support for a Royal Commission to look at NHS funding.)

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?
 - a. Does the wider societal value of the healthcare system exceed its monetary cost?

Yes. Medical capability has out grown the budget we have available. A Royal Commission is essential as outlined in (1) above.

- b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent? What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

There is widespread support in the profession for patient contributions to NHS care. The NHS is undervalued by a significant proportion of the population, who now take it for-granted. There are significant numbers of DNAs for outpatient appointments and procedures with out any sanction being applied. For many years, dentists in the NHS have charge for missed appointments and primary, secondary and tertiary medical services should be allowed to do the same.

There remains wide support for trauma and cancer care should be free at the point of entry to the system, but there already exists the mechanism to claw back some costs from road traffic accidents via motor insurance

The NHS Act should be amended to allow provision for NHS and private care to be incorporated in individual care packages (e.g. paying the NHS for an upgraded prosthesis).

British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) – Written evidence (NHS0015)

d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

As above, the NHS Act should be amended to allow provision for NHS and private care to be incorporated in individual care packages (e.g. paying the NHS for an upgraded prosthesis).

Some procedures should be removed from NHS provision, but those must be decided by Royal Commission.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

Surgery has become very unattractive as a profession. Changes due to the EWTD and contracts are fundamentally to blame. The changes have demolished good will in the NHS and getting rid of the EWTD will change the quality of training and the ethos of those working in the NHS.

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

BREXIT would allow a return to acceptance of equivalence of training with Australasia, Canada, the Indian sub-continent, South Africa, Singapore and Hong Kong amongst others together with (re) validation of credentials before entry to the GMC register.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

See above. The quality of medical professionals from some European countries left much to be desired and AUTOMATIC entry to the GMC register, with out assessment of competence in their specialty and in colloquial and medical English was a travesty.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

Money is not the issue. Working conditions are and, if the new contract is inflicted on consultants, most over 55 will leave and many over 52 will seriously consider doing so. Doing the same with the trainees' contract has had the same deleterious effect on moral and work ethic.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) – Written evidence (NHS0015)

- a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

There no assessment of competence for doctors in the NHS. Revalidation does not weed out poor performance it is now accepted. Assessment of surgical competence is essential. No one would be allowed to be flown by a pilot who has not has their competence tested. Why should surgeons be any different?

- b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

'Pay peanuts and you will get monkeys' but ask surgeons to train other health care professionals to work with them as part of their team to deliver aspects of care will work and seems attractive, but continued job satisfaction and development will be an issue for this group.

- c. What investment model would most speedily enhance and stabilise the workforce?

Improve working conditions as soon as possible. Pay is not the issue. Conditions are the issue and if the Government values the work force and does not view them as adversaries, it will pay dividends.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

- a. How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?
- b. How can local organisations be incentivised to work together?
- c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

Social care and the whole infrastructure of the NHS needs to work 7 days a week to support trauma and urgent NHS provision of care at this moment in time. Currently, support care stops, to all intents and purposes at lunchtime on a Friday and re-opens late morning on a Monday. 7 day NHS/social/support care will cost a fortune. To pay for that, other aspects of wider care can no longer be funded. Only a Royal Commission can decide upon that. Politicians and the medica and para-medical professions cannot.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

Advertising carries a lot of the responsibility for poor public health as does the loss of physical education from the school curriculum and the wider life style of families The

average reading age is now 9 in this country and the level of understanding has to be taken as the same. Advertising of foodstuffs needs to be looked at by the CAP with appropriate diatetic support and there must be exercise programmes in every school from the earliest age.

- a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?
- b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?
- c. Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

Levying VAT, together with an additional health tax on cigarettes, alcohol and on unhealthy eating will help fund NHS provision of care. Legalisation of some currently illegal drugs will allow the imposition of the same taxes to pay for the care of these who wish to partake. Perhaps all substances of addition should be taxed to help pay for the care of those who become addicted?

- d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?
 - e. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?
 - f. What are the barriers to taking on received knowledge about healthy places to live and work?
 - g. How could technology play a greater role in enhancing prevention and public health?
7. What are the best ways to engage the public in talking about what they want from a health service?

A Royal Commission

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?
 - a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?
 - b. What is the role of 'Big Data' in reducing costs and managing demand?
 - c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?
 - d. How can healthcare providers be incentivised to take up new technologies?
 - e. Where is investment in technology and informatics most needed?

British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) – Written evidence (NHS0015)

Here is a conflict. EPR Data in the USA is used for billing not for audit or collection of patent based outcomes. EPR and big data are confused in the UK and systems from the USA tried to be adapted when not fit for purpose.

1 September 2016

British Dental Association – Written evidence (NHS0117)

Introduction

1. The British Dental Association is the professional association and trade union for dentists in the UK. Our members work in all spheres of practice including general dental practice, the hospital and community dental services, university teaching and research and the armed forces. Throughout this evidence we have mainly used dentistry examples but many of the points apply equally across the whole of the NHS.

Resource issues, including funding, productivity, demand management and resource use

2. We agree that there is a real need to look at the long-term financial sustainability of the NHS and this should be part of a fundamental review by government. Long-term planning for the NHS is essential; a five year plan is not nearly long enough.
3. Despite access to healthcare on the basis of clinical need, not ability to pay, being a founding principle of the NHS in 1948 – restated in the NHS Plan (2000) and NHS Constitution (2015) – dental services have been subject to patient charges since 1952. NHS charges were initially intended to raise money, to reduce demand and unnecessary use of the NHS, and, in the case of dental and sight test charges, to fund rearmament prior to the Korean War²⁰². Since then, numerous studies have found patient charges to be among the main barriers to accessing oral healthcare.
4. NHS dental charges are one of the few examples of adults making a contribution to the cost of their NHS care. Dental charges were raised by the substantial amount of 5% in 2016 and will rise again by 5% in 2017. This is not in the best interests of patients and impacts most on those needing advice and care. The Adult Dental Health Survey reports that just over a quarter of adults (26%) say that the type of dental treatment they opted for has been affected by the cost of this treatment - and almost one-fifth (19%) say that they have delayed dental treatment for the same reason. At the same time, we know that charges are driving 600,000 people a year to seek dental treatment with their GPs, who are not set up to provide the care they need. This costs the NHS £26 million a year. Many patients on low to moderate incomes are offered no exemptions from these charges by government.
5. Direct government spending on NHS dentistry in England has fallen by £170 million since 2010, and is being topped up by these inflated patient charges. Patient charges are expected to make up a third of the England's NHS dental budget by 2020 and could overtake government spending as the largest source of revenue for the service within a generation.
6. Even with patient charge revenue, the limited dental NHS spend in England enables less than 52% of the adult population to be treated. The number of children seen by

²⁰² NHS Charges, House of Commons Health Select Committee, 18 July 2006

an NHS dentist in the 12 months up to 30th June 2016 was 6.7 million. This equates less than 58% of the child population.

7. Charging for NHS dental services is one of the reasons for a strong private dental market in the UK. If patients are already paying for care, choosing to pay privately is not a significant step. The lack of a properly funded NHS dental system and poor reward for NHS work can encourage dentists towards private practice. This can lead to serious access problems for NHS dentistry.
8. There are some lessons to be learnt from the experience of NHS dentistry that should be heeded in respect of other parts of the NHS. Restricting access to NHS services might have an adverse impact on patient uptake and therefore on public health, particularly amongst those most in need of treatment.
9. NHS dentistry is currently a scarce resource that should be used productively in order to maximise its impact on the population's oral health. The BDA is concerned that this is not currently happening, largely because of the contractual framework for NHS dentists. The NHS contract needs to change to facilitate a prevention-based approach to dental care. This issue is covered below in more detail under the 'prevention' section.
10. Like other NHS providers, dental professionals have had to make year on year efficiency savings in the face of rising demand and increasing need. We cannot see this being sustainable across the NHS without consequent reductions in investment and diminishing quality of care. After years of efficiency pressures, dental, and other healthcare, providers, are at the point where they genuinely cannot see where the next efficiencies can be made. As the Nuffield Trust recently confirmed, the NHS in England will struggle to meet the requirement, set by the Five Year Forward View, to save £22 billion by 2020. Even in the unlikely event that NHS providers are able to make cost savings of 2 per cent a year, year after year, the funding gap would still stand at around £6 billion by 2020–21.
11. The level of recurrent, sustained efficiency saving required has never been achieved in the NHS and would still require funds to be taken from the Sustainability and Transformation Fund to balance provider deficits in the meantime. In dentistry, and across the NHS, activity is growing - overall by an estimated 3.1% per year. Even with efficiency measures, more NHS funding is required. Across the NHS, the amount that providers are paid, and the increase in contract values, has not covered provider costs. This can only damage the quality of care in the long term.

Workforce

What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

12. Looking specifically at oral health, disease patterns continue to evolve and with factors such as the projected changes in population demographics this will continue. Overall dental decay rates continue to fall but this is countered by increases in other oral diseases and it will be necessary to have a profession with a skill mix able to tackle these problems.
13. By mid-2024, the UK population is projected to increase to 69.0 million and to continue ageing.²⁰³ By 2030 51 per cent more people in England will be aged 65 and over and 101 per cent more people will be aged 85 and over compared to 2010.²⁰⁴ People have been increasingly retaining their teeth and the most recent Adult Dental Health Survey (ADHS) (2009) predicted that within decades half of the older population may be able to rely on their natural teeth alone.²⁰⁵ The increased retention of natural teeth, coupled with an aging population will result in complex dental needs, complicated by co-morbidities and care setting, and most probably result in an increased demand for crown and bridge work, endodontics and advanced periodontics.²⁰⁶ Severe periodontal disease²⁰⁷ is more prevalent in the older age groups and has an evident age trend. Incidence of oral cancer in Great Britain has increased by 92 per cent since the late 1970's²⁰⁸ and cumulative dental conditions such as tooth wear are becoming more prevalent.²⁰⁹ Given that cancer in general is most common in older people²¹⁰ and that almost half of oral cancer cases diagnosed in the UK are in those over the age of 65²¹¹ the projected increase of those in the older age groups over the coming decades could be accompanied by increasing incidence of oral cancers. The projected increase in conditions such as diabetes will also affect dental disease as dental problems are more common in those with diabetes.^{212 213} At the other end of the spectrum, with decay falling overall in younger age groups, the dental service needs clinicians and other members of the dental team, able to support preventive and non-invasive care. Changes in dental disease are accompanied by changes in public demands and expectations of the dental service with an increased demand for aesthetic treatment alongside the need to treat oral disease.
14. Policy implications for the NHS of these changes in disease patterns is the need to develop a workforce able to manage these changes - clinicians with an appropriate skill mix. Ensuring the appropriate skill mix is a long-term and complex project but should be ensured in order to provide an appropriate service. This requires investment in proper workforce planning so that we have the right number of practitioners focussed on prevention and the right number of specialists to deal with patients with complex clinical needs.

²⁰³ National Population Projections 2014-based Statistical Bulletin

²⁰⁴ NHS Sustainability Committee - Call for Evidence (004)

²⁰⁵ ADHS

²⁰⁶ ADHS

²⁰⁷ ADHS

²⁰⁸ <http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer/incidence>

²⁰⁹ SN02677

²¹⁰ SN02677

²¹¹ <http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer/incidence#heading-Zero>

²¹² https://www.diabetes.org.uk/about_us/news_landing_page/nhs-spending-on-diabetes-to-reach-169-billion-by-2035/

²¹³ <https://www.diabetes.org.uk/Guide-to-diabetes/What-is-diabetes/Related-conditions/#dental>

15. In order to provide an efficient service to an increasing population, inter-professional working and greater flexibility and collaboration in individual roles and skills to support and motivate patients to make healthy choices is essential. Dental hygienists, dental nurses and dental therapists have an important role to play in delivering treatment, prevention and oral health education to patients but they will never replace the highly skilled care that is provided by dentists.
16. The proportion of registered female dentists and female undergraduate dental students is increasing and possible increases in career breaks should be taken into account when determining workforce requirements. The majority of general dental practitioners are expected to be in their 30s in the 2020s and 40s in the 2030s indicating that overall an aging workforce will not be an issue for dentistry in the 15 – 20 years' time.

What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

17. As discussed above, in relation to oral health in particular, there is a need to consider skill mix requirements in dentistry, with the changing healthcare needs of the population possibly requiring an increase in the number of dental care professionals such as hygienists and therapists. These professions clearly have different entry requirements to dentists.
18. Non EEA dentists seeking to register and practise in the UK must pass the Overseas Registration Examination, meet appropriate work permit requirements and then if they want to work in NHS primary care, gain entry to the dentist performers list by equivalence all of which can be very expensive and difficult. This is particularly true for refugee dentists and more help and support for this group would be extremely helpful.
19. As a general policy position, it is inappropriate, and arguably immoral, for developed nations like the UK to continue to rely on overseas recruitment to staff health services. The UK's objective should be self-sufficiency in workforce planning.

What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

20. Over the last six years approximately 30 per cent of dentists joining the dental register have been from the EEA.²¹⁴ Under the European directive on the recognition of qualifications dentists, with a few exceptions, who have qualified within the EEA automatically have their qualifications recognised by the General Dental Council. It is not known how the decision to withdraw from the EU might affect the recruitment of dentists with EEA qualifications but there are serious concerns about a potential

²¹⁴ <http://www.gdc-uk.org/Pages/default.aspx>

shortage of NHS dentists. As with the rest of the health service, the UK's eventual exit negotiations must factor in the future need for appropriately skilled dental professionals.

What are the retention issues for key groups of healthcare workers and how should these be addressed?

21. Across the NHS, there has been a sustained deterioration in real terms pay and other conditions during the past decade. This has an inevitable impact on morale, motivation and retention. There has been a series of below-inflation pay awards and an attack on other conditions, NHS pensions in particular.
22. In order to retain dentists within the NHS, the terms and conditions for NHS dentists need to be improved. In England and Wales self-employed general dental practitioners' taxable income has fallen by 35 per cent in the last ten years due to NHS funding not keeping pace with rises in dental practice expenses. This will continue until at least 2020 and by that point we can see many dental practices being unable to continue within the NHS.
23. Dental providers in England face a huge regulatory burden, with excessive and costly regulation via the General Dental Council, with the additional jeopardy of Care Quality Commission and NHS England oversight. Care Quality Commission inspections demonstrate that dental services present a low risk to patients' safety in comparison to other regulated sectors²¹⁵ but dentists are faced with a high level of reporting and bureaucracy that burdens dental practices. Reducing bureaucracy would improve retention as would improving healthcare regulation.
24. BDA research shows that 39 per cent of community dentists and almost half of general dental practitioners reported high levels of stress. This is compared to an average of around 15 per cent for all British workers. Increasing workload pressures, which show no sign of abating, are having a negative effect on the motivation of dentists²¹⁶ and there are concerns that as pay continues to decline in absolute terms and relative to comparator professions this may affect recruitment and retention negatively in general dental practice. Low practice owner morale is a concern given the rise in expenses and the falls in income making dentistry a very difficult profession in which to run a business and deliver high quality healthcare with data illustrating a direct correlation between low morale and motivation with dentists with higher levels of NHS commitment.
25. The Community Dental Service (CDS) provides care for some of the most vulnerable members of society. Concerns have been raised that staff are unable to progress unless they are specialist trained. This could contribute to the eventual erosion of the workforce and a further increase in stress and pressure on those remaining to a level where retention would become a significant problem. Dentists in the CDS should be encouraged to enter further training with allowances, both time and financial, being

²¹⁵ <http://www.cqc.org.uk/content/cqc-inspectors-publish-new-style-reports-12-dental-practices>

²¹⁶ <https://www.gov.uk/government/organisations/review-body-on-doctors-and-dentists-remuneration>

made for this by their employer. As well as improving morale this would improve service provision and aid skill mix.

How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

26. In relation to dentistry, beginning at undergraduate level, students must have access to an appropriate range and number of patients to ensure that they are adequately exposed to, and familiar with, oral health problems in situ to prepare them as much as is possible for clinical situations. There must be adequate funding and investment for Dental Foundation Training (DFT) places to ensure that all graduates who wish to undertake this are able to. At the moment, there is a shortage of funded places, resulting in a waste of talent and a waste of the £150,000 training invested in a young dentist unable to work in the NHS. DFT in England, Wales and Northern Ireland and Vocational Training in Scotland introduces new graduates to general practice by providing a protected work environment whilst they undertake training to prepare for working in the NHS. Before a dentist can practise in the NHS they must either have a performer number, or show they have received experience or training equivalent to DFT or be exempt from DFT. In addition to allowing dentists to practise in the NHS, DFT aids preparation for postgraduate examinations such as the MFDS or MJDF, for careers in primary dental care or further training posts, such as Core Dental Training posts possibly leading to specialist training. The latter is an important consideration following the predicted changes in disease patterns and the growing importance of skill mix.
27. There is also a lack of investment in the training of dental care professionals and an almost complete reliance on the private sector or on individuals funding their own training. This is possibly a unique aspect for an NHS service.

Prevention and public engagement

What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

28. Dental disease is almost entirely preventable and it costs the NHS about £2.7bn every year. The current drive towards prevention must continue both with public health policy and NHS dental contracts. A new approach to NHS contracts is currently being prototyped in England. The BDA is fully supportive of the need to change the focus of NHS dentistry away from activity measures (which encourage intervention) to a contract that rewards a preventative pathway approach to oral health. This is entirely the right sort of approach for the whole of healthcare. However, the Department of Health must be courageous and abandon its commitment to the outdated and undermined 'Unit of Dental Activity' measure. We would like to see prevention and capitation-based contracts across dentistry in England. If prevention based contracts for general dental practice can be rolled out from 2018/19, by 2025-2030 there should be a real change in how NHS dentistry is delivered by dentists and their teams. Providing contractual incentives to deliver effective prevention must be the way

forward for the whole of the NHS. Dentistry could and should be in the vanguard of this change.

29. Sugar, tobacco and alcohol are drivers for dental and other diseases and must be addressed in public health policy. The BDA is very supportive of the introduction of a sugar tax with sugar the cause of dental decay in the UK. We believe the tax will help to reduce the incidence of oral ill health, particularly in children. Our main concern however is that none of the revenue raised by the tax will be spent directly on NHS healthcare. Whilst the proposed programmes for children's activity are laudable, we believe that there is an equally strong case for investment in children's oral health.
30. The introduction of plain packages for cigarettes is a positive development for public health and smoking and tobacco use should continue to be targeted. Where general health policy is currently regulated by EU law, for example anti-smoking measures,²¹⁷ equivalent measures must be retained following EU withdrawal and built upon to discourage tobacco use and further work into the possible effects of smoking substitutes, for example, e-cigarettes, should be acted upon in the interest of public health.
31. A further policy change to enable to NHS to shift to a more preventive and engaging form of dentistry would be the introduction of a robust co-ordinated and multi-disciplined promotion of tooth brushing, oral maintenance and healthy eating from the early stages of pregnancy through to school aged children highlighting the importance of maintaining good oral health, establishing good oral hygiene routines and eating well to protect against periodontal disease, caries, tooth wear and oral cancer. This would enable good habits to be picked up at an early age to help ensure continuing good oral health. Children's oral health programmes already operate successfully in other UK countries, for example Child Smile in Scotland, leaving England lagging behind.

What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

32. The State has the resources to fund a preventive healthcare strategy, backed up by the appropriate research. Public Health England in particular is well-placed to lead on the preventive agenda. Local authorities are finding it difficult to fund initiatives like smoking cessation and other public health interventions but they are the best organisations to fulfil this role because they are able to join up issues that affect health such as work, housing and education.
33. In relation to oral health in particular, though many population groups are benefitting from significantly improved oral health, the brunt of dental disease remains highest amongst the poorest sections of society with a clear relationship between increasing levels of deprivation in the population and increasing levels of dental

²¹⁷ CBP-7213

disease experience.^{218,219} With this in mind, dental care, preventive or otherwise, should be targeted to those who are in the greatest need. Targeted investment into existing practices located in deprived communities, and/or commissioning new dental practices located in deprived areas would allow for some of the inequalities, for example those due to access to care, to be reduced and enable the NHS to shift to a more preventive service. Devolved ring-fenced budgets would help this. Oral health promotion should continue to be tailored specifically to the patient.²²⁰ There also needs to be recognition that lifestyle choices can be severely restricted among the most marginalised and disadvantaged groups in the population.

What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

34. We support the 2010 Marmot Review's conclusions and strategy that action is needed to tackle the social determinants of ill health. This would be the most effective way of reducing health inequalities, including oral health inequalities. The NHS is the largest employer in Europe and ensuring that the NHS supports its workforce, pays fairly and ensures staff have satisfying and rewarding careers should be a key responsibility.

23 September 2016

²¹⁸ 20706226

²¹⁹ ADHS 2009

²²⁰ oral-health-promotion-general-dental-practice-1837385644741

British Dietetic Association – Written evidence (NHS0135)

Executive Summary

- 1.1. The BDA believes that dietitians have a vital role to play in the future sustainability of the NHS. Nutrition plays a vital role in keeping people healthy, treating disease and helping people to recover from ill health. As a relatively small but highly specialised profession, dietitians already do a great deal across healthcare to improve patient outcomes, drive NHS efficiency and improving public health to ensure it remains sustainable into the foreseeable future. This consultation response, summarised below, sets out our view on how wider sustainability can be achieved.
- 1.2. Demographic and health changes over the next 15 years fundamentally threaten the sustainability of the NHS. Diet and nutrition plays a critical role in reducing the impact of an ageing population and reducing the prevalence of long term conditions. 10.8% of all illness is caused by poor diet and for some conditions, better diet and nutrition can prevent them developing at all, while with others they can lessen their impact, speed recovery and reduce hospital stays.
- 1.3. The current spending envelope for the NHS is not realistic, and while we have a highly efficient health service we lag behind our neighbours in terms of outcomes, funding as a proportion of GDP and staffing numbers. We urgently need a model of funding that recognises the wider social impact of the health service, integrates health and social care and guarantees the principle of healthcare free at the point of delivery. There are opportunities to fund this through specific taxes, while also having desirable health outcomes through the use of sin taxes and levies.
- 1.4. There are currently insufficient dietitians in the UK to meet current needs, let alone the much wider roles that we believe they could perform. The removal of bursaries for dietitians, nurses and other AHPs will have an unknown effect upon the future expansion of the workforce. The government must take steps to ensure the UK still has access to talent from the EU and from around the world despite “Brexit”.
- 1.5. The NHS is struggling to retain existing staff, who have faced increasing demand while facing long-term pay restraint. The BDA’s own Safe Workload, Safe Staffing survey found 54.7% of respondents felt they could not see patients in a timely manner, and 39.7% felt they lacked opportunities to undertake important personal development work. Technology has the capacity to greatly increase the flexibility and agility of the workforce, but should not be regarded as a panacea that will enable the health service to do more ‘on the cheap’ with fewer members of staff.
- 1.6. Collaboration between healthcare organisations suffers because of the divide between investment and outcomes. Many of the most effective interventions or collaborative proposals will produce positive outcomes that do not directly benefit those paying for them. The imbalance in the current funding models between

secondary and primary care and between physical and mental health need to be addressed.

- 1.7. The most severe imbalance in funding and priorities is between prevention and treatment. Only 4% of the NHS's budget is currently spent on prevention, and public health is ringfenced and run separately by local authorities. This must change. The government should provide a strategic framework that encourages and facilitates healthy choices and lifestyles, using the full range of tools and levers at its disposal. Technology should play a key role, but is again not a panacea or a replacement for appropriate healthcare expertise.

2. About the BDA

- 2.1. The BDA is the only body in the UK representing the whole of the dietetic workforce. We are a trade union and professional body representing the professional, educational, public and workplace interests of our members. Founded in 1936, we are one of the oldest and most experienced dietetic organisations in the world. The majority of our members work in the NHS, Social Care or for an NHS funded service.
- 2.2. Membership is open to anyone working in dietetics, in nutrition, or who has an interest in diet or food, throughout the world. We represent the whole of the dietetic workforce - practitioners, researchers, educators, support workers and students.

What is a dietitian?

- 2.3. Registered dietitians are qualified health professionals that assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Uniquely, dietitians use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.
- 2.4. Dietitians are statutorily regulated, with a protected title and governed by an ethical code, to ensure that they always work to the highest standard. The spectrum of environments in which dietitians practise is broad and includes the NHS, private practice, industry, education, research, sport, media, public relations, publishing, non-government organisations and national and local government.

3. The Future Healthcare System

- 3.1. Demographic and health changes over the next 15 years fundamentally threaten the sustainability of the NHS. Age UK expects the number of people aged over 65 to increase to 16 million by 2030 – by 2040 one in four people will be aged over 65. They also estimate that by 2030, unless something changes, 6.25 million of those over 65s will have a long term limiting illness or disability, up from 4.5 million now.

- 3.2. 1.3 million over-65s are currently malnourished and a third of all older people admitted to hospital are at risk of malnutrition.²²¹ At current rates, 5.5 million Brits could have diabetes by 2030 according to Diabetes UK²²². The WHO and UK Health Forum estimate three quarters of men (74%) and two thirds of women (64%) in the UK could be overweight or obese by 2030²²³
- 3.3. 51 per cent (£8.8 billion) of expenditure in adult social services in 2012-13²²⁴ and two thirds of the primary care prescribing budget were on those aged 65 and over. While 70 per cent of health and social care spending is on people with long term conditions²²⁵.
- 3.4. Diet and nutrition plays a critical role in all of the above and in a whole host of other health conditions. 10.8% of illness caused by poor diet²²⁶, up to 35% of care home residents and 32% of over 65s admitted to hospital are malnourished²²⁷ which complicates care and has a detrimental impact on outcomes. In some instances better diet can prevent conditions developing at all, in others they can lessen their impact, speed recovery and reduce hospital stays.
- 3.5. To make the NHS sustainable we should not consider how we can adapt services to cope with additional disabilities, obesity or diabetes, but instead act quickly and decisively to prevent and reverse these trends. Our healthcare system needs to realign itself fundamentally to prevention, even if that involves shifting funding from acute care and regulating to improve the public's diet. At the same time the UK population needs to take greater responsibility for its own health and wellbeing, or face losing the NHS it values so much.

4. Resources

- 4.1. The current spending envelope for the NHS is not realistic. There are certainly efficiencies that can be made to reduce wastage in some areas, and services could

²²¹ Later Life in the UK [Internet]. Ageuk.org.uk. 2016 [cited 23 September 2016]. Available from:

http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

²²² One Million People Unaware they have T2 Diabetes [Internet]. Diabetes UK. 2016 [cited 23 September 2016]. Available from: https://www.diabetes.org.uk/About_us/News_Landing_Page/One-million-people-in-UK-unaware-they-have-Type-2-diabetes/

²²³ Meikle J. WHO report: 74% of men and 64% of women in UK to be overweight by 2030 [Internet]. the Guardian. 2015 [cited 23 September 2016]. Available from: <https://www.theguardian.com/society/2015/may/05/obesity-crisis-projections-uk-2030-men-women>

²²⁴ HSCIC Adult Social Care Statistics team. Personal Social Services: Expenditure and Unit Costs, England [Internet]. London: HSCIC; 2016 p. 5. Available from: <https://catalogue.ic.nhs.uk/publications/social-care/expenditure/pss-exp-eng-12-13-prov/pss-exp-eng-12-13-prov-rpt.pdf>

²²⁵ 5. Oliver D, Foot C, Humphries R. Making our health and care systems fit for an ageing population [Internet]. London: The Kings Fund; 2014 p. p1. Available from: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

²²⁶ 6. Newton J. The burden of disease and what it means in England | Public health matters [Internet]. Publichealthmatters.blog.gov.uk. 2015 [cited 23 September 2016]. Available from:

<https://publichealthmatters.blog.gov.uk/2015/09/15/the-burden-of-disease-and-what-it-means-in-england/>

²²⁷ Malnutrition Factsheet | Malnutrition Task Force [Internet]. Malnutritiontaskforce.org.uk. 2016 [cited 23 September 2016]. Available from: <http://www.malnutritiontaskforce.org.uk/resources/malnutrition-factsheet/>

be reformed to improve their effectiveness. However, it is also true that we do not spend enough money in general on health if we wish to achieve the same sort of outcomes as our European neighbours. The King's Fund, working from OECD data, shows that the UK around 2% less of our GDP on healthcare than the Netherlands, Denmark, France, Germany and Sweden²²⁸. We have fewer health professionals per person than many of our western neighbours²²⁹. This is also true in the specific case for dietitians – Canada had 25.92 dietitians per 100,000 in 2006²³⁰ while the UK still has only 13.55 per 100,000 as of 2016²³¹.

- 4.2. Analysis from the Commonwealth Fund, which places the NHS as the best healthcare system on the world, highlights this critical problem. Although the quality of care and access to care is the best, the outcomes are amongst the worst – we continue to have much higher death rates from conditions amenable to medical care than nearly every other country from the 11 studied²³². The efficiency and quality of our services should be lauded – but imagine what we could do if we resources those services as well as our neighbours.

Wider Societal Value

- 4.3. The NHS and wider healthcare system clearly has a social impact beyond simply its monetary cost. Improving quality of life, keeping people in work and improving productivity, the healthcare system has a huge impact in all these areas and more. The link between health (as measured in various forms) and economic performance has been recognised for some time; for example cardiovascular disease²³³. Models have been developed by NICE and others that can quantify the wider societal benefits of certain treatments or health interventions²³⁴.
- 4.4. However, it is clear that despite the wider impact of health services, this influence is not properly factored into our healthcare policy or the way we plan and fund healthcare. Research by the Office of Health Economics has shown that in the UK, like many of its neighbours, the link between health and wealth, including productivity gains and savings in other areas, does not influence decision making²³⁵.

²²⁸ Health care spending compared to other countries [Internet]. The King's Fund. 2016 [cited 23 September 2016]. Available from: <http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/health-care-spending-compared>

²²⁹ Tables 29 & 31, Health: Key Tables from OECD - OECD iLibrary [Internet]. Oecd-ilibrary.org. 2016 [cited 23 September 2016]. Available from: http://www.oecd-ilibrary.org/social-issues-migration-health/health-key-tables-from-oecd_20758480

²³⁰ Dietitians of Canada. The Dietitian Workforce in Canada [Internet]. Dietitians of Canada; 2011 p. 10. Available from: <http://www.dietitians.ca/Downloads/Public/Workforce-Meta-Analysis-Report-English-pdf.aspx>

²³¹ HCPC - Health and Care Professions Council - Professions [Internet]. Hcpc-uk.co.uk. 2016 [cited 23 September 2016]. Available from: <http://www.hcpc-uk.co.uk/aboutregistration/professions/index.asp?id=5>

²³² Davis K, Stremikis K, Squires D, Schoen C. Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally [Internet]. Commonwealthfund.org. 2014 [cited 23 September 2016]. Available from: <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>

²³³ Suhrcke M, Urban D. Are cardiovascular diseases bad for economic growth?. Health Econ. 2010;19(12):1478-1496.

²³⁴ NICE. Methodology for estimating "Wider Societal Benefits" as the net production impact of treatments. NICE; 2011.

²³⁵ Garau M, Shah K, Sharma P, Towse A. IS THE LINK BETWEEN HEALTH AND WEALTH CONSIDERED IN DECISION MAKING? RESULTS FROM A QUALITATIVE STUDY. International Journal of Technology Assessment in Health Care. 2015;31(06):449-456.

Funding Models

- 4.5. As discussed above, changes to the way that funding is distributed are less important than ensuring that the quantum of funding is sufficient. Current mechanisms are intended to prioritise areas of greatest need, but still lead to a “postcode lottery” because some areas are always destined to lose out.
- 4.6. The government is already committed to guarantee funding as a proportion of GDP in both Defense and International Aid/Development. We believe it would be appropriate for a similar approach to be taken to health spending. At the moment, according to the Kings Fund, healthcare spending as a proportion of GDP will fall to 6.6 per cent in 2020/21 compared to 7.3 per cent in 2014/15²³⁶. If instead the government was committed to maintain healthcare spending as a proportion of GDP by 2020/21 there would be an additional £16 billion a year in funding to the NHS. By linking to GDP growth healthcare funding becomes sustainable and linked to the nation’s capacity to afford it.
- 4.7. The Barker Commission²³⁷ has highlighted the need to fully integrate and ring-fence the budgets of both health and social care. The NHS may have its budget protected to some degree, but it will feel the impact of a failing social care system that is seeing significant cuts unless something changes soon. Dietetic services in both community and secondary settings feel the impact of inadequate social care in the form of increased referrals, for example for malnutrition, when issues could have been dealt with at a much earlier stage within the care setting.
- 4.8. Ensuring budgets are managed by those with the most expertise involved is a positive way to reduce unnecessary wastage, such as in Rotherham, where the nutritional products budget is managed by the dietetic department²³⁸. Efforts to encourage a collaborative or cooperative approach to care with patients and reduce unnecessary or unwanted treatment could have a significant effect. The Academy of Medical Royal Colleges’ Choosing Wisely campaign is a good example²³⁹.

Hypothecated health taxes/sin taxes

- 4.9. The BDA believes that there is scope to make constructive use of the tax system to both raise funds for specific health interventions, and to drive behaviour change on important issues of public health. We have already seen the successful use of “sin taxes”, in combination with comprehensive public health campaigns, to drive down smoking rates, and believe similar outcomes could be achieved through the introduction of others, such as the sugar levy which has been proposed by the

²³⁶ How does NHS spending compare with health spending internationally? [Internet]. The King's Fund. 2016 [cited 23 September 2016]. Available from: <http://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally>

²³⁷ Barker K. A new settlement for health and social care [Internet]. The King's Fund. 2016 [cited 23 September 2016]. Available from: <http://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care>

²³⁸ Nutritional products on prescription | Rotherham NHS Foundation Trust [Internet]. Therotherhamft.nhs.uk. 2016 [cited 23 September 2016]. Available from: http://www.therotherhamft.nhs.uk/Nutrition_and_Dietetics/User_Content/Nutritional_products_on_prescription/

²³⁹ Choosing Wisely - Academy of Medical Royal Colleges [Internet]. Academy of Medical Royal Colleges. 2016 [cited 23 September 2016]. Available from: <http://www.aomrc.org.uk/quality-policy-delivery/healthcare-policy/choosing-wisely/>

government. The BDA has welcomed²⁴⁰ the introduction of the levy, and believe it could be extended more widely.

- 4.10. Critically, we believe there is a strong argument for the funds raise by sin taxes to be specifically directed towards the services that deal with the consequences of those sins, and on the basis of need. In Again this has been reflected in the government's decision to spend the monies raised from the Sugar Levy on school sports, which is positive. We would argue that this funding should also be spent on nutrition education and skills, especially as our obesity epidemic is more a consequence of excess consumption than a lack of exercise.
- 4.11. Given that we believe that the NHS requires more funding to become sustainable, other taxes that might raise the required funding should be considered.

Free at the point of use

- 4.12. We would object to any change to the principle that the NHS is free at the point of use. However, this does not preclude services from making informed decisions about the cost effectiveness of treatments and procedures. The BDA does not believe that anything and everything should be made available on the NHS, and efforts should be made to reduce unnecessary treatment and wastage due to issues such as over- or mis-prescribing of drugs, borderline substances and treatments.

5. Workforce

- 5.1. The NHS as a whole is facing a recruitment problem. A report by the Smith Institute indicates that NHS trusts and local government health teams are finding it difficult to fill staff vacancies²⁴¹, particularly in more highly skilled roles.

The requirements of the future workforce

- 5.2. The BDA believes that there are currently insufficient dietitians in the UK to meet current needs as discussed above, let alone the much wider roles that we believe they could perform. Dietetic training programmes produce a workforce that can have much wider impact on NHS and public budgets, improve patient satisfaction and provide valuable consultancy, training and support to the wider healthcare team. Good nutrition is a crucial factor at the heart of positive outcomes from the majority (if not all) conditions. Given that long term conditions where nutrition is a factor (in particular diabetes and obesity) are increasing and our population and workforce is ageing we will need more nutritional and diet expertise in both clinical and community settings.
- 5.3. Steps being taken by the government to remove bursaries and in doing so the cap on student numbers for dietetic courses may increase the number of newly

²⁴⁰ Sugar levy on sugar sweetened beverages announced in today's budget speech [Internet]. Bda.uk.com. 2016 [cited 23 September 2016]. Available from: [https://www.bda.uk.com/news/view?id=110&x\[0\]=/news/list](https://www.bda.uk.com/news/view?id=110&x[0]=/news/list)

²⁴¹ The Smith Institute. From pay squeeze to a staffing crisis a study of recruitment and retention in the NHS and local government [Internet]. London: The Smith Institute; 2015 p. 10-18. Available from: <https://www.unison.org.uk/content/uploads/2015/09/From-pay-squeeze-to-a-staffing-crisis.pdf>

qualified dietitians available, although there are concerns about the availability of sufficiently high quality placements to ensure these students are properly trained. We would also want to ensure that dietetics remains a profession open to all. More detail on the BDA's position in relation to this can be found in our response to the government's consultation on reforming healthcare education funding²⁴².

Options for increasing supply

- 5.4. It is vital that professions such as dietetics are made as appealing as possible to the widest possible pool of talent. Ensuring that the education and training system is mindful of the widening participation agenda and tailors its offering to non-typical student population.
- 5.5. Dietetic courses already attract a disproportionately mature and female student makeup, often those beginning second or third careers and often with caring responsibilities. These students bring a unique and valuable skill and experience mix, but need to be specifically supported both in their training and once they enter the healthcare workforce.
- 5.6. It is also important that those that reach the higher reaches of the profession have sufficient opportunity to progress. Dietitians cover business and management issues, behavior change and leadership within their pre-registration curriculum, so are well placed to work in leadership roles. There need to be more aspirational band seven and eight positions available; there are currently very few (only nine) consultant dietitian posts in the whole of the English NHS²⁴³.

Effect of leaving the European Union on the continued supply of healthcare workers from overseas

- 5.7. It is well known that a considerable proportion of the UK's healthcare workforce come from the EU and elsewhere overseas. Over half of NHS trusts reported in 2015 that they intended to recruit from abroad and 41% said they would be recruiting more than in previous years²². Foreign born healthcare professionals are a vital part of our workforce and should be made to feel as welcome and valued as possible. In the case of dietitians, registration with qualifications from abroad can be difficult, but EU students who study dietetics in the UK may find it difficult to remain in the UK to work as dietitians if income floors are imposed.
- 5.8. Uncertainty over their future security may drive existing healthcare workers to leave, or prevent or discourage much-needed healthcare workers from coming to the UK. The BDA has already received anecdotal evidence that foreign-born and BAME dietitians (from both within the EU and without) and healthcare staff more generally have seen an increase in racist and inappropriate behaviour directed

²⁴² 5. Reforming healthcare education funding: creating a sustainable future workforce [Internet]. Bda.uk.com. 2016 [cited 23 September 2016]. Available from: https://www.bda.uk.com/careers/education/bda_response

²⁴³ NHS Workforce Statistics - April 2016, Provisional statistics [Internet]. Digital.nhs.uk. 2016 [cited 23 September 2016]. Available from: <http://digital.nhs.uk/article/2021/Website-Search?productid=21281&q=staff+by+grade&topics=13209&sort=Relevance&size=10&page=1&area=both#top>

towards them following the referendum vote. There is also a risk that EU students will no longer choose to study in UK universities at the same levels as before if required to pay full international fees.

- 5.9. The BDA has called on the government²⁴⁴ to take steps to ensure that as part of our “Brexit” negotiations the UK still has access to talent from the EU and from around the world, without which the NHS would be under even greater staffing pressure.

Retention issues for key groups of healthcare workers

- 5.10. Not only are we not recruiting sufficient dietitians, the NHS is struggling to retain those it does have, a trend borne out elsewhere in the NHS. Existing staff are facing increasing demand while facing long-term pay restraint, which has left them, according to the Nuffield Trust, “feeling undervalued”²⁴⁵. Analysis of the NHS workforce survey by Quality Watch shows that stress related illness has increased (reversing a downward trend) and that 47% said there were not enough staff for them to do their job properly²⁴⁶. Constant drives to improve efficiency and productivity are also reducing staff’s morale and stifling their capacity to innovate which would otherwise improve the sustainability of the NHS.

- 5.11. The BDA’s own Safe Workload, Safe Staffing survey of the dietetic workforce in 2015 identified some key concerns that reflect those seen elsewhere in the health service. 54.7% of respondents felt they could not see patients in a timely manner, and 39.7% felt they lacked opportunities to undertake important personal development work. Perhaps most worryingly, a fifth (21% and 20% respectively) reported poor health at work and low staff morale as significant concerns²⁴⁷. As mentioned above, given the dietetic profession’s overwhelmingly female workforce, flexibility and support are particularly important to help people stay in work and continue to be carers.

Ensuring a sufficiently and appropriately trained health and social care workforce

- 5.12. The UK’s standard of dietetic training is currently very strong, with world class university-level education. However, as mentioned above, dietitians are finding it increasingly difficult to free up time for personal development and training once they are qualified, despite this being an important part of HCPC accreditation. Health Education England funding for CPD has been cut significantly this year and

²⁴⁴ BDA welcomes new Prime Minister and calls on government to take urgent action on obesity and position of EU-born healthcare professionals [Internet]. Bda.uk.com. 2016 [cited 23 September 2016]. Available from: [https://www.bda.uk.com/news/view?id=128&x\[0\]=/news/list](https://www.bda.uk.com/news/view?id=128&x[0]=/news/list)

²⁴⁵ Health and social care priorities for the Government: 2015–2020 | The Nuffield Trust [Internet]. Nuffieldtrust.org.uk. 2016 [cited 23 September 2016]. Available from: <http://www.nuffieldtrust.org.uk/node/4154#Chapter5>

²⁴⁶ Quality Watch. Cause for Concern: QualityWatch annual statement 2014 [Internet]. London: The Health Foundation and Nuffield Trust; 2014 p. p18. Available from: http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QW%20annual%20statement%2014%20%28final%29.pdf

²⁴⁷ British Dietetic Association. Safe Caseload, Safe Staffing A guidance document and toolkit focused on the issue of safe workload and safe staffing levels in dietetics [Internet]. The BDA; 2015. Available from: https://www.bda.uk.com/professional/workforce/safe_caseload_safe_staffing

Allied Health Professionals already receive a smaller proportion of this funding than their workforce would justify²⁴⁸.

- 5.13. The BDA is committed to increasing the range and number of professional development opportunities across the UK for dietitians, support workers and others, including online and remotely. It is important that the NHS and indeed all healthcare providers that employ healthcare professionals allow time and resources for their staff to undertake training and development. Dietitians and other Allied Health Professionals would benefit from a more structured career development pathway after graduation (more akin to doctors). Development and promotion within the current grading structure is ad hoc and opportunistic, which means promising newly qualified dietitians can miss out.
- 5.14. It is also important that pre-registration dietetic students have broad opportunities to train in a number of vital sectors including charity and third sector, public health and social care beyond the usual secondary care settings.

New technologies to increase the agility of the health and social care workforce

- 5.15. Technology has the capacity to greatly increase the flexibility and agility of the workforce, such as increasing ease of access to patient data or allowing dietitians to undertake virtual clinics or consultations with patients in their homes.
- 5.16. However, the BDA strongly believes that technology should not be regarded as a panacea that will enable the health service to do more ‘on the cheap’ with fewer members of staff. Proper and effective use of technologies will require investment both in the resources and infrastructure of new technology and in training healthcare professionals in its use. Technology should be regarded as a means of helping our members to do their jobs better, rather than as a replacement for the vital skills of a dietitian. We have already seen examples from within the public health sphere of dietitian-led programmes being replaced with online toolkits or advice pages. Removing dietetic expertise from the process is a retrograde step and means patients no longer have access to the best advice.
- 5.17. In the BDA’s experience, the adoption of new technologies within the NHS is currently patchy. Successes, such as Focus on Undernutrition²⁴⁹ in Durham and Darlington, are usually down to individual skills and enthusiasm, and are not rapidly replicated elsewhere. Effort should be made to improve simple things such as standardising processes and resources – such as education literature for example – and making patient records more easily accessible across teams and systems.

Cost implications of a workforce equipped with a more adaptable skill mix to better meet the needs of patients

- 5.18. Dietitians qualify with the skills to impact across all areas of healthcare and can therefore be mobile and adaptable in the way they deployed. Dietitians don’t just to

²⁴⁸ Workforce trends slidepack [Internet]. Kingsfund.org.uk. 2016 [cited 23 September 2016]. Available from: <http://www.kingsfund.org.uk/sites/files/kf/media/workforce-trends-slidepack-final.pptx>

²⁴⁹ Focus on Undernutrition - About Focus [Internet]. Focusonundernutrition.co.uk. 2016 [cited 23 September 2016]. Available from: <http://www.focusonundernutrition.co.uk/about-focus>

help those who are ill but also focus on prevention and to help the ‘well’ remain active, mobile and productive. The barriers to a more adaptable workforce that is in the **right place at the right time** are often the systems, rather the abilities of the dietetic workforce. This includes the systems for professional development which need to be in place to ensure dietitians continue to have the opportunity to update their skills, such as in digital technologies.

Dietitian 2025

- 5.19. We have recently commissioned a piece of research, currently entitled Dietitian 2025²⁵⁰, with the express purpose of considering the future needs and competencies of the dietetic profession in the future. The research is being independently undertaken by the University of Plymouth, with input from across our diverse membership. The BDA would be pleased to share the findings of this research with the committee as they become available.

6. Models of Service

- 6.1. At the most basic level health and care services need to be combined under one ringfenced commissioning budget. The current divide between social care and health services is exacerbated by the different funding mechanisms and governance arrangements.
- 6.2. The government’s vanguards are attempting to deliver truly “borderless” collaboration between health services in a number of areas. Anecdotally however it appears that professional, financial and structural divides still exist between primary and secondary care or NHS and local government services.

Truly integrated budgets and Incentivising collaboration

- 6.3. One of the most fundamental problems that prevents healthcare organisations working together is the divide between investment and outcomes. Many of the most effective interventions or collaborative proposals will produce positive outcomes that do not directly benefit those paying for them.
- 6.4. For example, providing gluten free products on prescription in primary care improves coeliac patient’s adherence to a gluten free diet, and therefore reduces the number of episodes of ill health and resultant expensive referrals to gastroenterology in secondary care²⁵¹. However, because of pressure on prescribing budgets, many CCGs are choosing to remove gluten free products.
- 6.5. Pooling budgets, or linking them to the patient through personal budgets may be one way to improve integration. However, if a patient is unaware of the services available, and if the control over purse strings remains in the hands of one section

²⁵⁰ Dietitian 2025 [Internet]. Bda.uk.com. 2016 [cited 23 September 2016]. Available from: https://www.bda.uk.com/professional/practice/dietitian_2025

²⁵¹ Policy Statement: Gluten Free Food on Prescription [Internet]. Bda.uk.com. 2016 [cited 23 September 2016]. Available from: https://www.bda.uk.com/improvinghealth/healthprofessionals/policy_statement_gluten_free_food_on_prescription

or part of the health service, divides will remain. Ensuring that healthcare professionals and services have mutual aims and targets, where everyone is contributing to collective outcomes, might go some way to removing divides.

Balance between Hospital and Community Services

- 6.6. The current focus of most funding – particularly in dietetics – is in secondary and hospital care. There is an important role for dietitians here, but effective interventions at the primary and community care level has the potential to significantly reduce pressures on secondary care and improve outcomes for patients if appropriately funded and staffed. The pressure and underinvestment in primary care has been recognised by the government and NHS in the recent GP Forward View²⁵².
- 6.7. The BDA believes that there is a bigger role for dietitians in primary and community care, as part of a general redesign of the way primary and community care is run. Reform²⁵³ and the NHS Alliance²⁵⁴, amongst others, have highlighted the significant number of GP appointments that could be handled by other, more appropriately skilled health professionals. This could be done by creating much easier access to dietitians from secondary care or by directly employing dietitians (and other allied health professionals and healthcare specialists) within primary care. Examples would include patients with diabetes, where dietitians may be better placed than GPs to provide support to patients for self-care.
- 6.8. This model, as epitomised in the much publicised “Southcentral model”²⁵⁵ from the US, has the potential to save significant resources while ensuring that the patient receives the most appropriate treatment as quickly as possible. For example, patients with conditions such as Diabetes, Irritable Bowel Syndrome or Coeliac Disease can be supported by dietitians without first needing a referral from their GP, and provided with the most appropriate dietary and lifestyle advice, when they need it, to help patients manage their condition themselves. However, if primary care remains the poor relation within our healthcare system such significant change is unlikely to occur.

Balance between mental and physical health and care services

- 6.9. It is well recognised that the current balance between the prioritization of physical and mental health is skewed towards physical health. The Health Secretary Jeremy Hunt has called for “parity of esteem” between the two areas²⁵⁶, and others, such

²⁵² NHS England. GENERAL PRACTICE FORWARD VIEW [Internet]. London: NHS England; 2016. Available from: <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

²⁵³ Ewbank L, Hitchcock A, Sasse T. Who cares? The future of general practice [Internet]. London: Reform; 2016. Available from: http://www.reform.uk/wp-content/uploads/2016/04/Reform_who_cares_the_future_of_general_practice.pdf

²⁵⁴ NHS Alliance publishes new report, Making Time in General Practice - NHS Alliance [Internet]. NHS Alliance. 2015 [cited 23 September 2016]. Available from: <http://www.nhsalliance.org/mediacentre/making-time-in-general-practice/>

²⁵⁵ Intentional whole health system redesign [Internet]. The King's Fund. 2016 [cited 23 September 2016]. Available from: <http://www.kingsfund.org.uk/publications/commissioned/intentional-whole-health-system-redesign-nuka-southcentral>

²⁵⁶ Making mental health matter more - Press releases - GOV.UK [Internet]. Gov.uk. 2014 [cited 23 September 2016]. Available from: <https://www.gov.uk/government/news/making-mental-health-matter-more>

as the Mental Health Foundation make the further point that mental and physical health should not be regarded as separate but considered holistically²⁵⁷.

- 6.10. This is of course true in relation to diet and nutrition. People with mental health problems are at higher risk of physical health problems than the general population and often have coexisting co-morbidities. Having depression can double the risk of developing Coronary Heart Disease and people with mental illnesses such as schizophrenia are more likely to develop cardiovascular disease, obesity, abnormal lipid levels or diabetes²⁵⁸.
- 6.11. In the best instances, dietitians are able to work with a diverse multi-disciplinary team within a mental health setting by providing nutritional education, training, and developing resources and competency frameworks. This can lead to reduced malnutrition, weight management, reduction in nutrition related side-effects of psychiatric medications, improve self-care and management of co-morbid conditions, and improved health and nutritional status.²⁵⁹

7. Prevention and Public Health

Key elements of a public health policy to increase years of good health

- 7.1. Effective public health policy needs to be integrated, focused on the determinants of health as far upstream as possible, and perhaps most critically, have a long term outlook. Crises such as obesity and diabetes have developed over many years and have a wide variety of causal factors, from poor diet and exercise to economic hardship and poor education.
- 7.2. Any strategy needs to be led at a national level but delivered locally, with a focus on helping communities help themselves. However, there needs to be a particular focus on disadvantaged communities, where health outcomes are the worst.

Role of the state, the individual and local and regional bodies

- 7.3. As a nation we need to have a real conversation about the scope of NHS treatment and our role in looking after ourselves. The conflict between the desire to have the freedom to eat, drink and do as we please while maintaining a health service free at the point of delivery in nearly all circumstances is something we need to collectively address.
- 7.4. The BDA believes that if we wish to continue to protect our NHS services, it is clear that the population needs to either assume greater responsibility for our own wellbeing, or accept a greater role for the state to intervene to ensure we live healthier lives and therefore reduce pressure on the health service.

²⁵⁷ Physical health and mental health [Internet]. Mentalhealth.org.uk. 2015 [cited 23 September 2016]. Available from: <https://www.mentalhealth.org.uk/a-to-z/p/physical-health-and-mental-health>

²⁵⁸ De Hert, M, Dekker, JM, Wood, D et al (2009) Cardiovascular disease and diabetes in people with severe mental illness. Position statement from the European Psychiatric Association. European Psychiatry. <http://www.easd.org/easdwebfiles/statements/EPA.pdf>

²⁵⁹ Ibid 24

- 7.5. The government should provide a strategic framework that encourages and facilitates healthy choices and lifestyles, using the full range of tools and levers at its disposal. This would include the use of the tax and regulatory systems, funding for education and advertising and incentives to encourage positive lifestyle behaviours. Particular support should be provided to those in the most deprived areas to have the greatest impact and reduce health inequalities. We would argue that the government's recent *Childhood Obesity: A Plan for Action*²⁶⁰ falls well short in this regard, by failing to address the full scope of causal factors and to make use of its regulatory powers²⁶¹.

Mismatch between prevention and treatment

- 7.6. The NHS itself has recognised that there is a fundamental mismatch between the amounts the UK spends on treatment compared to prevention. The latest estimate is that the NHS spends only 4% of its budget²⁶² on prevention. If the NHS is to be put on a sustainable footing, it will be vital that efforts are made to slow or reduce future demand. This will only be possible if prevention is funded appropriately.
- 7.7. At the moment, because public health is the responsibility of local authorities, it is not ring fenced by central government in the same way as the NHS budget and faces ongoing cuts. The LGA, in their response to the government's latest public health budget have said that this "sends entirely the wrong message²⁶³" about the government's commitment to the NHS Five Year Forward View and its prevention focus. The BDA would agree completely.
- 7.8. If prevention and public health is to be funded properly, and given the limits placed upon the public finances and the health budget, it may be necessary to shift funding from acute care to prevention. Clearly this would be a difficult and potentially unpopular decision but if the government is truly committed to prevention we may require this kind of brave decision.

Should the UK Government legislate for greater industry responsibility?

- 7.9. Yes – there is an acceptance that voluntary measures only bring on board those that are already willing to take positive steps. Market forces mean that those that are willing to reformulate products to for example reduce sugar, risk losing their business to less scrupulous producers who are willing to do otherwise. Industry bodies such as the British Retail Consortium²⁶⁴ have themselves said they would benefit from the clarity provided by a clear regulatory framework for all retailers or

²⁶⁰ Childhood obesity: a plan for action - Publications - GOV.UK [Internet]. Gov.uk. 2016 [cited 23 September 2016]. Available from: <https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action>

²⁶¹ Much-delayed childhood obesity strategy "disappointing", say dietitians [Internet]. Bda.uk.com. 2016 [cited 23 September 2016]. Available from: <https://www.bda.uk.com/news/view?id=133&x%5B0%5D=news/list>

²⁶² NHS England and Public Health England. A call to action: Commissioning for Prevention [Internet]. London: NHS England; 2013 p. 3. Available from: <https://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf>

²⁶³ Local Government Association. Public health funding in 2016/17 and 2017/18 [Internet]. London: LGA; 2016. Available from: <http://www.local.gov.uk/documents/10180/11493/Briefing+-+Public+health+funding+in+2016-17+and+2017-18/981d88ec-b8d2-4461-99b8-a893494783cc>

²⁶⁴ Boseley S. Childhood obesity: retailers urge mandatory cuts to food sugar levels [Internet]. the Guardian. 2016 [cited 23 September 2016]. Available from: <https://www.theguardian.com/society/2016/aug/18/childhood-obesity-retailers-urge-mandatory-cuts-to-food-sugar-levels>

producers, rather than recommendations or guidance which is only implemented in a patchy fashion. In the same way that we expect industry to pay for the consequence of their actions in relation to issues such as pollution, it is not unreasonable to make the same demands of them with regard to their impact on public health.

- 7.10. To take the example of the Sugar Levy specifically, there is scope to go much further in terms of regulation, which currently applies only to sugar sweetened beverages. Excess sugar can be found in a whole range of products, and steps need to be taken to ensure that the public doesn't just substitute taxed soft drinks for other products.

By what means can providers be incentivized to keep people healthier?

- 7.11. There are steps that could be taken to remove the perverse funding incentives that see healthcare providers funded according to the number of patients they treat. Although the BDA doesn't doubt that all healthcare professionals only want what is best for their patients, this model does not encourage them to prevent patients coming to them in the first place, particularly when they feel that their funding is already stretched.
- 7.12. The biggest issue is that changes need to be sustained for many years to see improvement, so the money needs to go towards setting up the work and then measuring change over five, 10 or 20 years. Giving money for a two year project will not have the desired outcomes. There is uncertainty about what works, so the research also needs to be done.

What are the barriers to taking on received knowledge about healthy places to live and work?

- 7.13. One area of particular interest to the dietetic profession is the obesogenic environment and what changes can or should be made to our cities, homes and workplaces to encourage people to maintain a healthy weight, with all the positive knock-on effects this has for the wider health system.
- 7.14. Research has highlighted the significant effects of certain elements of environment, such as unhealthy food promotion and inappropriate portion sizes for children²⁶⁵ and the cities designed for exercise and active living²⁶⁶. However, the evidence base in this area is still developing, and the government's own Foresight report on this topic shows limited evidence that changing the obesogenic environment helps those most in need²⁶⁷. Simply increasing access to healthy food and places to exercise may not be sufficient to reduce unhealthy behaviour – and may only benefit those already making healthy choices. More research is required to understand how we should change where we live to encourage healthier lifestyles.

²⁶⁵ Osei-Assibey G, Dick S, Macdiarmid J, Semple S, Reilly J, Ellaway A et al. The influence of the food environment on overweight and obesity in young children: a systematic review. *BMJ Open*. 2012;2(6):e001538.

²⁶⁶ NIKE Ltd. Designed to Move: Active Cities [Internet]. NIKE Ltd; 2015. Available from: <http://e13c7a4144957cea5013-f2f5ab26d5e83af3ea377013dd602911.r77.cf5.rackcdn.com/resources/pdf/en/active-cities-full-report.pdf>

²⁶⁷ Jones A, Bentham G, Foster C, Hillsdon M, Panter J. Tackling Obesities: Future Choices – Obesogenic Environments – Evidence Review [Internet]. DIUS; 2007. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295681/07-735-obesogenic-environments-review.pdf

- 7.15. The BDA has developed the Work Ready programme²⁶⁸ in an attempt to tackle unhealthy work environments, bringing dietetic expertise into the workplace. Using measurable and evidence-based interventions, dietitians are able to help companies and businesses make their workplaces healthier, improve the health of their workforce and in turn reduce sickness absence. Merseyrail’s “Heart on Track”²⁶⁹ is an excellent example of the sort of positive effect a dietetic intervention can have, but also highlights the commitment needed from employers.

How can technology play a greater role?

- 7.16. Technology and social media mean that it is easier for healthcare professionals to connect with members of the public and promote vital public health messages. The capacity to more accurately track progress against aims and to provide patient-led data on weight or health outcomes can help to improve the effectiveness of interventions.
- 7.17. Evidence from a number of studies have shown that telephone based counselling in conjunction with other materials is effective in promoting positive dietary change and weight loss in both healthy adults and those with chronic conditions^{270,271}. Systematic reviews have demonstrated that technology-assisted interventions (e.g. Internet/website, email, text messaging, mobile applications) can achieve positive dietary behaviour change and/or promote weight loss in adults who are overweight/obese compared to no intervention or minimal care^{272,273}.

8. Technology and digital services

Role for technology

- 8.1. There is a clear role for mobile technologies and virtual consultations, which are already being utilised within the dietetic and other healthcare professions. The BDA itself has launched the BDA Dietitian App²⁷⁴, which provides a Web-based Coaching suite for dietitians to use with clients and a secure communication channel. Healthcare services across the country are already using virtual clinics to increase

²⁶⁸ The British Dietetic Association. BDA Work Ready Programme Supporting healthier working lives through dietitian-led wellness initiatives [Internet]. Birmingham: BDA; 2015. Available from:

<http://www.healthynation.org.uk/workready/whitepaper/White%20Paper.pdf>

²⁶⁹ MerseyRail Case Study: The Heart on Track Challenge [Internet]. orr.gov.uk. 2016 [cited 23 September 2016]. Available from: http://orr.gov.uk/_data/assets/pdf_file/0006/3588/oh-case-study-heartontrack.pdf

²⁷⁰ Goode AD, Reeves MM, Eakin EG Telephone-delivered interventions for physical activity and dietary behavior change: an updated systematic review. *Am J Prev Med.* 2012 Jan;42(1):81-8. doi: 10.1016/j.amepre.2011.08.025. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/22176852>

²⁷¹ Desroches S, Lapointe A, Ratté S, Gravel K, Légaré F, Turcotte S. Interventions to enhance adherence to dietary advice for preventing and managing chronic diseases in adults. *Cochrane Database Syst Rev.* 2013 Feb 28;2:CD008722. doi: 10.1002/14651858.CD008722.pub2. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/23450587>

²⁷² Levine DM, Savarimuthu S, Squires A, Nicholson J, Jay M. Technology-assisted weight loss interventions in primary care: a systematic review. *J Gen Intern Med.* 2015 Jan;30(1):107-17. doi: 10.1007/s11606-014-2987-6. Epub 2014 Aug 19. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/25134692>

²⁷³ Hutchesson MJ, Rollo ME, Krukowski R, Eils L, Harvey J, Morgan PJ, et al. eHealth interventions for the prevention and treatment of overweight and obesity in adults: a systematic review with meta-analysis. *Obes Rev.* 2015 May;16(5):376-92. doi: 10.1111/obr.12268. Epub 2015 Mar 5. Abstract available from: <http://www.ncbi.nlm.nih.gov/pubmed/25753009>

²⁷⁴ BDA Dietitian app [Internet]. Bda.uk.com. 2016 [cited 23 September 2016]. Available from: https://www.bda.uk.com/professional/resources/bda_dietitian_app

their reach and save resources, and they are particularly effective for established patients, and is regarded by patients as preferable to often time consuming face to face appointments²⁷⁵.

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²⁷⁵ Stuckey C, Martin H, McLaughlin S. PTH-025 Dietitian-led Virtual Coeliac Disease Clinic Results In Cost Savings And Increased Patient Satisfaction. Gut. 2014;63(Suppl 1):A219.2-A219.

British Geriatrics Society – Written evidence (NHS0141)

Executive Summary

BGS believes that the future sustainability of the NHS is dependent on ensuring that people with the right skills, training and specialist expertise are available to meet the needs of the rapidly increasing numbers of older people living with frailty, dementia and multiple, complex long-term conditions, and that re-modelling to deliver services through a person-centred approach to care, which includes a review of social care and its funding, is essential.

Introduction

1. The British Geriatrics Society (BGS) is the professional body of specialists in the healthcare of older people in the United Kingdom. Our membership is drawn from doctors practising geriatric medicine including consultants, doctors in training and general practitioners, nurses, allied health professionals, researchers and scientists with a particular interest in the care of older people and the promotion of better health in old age. BGS has 3,500 members who work across England, Scotland, Wales and Northern Ireland.
2. BGS welcomes this opportunity to present a written submission to the Committee's Inquiry on the long-term sustainability of the NHS. We have noted the Committee's specific interest in UK Government policy and practice, and whether their strategies are sufficiently long-term, as well as what might usefully be done in practical terms to guarantee the sustainability of the NHS. We have ordered our submission under the main themes that are the focus of the Committee's Inquiry.

Resource, funding and demand issues

3. Financial viability. As the Inquiry recognises, the current model of health and social care is not financially viable in the long-term. Since 2000 the UK has significantly increased its spending on health, but as a percentage of GDP it is still lower than the EU average²⁷⁶, and it has been predicted that by 2030/31 the funding gap will be £28 billion at a minimum and could be as much as £58 billion²⁷⁷. The Health Foundation project that the funding gap for adult social care will be £6 billion by 2020/21 and £13 billion by 2030/31²⁷⁸, and the Office for Budget Responsibility projects that UK spending on health and care as a percentage of GDP is due to drop from 7.4% in 2016 to 6.9% in 2020. They also predict we may need to

²⁷⁶ Filling the gap. Tax and fiscal options for a sustainable UK health and social care system. The Health Foundation. 2015 <http://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf>

²⁷⁷ <http://www.health.org.uk/health-and-care-funding-nutshell#Current%20spending%20on%20health%20care%20and%20financial%20performance>
<http://www.health.org.uk/publication/filling-gap>

²⁷⁸ Filling the gap. Tax and fiscal options for a sustainable UK health and social care system. The Health Foundation. 2015 <http://www.oecd.org/health/health-systems/Focus-Health-Spending-2015.pdf>

raise the proportion to 8.8% of GDP, which represents an increase of £100 bn²⁷⁹.

4. Spending on social care. Our view is that the inter-dependent nature of health and social care services mean that the long-term sustainability of the NHS can only be secured if there is sufficient investment both health and social care. The fall in social care spending has led to some people being unable to access the care they need leading to poorer health outcomes, an increased likelihood of presenting at A&E, and people remaining on an acute hospital ward for longer than necessary. This has a negative impact on the health of older people with frailty which deteriorates with every additional day spent on an acute ward. The King's Fund briefing, *Deficits in the NHS 2016*, provides an up to date analysis which shows that despite transfers of NHS budget, social care has not kept pace with the increase in demand.

5. Reviewing social care and its funding. We therefore believe that a new approach to funding of social care is required so that it is fully integrated with health care provision and addresses the current lack of ring-fencing for social care budgets. A fundamental review of the future of social care funding by Government would be an extremely helpful step in the journey towards ensuring the effectiveness of the NHS in the long-term. The King's Fund's independent Commission on the Future of Health and Social Care in England, chaired by the economist Kate Barker, provides a helpful basis for further work. The report published this September by the King's Fund and Nuffield Trust, *Social Care for Older People, Home Truths*²⁸⁰ is also helpful in showing how reductions in central government grants to local authorities have been passed on to care providers in the form of reduced fees. The case studies in *Home Truths* show the devastating impact on older people's lives that under-investment in primary and community health services, combined with the challenges faced in social care, is having. For providers of social care dependent on local authority funding it is the quality and continuity of care of older people which is being compromised, and our members are seeing the knock-on effects of that when older people present at A&E departments and when their discharge from hospital is delayed because of lack of capacity in the social care sector.

6. Intermediate care. Investment in intermediate care is also critical if the NHS is to be sustainable. Services which provide a link between home and acute hospital for older people who need rehabilitation, re-ablement, or sub-acute treatment are essential in supporting older people in regaining independence after they have had an acute health issue. The National Audit of Intermediate Care²⁸¹ shows that intermediate care services are key to reducing financial, quality and activity pressures being experienced in secondary care and the care sector. It provides evidence which shows that 92% of people maintained or improved their dependency score in when they accessed intermediate care in community settings, and 93% maintained or improved their dependency score in bed based intermediate care. The critical role of occupational, physio and speech therapists needs to

²⁷⁹ Fiscal sustainability and public spending on health. OBR, 2016 <http://budgetresponsibility.org.uk/fiscal-sustainability-analytical-paper-published-today/>

²⁸⁰ Social care for older people. Home truths, the King's Fund, Nuffield Trust, 2016

²⁸¹ National Audit of Intermediate Care, NHS Benchmarking, 2015
<http://www.nhsbenchmarking.nhs.uk/CubeCore/uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf>

be understood, prioritised and built into any future re-design of the NHS. Delays in access have considerable costs, both to the health outlook for an older person and to the NHS. We have been encouraged by recommendations in the report by the Care Quality Commission published in July, *Building Bridges, Breaking Barriers*, which highlighted the need for increased capacity in services which provide a key link for older people between home and acute hospital.

7. Demand management. When demand management is discussed it is usually in the context of seeking to find ways of reducing demand on services. While it is difficult to quantify, our experience is that many older people under use health and care services because they are reluctant to ask for help, or they assume that a particular health condition is a natural part of ageing and cannot be treated.

8. Engaging the public. Our submission is based on the assumption that health and social care will be delivered through a model paid for by general taxation. At present there isn't a clear public mandate for a new funding model for health care. We consider that full open consultation and engagement with the public to be an essential ingredient of any proposals for changing the basis on which the NHS is currently funded.

Workforce

9. Addressing the current workforce crisis. The long-term sustainability of the NHS is partly dependent on its current viability. There is an urgent need for more geriatricians and specialists in older people's health care. Data collected by the Royal College of Physicians (RCP) shows that "geriatric and acute medicine has consistently had the largest number of posts being advertised, but they also consistently have the largest number of posts that cannot be filled."²⁸² At the same time there is a major GP and community nurse workforce crisis. The RCP report, *Underfunded. Underdoctored. Overstretched. The NHS in 2016* provides a wealth of data on workforce, and shows that between 2013 and 2015 the number of doctor vacancies increased by 60%. It also shows that there are not enough doctors in training to meet demand²⁸³ We welcome the wide range of initiatives at local, regional and national level, that are underway to improve access to and quality of health care, but we are concerned that these risk being undermined by the lack of adequate numbers of doctors, nurses and other health care professionals.

10. Training. The rapidly increasing number of people living with long-term and multiple conditions, mean there is a need for more generalist health professionals who have been fully trained in the specific needs of older people. As part of that training we would like to see the capacity for Comprehensive Geriatric Assessment (CGA) developed and delivered more widely. CGA is an interdisciplinary process focused on diagnosing an older person's medical, psychological and functional capability. There is a strong evidence base showing that use of CGA enhances an older person's overall resilience, and when it is used following

²⁸² Census of consultant physicians and higher speciality trainees in the UK, 2014-15, RCP, 2015

²⁸³ Underfunded, underdoctored, overstretched. The NHS in 2016. Royal College of Physicians. 2016
<https://www.rcplondon.ac.uk/guidelines-policy/underfunded-underdoctored-overstretched-nhs-2016>

an emergency admission to hospital it increases by 25% the patient's likelihood both of being alive and of being able to live in their own homes six months later²⁸⁴.

Models of service delivery and integration

11. The current health care system is based on a model developed at a time when life expectancy was 65 for men and 70 for women, and 48% of the population died before they reached 65. Health service design has been disease focused, which does not serve well people with multiple and long term medical conditions, including older people living with frailty.

12. The future health care system, if it is to cope with the rapid increase in the numbers of older people using it, needs to be based on person-centred design which enables all patients, including older people, to express what they want and need from health care systems so that they receive the most appropriate treatment. Measures of care should focus on what matters most to older people and their families. This includes end of life care, with person centred care that fully involves families and carers, and supports professionals in recognising when it is appropriate to move from treatment to palliative care.

13. Fully integrated services. NHS service design based on person-centred care requires a move to a fully integrated service model which ends the divide between health and social care, and a move away from the “tendency to ‘silo’ pathways of care”²⁸⁵ which we have referred to in more detail in paragraphs 6-7 above .

14. Better support for people with dementia is required in any re-modelling of the NHS, given that as many as 40% of hospital admissions are for people over 75, and 1 in 4 beds in acute hospitals are occupied by someone with dementia. They may not have an acute reason for admission but may have reached a crisis and there is not sufficient support outside a hospital setting to manage the crisis. Once admitted to hospital they are more likely to experience an overall deterioration in health. BGS calls for a new strategy for people living with frailty, dementia, complex needs and multiple long-term conditions, which ensures access to comprehensive geriatric assessment, personalised care plans for treatment and long-term follow-up for all older people with frailty, dementia and complex and multiple long-term conditions.

15. Use of technological solutions in service design. We agree with a statement by the Birmingham Policy Commission that “technological support for older people can contribute to health ageing, if the support is sensitively developed and applied”²⁸⁶. We fully recognise the benefits of technological support in health and social care, but at the same time caution against an over reliance on it, particularly when it comes to expectations of what can be achieved in terms of prevention.

²⁸⁴ Comprehensive geriatric assessment for older adults admitted to hospital, Ellis G, Whitehead MA, O'Neill D, Lanhorne P, Robinson D, 2011 <http://www.ncbi.nlm.nih.gov/pubmed/21735403>

²⁸⁵ <https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf>

²⁸⁶ *Healthy Ageing in the 21st Century: the best is yet to come*, Birmingham Policy Commission, 2014, <http://www.birmingham.ac.uk/Documents/research/policycommission/healthy-ageing/Healthy-Ageing-Policy-Commission-Report.pdf>

Prevention and public engagement

16. Prevention and treatment of frailty in older people. We know that disability-free life expectancy is rising more slowly than life expectancy, and that most people aged 75 and over have one or more health conditions, and 1 in 4 of those aged 85 and over are frail.²⁸⁷ We caution against the use of overly ambitious outcome targets if there is not the evidence to support their achievement. Whilst prevention and treatment strategies together can have excellent outcomes, we must not overlook the basic realities of ageing which mean that older people will always have health issues that need treating. This needs to be taken account of when incentives to keep people healthy for longer are being developed .

17. Community and tertiary provision. The roles of community geriatricians, community nurses and other specialist health professionals, are key to enabling older people to remain independent and living in their own homes for as long as possible. While there are limits to how far preventative strategies can go in avoiding people needing to access health services, the benefits of tertiary service provision for older are significant. For example we might not be able to prevent some older people falling and sustaining fractures, but the benefits of helping them to re-gain their previous level of mobility following a fracture are key to maintaining independence. We are therefore keen to ensure that future strategies for prevention and public health draw on the clinical knowledge of the ageing process.

18. Availability of age-appropriate infrastructure. The provision of accessible age-appropriate housing and other infrastructure, including transport, is an essential ingredient in considering strategies to guarantee the sustainability of the NHS. Age UK point to the need for attractive housing alternatives that promote healthy lifestyles and meet the needs and wants of older people, and the difficulties of getting simple home adaptations and repairs carried out quickly and affordably²⁸⁸. At BGS our members are regularly seeing patients who are well enough to be discharged from an acute hospital ward, but whose lack of appropriate housing, means that their discharge is delayed.

Digitisation of services, big data and informatics

19. Rationalisation and accessibility of records and better integration of data. We can only deliver fully integrated, person-centred care if we have a system which allows the use of person-held records in a single assessment document that is available across specialisms and settings, so that clinicians and other professionals have immediate access to the full picture regarding the patients they are treating. The Care Quality Commission recently highlighted that older people often have multiple care plans that are not being routinely linked, and what where initiatives to enable integration have been successful they have

²⁸⁷ *Crisis in health and social care*, Age UK report, citing ONS statistics on life expectancy

www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2011-13/rfd-1.xls

²⁸⁸ Housing in later life, Age UK, 2014. <http://www.ageuk.org.uk/Documents/EN-GB/Political/Age%20UK%20ID201813%20Housing%20Later%20Life%20Report%20-%20final.pdf?dtrk=true>

often been short-term with only partial or temporary funding²⁸⁹. Investment in systems that support the full development of up-to-date integrated records and plans is an important part of improving health care for older people, whose health and care needs can change rapidly. They are also essential to being able to measure health outcomes, and to ensuring that what matters most to older people and their families is fully measured and improvements can be tracked over time.

Conclusion

20. The Committee's Inquiry is of fundamental importance to our members and those older people they work with. We wish to support the Inquiry in any way we can and would be very happy to discuss our submission with the Committee and to attend an oral evidence session if called on to do so.

23 September 2016

²⁸⁹ Building bridges, breaking barriers. Care Quality Commission, 2016.
http://www.cqc.org.uk/sites/default/files/20160712b_buildingbridges_report.pdf

British Healthcare Trades Association – Written evidence (NHS0056)

How can we ensure a sustainable future for the NHS?

1. Executive summary

1.1 Much greater use must be made of Healthcare and Assistive Technology (ie any product or service designed to enable independence for disabled and older people, from eg wheelchairs to stairlifts, aids for daily living to artificial limbs) in order to address the growing demands upon the NHS. Making more use of it will help to address the demands upon the NHS in a cost effective way, whilst providing long term savings in other areas of public expenditure including admissions to hospital and residential care. Greater use of Healthcare and Assistive Technology enables people to live more independent lives, keeps them safe and enhances well-being in ways that reduce demand on the NHS whilst often avoiding more costly interventions. It encourages self-care and underpins a preventative agenda.

1.2 Provision of appropriate Healthcare and Assistive Technology often enables more people to contribute more to society including through employment whilst making them less dependent upon welfare benefits and medical intervention. It can reduce the need for treatment relating to issues such as stress and depression both amongst those who benefit from such technology directly, as well as amongst their families and carers. Treating mental health conditions can be costly, but failing to treat them can be more costly because the problems associated with such issues often result in many other costs to society, including those that may result from relationship breakdowns and increased demand for social housing.

1.3 A study, undertaken by London School of Economics' Personal Social Services Research Unit in 2012, drawing on extensive research and analysis in the field, found that every pound spent on adaptive technologies delivers a net saving of £1.10 to the public purse²⁹⁰. The Government estimated then that there were over half a million people over 60 requiring an adaptation to their home²⁹¹. According to the report, if the need for these home adaptations was met, it would deliver net saving of £625m, which could be re-invested in the NHS. A similar case can be made for greater use of Assistive Technology generally, and a campaign to raise awareness of the benefits to potential users would also drive growth in private provision that could reduce burdens on the NHS and help to provide greater resources for it.

²⁹⁰ Building a business case for investing in adaptive technologies in England: www.pssru.ac.uk/archive/pdf/dp2831.pdf

²⁹¹ Disabled Facilities Grant Allocation Methodology and Means Test Report 2011: <https://www.gov.uk/government/publications/disabled-facilities-grant-allocation-methodology-and-means-test--2>

2. Introduction

2.1 There are significant savings to be made from the complete integration of health and social care. Much equipment our members provide has value in both areas, enabling people to keep safe (eg call alarms, call blockers), prevent falls (eg grab rails, level access showers, stairlifts), prevent pressure sores (eg specialist cushions, chairs, mattresses), stabilising, improving and preventing deterioration in condition, enabling and enhancing independence. Savings brought about by the private sector are most evident where provision of equipment eliminates (or reduces) the need for people intervention, and for costly stock-holding, by the public sector.

2.2 There needs to be much greater promotion of the case for using Healthcare and Assistive Technology. Following proper assessment for potential recipients of it, there needs to be adequate signposting to where people can safely buy equipment for themselves when local authorities cannot provide it as their budgets are squeezed. In order to protect users, it is important to signpost businesses belonging to a trade association with a consumer Code of Practice, associated mediation and dispute resolution services to offer security in terms of business behaviour and having the necessary specialist knowledge and commitment to assessment and support. Enabling safe self-care and preventative measures for those who do not consider themselves (or indeed are not yet) ill, reduces call on the health service.

2.3 The need for care and support can be delayed and reduced by provision of equipment. This is particularly evident when considering what is needed to help carers. Hoists and bathroom adaptations can enable them to continue caring for someone without the need for outside intervention or reducing the frequency with which this is needed. Very simple aids such as kettle tippers and other aids for daily living can mean the difference between someone being able to continue to make their own drinks and meals and needing assistance with this. For people with long-term conditions the right equipment at the right time reduces the call on other services.

2.4 Falls often lead to hospital admission, as can illnesses and complications brought about by preventable pressure sores, or malnutrition due to inability to use the kitchen. Equipment can help people avoid all of these. Equipment is particularly essential when people need to return home after a hospital stay, and it is here that facilities such as community equipment loan stores have an important role to play. The loan stores addressed the problems of integrating health and care long before this became a government focus and are most often led by local authorities. Early identification of what someone will need, delivering it and showing them how to use it makes the difference between someone being able to go home rather than into intermediate, or full-time care.

3. Reducing NHS costs, greater equipment provision, personal choice

3.1 Enabling money to genuinely follow the patient is the only way of ensuring they that will in future be able to access the equipment they need. Personal budgets (based on the principle in some cases of there being only 'limited subsidies' available for some

healthcare products and services) can only help in this regard. Bringing together budgets from other areas such as education, access to work programmes, and housing to ensure a holistic approach, is also necessary. Budgetary silos urgently need to be overcome and until the barrier between health and social care is broken down and it becomes clear to everyone what is “free”, what is “paid for”, what is “not provided at all” then timely and adequate equipment/adaptation provision will continue to be very difficult to achieve. With an ageing population, causing substantially more demand for a growing range of products, some of which cannot be considered to be cheap, we have to address the question of greater contribution by some individuals to their own care.

3.2 Addressing the longer term. People with long-term conditions have a lifetime need and the current system of short-term budgets fails to address the lifetime cost of providing support. Equipment/adaptations provision is a vital component for minimising that cost, enabling self-care, reducing the need for surgical intervention and enhancing well-being through independence.

3.3 Tariffs which are outcome based fit well with provision of equipment. The health system, in particular, focuses on what a person’s condition is, whereas equipment tends to address task/life scenarios. It is easily overlooked, but a “whole person” approach should include equipment as part of a solution. For people with complex needs and for children and their families in particular, personal budgets calling on tariffs, with known rules of engagement, can make a huge difference to timely access and delivery. Tariffs can also assist in ensuring a consistent service is available across the country and can overcome the problem of short-term budgets versus long-term needs.

3.4 Public perception is also important. Members of the public accept that if they need a mobility scooter they will have to buy it themselves. Yet these vehicles are simply another form of wheelchair. We all accept that we will choose our spectacle frames and pay for them. Increasingly, local authorities are limiting the equipment they will provide and people have to buy their own simple aids for daily living. Is it time to open up the debate about what the public sector must provide and what people will have to purchase for themselves? It is time to link equipment from which any elderly, frail person may benefit to public health messages and encouraging people to think ahead and provide more for themselves?

4. Skilling up the workforce

4.1 There is a need to develop and enhance skills in the workforce in the Healthcare and Assistive Technology sector. If there is to be the necessary increase in provision of Healthcare and Assistive Technology, then the sector needs to become one which is visible to young people as a career option, and to older people as a second career option. The sector crosses boundaries between sector skill councils and does not fit entirely with any of the existing provisions, with for example, engineering, health, and care. There needs to be more formal training within the sector and ongoing training of staff which is not yet the norm throughout the sector. With a large number of small businesses, this needs to be addressed. Signposting to opportunities for funding of training and the potential for apprenticeships needs to be improved.

5. Removing barriers to innovation

5.1 Public sector tendering systems reduce the opportunity for introduction of innovation if they are based upon existing, known, equipment. It is difficult to introduce something new once an agreement is in place. Commissioners and procurers tend to be risk averse and stick to the products they know, even when evidence is in place to support new solutions. In terms of gaining approval for use on the market there are barriers in relation to proving the efficacy of products. The equipment provided by this sector is often low cost, relatively simple, used primarily in a care setting or a person's own home, with minimal healthcare professional input. The level of proof required by NICE, for example, may simply not be an option. Where it is, NICE should give precedence to examining UK-led innovation. A further factor impacting negatively on this is the length of time it is taking for CCGs to fully get to grips with their budgets and many of them are largely oblivious to this sector.

6. Recommendations

6.1 Provision of Healthcare and Assistive Technology/equipment is central to successfully integrating health and social care. The continuation of community equipment loan stores (with appropriate recycling of more expensive pieces of equipment) is essential to bridging the gap between health and care provision, especially at discharge, and ensuring value for money.

6.2 Disabled Facilities Grants provide long term value for money and are essential for people who cannot carry out adaptations to their home themselves. Better signposting is also needed for people who do not pass the means test and will need to source trustworthy suppliers.

6.3 There needs to be greater use of personal budgets, involving the combining of care and health budgets. This will help to manage the growing demands upon limited resources and enable more people to take charge of what they need, enhancing their well-being and helping to provide the physical assistance that they need. Personal Health Budgets encourage choice and can enable better management and control of resources. They start a process where users and their relatives become more minded to contribute themselves ("top up") over time to obtain more support than the state can provide, without removing them completely from the state sector. This can shift some of the burden from the public sector, thereby enabling it to provide greater support to those most in need. It took a long time for it to happen, but the optical model is now an accepted one. Greater use of Personal Health Budgets, combined with Personal Care Budgets, will also stimulate competition and innovation, both of which are being stifled by the current procurement model. The move to introduce Personal Health Budgets for wheelchair provision has been welcomed across patient groups, industry and clinicians.

6.4 Greater promotion of the benefits of Healthcare and Assistive Technology is essential. Also needed is clear signposting to businesses adhering to appropriate consumer Codes of Practice, as this is important to provide self-funders with protection and give them confidence to buy things for themselves.

About the British Healthcare Trades Association (BHTA)

The British Healthcare Trades Association is the UK's oldest and largest healthcare trade association, founded in 1917. Our members - almost 500 companies employing over 17,000 people - make or sell healthcare and assistive technology products that help people live more independently. These range from wheelchairs to stairlifts, seating and positioning products, specialist beds, stoma and continence products, prosthetics, orthotics and independent living products. The definition of assistive technology which we employ is "any product or service designed to enable independence for disabled and older people".

22 September 2016

British Medical Association – Written evidence (NHS0116)

About the BMA

The British Medical Association (BMA) is a professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 168,000, which continues to grow each year.

Executive Summary

The NHS is facing a funding crisis which can only be solved through increasing investment based on a realistic assessment of what is needed to meet the health needs of current and future generations. We have identified current challenges facing the NHS and explored how these can be addressed through additional investment and measures that can be used to promote long-term sustainability.

- The BMA is committed to an NHS which is publicly provided, publicly delivered and free at the point of need. Healthcare funding is a basic function of government and the NHS must continue to be funded directly through general taxation.
- The NHS offers the UK population financial protection from the potentially catastrophic costs of ill health. By comparison, in the US, medical debt is the largest cause of personal bankruptcy²⁹². By removing patients' concerns over their ability to pay, doctors can better focus on their clinical needs, eliminating an unhelpful distraction in the doctor-patient relationship.
- Current funding levels are the biggest single threat to the sustainability of the NHS. There are four main areas of concern that should be urgently addressed – the crisis in general practice, hospital deficits, cuts of public health and inadequate levels of social care funding.
- More attention must be paid to the serious and ongoing problems in recruiting and retaining all grades of doctors and the impact this has had on already stretched services. Effective workforce planning must be undertaken to ensure the right number of healthcare workers are employed with the right skills and in the right places.
- A cross-government action plan is required setting out short, medium and long-term actions to help create a more preventative service. This should be complemented with measures to mitigate the negative effects of austerity and welfare reform on health, including a 'health in all policies' approach.
- Increasing health literacy, particularly from an early age, is key to achieving public health prevention measures and promoting better awareness of self-care. This will also help to reduce pressure on overstretched health services and support the sustainability of the NHS by preventing ill-health in the long-term.

²⁹² C. LaMontagne, NerdWallet Health Study: Medical debt crisis worsening despite health care policy advances, NerdWallet, 2014, <http://www.nerdwallet.com/blog/health/2014/10/08/medical-bills-debt-crisis/>

- Technological advances can support the redesign and delivery of healthcare to manage increased demand on the NHS, but only if they are one part of a broader strategy of investment.

BMA response to the House of Lords Select Committee inquiry into the Long-Term Sustainability of the NHS

Introduction

The BMA welcomes this opportunity to submit written evidence to the House of Lords Committee on the Long-Term Sustainability of the NHS and supports the aim of the Committee to explore the future delivery of healthcare in England. This is a timely inquiry given that the NHS is currently facing unprecedented demand across almost all services, an ageing population coupled with increasingly complex patient illnesses and a drastic funding shortfall.

We believe that fundamentally, the NHS is facing a funding crisis which can only be solved through increasing investment based on a realistic assessment of what is needed to adequately meet the health needs of current and future generations. In this response we identify current challenges facing the NHS and explore how these can be addressed through additional investment and measures that can be used to promote long-term sustainability, such as integration, increased recruitment and retention of the workforce and use of technology.

1. The future healthcare system

1.1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

It is of critical importance to maintain and build upon the NHS's fundamental principles of equality by ensuring that the NHS continues to be free at the point of use. It is also crucial that government explores new ways of delivering healthcare, such as those highlighted in the Five Year Forward View, alongside ensuring that adequate resource is available to meet the health and social care needs of the population.

1.2 Self-care will play an important role in helping to reduce pressure on overstretched primary care and emergency departments during periods of increased demand and will support the sustainability of the NHS by preventing ill-health in the long-term. It is crucial that patients' knowledge of self-care, and more widely their understanding of how to make healthy choices to promote overall wellbeing, are communicated and learnt from an early age.

2. Resource issues, including funding, productivity, demand management and resource use

2.1 To what extent is the current funding envelope for the NHS realistic?

Does the wider societal value of the healthcare system exceed its monetary cost?

The wider societal value of a healthcare system which is free at the point of use exceeds its monetary cost. On an individual and basic level, the NHS offers the UK population financial protection from the potentially catastrophic costs of ill health. By comparison, in the US,

medical debt is the largest cause of personal bankruptcy²⁹³. By removing patients' concerns over their ability to pay, doctors can better focus on the clinical needs of their patients, eliminating what would otherwise be an unhelpful distraction in the doctor-patient relationship²⁹⁴.

- 2.2 A successful healthcare system can have a positive impact on economic growth in the long-term, by creating a healthier, better educated, and more productive labour force. In particular, improved health of children is linked to better cognitive function, which in turn improves their life chances. Improved health can also play a key role in reducing instances of long term sickness leave²⁹⁵. Given these wider societal benefits, the government should fund the NHS adequately. However, recent trends such as A&E closures and increases in NHS waiting times²⁹⁶ are early signs of inadequate resources²⁹⁷.
- 2.3 Although the Westminster Government has recently made a commitment to invest £4.5 billion to deliver on commitments in the Five Year Forward View, this still falls short of what is actually needed²⁹⁸. Much of this funding has been made available through cuts in other areas including public health, education and training, capital spend and national bodies such as the NICE (National Institute for Health and Care Excellence). Spending in these areas is being cut by more than £3 billion over the next five years. Furthermore, this does not take into account funding for commitments for seven day services. The result of this will be a 6.7% reduction in health spending as a proportion of GDP by 2020/21, creating a significant funding gap that will make it more difficult to provide high quality, safe, sustainable health services.
- 2.4 We believe that current funding levels are the biggest single threat to the sustainability of the NHS and would draw the Committee's attention to four key areas of concern:
- **General practice is in crisis:** The proportion of NHS funding spent on general practice has fallen from 10.4% in 2005/6 to 7.4% in 2014/15, leaving practices receiving an average of only £141 per patient to deliver a year of general practice care. This approach is contrary to evidence that shows that investment in general practice reduces secondary care costs and is therefore crucial to NHS sustainability²⁹⁹. To address this crisis there needs to be a sustained, year-on-year increase in the proportion of NHS funding going to general practice on a recurrent, equitable basis for practices.

²⁹³ C. LaMontagne, NerdWallet Health Study: Medical debt crisis worsening despite health care policy advances, NerdWallet, 2014, <http://www.nerdwallet.com/blog/health/2014/10/08/medical-bills-debt-crisis/>

²⁹⁴ Porter & AL-Zaidy, A health service (re)designed to help doctors give the best possible care to their patients. In *The Health of the Nation: Averting the demise of universal healthcare*. Civitas 2016.

²⁹⁵ Suhrcke M, McKee M, Stuckler D, Sauto Arce R, Tsoлова S, Mortensen J: The contribution of health to the economy in the European Union. *Public health* 2006, 120:994–1001.

²⁹⁶ Quality Watch, NHS Waiting Times, November 2015, <http://www.qualitywatch.org.uk/news/%E2%80%98gradual-decline%E2%80%99-nhs-waiting-times-unlikely-improve-soon-other-areas-care-quality-show-more>

²⁹⁷ NHS England & NHS Improvement (2016) Strengthening financial stability and performance in 2016/17

²⁹⁸ BMA NHS funding and efficiency savings, pp. 4-5, <https://www.bma.org.uk/collective-voice/influence/key-negotiations/nhs-funding/nhs-funding-and-efficiency-savings>

²⁹⁹ Spend to save: The economic case for improving access to general practice A report for the Royal College of General Practitioners, p.5, <http://www.rcgp.org.uk/~media/Files/PPF/2014-RCGP-Spend-to-Save-Deloitte-report.ashx>

- **Hospitals are in deficit:** The aggregate NHS provider and commissioner deficit increased from £554 million in 2014/15 to £1.85 billion in 2015/16. In the provider sector alone deficits stood at £2.45 billion at the end of 2015/16. To try to cut the combined provider deficit to around £250 million in 2016/17, the DH (Department of Health) has made available £1.8 billion via the STF (Sustainability and Transformation Fund)³⁰⁰. As the STF can only be spent once, if most of the funds are used to plug deficits there will be little money being left over for the transformational change and long-term investment that the NHS needs to ensure its sustainability³⁰¹.
- **Cuts in public health spending will increase future costs:** Recent cuts to public health budgets will damage the health of the public and the NHS's long-term sustainability³⁰². The BMA has concerns about the Government's overall commitment to prevention in public health as demonstrated by the limitations of its recent obesity plan (which are considered in more detail later in this response).
- **A lack of social care funding is increasing costs for the NHS:** Between 2009/10 and 2014/15, funding for the provision of adult social care fell in real terms by an average of 2.2% a year, leading to a 25% reduction in the number of people receiving publicly funded social care³⁰³. One of the main consequences of this is delayed discharge of older patients out of hospital into more appropriate care settings. The RCP (Royal College of Physicians) has reported that the number of patients in hospital because of delays being discharged has risen by 80% over the last five years³⁰⁴.³⁰⁵ This results in worse patient outcomes and problems further down the line as older people can, for example, quickly lose mobility and the ability to do everyday tasks, as a consequence of being in hospital. It has been reported that in healthy older adults 10 days bed rest leads to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity³⁰⁶. Not only is this bad for the patients stuck in hospital, it means that people who do need hospital care cannot be admitted due to bed shortages, and is also wasteful of NHS resources. The gross cost to the NHS of bed days occupied by older patients no longer in need of acute treatment has been estimated at £820 million³⁰⁷.

2.5 What funding models would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

The BMA believes that public funding must be used prudently and effectively. Previous attempts to introduce new funding models in the NHS have lacked adequate scrutiny and effective risk assessment. An example of this is the introduction of PFI (Private Finance Initiatives), which have become a drain on the public purse, creating an enormous burden of debt. The Government must undertake evaluation and learn from past experience and

³⁰⁰ NHS England & NHS Improvement (2016) Strengthening financial stability and performance in 2016/17.

³⁰¹ Nuffield Trust (2016) Feeling the crunch.

³⁰² BMA Annual Representative Meeting 2016

³⁰³ Lafond S, Charlesworth A, Roberts A (2016). A perfect storm: an impossible climate for NHS providers' finances? The Health Foundation.

³⁰⁴ RCP: Underfunded, underdoctored, overstretched - the NHS in 2016, p.2

<https://drive.google.com/file/d/0B59chPQfmit1Y3RSSkN4OGZqam1BdzRGSHNCLWticWY4dVRZ/view>

³⁰⁵ National Audit Office (2016) Discharging older patients from hospital

³⁰⁶ Monitor (2015) *Moving healthcare closer to home: literature review of clinical impacts*.

³⁰⁷ BMA, minimum alcohol pricing briefing, <https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/alcohol/minimum-unit-pricing>

international comparators when instigating new funding methods in the NHS. This will avoid further instances of individual hospitals and CCGs becoming overrun by debt, compromising the care they are able to provide to patients.

2.6 What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

The BMA is committed to an NHS which is publicly provided, publicly delivered and free at the point of need. We strongly believe that healthcare funding is a basic function of government and the NHS must continue to be funded directly through general taxation.

2.7 We have supported some initiatives to increase the amount of funding available for public spending generally, for example the proposed Tobin Tax of 0.05% on the banking sector, which could have raised as estimated £20 billion. We also support taxation of some products and services which are proven to have negative health impacts on the population, as direct economic disincentives. We consider that it is appropriate to increase tax on tobacco, to introduce a minimum alcohol pricing of 50p per unit of alcohol sold³⁰⁸ and we welcome the Government's proposed soft drinks sugar levy. Measures such as these could help to boost public finances overall, which could then result in greater funding being made available to health and care services.

2.8 However, we have concerns regarding the ability of recent schemes, such as the social care precept (see Annex 1), to raise the funding that is needed to meet patient need. It is therefore crucial that these schemes are evaluated to ensure that they are effective and proportionate.

2.9 We have previously argued that it should be easier to share health and social care budgets where professionals have identified that it would be beneficial for patients and service users, either through existing mechanisms, or by creating new ways to pool budgets. However, these benefits will only materialise if high levels of trust exist between the relevant local partners and enough time is allowed for integration to be embedded³⁰⁹. We believe a national framework is needed to set out how the NHS, public health and social care will be funded, commissioned and organised in the future to meet the needs of the population.

2.10 Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

The BMA firmly rejects any proposal of a means-tested monthly levy to pay for the NHS or to charge for GP and hospital appointments³¹⁰. User charges have been shown to limit access to healthcare on the basis of wealth, undermining the very principles which lie at the heart of the NHS and quality of service. Specifically studies show that more

³⁰⁹ Williams et al (2013). Trust matters for integrated care? London: Kings Fund and Addicott R (2014). *Commissioning and contracting for integrated care*.

³¹⁰ BMA Annual Representative Meeting 2014

disadvantaged patients are likely to wait longer to seek medical care if a cost is involved, which ultimately can impact upon their recovery³¹¹.

3. Workforce issues and planning

3.1 What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

The BMA does not support unlimited immigration for doctors but believes that employers must have the capacity to recruit and retain overseas doctors where other solutions to staffing have been unsuccessful and where a clear workforce need exists. The immigration system must remain flexible enough to recruit doctors from outside the UK should the resident workforce be unable to produce suitable applicants to fill specialist or generalist vacant roles, or if an individual has particular skills and knowledge not readily available in the UK.

3.2 What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

In 2014, 10,242 doctors (6.6% of the UK medical workforce) received their primary medical qualification in another European Economic Area (EEA) country³¹². These doctors have become essential members of the UK's medical workforce and the NHS is dependent on them to provide a high quality, reliable and safe service to patients. It is vital that the Government offers EU nationals working in health and social care the right to remain in the UK. To help achieve this the BMA has joined the Cavendish Coalition, a newly formed coalition of 29 health and social care organisations, created to ensure standards of care are maintained as the Britain prepares to withdraw from the EU.

3.3 Currently medical research and the UK's expertise in planning and running health services are effective ways of generating revenue for the NHS and for individual employers. This in turn helps to resource services to patients and contributes to the sustainability of the NHS. The BMA recommends that for this to continue to be the case, following the UK exit from the European Union, there must continue to be a strong welcome for European and international students and trainees and a drive for the UK to go out and share its knowledge and expertise overseas.

3.4 What are the retention issues for key groups of healthcare workers and how should these be addressed?

The BMA is greatly concerned by the ongoing problems in recruiting and retaining all grades of doctors and the impact this has had on already stretched services. Effective workforce planning must be undertaken to ensure the right number of healthcare workers are employed with the right skills and in the right places. Parts of the NHS currently lack a

³¹¹ Rand Corporation, The Health Insurance Experiment, 2006 p.3 http://www.rand.org/pubs/research_briefs/RB9174.html

³¹² BMA Implications of the European Union referendum result for government policies on ensuring safe staffing levels in the National Health Service and social care services <https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/pa-briefeureferendumandsafestaffing-19-07-2016.pdf?la=en>

coherent and properly funded plan to deliver a workforce that will meet the demands of the population. Workforce planning needs to take account of the changing current and projected future demands and therefore needs to also look at training requirements as well as measures to support greater retention of doctors. Governments should retain control of workforce planning and development centrally, to prevent unacceptable regional variations in training quality, the output of training and workforce availability. The lack of robust data relating to the medical workforce across the UK is also a concern. Adequate data is necessary, not only for the effective delivery of current care, but also for sustainable planning, and in understanding the requirements for medical training provision. There needs to be improved availability, quality and accuracy of NHS data collection across the UK, particularly around workforce numbers and vacancies, which are not routinely collected.

- 3.5 General practice is the foundation stone of the NHS. However, just a year after the Government promised to recruit 5,000 more GPs, a survey by GP magazine Pulse found that around 12% of GP posts are vacant, the highest ever level of unfilled posts³¹³. The Government should work with doctors to promote the uptake of general practice, increase the number of GPs, and implement the recommendations included in the BMA's report *GP Safe working and locality hubs*³¹⁴. These include a safe level of appointments per day, appointment times that are sufficient to accommodate patient need, and support and promotion for the rollout and evidence base for locality hubs, which are beginning to be used to pool local primary care resources.
- 3.6 The BMA also has concerns regarding secondary care recruitment and retention. There are significant gaps in recruitment of some consultants, including psychiatrists³¹⁵, physicians³¹⁶ and emergency medicine³¹⁷. Some A&E departments have already had to impose temporary closures due to lack of medical staff³¹⁸. Rota gaps are frequently reported as a problem, with evidence showing that seven out of 10 doctors in training work on a rota with a permanent gap³¹⁹. In addition, only 52% of FY (Foundation Year) 2 doctors are now progressing straight to specialty training, a drop of around 20 per cent over the past five years, while the number of FY 2 doctors leaving medicine over the same period increased by nearly 10 per cent³²⁰.
- 3.7 Following the announcement of the imposition of a national model contract for junior doctors in England, morale amongst junior doctors has collapsed. Such a situation is hugely concerning for the future sustainability of the NHS as it will have a significant impact on

³¹³ Pulse, 29 April 2015, GP vacancy rate at highest ever, with 50% rise in empty posts <http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/gp-vacancy-rate-at-highest-ever-with-50-rise-in-empty-posts/20009835.fullarticle>

³¹⁴ GP Safe working and locality hubs, <https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-current-issues/safe-working-in-general-practice>

³¹⁵ Kings Fund, Workforce planning in the NHS, p. 7

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf

³¹⁶ RCP (2016) Underfunded. Underdoctored. Overstretched.

³¹⁷ The Guardian, 10 August, 2016, <https://www.theguardian.com/society/2016/aug/10/hospital-a-and-e-crisis-shortage-emergency-doctors>

³¹⁸ Inews, 10 August 2016, <https://inews.co.uk/essentials/news/health/emergency-departments-closing-nhs-trusts-deficit/>

³¹⁹ RCP: Underfunded, underdoctored, overstretched - the NHS in 2016, p.3

<https://drive.google.com/file/d/0B59chPQfmit1Y3RSSkN4OGZqam1BdzRGSHNCLWticWY4dVRZ/view>

³²⁰ 2015 F2 career destination report:

http://www.foundationprogramme.nhs.uk/download.asp?file=F2_Career_Destination_Report_2015_-_FINAL.pdf

retention figures for current and future junior doctors. To ensure the NHS is sustainable, the Government must prioritise improving the recruitment and retention of doctors.

3.8 How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

The BMA has set out a vision for pre- and post-qualification training and development of doctors³²¹, which centres on the purpose and goals of medical education, training and development being universally understood and agreed with the profession. Medical education, training and development must be responsive to the population's health requirements and rooted in an ethos of professional excellence. We also consider that there should be a process of continuous lifelong learning, which in turn is valued and supported by employers and infrastructure.

3.9 The BMA has concerns, which are outlined in our recent response to the Higher Education and Research Public Bill Committee³²², that new fee raising powers contained within the Bill, linking fees to the TEF (Teaching Excellence Framework) could, in the long-term, lead to noticeable differences in tuition fees across providers. We consider that in time this may negatively impact on the number of applications to study medicine, as well as discouraging some of the brightest students from becoming doctors. We recommend that the proposed flexibility of tuition fees based on their rating in the TEF should be reconsidered.

4. Models of service delivery

4.1 What are the practical changes required to provide the population with an integrated National Health and Care Service?

The BMA has consistently called for greater integration and collaboration between different parts of the health service, including health and social care, as well as more integrated working across the medical profession and other clinicians. We believe the focus needs to be on delivering joined-up services, rather than encouraging growth of the internal market.

4.2 We recommend that any local service redesign should involve primary, community and secondary care, including mental health, working in collaboration. When appropriate, it will also be important to involve public health, bringing service delivery and prevention closer together. Similarly, integration with social care must be improved. There needs to be a concerted effort to bridge the longstanding divides that exist between sectors. Without this, a successful transformation of the NHS to a genuinely coordinated and integrated health system is unlikely to be achieved.

4.3 Changes that don't ensure genuine collaboration will create division, particularly if they are perceived to be led by a certain sector or profession. We therefore recommend that any plan to integrate services must be based on collaboration without any group dominating. The process must involve consultation and engagement with all sectors and patient groups from the earliest possible opportunity. Any change must be clinically-led

³²¹ *Pre and post qualification training and development of doctors*, BMA, 2015, <https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/training-and-development-of-doctors>

³²² BMA response to the Higher Education and Research Public Bill Committee: <http://www.publications.parliament.uk/pa/cm201617/cmpublic/HigherEducationandResearch/memo/HERB28.htm>

and based on good clinical evidence that care will be improved or at least not compromised.

4.4 How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

The experience of our members suggests that cultural and behavioural change in organisations has the biggest impact on integration and other service redesign projects. Rather than merging budgets, the BMA recommends that organisations should be supported to work together, focusing on partnership working. We are concerned that pooled budgets could result in decisions made on health spend becoming rationed, to meet the existing outstanding needs of the care sector.

4.5 Overall, we believe that virtual integration should be prioritised over structural integration as evidence has shown structural integration is often insufficient in achieving better coordination and improved patient outcomes³²³. In Northern Ireland, for example, patients share many of the frustrations of patients in England despite integrated health and social care services. Organisations working in partnership, with or without shared budgets, can effectively develop multidisciplinary teams, managed clinical networks and joined-up care pathways. Virtual integration is also much less disruptive. Given the need for stability in the NHS and for stronger relationships to develop between service providers, this is very important.

4.6 We support local areas working together to maximise the benefits for patients in their locality and collaborating to make the most out of common resources. STPs (Sustainability and Transformation Plans) may present an opportunity to create a shared vision and objectives for all organisations within an area, including a single shared set of measures to assess performance. However, it is critical that these plans must not exacerbate the funding crisis in the NHS. In particular, it is important that STPs do not result in health funding being used to prop up depleted social care budgets rather than focusing on the health needs of the local population. The BMA strongly believes that if NHS funding levels are insufficient, the government must look at developing a new funding settlement for health and social care services.

4.7 We also consider that for STPs to be successful it is crucial that there is sufficient public awareness of them and that they have the support of patients and doctors. The BMA is therefore calling for all plans to be made public and for local clinicians to be fully consulted and involved in any planned changes. In addition, a good governance structure must be developed to ensure proper accountability in the long term.

4.8 How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

Encouraging and enabling providers to work collaboratively around the needs of patients should help deliver more joined-up services, with an improved balance between hospital and community services. The evidence available suggests that community-based care

³²³ Kings Fund (2010). Clinical and service integration: the route to improved outcomes
<https://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf>

improves patient access and experience while maintaining a level of quality that is equivalent with services offered in acute settings³²⁴. The evidence also suggests that managed care programmes, emphasising preventative healthcare and home treatment, as would likely be found in mature MCPs (Multispecialty Community Providers), would improve quality for patients with long term conditions³²⁵.

4.9 The BMA recognises that payment by results (PbR) systems can create perverse incentives to treat patients within secondary care systems. To address this, it is important that the government makes faster progress towards payments mechanisms that support integrated personalised care, while also recognising and rewarding good outcomes.

4.10 We believe that the overall level of funding available for the NHS must be increased. This would allow for an improved balance between mental and physical health care, as spending on mental health care currently only equates to 11% of the total UK NHS budget. We believe that this would move the NHS closer towards the desired aim of creating parity of esteem between the two. There also needs to be more integration of mental health services with physical health services, through careful commissioning and delivery that supports integration, such as implementing liaison psychiatry services. Better integration of these services enables patients with common comorbidities of physical and mental health problems to be helped and treated earlier with collaborative, holistic care.

5. Prevention and public engagement

5.1 What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service? What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

We believe that the 2010 Marmot Review³²⁶ sets out a comprehensive method to shift towards a preventative approach to healthcare based on action through the life course. The BMA strongly supports this approach, and believes that a cross-government action plan is required setting out short, medium and long-term actions against each recommendation in the Marmot Review. There is also a need to complement this action with measures to mitigate the negative effects of austerity and welfare reform on health, including a 'health in all policies' approach, which would require all policy to take into account the health implications of decisions, and avoid harmful health impacts, in order to improve population health and health equity.

5.2 Prioritising a focus on ill-health prevention activities to address the health risk factors significant to the development of long-term conditions, such as cancer and cardiovascular diseases, will contribute to promoting future sustainability of the NHS. These risk factors include smoking, alcohol misuse and poor nutrition. The BMA believes there is a need to

³²⁴ Sibbald B, McDonald R & Roland M (2007). 'Shifting care from hospitals to the community: a review of the evidence on quality and efficiency'. *Journal of Health Services Research & Policy*, **12** (2)

³²⁵ Singh (2005). *Transforming Chronic Care: Evidence about improving care for people with long term conditions*. Surrey and Sussex Primary Care Trust Alliance.

³²⁶ Marmot M, Allen J, Goldblatt P et al (2010) *Fair society, healthy lives. Strategic review of health inequalities in England post-2010*. London: The Marmot Review.

develop a long-term, comprehensive public health strategy aimed at improving health over a generation (ie 25 years). Focusing on the long-term is necessary to deliver sustained behaviour change among a population because of the way in which poorer health outcomes accumulate over time. It would also overcome the inherent weaknesses of existing strategies that are typically short-term, and that can radically change in focus after each parliamentary cycle. Its development, implementation and monitoring should be overseen by a standing Royal Commission on Public Health.

5.3 We recommend that investment in ill-health prevention programmes should be prioritised and proportionate to the burden of disease across the social gradient. There is also a need for the Government to utilise the full range of interventions: clinical; social; behavioural; educational; environmental; fiscal; and legislative, to tackle the main drivers of unhealthy lifestyle risks. BMA policies in relation to tobacco, alcohol and food and non-alcoholic drink products are included as Annex 2.

5.4 In addition, as highlighted at the start of this submission, we also recognise that increasing health literacy, particularly from an early age, is key to achieving public health prevention measures and promoting better awareness of self-care. This is crucial as people with low health literacy report worse physical and mental health, along with a higher prevalence of a number of serious health conditions³²⁷. This issue is compounded by the number of competing messages associated with commercial marketing. For example, there is a stark contrast between government expenditure on public health communications and the money spent by companies advertising unhealthy food and drink products. According to PHE, while the government's public health marketing programme Change4Life has an annual budget of £10 million, nearly £150 million was spent on marketing unhealthy food and drink products in 2013. We recommend that to address this, government must explore how to better promote health literacy from childhood and couple this improvement with reviewing existing promotions and advertising for unhealthy food and drink products.

5.5 **What are the best ways to engage the public in talking about what they want from a health service?**

It is important to involve patients and the public in the planning, monitoring and development of health services. Listening, engaging and empowering patients will help deliver services that reflect what patients want and need. NHS England has produced specific guidance for commissioners on how to involve patients and the public in this area which includes some helpful best practice case studies³²⁸. Commissioners need to make sure they engage with all parts of their local communities, especially disadvantaged and disenfranchised groups, as their needs are often amongst the most challenging.

5.6 The BMA actively promotes the importance of communication and genuine cooperation with patients, and their families and carers, through its PLG (Patient Liaison Group). Since its launch in 2004 the PLG has produced a number of patient-focused resources on topics ranging from self-care to toolkits for doctors on patient involvement. It also provides support for doctors, offering communication skills courses and an online

³²⁷ Rowlands G, Protheroe J, Richardson M et al. Defining and describing the mismatch between population health literacy and numeracy and health system complexity. Submitted for publication.

³²⁸ <https://www.england.nhs.uk/commissioning/primary-care-comm/involving-the-public/>

toolkit. We believe that this focus on patients should be ingrained into the delivery of health care in the England.

6. Digitisation of services, Big Data and informatics

6.1 How can new technologies be used to ensure the sustainability of the NHS? What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

Technological advances can support the redesign and delivery of healthcare to manage increased demand on the NHS, but only if they are used as one part of a broader strategy of investment. We consider there is a role for technology to support patients to self-manage conditions, as well as to support clinicians to deliver care more quickly, access improved decision support and communicate more effectively between primary, secondary and social care. For example, Asthma UK reports that trials of smart inhalers to monitor medication adherence are showing evidence of improved asthma control, through both improving self-management and providing clinicians with real time, precision data to inform the development of asthma action plans³²⁹. The BMA is supportive of further work to develop our understanding of the potential benefits and risks associated with these types of innovations.

6.2 However, there is currently limited evidence that emerging technologies such as telemedicine, wearables and apps do in fact reduce costs and manage demand. There is also inconclusive evidence as to whether or not remote consultations reduce the number of in-person consultations or improve clinical outcomes. Research into genome medicine remains at an early stage, so the role it could play in reducing costs and managing demand is still unknown.

6.3 What is the role of ‘Big Data’ in reducing costs and managing demand?

The BMA believes that ‘big data’ technologies offer considerable opportunities for research into health, healthcare delivery and public health. We are supportive of uses of data for secondary purposes, with appropriate safeguards and transparent processes in place. Given the scale of datasets used in big data, it is of paramount importance that the public fully understands and supports the use of big data technologies, and all data uses are fully transparent and in line with patient expectations.

6.4 What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

One of the key barriers to large scale roll out of new technologies and big data is the lack of resources and capacity available to do it properly. The NHS is experiencing intense financial and workload pressures, directly caused by continued underinvestment. The government needs to provide significantly increased and ongoing investment if healthcare organisations are to resource and deliver IT programmes that actually achieve the desired outcomes of reduced costs and demand. Any intention to roll out programmes for new technologies needs to ensure that the mistakes of the 2002 – 2011 National Programme for IT are not repeated. For example, additional funding would be needed to successfully implement and embed an IT programme for a range of activities, including training clinical leadership to understand digital opportunities and technologies. In addition, extensive planning and

³²⁹ Asthma UK. 2016. Connected asthma: how technology will transform care. Report.

piloting would be needed to develop evidence that the intervention will be clinically beneficial.

6.5 Many of the opportunities offered by advances in technology and informatics require changes to the way information about patients is collected, stored and shared. For the NHS to realise the benefits offered by data sharing between providers and from wearable technologies into patient records, NHS Digital needs to continue its current work of ensuring all systems and third party providers are fully interoperable.

6.6 Fragmented IT development leads to difficulty achieving interoperability, which limits collaboration and undermines the quality of care that can be provided. Local IT systems in the health and social care sector are often outdated and unsupported³³⁰ and present a serious barrier to the successful uptake and embedding of new technologies. There needs to be increased and sustained investment in programmes of regularly updating software and hardware. For example, if clinicians are expected to reduce workload by using telemedicine tools like video consultation, the software used needs to provide adequate resolution and fully integrate with the clinical system.

6.7 Healthcare professionals often do not have access to general IT help and support to resolve technical issues in a timely manner, often meaning that using technology inhibits the safe and efficient delivery of care rather than enhancing it. Relevant bodies should ensure there are adequate dedicated resources made available to provide technical support for IT systems, either through contracts with suppliers and/or a dedicated support service.

6.8 How can healthcare providers be incentivised to take up new technologies?

In addition to addressing the barriers described above, healthcare providers would be incentivised to develop and deliver programmes using new technologies if there was a comprehensive, peer-reviewed evidence base showing that there are measurable benefits of using new technologies for reducing workload and managing demand.

6.9 Where is investment in technology and informatics most needed?

Programmes should focus on improving how healthcare professionals currently work, finding new ways to work more efficiently, with fewer errors. Long-term investment in research and delivery is required to understand what technology is useful for patients and professionals, as well as what technology creates unintended negative consequences. Any large-scale implementation of technology-enabled services also requires significant and long-term funding in change programmes to ensure that technology is embedded within an organisation and used effectively, rather than imposing further workload on clinicians and creating potentially dangerous situations for patients.

6.10 75% of doctors feel that doctors and medical students need more training and education about information, data and technology³³¹. If IT and new technologies are to be used more within the NHS, increased and sustained investment in training will need to be prioritised to ensure that healthcare professionals can use emerging IT competently.

³³⁰ National data guardian for health and care. 2016. Review of data security, consent and opt-outs. Report.

³³¹ BMA. 2015. BMA member survey – NHS IT. Survey of ca 500 doctors across all branch of practices, conducted between 13 January and 3 February 2015.

Annex 1.

Social care precept

The social care precept, that enables local authorities to increase Council Tax by up to 2% a year to help fund adult social care, is unlikely to raise the amount needed to cover costs for social care services. The IFS (Institute for Fiscal Studies) has estimated that this mechanism would raise £1.7 billion by 2019/20 if used in full and would also need to cover the cost of the new National Living Wage³³² which is estimated to be £1.4 billion by 2020.³³³ Another issue is that the precept will raise the least funding in the areas of greatest need of social care.³³⁴ The BMA is concerned that this will exacerbate existing health inequalities.

Annex 2.

Summary of BMA policies in relation to tobacco, alcohol and food and non-alcoholic drink products

Tobacco

- Increase taxation on all tobacco products above the rate of inflation and introduce a minimum consumption tax.
- Implement a positive licensing scheme to control and reduce the amount of tobacco legally on sale.
- Introduce a requirement for tobacco companies to report on sales data, marketing strategies and lobbying activity
- Introduce an annual levy on tobacco companies to provide funding for future tobacco control, applied proportionately according to a company's market share

Alcohol

- Introduce a minimum price of at least 50p per unit of alcohol for all alcohol sales.
- Ensure duty on alcohol is increase annually above the rate of inflation and that the tax on every alcohol product is proportionate to the volume of alcohol it contains.
- Prohibit all alcohol marketing and establish an independent body to provide education about alcohol and regulate product and packaging design.
- Reduce licensing hours in on and off licensed premises, including restricting the sale of alcohol in shops to designated areas.
- Implementing mandatory labelling of alcohol products that include an evidence-based health warning specified by an independent regulatory body.

Food and non-alcoholic drink products

- Introduce a mandatory, standardised approach for displaying nutritional information on all pre-packaged food and drink products.

³³² Phillips D (2015). *Local government and the nations: a devolution revolution?* Institute for Fiscal Studies Autumn Statement briefing.

³³³ Resolution Foundation (2015). *Care to pay? Meeting the challenge of paying the National Living Wage in social care.*

³³⁴ Association of Directors of Adult Social Services (2016). ADASS Budget survey.

- Prohibit the marketing of unhealthy food and drink products that appeals to children and young people.
- Review of how the regulation of sales promotions can be strengthened to ensure they favour healthy options and deliver public health benefits
- Prohibit retailers from displaying and promoting unhealthy food and drink products at checkouts and in queuing areas.
- Provide local authorities with the power to restrict the future number, clustering and concentration of fast-food outlets locally.
- Set mandatory targets for manufacturers, retailers and caterers to reduce calorie, fat, saturated fat, salt and added sugar levels in pre-prepared and processed products.
- Introduce a tax on all sugar-sweetened beverages, which increases the price by at least 20%.

23 September 2016

The British Psychological Society – Written evidence (NHS0057)

About the Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry. Please direct all queries to:-

The British Psychological Society welcomes the opportunity to contribute to the Select Committee's review. Our responses to specific aspects of the review are provided below.

Section 2: Resource Issues, including funding, productivity, demand management and resource use

The Society supports an NHS that is free at the point of delivery; charging at the point of delivery or means testing fees will cause greater health and social care inequalities. There are efficiencies that can be made in building on the skills within the current workforce and developing a new, broader multi-skilled workforce that works within a patient pathway alongside more specialist staff.

Section 3: Workforce

What are the requirements of the future workforce going to be?

In a time where at least 6 out of 10 causes of death identified by the World Health Organisation³³⁵ are behavioural, behavioural health and psychological aspects of healthcare

³³⁵ <http://www.who.int/mediacentre/factsheets/fs310/en/>

are critically important for the future sustainability of the NHS, public health and promotion of well-being in work, schools and FE educational provisions. Psychological aspects of healthcare are much broader than mental health: they also have a significant impact within other long term physical health issues such as diabetes, obesity, stroke, cancer and dementia as well as contributing to the understanding of stress within the NHS and the wider health and social care workforce. In an ageing population, the workforce needs to be provided with the means to stay in work for longer.

The existing workforce is suffering from burnout, leading to the workforce retiring earlier and placing additional strain on the NHS to fund not only a replacement workforce of its own but to also treat the wider workforce in society. Behavioural health and medicine have a vital role to play in supporting the NHS to create a more agile, responsive, efficient and resilient workforce now and for the future. The Society would like to propose a solutions based, psychologically informed approach to delivering this.

How can the supply of key groups of healthcare workers be optimised for the long term needs of the NHS?

The Society strongly encourages the recognition of the need to develop a holistic workforce that is trained to be multi-disciplinary in its approach. This workforce should have a breadth of knowledge that addresses both mental and physical health, therefore providing an efficient and agile workforce. This training should be aligned with psychological practices and include aspects of nursing, social care, occupational therapy and physiotherapy and have a broad remit within healthcare and statutory settings e.g. schools.

The psychiatric nurse workforce has declined by 11.4% from 40,602 in September 2009 to 34,971 in January 2016³³⁶ and a multi-disciplinary workforce could help fill that gap. This multi-disciplinary role could provide for a progression route for the many Health Care Assistants that are currently employed in the NHS (aiding agility and retention of staff). This training could be developed as part of a Higher Level Apprenticeship (band 5 or 6 on the NHS pay scale), allowing the NHS to fund the training through their Apprenticeship Levy, estimated to be up to £225million³³⁷. Utilising the Apprenticeship model of training makes training not only accessible to the 18-21 year old demographic but also to people who wish to retrain later in life and who are unable to take an extended period of time out to go back to university on a full time basis.

Section 4: How can the UK ensure that its health and social care workforce is sufficiently and appropriately trained?

Often workers train for a specific job; however, their learning and skills development does not stop once initial training is complete – workers develop a wide range of skills and competencies throughout their working lives. The Society recommends that workers,

³³⁶ Digital.nhs.uk/article/2021/Website-Search?productid=20703&q=psychiatric+nurse+figures&sort=Relevance&size=10&page=1&area=both#top

³³⁷ Based on a £45billion pay bill.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/492233/NHSPRB_report.pdf

particularly, but not limited to, those working as Psychologists, should be recruited by competency not by the specific title that they trained under; thus allowing for agility of the workforce and aiding retention of staff.

Psychologists in particular are trained at Doctoral level, developing core principles in change, research, criticality and reflexivity ensuring that they are a flexible workforce with practice that is firmly evidence based, impactful and valuable. They are also adaptable ensuring that they can meet the priorities that are constantly evolving in our Government, society, schools and life stages. Psychologists, and other professionals, work in an evidence based way that not only sits within NICE guidelines, but also uses broader evidence based findings that add to and go beyond current NICE guidelines.

Section 5: Models of Service Delivery and Integration

The Society recommends a review of the Behavioural Health Specialist model³³⁸ that is adopted in the USA. In this model, the post holder tends to work in clinical settings and provides an integrated service to adults and children and between mental and physical health. The model in the USA usually expects a trainee to have a psychology (or related) degree or sometimes relevant experience. There is also evidence in the USA of Social Workers having greater involvement in mental health care than in the UK; as Social Work training in the UK is currently being redesigned it is an opportune time to consider the relationship between social work and psychology and how more integrated training can benefit the service user and NHS.

The Society also recommends that Applied Psychologists (band 8) operating within the NHS (Clinical, Counselling, Health, Educational and Forensic) should lead teams working in an integrated manner with an agile and multi-skilled workforce, including the suggested Multi-disciplinary Workers and Behavioural Health Specialist mentioned above and also specialist workers such as Psychological Wellbeing Practitioners (PWP) and High Intensity (HI) workers that exist in the Improving Access to Psychological Therapies (IAPT) services.

Upskilling the workforce and integrated commissioning

It is important when looking at multi-disciplinary roles that integration factors are considered:

- integrating primary care with secondary care
- integrating health care with social care
- integrating mental health care with physical health care
- integrating children's services with adult services
- Integrating mental health care with school services

The Society recommends that workforce training be linked to the above integrating factors. For example, the current PWPs are integrating mental health and preventative treatments

³³⁸ http://study.com/articles/Behavior_Specialist_Salary_Requirements_and_Duties.html

through the use of behaviour change methods and this could be extended to other professional groups. Investing in training that covers both physical and mental health aspects is both beneficial to service users and provides a cost effective service and training methodology.

There is a further need to integrate education, employment, homelessness, housing, prison and other forensic services too; early intervention, in terms of lifespan and illness, in both physical and mental health, provided through an integrated pathway, with a multi-disciplinary workforce and workers spanning multiple settings and trained in psychological literacy would ensure earlier and more cost effective intervention as well as person-centred, individualised care.

Using a “pathway” model to design and implement services is a powerful driver for clinically effective, evidence based and cost effective services and the Society recommends that it should be rolled out across health and social care services. Services should be linked and follow a patient pathway; these pathways should be made clear across a range of health and social care needs, breaking down waiting times and ensuring a cost efficient service. For example, at dementia care and memory clinics service users are assessed by a nurse or social worker initially and then work their way through a pathway until seeing a psychologist for diagnosis and treatment plan and then back down the pathway for the implementation and review of the plan.

The Society recommends that models currently adopted in Learning Disabilities and Child and Adolescent Mental Health Services (CAMHS) should be more widely implemented; workers across a range of job roles and grades are ‘skilled up’ by fellow colleagues in behavioural management, risk assessment, team development and reflective practice. This allows for an inclusive and integrated approach to both health and social care for service users. This integrated model could be adapted within the educational setting, for example many teachers are faced with situations involving self-harm but they feel that it is too specialised for them to become involved in. Building in this psychological training into teacher training would allow for early intervention from teachers, resulting in more effective and cost efficient treatment and reduction in work related stress in the teaching workforce. The relationship between CAMHS and education providers should be further strengthened so the team of support is built around the child and the family and not limited to a single service provider. Consideration must be given to the significant gaps that are provided within a Further and Higher Education setting where services are significantly reduced.

An example of excellent practice in an integrative approach to health and social care is Kensington and Chelsea, where there is a single oversight of health and social care multidisciplinary teams and associated budget which is focussed on meeting the needs of the clients.

The Society also recommends that formulation be integrated into the teaching of all relevant health and social care staff. Formulation is fundamental in the training of Applied Psychologists; however, this should be encouraged more widely and training should be

developed more universally. Psychologists are well placed to consult with other professionals and provide support and high quality supervision.

An increasing number of GP consultations are related to mental health issues, which GPs are not specifically trained to deal with, nor feel they have sufficient consultation time to deal with adequately³³⁹. Other professional groups have the expertise to carry out the initial assessment and to case manage such clients. The Society recommends that by encouraging CPNs and Psychologists to take up the role of Principal in a GP practice and offer a direct referral method within the Primary Care setting, the burden on GPs in a time of a recruitment crisis would be reduced, whilst integrating behavioural medicine more fully into the Primary Care setting.

Section 6: Prevention and Public Engagement

The Society welcomes the notion of psycho-education, in educating society to ensure that people are equipped to take responsibility for their own health and wellbeing. We need to ensure that the public have the knowledge, skills and self-efficacy to make changes; however there are also complex contributing factors, for example lack of finances, access to services, adequate housing, that also need to be factored and a unified approach is required. Many public health measures have a huge significance on the health and wellbeing of many e.g. seatbelts in cars, smoking ban, fluoride in the water, an increase in this work would be welcomed. Research³⁴⁰ shows that major life change transition points are when people are more receptive to change; public health messages should focus around these major life changes for maximum impact.

In our ageing society, we have an expanding 'unpaid workforce' caring for family members with dementia and chronic long term health conditions. The Society recommends that the provision of training and support for this significant, and unpaid, workforce should be part of this integrative approach to health and social care. Patients and their families should also be equipped with the skills, knowledge and belief in their ability to self-manage as failure to do so increases the likelihood of patients returning to the NHS repeatedly for avoidable treatments. Psychologists are well placed to provide this type of preventative, behavioural medicine. A stepped care approach to the treatment of common mental health problems already exists through the Improving Access to Psychological Therapies programme. The Society recommends that the feasibility of broadening this approach to treatment in other areas, including older people, and the huge unpaid workforce, should be properly evaluated

22 September 2016

³³⁹ www.rcgp.org.uk/~media/Files/Policy/A-Z-policy/The-2022-GP-Compendium-of-Evidence.aspx

³⁴⁰ Verplanken, B. and Roy, D., 2016. Empowering interventions to promote sustainable lifestyles: testing the habit discontinuity hypothesis in a field experiment. *Journal of Environmental Psychology*, 45, pp. 127-134.

British In Vitro Diagnostics Association – Written evidence (NHS0039)

1. The British In Vitro Diagnostics Association (BIVDA) welcomes the opportunity to provide written evidence to the House of Lords Long Term Sustainability of the NHS Committee Inquiry on ‘How can we ensure a sustainable future for the NHS?’
2. BIVDA is the UK trade association for manufacturers and suppliers of *in vitro* diagnostic (IVD) tests. We currently represent over 100 members from the IVD industry, ranging from British start-up companies to UK subsidiaries of multinational corporations. BIVDA member companies employ more than 8,000 people in the UK, with a total industry turnover of approximately £900 million.

Summary

3. The IVD industry understands that the NHS is under financial strain but considers all possible actions must be exhausted before serious consideration is given to changing the funding model of the NHS.
4. Greater adoption of IVDs could improve efficiency and productivity within the NHS while also improving patient care.
5. However, due to the way budgets operate in the NHS, there can be disincentives to increasing the adoption of innovative healthcare technologies in the NHS. This situation needs to be addressed.
6. Given the UK’s decision to leave the EU, the Government should take steps to ensure the NHS and life sciences sector still has access to a strong supply of appropriately trained healthcare professionals.
7. BIVDA would also like to see more value placed on the role of pathologists in the NHS, to ensure that the profession continues to attract talented people in the future.

Response from BIVDA

Resourcing issues – including funding, productivity and demand management. Is the current funding model for the NHS realistic in the long-term? Should new models be considered? Is it time to review exactly what is provided free-at-the-point of use?

8. The IVD industry appreciates that the NHS is under considerable financial strain and as a result, it is inevitable that steps need to be taken to ensure the NHS has a secure financial footing to protect its future.
9. While it may be necessary at one point to examine alternative funding models, the central advantage of the NHS for patients is that treatment is provided free-at-the-

point-of-care. Should this change in the future, it could have serious implications for the more vulnerable and less financially secure patients.

10. Therefore, it is important that all possible action is taken to ensure the NHS is as productive and efficient as possible, before the funding model is reviewed. Increasing the adoption of IVD tests is one way in which the productivity and the efficiency of the NHS could be improved, while also improving patient care.
11. IVD tests are central to the successful diagnosis, treatment and management of patients. 70% of clinical decisions by healthcare professionals are made using one form of IVD³⁴¹. Diagnostics are also used to monitor, screen and assess people for potential health problems while allowing people to manage their own conditions. Better use of these tests could:
 - **Transform patient pathways** – ground-breaking mobile diagnostics services are delivering laboratory standard test results outside of hospital and allowing patients to be diagnosed and treated at the point of care.
 - **Release resources for use elsewhere in the NHS** – a new generation of highly sensitive diagnostic tests can either confirm or rule out a heart attack diagnosis in as little as 2-3 hours. If these tests were used on 10 patients a day in a single A&E department, it is estimated that it could save up to 28,000 hours of staff time per year, increasing productivity³⁴².
 - **Prevent unnecessary hospital referrals** – by 2025 it is expected that five million people in the UK will have diabetes. Diagnostics are essential to diagnose this at risk population rapidly and help them to manage their disease and prevent hospital stays³⁴³.
12. Despite the ability of IVDs to increase the efficiency of the NHS and improve care for patients, there is still a glass ceiling when it comes to the uptake and diffusion of new tests within the NHS. The NHS Five Year Forward View has highlighted the need for new models of care that allow for greater access and uptake of diagnostics. The priority must be shifting healthcare out of hospitals and into the community. This will help to reduce emergency admissions, reduce demand and improve patients' ability to self-manage their care.
13. However, there are scenarios in which there is a complete disincentive to introduce cost-saving and potentially life-saving new tests because while the up-front costs are borne by the innovators, the savings accrue further down the patient pathway.
14. For the benefit of both patients and the NHS, steps need to be taken in order to ensure that the uptake of innovative medical technologies which could assist financial efficiencies, is not being hampered by financial disincentives.

³⁴¹ <https://www.england.nhs.uk/wp-content/uploads/2014/02/pathol-dig-first.pdf>

³⁴² <http://www.bivda.co.uk/Portals/0/Documents/Policy%20and%20Media/Bivda%20Manifesto%202015%20web.pdf>

³⁴³ <http://www.telegraph.co.uk/science/2016/06/11/blood-test-could-pick-up-diabetes-five-years-before-it-develops/>

Workforce – including supply, retention and skills. How can an adequate supply of appropriately trained healthcare professionals be guaranteed? Are enough being trained and how can they be retained? Do staff in the NHS have the right skills for future health care needs?

15. Given the United Kingdom’s decision to vote for Brexit, it is vital that the Government takes action to ensure that there continues to be a strong supply of appropriately trained healthcare professionals working in the NHS.
16. The movement of highly-skilled workers from the EU and further afield into the UK, especially into the life sciences and healthcare sectors, has been and is likely to remain important in maintaining the UK’s productivity and ability to provide an effective and efficient NHS and vibrant life sciences sector.
17. The removal of free movement of workers post-Brexit will affect the provision of healthcare and in the short-term adversely restrict the talent pool for the NHS. As a priority, the UK Government should provide clarity on the visa system for skilled workers in the healthcare and life science sectors and ensure there are no barriers preventing them from continuing to work in the UK.
18. In addition, we are concerned that not enough value is being placed on the role of pathologists within the NHS. Recently, a letter was sent from NHS Improvement to all Chairs and CEOs of NHS Trusts instructing them to make financial savings by consolidating ‘back office and pathology services’, with proposals to be agreed by the end of July.
19. Pathology services form a vital part of the patient pathway. Nearly 800 million tests are performed annually in the NHS and 70% of clinical decisions are made using some form of IVD test.
20. However, the role of pathology is not limited to providing test results. As mentioned earlier in this submission, diagnostics are also used to monitor, screen and assess people for potential health problems while allowing people to manage their own conditions. Better use and adoption of these tests could transform patient pathways by allowing the targeted use of precision medicines, release resources for the NHS by reducing the time it takes to confirm or rule out a diagnosis and prevent unnecessary hospital referrals by allowing patients to manage their own conditions.
21. Therefore, a decision to categorise pathology as a ‘back office service’ is a failure to appreciate the critical role that pathology has to play in patient care and chronic disease management. The IVD sector works closely with NHS pathology staff and we are keen to demonstrate our support for their valuable and dedicated work.

22. We are also concerned that the current language used around the consolidation of ‘pathology and backroom services’ may undermine the profession, making it difficult to attract the strongest individuals in the future.

About BIVDA: We currently represent 100 members from the IVD industry, ranging from British start-up companies to UK subsidiaries of multinational corporations. BIVDA member companies employ more than 8,000 people in the UK, with a total industry turnover of approximately £900 million.

As part of Life Sciences UK, we provide the secretariat to the **Life Sciences APPG**.

21 September 2016

British Society for Histocompatibility and Immunogenetics – Written evidence (NHS0026)

1. Health Care Scientists in Histocompatibility and Immunogenetics (H&I) perform investigations and provide advice in respect of donor and recipient compatibility for solid organ and bone-marrow transplantation. These investigations are of two main types - HLA typing which facilitates donor-recipient matching; and serum screening/crossmatching, which determines recipient sensitisation against donor HLA mismatches. There is little to no H&I expertise amongst service users, from results of these tests high-level post-analytical advice will therefore be given to clinical colleagues regarding progression of patients to transplantation and on their post-transplant management. This will include decision making at the highest level i.e 'yes' or 'no' to transplantation.

2. Laboratory workloads are intimately linked to clinical activity in the transplant programmes which they support. Most UK centres experienced a doubling in activity in the period from 2000-2010 under a DH initiative to increase rates of transplantation. A further intended increase in transplant numbers was signalled in the 2013 NHS-BT ODT report *Strategy for Organ Transplantation to 2020*. Delivery of the aspirations of this report requires a 10% year-on-year increase in laboratory activity. This growth will occur not only from increased numbers of 'routine' cases but also from strategies that place heavier resource demands on laboratories owing to use of novel donor sources or recipient progression via managed desensitisation.

3. The 2020 strategy acknowledges the workload pressures that will result for teams involved in support and delivery of transplant programmes and calls upon commissioners to develop plans to address shortfalls in the transplant workforce. Unlike other elements of the transplant multi-disciplinary team H&I has not received additional funding to support programme growth and the majority of UK laboratories have absorbed the workload increases without a concomitant increase in their staffing establishments. This has been achieved through development of minimum-safe testing programmes and use of automation to the extent that is possible. Continued unsupported expansion would create unacceptable pressures on labs and place UK transplant programme development and patients at risk.

4 The situation described above is not sustainable into the future and concerns have already been raised with NHS-BT ODT, NHSE, HEE and with the Chief Scientific Officer, Professor Sue Hill.

5 In respect of the five main themes of the Select Committees inquiry The British Society for Histocompatibility and Immunogenetics (BSHI) would comment in three areas as below.

6. Resource issues

6.1 Transplant services are commissioned by NHS England. There is no direct commissioning relationship for H&I and these services are usually paid for as part of a bundle of laboratory medicine services, as a Pathology 'top-slice' on clinical budgets or Pathology service level

agreement, meaning that in many instances laboratories have to compete with other Pathology/Laboratory Medicine disciplines for funding. BSHI has previously proposed a direct commissioning relationship for H&I services in an arrangement linked to activity levels in the transplant programmes served. This funding model should be revisited to improve financial stability of services and ensure delivery of best quality of care.

6.2 It may be that traditional models of providing and funding laboratory testing through centralised 'Pathology' facilities are not the optimal means of delivery of all aspects of laboratory medicine and that integration of, particularly, specialist services into the medical disciplines served would facilitate both better planning of these services and would ensure their sustainability. This would be a radical departure from current thinking but provides an alternative means of addressing the issues identified in 6.1.

7. Workforce

7.1 New entrant training levels are in decline. This corresponds to a centrally led change in training programme delivery, with a fall from more than 40 trainee registrants for the previous, NHS recognised, BSHI Diploma route, to just 7 trainees now enrolled over the whole four years of the replacement MSC STP programme. These figures are a source of major concern for the discipline. Discussions with HEE have identified problems with MSC training programme configuration and delivery that are being actively addressed in partnership with them. BSHI would nevertheless advise that a workforce gap is now envisaged as a result of this situation. There is also concern that the focus of the MSC programme to deliver a more flexible workforce has been at cost to the development of subject specific expertise with implications for future service quality. These concerns were infact communicated *a-priori* during development of the MSC programme where the likely adverse impact of the initiative on specialist discipline recruitment was raised.

7.2 Recently announced changes to the funding model for STP training, which will increase the financial indebtedness of scheme graduates are unlikely to encourage uptake of training contracts and are expected to reduce the number of applicants for available posts with further severe consequences for workforce stability. BSHI fears that the costs for trainees in smaller disciplines will be greater than for larger ones owing to a more limited geographic availability of specified HEI courses and will therefore be a powerful disincentive to training in these disciplines.

7.3 BSHI would advise that future overarching proposals for revisions to Health Care Scientist training programmes make specific provision for smaller disciplines to ensure that these are not compromised. It would additionally point the Select Committee to the lower cost professional, as opposed to HEI, delivered courses as offering the highest value to a financially constrained NHS and would recommend that this option be re-evaluated.and considered for funding.

8. Models of Service Delivery

8.1 BSHI has previously been consulted on the models for service delivery and has consistently maintained a position that, in regard to responsiveness and accessibility, co-

location of H&I services together with the transplant programmes they serve is the optimal model. This does not however preclude some level of partnership working with other organisations in delivery of elements of service, especially in respect of the national organ sharing programme, nor does it presume an entirely stand-alone staffing structure for each laboratory in each centre.

8.2 Pragmatically BSHI accepts that some rationalisation is required to achieve the efficiencies needed to ensure development of services and that global service provision should not be the ideal pursued by every laboratory. In this regard scope for further development of network arrangements, beyond the level currently in place, exists and should be explored.

16 September 2016

BUPA UK – Written evidence (NHS0099)

About Bupa UK

1. Bupa UK sees its role as contributing to a strong and sustainable UK healthcare system. We are the UK's largest health insurer with 2.9 million insurance customers. We provide personal, corporate and small business health insurance, as well as ancillary health insurance products, such as cash plans, dental and travel insurance.
2. We also provide a range of self-pay healthcare services including dental, health assessments, GP services and physiotherapy across a network of centres in the UK and run the Bupa Cromwell hospital in central London. The combination of our services across funding healthcare and as a service provider gives us a unique perspective on the challenges facing the whole healthcare system in the UK.
3. We are also the second largest residential care provider in the UK, and care for c.40,000 individual residents every year in our care homes and care villages. The care of c.72% of Bupa's residents in the UK is funded by the public sector (either by local authorities or by the NHS) which means that our partnership with the NHS is a vital component of the whole healthcare system.
4. In this response we also bring the perspective of a global health care organisation which serves 32 million customers worldwide and employs 84,000 people, principally in the UK, Australia, Spain, Poland, New Zealand and Chile, as well as Saudi Arabia, Hong Kong, India, Thailand and the US. With this global perspective we see that the world is changing rapidly.
5. The political and economic backdrop in many countries is uncertain, with powerful global social trends. Populations are ageing, public health solutions are ever-evolving, governments are facing funding issues in healthcare and aged care, and competition is intense – both from traditional and non-traditional players. Customer expectations are rapidly changing too. Expectations are higher and needs are growing. People demand a highly personalised, quality service, and 'on-demand' products and services.

Overview

6. We welcome this opportunity to submit written evidence to the House of Lords Committee on the Long-term Sustainability of the NHS. This is an important and timely inquiry that we hope will play an important role in ensuring we have an impartial and evidence-led debate on the issues affecting the long-term sustainability of the NHS and potential policy solutions.
7. The Committee is rightly seeking views on which funding mechanisms provide an opportunity to bring greater resources into the healthcare system. If the UK is to have a sustainable healthcare system, we believe that policy options to bring a greater proportion of private funding into the system alongside public financing, should be

evaluated. As a country, we need to find a way forward where private funding supports the NHS more in meeting the UK population's increasing healthcare needs and challenges.

8. An increase in spending by individuals and businesses on health services, including health insurance, can free up extra resource in the NHS. If the Government is to put the NHS on a sustainable footing over the long-term it must ensure it does not bring forward policies that discourage individuals and businesses from funding healthcare where they choose to. It is in this context that we believe that health insurance has a crucial role to play in ensuring a sustainable footing for the UK health system.
9. While this inquiry is focused on the NHS, we believe it is impossible to properly assess the long-term sustainability of the NHS without also considering the pressures and challenges facing adult social care. The adult social care system is similarly facing huge pressures and we, along with many in the sector and across the NHS, have serious concerns about the financial sustainability of local authority and NHS funded adult social care. If these concerns are not addressed with viable long term solutions to place the sector on a sustainable footing there will be a significant long-term impact on the whole healthcare system.
10. We see the private healthcare sector as part of the whole UK healthcare system facing challenges alongside the NHS and this response is drafted in this spirit.

Resource issues

11. As the Barker Commission noted *“any serious analysis concludes that demands for health and social care in England are increasing significantly.”* To meet this demand extra funding needs to be identified and brought into the healthcare system.³⁴⁴
12. Currently, the UK spends less of its GDP on health care than many other similar countries. The Nuffield Trust calculated that in 2012 total health care expenditure in the UK made up 9.4% of GDP. This compared to an EU average of 10.2% and an OECD average of 12.6%.³⁴⁵ In real terms, total health care expenditure in the UK in 2013 was £153 billion. Of this, 83% was public expenditure and 17% was private expenditure.³⁴⁶
13. If the UK is to meet the growing demand for health and social care over the long term, the proportion of GDP spent on healthcare is likely to need to increase. We do not believe it is a question of *either* public spending *or* private spending increasing; to put both the NHS and the wider health and social system on a sustainable long-term footing, both sources of funding will need to grow.

³⁴⁴ Barker Commission Final Report

(http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf)

³⁴⁵ Nuffield Trust (<http://www.nuffieldtrust.org.uk/data-and-charts/uk-health-spending-share-gdp>)

³⁴⁶ Nuffield Trust (<http://www.nuffieldtrust.org.uk/data-and-charts/uk-spending-public-and-private-health-care>)

14. We believe in a publicly funded NHS. Public expenditure will continue to provide the larger part of healthcare funding but we believe that private funding can play an important supplementary role.
15. As Lord Warner noted in his March 2014 report for Reform, *“private payments and private insurance have always played a bigger role in funding care than is often realised.”* We share Lord Warner’s view that it is *“almost inevitable”* that private sources of funding *“will play an increasing role in the future”* and it is therefore important to *“have a wider, better-informed debate about what is involved.”*³⁴⁷ Currently, private funding is under-used and it could be making a much bigger contribution to reducing cost and demand pressures on the NHS.
16. In broad terms there are two ways that more private expenditure can be brought into the healthcare system alongside increased public expenditure: user charges/co-payments and health insurance.
17. We believe that health insurance offers the most viable option to increase the proportion of private funding in the health system because it is the most effective way of pooling risk and managing cost to deliver affordable access, particularly for complex treatments such as cancer care, cardiology or muscle, joint and bone conditions.
18. A strong health insurance sector enables those who can afford to, and who choose to fund some of their healthcare to do so. As people fund elements of their healthcare, this removes demand for NHS services, as well as bringing extra funding into the system as a whole. We would argue strongly that in order to support the sustainable development of a healthcare system, governments should take care not to weaken the health insurance sector or discourage individuals and companies who wish to fund part of their own healthcare.
19. Recent policy changes, specifically increases in Insurance Premium Tax run counter to this. The rise in IPT to 10% announced in the March 2016 Budget, on top of the increase in IPT from 6% to 9.5% from November 2015, will directly hit consumers and the many small, medium and large companies who fund access to healthcare and health insurance for their employees.
20. The UK health insurance market has seen an overall decline over the last decade – and we will not see more people taking up health insurance unless it becomes more affordable: and taxation is part of that equation. The latest analysis from Laing & Buisson shows that there has been little change in the total number of private medical cover policies, which remain 9% below the peak of 4.32 million at the end of 2008.
21. A shrinking health insurance market will add further pressure on the already strained NHS as a number of those abandoning their health cover are likely to turn to the NHS for significantly more, or even all of their healthcare needs. The Treasury does not appear to

³⁴⁷ *Solving the NHS cash and Care Crisis*, Lord Warner, Reform, March 2014

have considered the impact of this market impact over either the short or the long-term on NHS expenditure.

22. To ensure that the health insurance sector can play its full role in bringing additional funding into the UK healthcare system over the long term, it is crucial that HM Treasury avoid causing further harm and works with the sector, consumer and employer groups to explore how health insurance is treated in the fiscal system so that it both creates the conditions for employers to expand support to more of their employees, and for individuals to take more responsibility for their healthcare.

Workforce

23. As a major employer of healthcare professionals and care workers, the future of the health and care workforce is of critical importance to us.
24. Recruiting sufficient numbers of appropriately trained and qualified nurses and carers is a significant challenge for social care providers. To ensure we have the staff needed, the sector as a whole has to recruit a significant number of non-British staff. Skills for Care estimate that in 2013/14, 5% of the adult social care workforce were EEA nationals and a further 11% were non-EEA nationals.³⁴⁸ This is unlikely to change in the long-term. This view has been upheld by the Migration Advisory Committee's inquiry into supply of nurses³⁴⁹.
25. Future immigration policy is therefore a key area of interest for the health and care sector, even more so since the vote to leave the European Union.
26. The focus of public and political discussion is often on the importance of overseas staff to the NHS workforce. While this is welcome, it is crucial that a false divide between health and care providers does not emerge, for example exemptions from future charges/restrictions for nurses working for the NHS but not for those working for a social care provider.
27. The sector as whole requires skilled staff and if social care providers are placed at a disadvantage relative to the NHS when recruiting appropriately trained and qualified nurses, the social care sector will struggle to maintain a sustainable workforce over the long-term.

Models of service delivery and integration

28. Greater integration and even coordination between the NHS and the social care system has the potential to improve the quality of care patients receive while helping to ensure that money is spent where it can bring most benefit to patients.

³⁴⁸ *The state of the adult social care sector and workforce in England, Skills for Care, 2014*

³⁴⁹ *The labour market for nurses in the UK and its relationship to the demand for, and supply of, international nurses in the NHS, Migration Advisory Committee, July 2016*

29. If the benefits to patient care that a more integrated health and care system can deliver are to be realised, a number of practical challenges must be overcome. We believe the most significant of these is finding the additional funding needed to place social care provision on a sustainable footing over the long-term.
30. While the focus of this inquiry is on the long-term picture, it is important to acknowledge the current situation in the social care system in order to understand the scale of the challenge that the Government faces in making the system sustainable over the long-term.
31. The aged care sector has operated for many years in an environment where fees paid by the majority of local public sector commissioners are well below the true cost of providing care.³⁵⁰ Once the full range of factors that contribute to the cost of care, for example the costs of home maintenance, are accounted for, the fees paid by local commissioners can, in our experience, be up to 20% below the true cost of care.
32. This gap between the fees paid by public sector commissioners and the actual costs of providing care is unsustainable. This gap has grown in recent years as a number of factors have combined to put significant pressure on local authority adult social care budgets including cuts to public spending, the Care Act 2014, above inflation increases in the National Minimum Wage, introduction of a National Living Wage (NLW) and a changing demand profile. This is putting huge pressure on providers and, as the King's Fund and Nuffield Trust have observed, *"the possibility of large-scale provider failures is no longer a question of 'if' but 'when'."*³⁵¹
33. The Government's decisions in the 2015 Spending Review to allow local authorities to raise additional council tax revenue to fund care for older people and to expand the Better Care Fund were positive steps.
34. However, they are insufficient to address the funding gap in adult social care and alone will do little to place the sector on a more sustainable long-term footing. For example, a joint analysis by the Nuffield Trust, Health Foundation and King's Fund argued that the introduction of the NLW, even after the Better Care Fund and council tax precept are taken into account, will leave a funding gap in adult social care in England of between £2.8 and £3.5 billion by 2020.³⁵²
35. A potential consequence of this funding gap is an increasing number of beds being lost, homes closed and ultimately, providers exiting the market. Figures from LaingBuisson show that from October 2014 to March 2015 the loss of capacity from home closures for the first time exceeded the capacity gain from new openings, by 3,000 beds.³⁵³

³⁵⁰ *Who Cares – Funding adult social care over the next decade*, Bupa, 2011; *A Fair Deal – Ensuring local authority fee levels reflect the real costs of caring for vulnerable older people*, Bupa, 2011; *Bridging the Gap*, Bupa, 2012

³⁵¹ *Social Care for older people: Home truths*, King's Fund and Nuffield Trust, September 2016

³⁵² *The Spending Review – what does it mean for health and social care?*, King's Fund, Nuffield Trust, Health Foundation, Dec 2015

³⁵³ *Care of Older People: Market Report 2014-15*, LaingBuisson, September 2015

36. If the current pressures facing the social care system are not addressed the long-term future of the sector looks increasingly precarious. As the King's Fund has noted, *"England remains one of the few major advanced countries that has not reformed the way it funds long-term care in response to the needs of an ageing population."*³⁵⁴
37. This lack of reform to provide sufficient funding for social care has a direct impact on the NHS and the wider healthcare system, not least through delayed discharges with the number of delays attributable to social care rising 33% year-on-year³⁵⁵. If health and care integration is to be achieved and the whole system placed on a sustainable footing in the long-term the funding gap in social care must be addressed as a matter of urgency.
38. The Government has repeatedly expressed an ambition to see the private sector develop a range of new financial products to encourage people to invest and save to cover care costs in later life.
39. Bupa, along with other financial services providers, have explored options for new products along these lines in the past but a clear consensus has emerged that these types of products are currently unviable in the UK market for a range of reasons including the lack of public awareness about the costs of aged care (including a common misunderstanding about what the NHS will provide free at the point of need), and a lack of long-term public policy stability.

Prevention and public engagement

40. We believe that businesses can make an increasingly important contribution to supporting the health and wellbeing of the working age population. Not only can the workplace be an effective location for the promotion of public health messages and engaging people in their health, businesses can also be an effective channel to bringing additional funding into the healthcare system.
41. Ill-health among the working age population is a major economic burden to society, manifesting in increases to long-term sickness absence and rising healthcare costs. Musculoskeletal and mental health conditions are the two most prevalent causes of workplace ill health; and the Government's own Review on Sickness Absence published in 2012, employers reported delays in access to publicly-provided health treatments as a barrier to supporting ill employees to stay in work or return to work at a reasonable time.
42. Many businesses are already investing in health services and funding access to treatment. However, the contribution and impact of this investment is often overlooked in policy.
43. NHS Chief Executive, Simon Stevens has similarly recognised the wider benefit to the NHS which comes from more investment by employers in health and wellbeing services

³⁵⁴ *Social Care for older people: Home truths*, King's Fund and Nuffield Trust, September 2016

³⁵⁵ NHS Indicators: England, September 2016

for employees. The NHS Five Year Forward View expresses an ambition to encourage employers to do more for the health and wellbeing of their people and the useful role that fiscal mechanisms should play to stimulate investment and action.³⁵⁶

44. However, there is a lack of understanding about the workplace health market and the role that funding mechanisms such as health insurance play. It is not viewed in public policy terms as a solution to provide access to diagnosis and treatment for employees or a foundation for further investment in workplace health solutions.
45. The Government's focus on reducing long-term sickness absence is welcome. In 2014, the Government launched the Fit for Work Service to assist employers to help an employee return to work following injury or ill-health. However, this is only available after a period of four weeks' absence. Encouraging employers to fund early intervention is currently not seen as a priority by policy-makers despite the economic benefits to help people living with fluctuating long term conditions stay in work. Intervening after the point of sickness absence is often too late and has a limited impact on health outcomes.
46. The Government has acknowledged the principle that tax treatment of workplace health support can be a useful tool to stimulate greater investment from employers, and increase the uptake of health at work services by employees. The introduction of tax relief on spend of up to £500 on medical treatment is a welcome step and demonstrates the government's commitment to supporting employers investing in workplace health support and removing the cost for employees to access this support. It has had, however, a limited impact as it mainly applies to one-off interventions and excludes any treatments funded through health insurance and other insurance-based products.
47. Employers often choose to use health insurance as a preferred mechanism to fund access to treatment and support given how it is a more effective way to pool risk, ensure effective spending and in doing so expand the reach of programmes to more employees.
48. The majority of European countries – 19 out of 35 – offer some form of fiscal support for people to fund part of their healthcare and largely these are aimed at employers.³⁵⁷ The Government should work with employers to examine similarly well-targeted measures. This means assessing the feasibility of further financial incentives to encourage employers to introduce workplace health and wellbeing interventions. The fiscal incentives could range from broadening the £500 tax-exemption to reviewing the current taxation of employer-funded health interventions, which are currently taxed as a benefit in kind through P11D. Policy-makers could also test the feasibility of different fiscal approaches, such as matched funding, or levy systems that direct focus to ensure whole of workforce and include lower paid workers.

Conclusion

³⁵⁶ *Simon Stevens speech to Institute of Directors Annual Convention, 7 Oct 2015,* <https://www.england.nhs.uk/2015/10/directors-convention/>

³⁵⁷ *Voluntary health insurance in Europe: role and regulation,* The European Observatory on Health Systems and Policies, 2016

49. To place the NHS and the wider healthcare system on a more sustainable footing, more funding, both public and private, needs to be brought into the healthcare system.
50. Health insurance provides the most viable and effective route to bring greater private funding into the system while simultaneously reducing demand on the NHS. As a minimum, the Government should take care that the tax system does not further discourage individuals and employers who wish to fund healthcare through mechanisms such as health insurance.
51. The NHS does not exist in isolation and if it is to be sustainable over the long-term then the Government needs to act urgently to place the social care system on a stable, financially secure footing.
52. Encouraging employers to take greater ownership of the health of their workforce through workplace health initiatives can play a crucial role in building a sustainable healthcare system. The Government should continue to look at ways to incentivise and support employers who choose to invest in the health of their employees.

23 September 2016

Ms Gemma Burford – Written evidence (NHS0112)

While I am a Co-Director of the Global Initiative for Traditional Systems of Health, a member of the South Region Sustainability and Health Network, and a Research Officer in Values and Sustainability at the University of Brighton, I am submitting this statement in a personal capacity. The views contained in this document are my own and should not be interpreted as representing the official position of any of the organisations listed above.

Responding to the theme on Prevention and Public Engagement

I am sure that I echo many other contributors in calling for the promotion of sustainability within the NHS to be viewed holistically, in recognition that initiatives promoting environmental and social sustainability also have much to contribute to cost savings and the creation of a genuinely sustainable health service. To this end, it is essential for the NHS to be seen within the wider context of national and global efforts to achieve the Sustainable Development Goals. The ‘sustainability competencies’ that will enable countries to meet their commitments under the SDGs framework, and the ‘education for sustainability’ that must be delivered in order for this to be achieved, are no less applicable to the NHS than to any other large corporation.

I would like to draw attention, in particular, to the report published earlier this year by the International Development Committee of the House of Commons entitled “UK implementation of the Sustainable Development Goals: First Report of Session 2016-17.” In it, the Committee highlights the need for a cross-Government response, and particularly for multi-sector partnerships towards the Goals. The roles of civil society and the private sector are no less important, in this respect, than that of government; and within government, synergies between different departments must be identified and developed as a matter of urgency, and potential policy conflicts resolved. In shifting the focus from acute care to *sustainable wellbeing*, in the sense of wellbeing that is sustained not only through the years of productive employment but also into old age, the NHS cannot work alone. It may serve as the hub, or merely as one player, in a vast and interconnected network of organisations contributing to the wellbeing of people, places and communities – in full recognition that it is impossible to have one without the others.

As an academic turned social entrepreneur, I am directing most of my attention towards the integration of diverse approaches to human wellbeing, and the creation of effective multi-sector partnerships. Much of what has been learned through research funding schemes such as the Arts and Humanities Research Council’s innovative *Connected Communities* programme, in terms of the benefits and challenges of collaboration and the essential requirements for a positive experience of co-creation, can be applied equally to the construction of partnerships between the NHS and other stakeholders. Many of the lessons from evidence-based integrative health care initiatives, which have recently become widespread in the United States and Israel but have also been a reality of health care provision for many decades in India and China, could be systematically applied within the context of the transformation of the NHS.

Antibiotic resistance is only one example of a problem that biomedicine has found difficult to overcome, while traditional and complementary health care systems have effective strategies to hand. Indeed, it could be argued that the entire process of extracting the ‘active ingredient’ from a plant or fungus, which has been the cornerstone of the biomedical and ethnobotanical research enterprise for many decades, is perfectly designed to produce antibiotic resistance. The holistic approach of traditional and complementary health care, by contrast, will typically involve treating the patient with a polyherbal preparation in which each herb may contain multiple active substances, often with synergistic effects. At the same time, the patient is subjected to a treatment regime that may include recommendations on diet, rest, exercise, and many other interventions that have been shown to increase immune function. Another important aspect of traditional systems of health care, often overlooked by researchers, is the use of outdoor sites such as ‘sacred groves’ and other places that are specifically dedicated to the restoration of health. In India, for example, even the National Ayurvedic Hospital has an outdoor area with seating where patients are encouraged to spend time among the sacred trees.

It is encouraging to see the growing interest in ‘connection to nature’ within the NHS and elsewhere, which is exemplified by – among others – the Ecominds initiative, the excellent work of the South Region Sustainability and Health Network, the Nature Connections Network based at the University of Derby, the work of the Wildlife Trusts and the National Trust, and the Valuing Nature Network that brings together several of the UK Research Councils. These initiatives, individually and collectively, are amassing a large body of research evidence relating to the physical, psychological, emotional, social, practical and spiritual benefits of reconnection with nature.

There is enormous scope, at a policy level, for building on these promising initiatives. ‘Health walks’ and ‘green exercise’ schemes cost almost nothing, but have enormous benefits for people with mental health challenges, obesity and a number of physical health conditions. It would be entirely feasible to require all hospital inpatients to have a ‘daily dose of nature’, weather permitting, and for GPs to consider prescribing these interventions as a first line of treatment.

In establishing the Re:Connecting Global Partnerships Initiative, I have acknowledged that there is more to reconnection than ‘nature’ alone. The Initiative seeks to promote and encourage reconnection not only with nature, but also with the arts (and especially engaging patients in creative practice), with the body through practices such as dance and yoga, and with community-building initiatives in recognition of the importance of the social dimension in wellbeing. To be kept updated on the work of the nascent Initiative, please visit <http://www.we-are-reconnecting.net>.

23 September 2016

The Care and Support Alliance – Written evidence (NHS0097)

About the Care & Support Alliance

The Care & Support Alliance was established in July 2009. We represent more than 90 of Britain's leading charities campaigning for a properly funded care system alongside the millions of older people, disabled people and their carers who deserve decent care.

1. Executive Summary

- A. We share the concern of the Chief Executive of NHSE that underfunding in social care is undermining the sustainability of the health service.
- B. Underfunding is having a significant, unacceptable impact on older people, disabled people and carers. Appropriate social care can delay or prevent inappropriate and costly hospital admissions, and enable patients to be discharged more quickly and safely. It can be more cost-effective than acute care.
- C. People without adequate social care support are more likely to reach crisis point and turn to NHS at a point of high need.
 - I. A third of delayed discharges from hospital are attributable to lack of availability of social care. The time an older person spends in hospital can reduce their level of independence upon discharge.
 - II. GPs believe social care budget cuts have led to increased pressures on their surgeries.
 - III. Underfunding of social care has led to a fragile care market. It is increasingly likely care operators will withdraw from the market on a scale that would have a colossal impact on the NHS, in terms lost care bed places flowing through to hospitals.
- D. Integration of health and social care can improve the experience of patients and service users, but does not answer the immediate financial challenges facing the health and social care systems. There is a need for clarity about what integration means and what its financial aims are.
 - I. The Better Care Fund that has been spent on adult social care has been used to 'prop up' the system rather than providing it with additional funding.
 - II. Pressures on social care budgets have impacted the ability of local authorities to integrate with health services.

2. Recommendations

1. The Government must urgently provide a sustainable funding settlement for social care, which *at the very least* meets the annual funding gap of £1bn each year of this Parliament just to keep the system 'standing still'.³⁵⁸
2. The Government needs to make clear its plans for equalisations measures so that different local authorities are able to access sufficient funds to meet statutory

³⁵⁸ ADASS Budget Survey 2016

requirements. The social care precept has meant that different local authorities have been able to raise differing amounts to help fund local care services.

3. The Government must model the impact on the NHS if social care funding continues at current levels.
4. The Department of Health and NHS England should work together to fully understand:
 - a) The reasons behind those delayed transfers of care which are attributable to social care;
 - b) How much this costs the NHS;
 - c) The impact of delayed transfers of care to patients' long-term health and wellbeing.
 - d) The comparative costs for the local authority to provide adequate care in the community to the cost of NHS intervention at crisis point.
 - e) To what extent the underfunding of social care is preventing local systems in meeting their care act duties, and is stalling the NHS Five Year Forward View.

3. Social care funding is insufficient

Demographic changes mean that demand for social care is rising. For example, Office of National Statistics modelling predicts a rise in demand for adult social care services of 18% by 2020 and 44% by 2030.³⁵⁹

Yet while demand has been rising, the amount of money invested in care has been going down and the numbers receiving care shrinking. £4.6 billion was cut from social care budgets between 2010 and 2015.³⁶⁰ At least 500,000 fewer people received services over this period.³⁶¹

3.1 The 2015 Spending Review

New powers granted in the Spending Review allow councils to increase council tax by 2% without a referendum as long as the money raised is spent on social care. However, it is clear that the money raised through this mechanism will stretch far enough. For example, ADASS estimate that the precept will raise less than two-thirds of the calculated cost impact of implementing the new national living wage.³⁶² At maximum, the Kings Fund estimates that the precept would raise just £800 million a year by the 2020, lower by half than the Government's initial estimate.

The Spending Review also committed to an additional £1.5 billion of investment through the Better Care Fund (BCF) by 2019/20, which the Government is proposing to use to 'top up' those authorities that will raise less from the social care precept.

While it is positive that the government is seeking to distribute funding for social care more fairly, additional BCF funding will not start to be introduced until 2017/18, when it will deliver only £100 million. The social care system is in need of investment immediately, but it the commitments in the spending review are too little too late.

³⁵⁹ Centre for Workforce Intelligence analysis of ONS (2012) and Emerson et al. (2012) data

³⁶⁰ ADASS Budget survey 2015

³⁶¹ LSE PSSRU, 2013

³⁶² £380m, ADASS Budget Survey calculation

3.2 The funding gap

Despite the new mechanisms introduced in the Spending Review, the Nuffield Trust and the King's Fund estimate that by 2020 there will be a funding gap in adult social care of between £2 and £2.7bn. The July 2016 ADASS budget survey concluded that the sector would require £1 billion per year, just to enable provision to 'stand still', regardless of unmet need.

3.3 The risk of provider failure

Between October 2014 and March 2015, there was a net loss of 3,000 beds in care homes across the UK. More than a quarter of providers are reported to be at risk of going out of business within three years. 80% of Directors of Adult Social Services said that care providers they work with are already facing financial difficulties.³⁶³ Think tank ResPublica recently forecast that the sector will lose 37,000 social care beds by 2020/21. Older people and disabled people in care homes will be forced, inappropriately, into hospitals.

Although the Care Quality Commission is monitoring the top 20% of providers, the CSA is concerned that this monitoring regime is not capturing small provider failure, which is leading to a gradual attrition of social care services.

4. The impact on people

Funding cuts have led to a lack of social care availability and supply. As a result, people have been cut out of the system, or seen cuts to the care they receive. An estimated one million older people have unmet needs for care and support in England and at least 2 in 5 disabled adults are not having their basic needs met.³⁶⁴

Despite a demographic demand increase of 3% each year, there has been no increase in the numbers of older people receiving care. ADASS found that a quarter of 2016/17 savings will come from cutting services or reducing personal budgets for people who need care.³⁶⁵ This is despite the warning from the Public Accounts Committee that councils must not use service personalisation as cost cutting.³⁶⁶

A lack of adequate support with activities of daily living is causing people to reach crisis point, and is putting unnecessary pressures on NHS services. A lack of social care is also making it harder to discharge people safely from hospital.³⁶⁷

4.1 Pressure on carers

Each year, carers providing unpaid care make the enormous economic contribution of £132 billion, which is the equivalent of the total public spend on the NHS. Only a third (35%) of carers who had an assessment in the last year felt that the support they need for their own mental and physical health alongside caring was properly considered.³⁶⁸

Respite services, which give carers a break, have been cut. 42% of local authorities in England have reduced their total spending on respite care by an average of £900,000, and two thirds of carers (66%) felt more isolated and had been forced to reduce their time spent taking valuable respite.

³⁶³ ADASS Budget Survey

³⁶⁴ Scope: Ending the other care crisis: Making the case for investment in preventative care and support for disabled adults, May 2013.

³⁶⁵ ADASS Budget Survey 2016

³⁶⁶ Public Accounts Committee report as a result of NAO's Personalised Commissioning inquiry

³⁶⁷ *Discharging Older Patients from Hospital*, NAO 2016

³⁶⁸ State of Caring report, Carers UK 2016

This year, one of our members, Carers UK found that 1 in 5 (20%) of carers providing 50 hours or more of care each week are receiving no support with their caring role, and more than half (59%) of carers reporting a change say the amount of care and support services they receive has been reduced because of cost or availability.

If carers are not supported to continue to care for their loved ones, hospital admissions are the inevitable result of domestic crisis. Cuts to services for carers mean more NHS bed days.

5. Case Studies

The CSA has collected case studies from members' service users and their carers. They paint a concerning picture of people being forced into the health system because they can't be supported in their own homes and communities.

5.1 Carers

The CSA spoke to:

- A working-age adult with a severe physical disability being forced to receive care and support from her frail 77-year old father, who is recovering from a double knee replacement. This person's hours of care were cut from 8 to 0.
- An adult with autism who can't prepare food or administer their own medication and was told that 'autism is not an eligible diagnosis': this person's parents, who are in their 70s, must provide care for them each day. This is inappropriate: this person's mother is recovering from a recent heart attack, and this is preventing the person from leading an independent adult life.
- A carer, forced to provide intimate care for his mother when her 10 hours of personal care a week were cut to 0, says their relationship is strained, she is falling more often, neither of them have any leisure time and his kindness as a carer is being 'exploited'.

5.2 Mental health crisis

The CSA spoke to:

- People with severe mental health problems being entirely cut out of the social care system, risking mental health crisis and unplanned hospital admissions.
- People losing access to their communities, as social support is considered a 'luxury'. This is leading to isolation and loneliness, both of which have proven health impacts, and lead people to over-present in primary care services at a cost to the system.³⁶⁹
- A person who has had their access to a self-help group cut, which was invaluable peer support. This person now struggles to manage their condition and feels increasingly isolated, which is affecting their mental health.

5.3 Deteriorating physical health and new, avoidable conditions

The CSA discovered:

- Due to insufficient levels of care, a wheelchair user with a degenerative spinal condition, who struggles also to use their hands is falling 'most days' without support

³⁶⁹ The Campaign to End Loneliness found that over three quarters of the GPs see between one and five lonely people a day, and one in ten doctors questioned reported seeing between six and ten lonely patients a day (2013).

to do basic tasks, resulting in injury. This person lives off sandwiches as they have no support to cook. This has led to a diagnosis of malnutrition, and a lack of access to the outside has led to a vitamin D deficiency, both of which are being treated by the NHS.

6. Health and care leaders agree: cutting social care is damaging the NHS

- 85% of Directors of Adult Social Services believe the NHS is under increased pressure due to social care budget cuts that have already been felt, and 91% believe the NHS will be under increased pressure in the future due to budget cuts in social care.³⁷⁰
- 9 out of 10 (88%) GPs believe reductions in social care have contributed to the pressures faced in their surgeries.³⁷¹
- 99% of NHS leaders believe that cuts to social care funding are putting increasing pressures on the NHS as a whole.³⁷²
- Simon Stevens, Chief Executive of the NHS has said: *“I think there is a strong argument that, were extra funding to be available, frankly we should be arguing that it should be going to social care.”*³⁷³

7. NHS long-term sustainability

Adequate social care prevents people from needing acute interventions. The lifetime cost for the person is far less, as social care prevents needs escalating and conditions worsening.

The health service spends £820 million a year treating older patients who no longer need to be in hospital.³⁷⁴ Over a third of delayed discharges can be attributed to social care, with the main reason (33%) being a wait for a care package at home.³⁷⁵ People waiting for a care package to be arranged for when they got home accounted for 19,700 delayed days lost in June, up from 15,000 in June 2015.

CSA member, United Kingdom Homecare Association (UKHCA) estimates that the amount the NHS spends on excess bed days due to people awaiting homecare could pay for an extra 5.2 million hours of homecare per year, or 431,000 hours per month, or 14,900 hours per day.

8. Conclusion

It is shortsighted to view NHS sustainability as an isolated NHS funding or efficiency issue. Investing now, and in a sustainable way, in social care will save the NHS billions, and prepare the entire system from the unprecedented pressures it will face.

We welcome the opportunity to respond to this call for evidence and would encourage the committee to hear oral evidence from the social care sector, to take a system-wide view in their inquiry.

An adequately funded, sustainable social care system is a prerequisite for a sustainable NHS.

Care and Support Alliance members:

³⁷⁰ ADASS Budget survey 2016

³⁷¹ CSA GP Poll, January 2015

³⁷² NHS Confederation, National survey of NHS leaders, June 2015

³⁷³ NHS Confederation Speech, July 2016

³⁷⁴ *Discharging older patients from hospital*, NAO, May 2016

³⁷⁵ This is an increase from 26% in January 2015

ACEVO, Abbeyfield, Action Duchenne, Action on Hearing Loss, Advice UK, Advocacy Project, Age UK, Alzheimer's Society, Ambitious about Autism, Anchor, Arthritis Care, Arthritis Research UK, Association for Real Change, British Heart Foundation, British Lung Foundation, British Red Cross, Care England, Carers Trust, Carers UK, Centre for Policy on Ageing, The Chartered Society of Physiotherapy, CLIC Sargent, Colostomy Association, Contact a Family, The Disabilities Trust, Disability Rights UK, Disability Living Foundation, Down's Syndrome Association, EDCM Epilepsy Society, FitzRoy, Focus on Disability, Friends of the Elderly, Grandparents Plus, Guideposts Trust, Guide Dogs, Help the Hospices, Home Group, Housing & Care 21, Huntington's Disease Association, Independent Age, International Longevity Centre, Leonard Cheshire Disability, Local Solutions, Macmillan Cancer Support, Marie Curie Cancer Care, Mencap, Mental Health Foundation, Midland Heart, Mind, MND Association, MS Society, Muscular Dystrophy Campaign, National Association of Care Catering, NAT, National Autistic Society, National Care Forum, NASS, NCPC, National Family Carers Network, National Housing Federation, National Rheumatoid Arthritis Society, National Voices, Neurological Alliance, Papworth Trust, Parkinson's UK, Patients Association, PSP Association Real Life Options, Relatives and Residents Association, Rethink Mental Illness, Royal British Legion, RNIB, Royal Voluntary Service, Scope, SeeAbility, SEMPA, Sense, Shaping Our Lives, Shared Lives Plus, Spinal Injuries Association, Stroke Association, Sue Ryder Care, Terrence Higgins Trust, Thomas Pocklington Trust, Turning Point, UKHCA, United Response, Vitalise, VoiceAbility, Volunteering Matters.

23 September 2016

Care England – Written evidence (NHS0089)

The importance of social care for NHS sustainability

1. Introduction

Care England is the leading representative body for independent social care providers in England. Our members provide services for adults with care and support needs including in residential and nursing settings, homecare, and community-based support. Our members deliver specialist services such as rehabilitation, respite, palliative care and mental health services.

Recognising its vital role in NHS sustainability, in July 2016 at the NHS Confederation conference in Manchester, Simon Stevens said: *“were extra funding to be available, frankly we should be arguing that it should be going to social care.”* A well-funded, sustainable social care system underpins a sustainable NHS. Delayed Discharge is linked to rising social care demand, caused by the greatest social and political challenge of our time: the ageing population. At least one third of delayed transfers of care (DTC) can be attributed to social care. Delayed transfers limit the capabilities of the NHS, stretch the system, and lead to undignified and stressful experiences for vulnerable people and their families.

Care England’s evidence is divided according to the Committee’s five key lines of inquiry. We would be pleased to present oral evidence to the committee about how social care market sustainability is vital for the NHS’s future.

2. Resourcing issues:

2.1 The underfunding of social care

Demand for social care is rising: it is predicted to increase 44% by 2030.³⁷⁶ More people are living longer with more complex, long-term conditions that require a higher level of expertise. As well as an increase in demand for care for older people, it is predicted that there will be a significant increase in the numbers of adults with learning disabilities. Forecasts suggest that as many as 113,000 additional adults with learning disabilities will require services in the next 10 years.³⁷⁷ £4.6 billion was taken out of social care between 2010 and 2015.³⁷⁸ Despite numbers of older people increasing by 3% each year, there has been no increase in the numbers of older people actually receiving care.

Four fifths of Directors of Adult Social Care think care providers in their area are already facing financial difficulties, 77 councils report that at least one care home provider has ceased trading in their area in the past six months,³⁷⁹ and 28% of care homes are thought to be at risk of financial failure.³⁸⁰

³⁷⁶ Office of National Statistics and Centre for Workforce Intelligence analysis, 2012

³⁷⁷ Emerson et al, 2012

³⁷⁸ ADASS Budget Survey, 2015

³⁷⁹ *ibid.*

³⁸⁰ BBC Radio 4, 2016

The National Living Wage (NLW) will add £2.3 billion to providers' payroll bills by 2020, on top of the £1.7 billion cost of increases in the National Minimum Wage.³⁸¹ This year, the social care precept raises less than two-thirds of the costs of the NLW. In August 2016, the Resolution Foundation *'call(ed) on the government to ensure that there are sufficient funds for providers to continue to implement the NLW without adverse consequences for workers; to recruit and retain the staff needed to meet the demands of an ageing population...'* but there has been no commitment to fully fund the impact of the NLW.

Five of Care England's largest corporate providers have calculated that the impact of the NLW, regardless of existing underfunding of the sector, will be a workforce cost increase in 2016 of £18 per bed, per week. Modelling from these care providers shows that, of the 1157 homes they operate, 50% (579) will be rendered commercially unviable by the National Living Wage. As a result of rising demand and falling funding, think tank ResPublica recently forecast that the sector will lose 37,000 social care beds before 2020/21.

ADASS calculates that the sector would need £1bn per year until the end of this parliament, just to *'stand still'*.

2.2 The Social Care Precept

Care England undertook a data collection exercise to demonstrate the national picture of low fees for care, and how the social care precept is failing to prevent market crisis.³⁸² Providers are being asked to care for as little as £2.25 per hour in 2016/17. Average council fee rates have fallen by 6.2 per cent since 2011.³⁸³

Fee uplifts for care for older people

22% of local authorities are offering 0% uplift.

74% (113 out of 152) councils are paying unacceptably low uplifts this financial year, despite the existence of the social care precept.

13% of (20) councils are still yet to give their fee offers from April 2016. Late offers are harmful to providers, residents and families.

Fee uplifts for learning disability care

Only **39** Councils have given offers: 113 councils have still not notified providers of their 2016/17 fees, effectively asking providers to 'buy blind'.

17 out of 39 offer 0% uplift.

Of **22** others, 11 offer 1% uplift or lower: a negligible amount.

- The other 11 offer very low rates, between 1 and 5%.

Local authorities like Essex have admitted to providers that they know their fees don't cover the cost of care.³⁸⁴ Independent care providers are being forced to subsidise councils in many areas, risking facing financial failure, and putting older people at risk of crisis and hospital admission.

³⁸¹ Gardiner, 2015

³⁸² Which will raise £380 million this year, according to the ADASS Budget Survey, 2016

³⁸³ *Home Truths*, The Kings Fund, 2016

³⁸⁴ <http://www.communitycare.co.uk/2016/08/22/council-fee-proposals-risk-care-home-closures/>

2.3 Continuing Healthcare (CHC)

If a care home resident has a primary need for nursing care, the NHS covers the full cost of care and accommodation. This is known as ‘Continuing Healthcare’ (CHC). The right to CHC is not means-tested. The National Tariff rules on CHC, state: *‘Where prices are determined locally, it is the responsibility of commissioners to negotiate and agree prices having regard to relevant factors... In addition, commissioners should ensure that local prices are in the best interests of patients.’*

The Tariff rules also demand that commissioners and providers work in the best interests of patients, and engage constructively with each other when trying to agree local payment approaches. The sector is concerned: CCGs are setting standard CHC rates without knowledge or enquiry into what it costs providers to deliver the services. Standard CHC rates fall significantly below the actual costs of care. Serious underfunding of CHC is not in patients’ best interests and is therefore a breach of the governing rules. CCGs are not adequately (if at all) engaging with providers over CHC fee rates.

The serious underfunding of CHC is making it increasingly difficult for providers to obtain and retain qualified nurses in a market where there is already a profound nursing shortage. As a result, providers are either reducing their nursing bed provision or withdrawing from the nursing care market entirely, threatening hospital efficiency.

2.4 Is it time to review what is free at the point of use?

This question posed by the Committee is relevant to social care. When William Beveridge wrote the report that would establish the National Health Service as we know it, lives were shorter and dementia was far less common. Today, millions of people with dementia are cared for in social care settings, and the costs of the disease must be covered by families, or local authorities.

It is perhaps too radical for this Committee to argue for the re-categorisation of Dementia as a health condition, and fund it accordingly. But it is not too radical to ask that, if local authorities are to be responsible for funding care for people with dementia, they should have the resources adequate to pay for the cost of care, and that the government should financially commit to strengthening local social care budgets in order to do so.

3. Workforce

To meet the rise in need for adult social care outlined in the previous section, the social care workforce will have to expand by 16%.³⁸⁵ It is important to remember that the NHS employs 1.4 million people, and that social care employs 1.6 million. The social care workforce offers a strong foundation for functioning local health and care systems.

Under a new Care Act duty, local authorities must undertake meaningful local market shaping. However, Care England has found that many have failed to identify issues affecting workforce supply and demand. This must be a key area of priority for local councils: we face

³⁸⁵ Office of National Statistics and Centre For Workforce Intelligence analysis, 2012

a national shortage of nurses and care workers, which limits NHS sustainability.³⁸⁶ Anecdotally, our members have informed us that recruitment and retention of all staff has continued to worsen despite the implementation of the National Living Wage in April of this year.

3.1 The nursing shortage

Our 2014/15 research showed that the nursing shortage was having a profound impact on social care nursing. Our respondents comprised of 26 organisations providing a 58,527 nursing beds, owning approximately 2,000 homes employing 8,900 nurses: we estimate this represents 15% of the sector. 100% of respondents struggled to recruit nurses, the average vacancy length of a nursing role was 10 months, and respondents told us that they could wait as long as 2 years to fill nurse vacancies. The National Minimum Data Set for Social Care records that the overall turnover rate for registered nurses in adult social care is 31.2 %, and the overall vacancy rate for registered nurses in adult social care is 8.9%. This is high: the total average sector vacancy rate is 6.4%.

In terms of age profile, 28.7% of registered nurses in social care are aged 45 to 54 and 25.4% of registered nurses in social care are aged 55 to 64. This means that over a quarter of nurses in social care are nearing retirement. Health Education England (HEE) has historically not planned for the nursing workforce across health and social care, and was criticised for this failure by the Migration Advisory Committee in 2016.³⁸⁷ In order to protect long-term NHS sustainability, HEE must start planning for the social care workforce now: rising demand due to the ageing population must be met with increased nursing capacity in the sector.

HEE, working with the social care sector, must start a dedicated recruitment drive for care home nurses. This could be through return to practice schemes or more student nursing placements in nursing homes. HEE, the NHS and local health and social care partners must work together to tackle local competition for nurses, which leads to unconstructive approaches like poaching nurses from social care to work in the NHS. Taking nurses away from social care damages whole systems, and leads to more delayed transfers of care. Nursing homes are safe and appropriate places for older people with a nursing need, and reduce pressure on the NHS.

3.2 Provider case studies: the nursing shortage

We collected several case studies illustrating the impact of the nursing shortage on the sustainability of social care in 2015/16:³⁸⁸

One provider explained that it was ‘extremely difficult to recruit’: across 72 homes they currently have more than 40 vacancies for Registered Nurses. Their pay rates are set competitively; they actively advertise, use agencies, attend job fairs, distribute leaflets and have even raised pay rates, to no avail. As a result, this provider has several nursing homes that they cannot operate as such. These are large homes of around 80 beds, and make up a significant portion of their

³⁸⁶ Local authorities’ Market Position Statements

³⁸⁷ Migration Advisory Committee report on adding nurses to the SOL, 2016

³⁸⁸ Care England can provide the committee with further examples of this

Many providers are forced to change the purpose of nursing homes due to inadequate funding, and the extent of

A national charitable care provider told us: *'We have opened three new homes in the last two years which we had originally planned to provide nursing beds. As a result of our inability to source nurses we changed the category of care to residential or residential dementia. This represents approximately 120 places that would have been provided as nursing beds but are now residential. These are all in one county.'*

Another provider explained that they had been forced to de-register nursing beds across five separate homes due to the nursing shortage, and had closed one home in significant part for this reason. The provider said: *'that doesn't mean to say it won't happen again: care providers don't know what impact Brexit will have.'*

The impact of these scenarios will be a greater strain on hospitals and community nursing care.

To ensure NHS long-term sustainability, a long-term strategy for social care nursing is essential. The recent increase in Funded Nursing Care (FNC, paid by the NHS when a care home resident's nursing need is ancillary to social care needs) and the decision to add nurses to the Shortage Occupation List were welcomed by the sector. However, both are temporary measures, and must be made permanent to limit undue pressure on hospitals due to the failure of nursing homes. Care England has further concerns about the impact of Brexit on the supply of care workers and nurses.

3.3 The winter flu jab

NHS workers are entitled to a free flu jab in winter time, to protect them, the people in their care, and their employers from the impacts of infection. However, in perfect illustration of fundamental inequalities between health and care, there is no such allowance made for those working in social care, although the risks they face are just as great, and it is in the interest of whole systems' sustainability that social care workers are immunised.

The cost of annual immunisation is too much for care providers, who are badly squeezed by underfunding. The cost impact of losing staff to flu over winter, considering this paper's discussion of the profound nursing (and care staff) shortage, is damaging. A lack of care staff immunity to flu damages local systems, as older residents who can't be cared for adequately rely increasingly on hospitals. In the interest of local systems' resilience in wintertime, Care England believes that is a public health issue, and should be funded centrally.

4. Models of service delivery and integration

4.1 The Better Care Fund

As the National Audit Office recently reported: *'Only 40% of local authority areas had achieved their planned reduction in delayed transfers of care...the Better Care Fund has struggled...'*³⁸⁹ Over half of Directors of Adult Social Services feel that the BCF was

³⁸⁹ *Discharging older people from acute hospitals*, National Audit Office report, July 2016

inadequate to protect social care in 2015/16.³⁹⁰ Care providers do not know how the BCF has been spent locally, or what difference it has made to the lives of people needing care.

Although government has said that the BCF and the precept will amount to £3.5bn for the sector, the figure is closer to £3.3bn.³⁹¹ From 2017 the BCF will redistribute funds across local authority areas to compensate for the inequalities of the social care precept, detracting from its original purpose to integrate health and social care.

4.2 Continence care in care homes

Care England has discovered that just half of Clinical Commissioning Groups (CCGs) in England are funding or supplying continence aids for every care home resident, as they have a statutory duty, and as they are funded, to do. The other half of CCGs are either providing continence aids to some residents and not others on an arbitrary basis, or are not providing continence aids to any care home residents. CCGs were found to be prescribing ‘maximum amounts’ of aids, not responding to need in reassessing continence needs, and reimbursing care homes for the provision of aids at a very low rate: an average of £5.38 per resident, per week. In Wales, a recent review found the cost of providing high quality continence aids was £11 per resident, per week. The inadequate price paid in England must be immediately reviewed.

Experts and the continence team at NHS England have been clear that poor continence management can lead to infection and hospital admission. The NHS, through CCGs, must provide in full, or reimburse at a realistic rate for continence aids, while abolishing ‘maximum’ amounts and ensuring timely continence assessments to keep older people out of acute settings avoidably.

4.3 How social care can support future NHS sustainability

The social care sector has a number of innovative ideas to mitigate the present crisis it faces, and to support NHS sustainability. Care England has developed a national ‘Teaching Care Home’ pilot with five test sites across the country, aimed at upskilling the workforce.³⁹²

Care England has also done significant work to further the development of the sector-led Care Practitioner role, a role between a care worker and a nurse, offering career progression and better nursing competencies in teams.³⁹³ Both of these pilots will relieve the pressure of the nursing shortage on health and social care, ensuring long-term NHS sustainability in the face of demographic demands, and offering career progression for care staff.

The sector has developed the proposal of the Fast Track Discharge Fund, to use beds in care homes to relieve pressure in hospitals, while ensuring local care market sustainability.³⁹⁴

4.4 Sustainability and Transformation Plans

It is absolutely vital that these plans, about which very little is known, lead to genuine health and social care integration, and that social care is not just an adjunct to plans for NHS sustainability. It is essential that money for local systems is not absorbed by health alone

³⁹⁰ ADASS Budget Survey 2016

³⁹¹ Analysis by ADASS

³⁹² <http://www.careengland.org.uk/teaching-care-home>

³⁹³ <https://www.nursingtimes.net/break-time/care-practitioner-role-would-reverse-nursing-staff-shortage/5087465.article>

³⁹⁴ <http://www.respublica.org.uk/our-work/publications/care-cure-creating-fast-track-pathway-hospitals-homes/>

(like the BCF, mentioned above). If £1.8 billion is going into reducing Trusts' deficits, just £300 million of the £2.1 billion STP budget is left for entire systems integration, and the entirety of the social care sector. If STPs are to ensure sustainability, they must allow adequate resources for social care, and involve the independent social care provider sector in planning, which has not been done to date.

5. Prevention and public engagement

Prevention, enshrined in law in the Care Act, is failing because social care underfunding is causing personal crisis, and is leading to avoidable admissions and delayed discharge. There are plans to work across systems to prevent hospital admission, like the Wakefield Vanguard, but with even less funding, and failures of the BCF to demonstrate improvement metrics, how will local health and care systems be able to roll out preventative measures and new models of care?

6. Digitisation, data and informatics

Care England would advise the Committee to take note of the NHS England Care Homes Vanguards, due to report in early October 2016. The Wakefield and the Airedale Vanguards have used technology to particular effect. However, technology is not a panacea: people can't, and shouldn't, be replaced by machines in care. Indeed, Assistive technologies can help to keep people out of hospitals and in their own homes, but local authorities cannot invest in new technologies when they can't pay the existing costs of care.

23 September 2016

Mr Andrew Carmichael – Written evidence (NHS0017)

This evidence is based around:

1. Resource issues, including funding, productivity and demand management;
2. Models of service delivery and integration

The experience of the writer as a Governor of an NHS Foundation Trust, Chair of a Charity, Clinician and NHS patient is relevant to this submission.

It is considered that integration of the NHS and Social Care will be advancing slowly over the period of consideration by the Committee and this submission may reflect some actions already instituted or in process.

The process of integration is hampered by the long- held view of the two services as separate entities which are funded from different budgets and thus subject to arguments over 'my patch' and 'my budget'. This results in delayed discharges and 'bed-blocking' neither of which are the fault of the patient but which pile up to the detriment of all especially in times of overly restricted budgets as at present. Trying to hive these problems off to the private sector exacerbates the situation when profit is required.

Many hospitals have wards closed and unused even with a bed availability crisis simply because the NHS budget will not cover the extra staff needed. Some hospitals are closed. Many trusts are required to have a bed occupancy of 99.5% - a figure which no hotel could achieve long-term.

Similarly there is a massive shortfall of social care places outside hospitals. It should not be beyond the wit of any Secretary of State for Health or Departmental Head to devise a crossover of funds to allow use of disused hospital buildings and beds with minor modifications to become social care facilities. These NHS assets, otherwise unused, can be quickly made useful at small cost and fulfil their purpose.

2/

Most of the facilities of a care home are already built in to hospital wards and staffing would be required only to care home level. Clearly meals provision, health care and sanitary disposal would be on site already. Common sense will dictate cross-funding matters in the form of charges for services provided.

This use of NHS facilities would allow 'acute' beds to be freed up for their proper purpose and relieve an ongoing crisis situation. It would save a lot of costs of social workers visiting hospitals to arrange expensive transfers for individual patients. It would facilitate rapid treatment for any 'discharged' patient who relapsed. Former acute wards would need less staff and the cost savings are obvious. Unused hospitals – already paid for – are available free and can be quickly adapted. Most are near smaller towns and thus convenient for visitors.

These small changes will make a large contribution to productivity and demand management at minimal cost to the budgets of both NHS and Social Care.

This model of integration at the point of discharge from acute care to social care would be greatly improved by the introduction of a combined budget for both services but this must not be seen as a loophole for overall reduction of budgets until the system is fully integrated. It would be much less costly if the purchaser/provider market is deleted from the equation. The extra costs and complication of this split 'market' exercise is a huge drag on integration of services that should be smoothly combined.

This integration will require great co-operation between central government and local authorities of all shades and may be a tough target. It will be worth the effort and the eventual savings will be found.

6 September 2016

Centre for Applied Psychology Ltd – Written evidence (NHS0063)

1. The future healthcare system

- 1.1 More babies with impairments are surviving after difficult pregnancies and births. More people with long term disabilities are living longer. More people with deteriorating conditions are also living longer. On the one hand such changes are welcomed as the result of successful prevention and healthcare in the past. On the other hand they raise questions about the purpose and quality of the lives that have been preserved or lengthened. Such changes emphasise the need for a holistic approach to planning services, in which the provision of an adequate diet, accommodation, transport, opportunities to meet and mix with other people, and an adequate income to permit a satisfactory quality of life, are all considered alongside the healthcare that makes those lives possible.
- 1.2 However whilst the need for intermittent or long term treatment and care has increased, owing to other trends the need for acute healthcare has not decreased. For example, the aim to minimise the number of working age adults who cannot work implies services to restore or maintain their fitness for work; the Improving Access to Psychological Therapies programme is just one example of that kind of service development. Whilst infectious disease has become less of a problem, at least until antibiotics finally lose their potency for controlling resistant organisms, environmental causes of ill-health such as pollution and obesity-creating marketing, and behavioural causes such as deliberate self harm, suicide and dangerous driving of vehicles continue to contribute to the demand for urgent care. The 14 year planning horizon set by the question may limit the range of options for maintaining a healthy population that can be considered, but the introduction of more population-oriented, holistic planning of 'joined up' services is certainly feasible.
- 1.3 We anticipate that advances in information technology will lead to substitution of the service aspects of healthcare. In many settings the notion of a 'bedside manner' will be reframed as a person-friendly avatar or person/machine interface. Psychologists already contribute to improving the interfaces between technology and human individuals. There will also be a continuing increase in self diagnosis and treatment. Consequently people will need more information about the meanings of diagnoses, and easy access to professionals = face-to-face 'in the flesh' or via the internet - who can verify their findings and help them find the treatments they need.
- 1.4 More specifically, at least 25% of all patients presenting at general practice are experiencing some challenge to their mental stability and capacity to cope with their life. Our strategy has been, and is to promote the establishment of Centres for Applied Psychology alongside NHS General Practices or even integrated within them, to improve the quality and effectiveness of primary health care without requiring more GP time and more expenditure on drugs.

2. Resource issues, including funding, productivity, demand management & resource use

- 2.1 The current funding envelope for the NHS is clearly not realistic. By comparison with other developed countries the UK is currently a low spender on healthcare. Governments of all parties have implicitly realised that, in the sense that no political party has sought publicly to justify, or a made a manifesto commitment to reducing

the funding of the NHS from 8.8% of GDP in 2009 to 7.3% in 2014, when our European neighbours were spending 10.1% of GDP in 2009 and have been increasing that (figures from the Kings Fund). The Blair Government committed itself to raising spending healthcare up to the European average and made a start on doing so. More recent Governments have effectively cut spending on healthcare as a proportion of GDP without seeking an explicit public mandate to do so, whilst telling the electorate that the country cannot afford more spending on healthcare; in our view they have thereby implicitly acknowledged a deliberate shortfall in funding.

2.2 For those working in the NHS or familiar with its financial problems, three sources of massive waste of money cause particular regret and frustration:

- the quasi-competitive market – there can be no market when demand for services significantly exceeds supply (as it does) and there is a growing shortage of competent staff to commission services and to provide them; there is no case for maintaining the current costly arrangements;
- PFI contracts – these appear to take money out of service provision and into the profits of private companies; we share the view of many knowledgeable commentators that the Government should aggregate all NHS PFI contracts centrally and manage the result centrally;
- structural re-organisations – the majority of NHS staff and knowledgeable commentators were profoundly opposed to the passing and implementation of the Health and Social Care Act 2012. It is acknowledged that Act cannot be rescinded without further organisational upheavals but Government needs to be aware that statements about the shortage of money for healthcare have very little credibility in the face of politically-driven reorganisations.

2.3 The problem of how to sustain funding to the NHS over the long-term (i.e taking account of the human life-span) has been recognised at least since 1974. Then it was predicted that by now the entire budget of the NHS would be taken up by care of the ageing population.

2.4 No Government since then seems to have tackled the financial significance of that and similar observations. As a consequence they have failed to allay uncertainty in the workforce. That uncertainty may not have been felt acutely, but it has created a mood within which other changes have been accepted more readily than might have been expected, for example the shift from trying to provide the highest standard and quality of health care to trying to ensure that budgets are not overspent regardless of the standards of service being provided. From a psychological perspective, we believe that politicians have not understood that, at face-to-face service level, uncertainty over the future funding and organisation of services is a serious stressor. It erodes performance and threatens both the safety of patient care and the psychological well-being of the staff. Those working in healthcare need to know that they have a secure, long term future so that they can invest themselves in their work. The alternative is vacant posts, UK staff moving to work abroad and the NHS becoming dependent on other nationals to undertake a wide range of professional and non-professional roles.

Ref 2A: Although health economists have developed sophisticated techniques for investigating value, for the majority of the population health is beyond value; it is what makes the living of life possible and worthwhile. So whilst 2A is an important question for Government, for the majority of those who elect the Government it is

not a meaningful question. That has been demonstrated in surveys which have shown the willingness of taxpayers to pay extra taxes to support the National Health Service. However, psychologists in their professional capacity welcome opportunities to contribute to research into how comprehensive the system of services needs to be in order to maintain a healthy population and electorate.

Ref 2B: Psychologists are well aware of the truth of epidemiology, that the psychological and social health of the individuals within a population derives firstly from the health of the population of which they are members. That is demonstrated, for example, by the research on the relationship between deprivation and ill health, including psychological ill health. The appropriate funding model for health and social care services that build on maintaining public health is funding out of general taxation. That helps to ensure that those who are most able to pay, pay most (through the taxation system) and avoids the related problem that those who are most in need of health and social care are often those who are least able to afford it.

Ref 2C: same answer as 2B. The American experience demonstrates the problems of having significant numbers of people in a population who have little or no healthcare because they are unable to pay for it. It also demonstrates the burden on the economy as a whole of having insurance-based and personal funding of healthcare. That observation does not preclude the possibility of various fee-for-service or item-or-service charging arrangements but there is reason to suspect that a considerable proportion of the upcoming generations of young people will not have sufficient income to pay such fees owing to the costs of housing, repayment of student loans and the lack of well-paid employment.

2D: We recommend that ability to pay is best assessed through the tax system. The problems with means-testing at the point of service delivery are that it creates incentives for dishonesty and it diverts money from service provision to the potentially expensive systems required to administer it.

3. Workforce

3.1 The use of the word 'optimised' in the question implies a precision in planning that has not been achieved and will not be achieved until there is a clearer consensus about the model for health and social care in the future. Whilst it is likely that there will be a continuing need for more 'hands on, face-to-face' care workers of various kinds, the recent evidence has been of shortage in most of the healthcare professions.

Ref 3A. The main option for increasing supply is to create more training places for the 16 to 21 year old population. Many young people see health and social care as an attractive area of work but are unable to get the requisite training and employment opportunities.

Ref 3B. Unknown, but clinical psychology as an NHS profession has always drawn a proportion of its staff from the old Commonwealth, American and English-speaking EU psychologists. That has allowed the NHS to train fewer UK students than would be needed to fill all the available posts.

Ref 3C. Without a workforce that feels well and performs at its peak, nothing else works. According to the NHS Staff Survey 2015 which surveyed over 750,00 people, that is nearly two thirds of the NHS workforce, over a 3 month period 63% came to work when they were unable to discharge their responsibilities effectively. People who come to work 'in body but not in mind' cost the British economy £100 billion a year

(OECD) in under performance, flat productivity, increased insurance premiums and kindred features. The true level of ‘psycho-presenteeism’ amongst the NHS workforce is not really known but judging by the Staff Survey quoted earlier it is probably huge,. The costs of psycho-presenteeism have been calculated as five times the costs of sickness absence and staff turnover (it varies from twice to five times depending on sector, but other factors in the NHS indicate it is the higher figure). It isn't simply the loss of resources, serious though this is, it is the loss of energy, innovation and enthusiasm (and other factors) that accompany ‘psycho-presenteeism’. Psych-presenteeism is reversible; the biggest problem has been that Ministers simply aren't interested. The savings to be achieved by reducing psycho-presenteeism plus the restoration of genuine engagement in the NHS should now be regarded as an ethical matter, not only because the current situation means the country is wasting resources, but also because patients have no guarantee of a safe service.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

4.1 In addition to more accurate forecasting of need for training in technical and professional skills, we identify a need for universal training in 'care of the person' skills. These skills focus on the care of whole person needs whilst specialists tackle the person's specific clinical needs. Because of the positive impact of these skills on the experience and progress of patients, staff who have demonstrate excellent skills should be accorded extra respect and rewards.

5. Models of service delivery and integration

5.1 The questions in this section ask “How ...” as though there is already agreement at national and local government levels that there shall be an integrated National Health and Care Service. Yet both the NHS and local government are still obliged to work within a ‘competitive market’ framework. Whilst it is true that some potential answers to “How” have been explored through the debates on increased devolution of powers to the English regions, as yet there is no evidence that the current Government supports and will progress those initiatives, so the people and organisations with the power to integrate services are inevitably less able to do so without the support and leadership of national Government.

Ref c(a). The management of hospital and community services could be vertically integrated, such that those responsible for providing the community services manage the hospital services as a supportive back-up to community care.

Ref c(b). “Mental” and “physical” is a false dichotomy reflecting intellectual traditions which have been inappropriately carried forward from previous centuries. Clinical and other applied psychologists are trained in innovation and have been in the forefront of reconceptualising needs for services that take account of the ‘whole person’ and the communities within which people live. Given a mandate to do so, psychologists can develop and promote innovative solutions to problems that cannot be resolved within a biophysical framework.

6. Prevention and public engagement

6.1 We emphasise a point made earlier. Health is not an end in itself, it is one of the foundations of a satisfying and productive life. There is a need for Government to express that truth through a holistic approach to planning services, in which the provision of an adequate diet, accommodation, transport, opportunities to meet and

mix with other people, and an adequate income to permit a satisfactory quality of life, are all considered alongside the healthcare required at the beginning and end of life, and as a result of disease, injury or trauma.

7. What are the best ways to engage the public in talking about what they want from a health service?

7.1 We puzzled over this question, as citizens as well as as psychologists. It seems to us, firstly, that the media are flooded with people saying what they want from the health and social care services and often expressing frustration that the various planning authorities do not appear to take account of what they are saying. Secondly, we have been aware of inauthentic formal consultations concerning changes to services, in the sense that there was little doubt that the proposed changes would be implemented and attempts to engage in debate about the need for the change or to offer alternatives were not welcome. In our view, closing what might be described as the ‘credibility gap’ between the public and the planners, by listening to views that are already expressed publicly, and by demonstrating an authentic desire to learn from formal consultations, will produce the answer to this question.

8. Digitisation of services, Big Data and informatics

8.1 The way in which a health service is provided has a significant impact on the effectiveness of that service. With the rapid and widespread shift from face-to-face human delivery of services to various kinds of digital delivery in the interests of economy and efficiency, there is a risk of unintended loss of effectiveness. Business understands this well, and tries to substitute the loss of personal service with ever more intensive digital links with customers, including seemingly endless surveys about how we feel about their products, services and the business. Applied psychologists already contribute to the design and implementation of human – system interfaces in business and public service settings and the NHS could be drawing on their knowledge, skills and experience to help bring about these important changes in practice.

22 September 2016

Centre for Health and the Public Interest – Written evidence (NHS0050)

Summary

The Centre for Health and the Public Interest is an independent think tank promoting evidence-based policy in line with the founding principles of the NHS. We publish reports and analyses on key issues affecting the NHS, social care and public health. These reports are produced by respected academics and health and social care practitioners. We welcome the opportunity to respond to this inquiry.

1. This submission focuses on:
 - the meaning of sustainability when applied to a public service;
 - rising healthcare costs as an international trend;
 - why an ageing population may not bring greatly increased costs;
 - the burden of payment through changes in the dependency ratio;
 - how cost effective the NHS is; and
 - the lessons to be learned from the current hospital deficit.

2. We make recommendations on containing costs and reducing future need by appraising:
 - the costs of the current marketised structure;
 - PFI schemes;
 - changes needed in the provision of adult social care;
 - the value of general medicine for the management of long-term conditions;
 - mental health, especially in relation to physical health;
 - socio-economic inequality and its impact on health;
 - the need for a stronger commitment to investment in prevention; and
 - models of service delivery and integration.

3. We would welcome the opportunity to discuss the issues raised in our submission or to provide further information.

The long-term sustainability of the NHS

The meaning of sustainability in relation to a public service

1. 'Sustainability' in relation to a public service has two aspects: first, whether there is a willingness to provide the resources needed to sustain it at a given level of quality and coverage, and second, whether the resources made available are being allocated and used as efficiently as possible. The first question has been consistently answered in the affirmative by all mainstream political parties. As a society we have chosen to have a health service free at the point of access offering a high quality comprehensive service to all. The practical questions about sustainability have to do with how well the resources made available are used, assuming that they are adequate for the purpose.

2. The trend for all developed OECD economies is for increasing health care expenditure over the coming years, which will partly be due to increased costs but partly also to measures that improve the health and quality of life of their populations. In the UK the public has consistently made it clear that it wants a free-at-point-of-use NHS to be sustained, with three quarters consistently opposed to its scope being reduced.³⁹⁵ Yet for considerable periods of the NHS’s existence it has been underfunded relative to other leading economies. Resources are not unlimited; choices have to be made in how they are allocated. But both the scale of the resources made available for health care and how they are allocated are political choices.

3. A comparison with other major advanced economies suggests that we could afford to spend substantially more:

Country	Spending (% GDP)	\$ Per capita spending
Austria	10.3	4,896
Belgium	10.4	4,522
France	11.1	4,367
Germany	11.0	5,119
The Netherlands	10.9	5,277
Norway	9.3	6,081
Sweden	11.2	5,065
Switzerland	11.4	6,787
United Kingdom	9.9	3,971
Average (excl. UK)	10.7	5,264

Source: OECD (Spending - 2014); (2014 Current prices and PPPs);

NB Comparison with advanced EU economies who follow the latest international accounting standards for health

4. The UK’s spending on health care ranks in the middle of the range of OECD countries at 9.9% of GDP and \$3,971 per capita (2014 at current prices), but significantly below the average of the major economies of Europe at 10.7%.³⁹⁶ If the UK were to increase its spend to 10.7% this would equate to an extra £15bn of health funding.

The drivers of rising health care costs

5. OECD projections suggest that the UK will not face a greater ‘sustainability’ challenge than most developed countries over the next 20 years. In a ‘cost pressure’ scenario the UK is expected to spend 14.2% of GDP on public health and long term care spending by 2060 compared with the EU 15 average of 14.5%.³⁹⁷ The rising cost of healthcare spending is an international trend.

³⁹⁵ British Attitudes Survey 2015. NHS. http://www.bsa.natcen.ac.uk/media/39062/bsa33_nhs.pdf (accessed 5th September 2016)

³⁹⁶ OECD, Health statistics. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT# (accessed 5th September 2016)

³⁹⁷ Maisonneuve C, Martins J. The future of health and long term care spending. OECD Journal: Economic Studies. Volume 2014. <https://www.oecd.org/eco/growth/The-future-of-health-and-long-term-care-spending-OECD-Journal-Economic-Studies-2014.pdf> (accessed 5th September 2016).

6. The gradual increase in the share of GDP spent on health care internationally is not surprising. As the American economist William Baumol pointed out, there are limits to productivity improvement in any activity in which skilled labour is irreducibly involved.³⁹⁸ Productivity in health care can rise through the use of technology and better organisation – major improvements have been achieved in the NHS by both means. But its dependence on highly skilled labour and the complexity of individual cases mean that the share of resources devoted to activities like health care tends to rise relative to other sectors in which productivity is raised through the substitution of capital for labour. However, the resources released by growth in these other sectors make it possible to spend more on health care while also increasing consumption.

7. As knowledge and techniques improve, many conditions which would have once been fatal, such as extreme prematurity, cancer, and major trauma have changed from being fatal to long-term conditions. This can lead to increased spending on long term care, but represents a welcome advance in life expectations and quality of life.

What is the impact on health costs of an ageing population?

8. Whilst an ageing population does present a challenge to the structure of healthcare provision, ageing in itself does not give rise to heavy additional costs.

As life expectancy has risen, so has the number of years of healthy living. Due mainly to improvements in diet and health awareness many citizens in their 70s and 80s are healthier than in previous generations. Most of the cost of healthcare provision for any individual still relates to the last year of life regardless of age, and this expenditure is incurred by only a small percentage of the population each year.³⁹⁹ The OECD estimates that demographic changes will only add 0.3% to UK health and long term care expenditure by 2060.³⁹⁷

9. However, the distribution of healthcare expenditure over lifetimes will change. In 2010 40% of the average OECD healthcare expenditure was on over 65s. By 2060 this proportion is predicted to be 60%.³⁹⁷ Part of this will involve an increase in costs whilst some will mean a re-allocation of existing service provision, discussed in paragraphs 27-32 below.

The burden of payment

10. An ageing population does raise questions about who will pay for the cost of health care and other services. The dependency ratio in the UK is expected to rise from 310 people of retirement age per 1000 of working age in 2014 to 370 of retirement age per 1000 of

³⁹⁸ Baumol W J. Health care, education and the cost disease: a looming crisis for public choice. In Ruth Towse [ed.] Baumol's cost disease: The Arts and Other Victims. Edward Elgar 1997.

³⁹⁹ Aragon M, Chalkley M, Rice N. Medical spending and hospital inpatient care in England: An analysis over time. Centre for Health Economics Research Paper 127. https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP127_medical_spending_hospital_inpatient_England.pdf (accessed 5th September 2016)

working age in 2039.⁴⁰⁰ This implies that workers will be paying for the healthcare costs of a larger number of older people.

11. Currently, with a state pension age of 65 (males) and 63 (females) and a life expectancy of 79 years (males) and 83 years (females)⁴⁰⁰ many retired people have an average of 18 years of retirement. During these years they will pay less tax because their incomes will fall.

12. But, a rising state pension age (reaching 67 by 2028) will extend working lives, and recent research suggests that people who are over 45 now will on average face a pension gap of over £2,300 a year between their desired income and their pension income.⁴⁰¹ This means that more will continue working further into retirement, reducing the dependency ratio.

13. A further offset to the dependency ratio comes from the relative youth of a large proportion of immigrants. On the other hand, most social care is still provided by unpaid, mainly, female relatives, a model which is liable to become less acceptable. Overall a mix of factors looks likely to moderate the impact of ageing on the dependency ratio and the sustainability of health services.

The efficient use of NHS resources

14. Like any public service the NHS needs to ensure that its resources are well used and costs are contained. The evidence from the patient-reported outcome measures regularly surveyed by the Commonwealth Fund is that they are: the UK has consistently outperformed the health systems of comparable countries while also being nearly the cheapest.⁴⁰²

15. The principal reason for this, as Sir Derek Wanless concluded following a full investigation in 2002, is the nation-wide pooling of risk, the founding principle of the NHS, and the corresponding method of funding health services from general taxation.⁴⁰³

16. A second reason is that a centrally managed system makes it possible to minimise the cost of inputs, such as equipment and drugs, and even more important, staff: with 65% of providers' costs consisting of staff pay this is a critically important consideration.⁴⁰⁴ As a monopsony employer of medical staff the NHS is in a strong position to negotiate lower

⁴⁰⁰ Office for National Statistics. National Population Projections: 2014-based Statistical Bulletin.

<http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2015-10-29> (accessed 5th September 2016).

⁴⁰¹ Aviva. Over-45s' personal savings will leave them with a retirement shortfall of thousands – and the state pension may fail to bail them out. July 2015. <http://www.aviva.co.uk/media-centre/story/17506/over-45s-personal-savings-will-leave-them-with-a-r/> (accessed 5th September 2016).

⁴⁰² Commonwealth Fund. 2014. International Profiles of Health Care systems.

http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf (accessed 5th September 2016).

⁴⁰³ Wanless D. Securing our Future Health: Taking a Long Term View. Final Report: April 2002.

<http://si.easp.es/derechos/ciudadania/wp-content/uploads/2009/10/4.Informe-Wanless.pdf> (accessed 5th September 2016).

⁴⁰⁴ NHS Improvement. Performance of the NHS provider sector: year ended 31 March 2016.

https://improvement.nhs.uk/uploads/documents/BM1653_Q4_sector_performance_report.pdf (accessed 5th September 2016)

wages. Pay freezes can be and have been used to contain NHS costs during a time of low income growth.⁴⁰⁵ For example, qualified nursing staff median annual earnings since 2011 have been reduced by between 6.3 – 10.5% in real terms.⁴⁰⁶

17. Strong use of this power can only be occasional. Many nurses are choosing agencies to increase their earnings and also to gain flexible working hours, a reason cited by 14% of nurses who left the NHS between October and December 2014, so that the reduced wage bill has been increasingly offset by rising agency fees.⁴⁰⁷ It is clear that there will soon need to be improvements in pay and the flexibility of working conditions. .

18. The fact remains that system-wide management of training, recruitment and pay makes for significant savings over time.

Why are NHS hospitals in deficit?

19. An examination of hospital inpatient spend (25% of the total NHS spend) from 1998 to 2013 showed that most of the cost increases were due to an increased volume and complexity of the cases treated. Little of the growth was due to rising unit costs of treatment.³⁹⁹

20. The fact that the NHS provider sector ended 2015/16 with a deficit of £2.5bn is thus not an indication of inefficiency.⁴⁰⁴ The overspend was mainly accounted for by the high use of agency staff, delayed transfers of care out of hospital, and a shortfall in ‘cost improvement’, i.e. efficiency schemes. The need to use agency staff is an index of the limits having been reached to the control of staff pay and numbers and the stresses of working to the limits of hospitals’ capacity. Delayed transfers out of hospital were largely due to cuts to local authority budgets for the provision of social care after discharge from hospital. The shortfall in cost improvement was due to the difficulty of making the prescribed annual improvements in productivity without the investment in new technology and other capital assets needed to achieve them.

21. The ‘provider deficits’ are thus in reality a measure of the shortfall of resources in relation to patient need throughout the system, not of shortcomings on the part of management.

The agenda for cost containment and reducing the need for care

22. The public’s strong support for the NHS needs to be matched by ensuring that its resources are allocated and used as efficiently as possible. Extensive scope exists for improvement in this respect:

i) The cost of the now abandoned market model

⁴⁰⁵ Buchan J, Kumar A, Schoenstein M. Wage-setting in the hospital sector. OECD Health Working Papers, No. 77, OECD Publishing. <http://dx.doi.org/10.1787/5jxx56b8hqhl-en> (accessed 5th September 2016).

⁴⁰⁶ Royal College of Nursing. A workforce in crisis? The UK nursing labour market review 2015. October 2015. <https://www.rcn.org.uk/professional-development/publications/pub-005348> (accessed 5th September 2016).

⁴⁰⁷ Nuffield Trust. What will be the real cost of poor NHS staff wellbeing? October 2015. <http://www.nuffieldtrust.org.uk/blog/what-will-be-real-cost-poor-nhs-staff-wellbeing> (accessed 5th September 2016).

23. One of the distinctive cost advantages of the NHS – low administrative costs – has been severely damaged, though not yet entirely neutralised, by the adoption of a market model that has failed to produce the efficiencies claimed for it. The additional annual cost of running the NHS as if it was a market has been conservatively estimated at £4.5bn.⁴⁰⁸ The cost-containment case for terminating this experiment is overwhelming.

24. This means further reorganisation, which has costs, not only financial – each of the three main phases of reorganisation of the NHS on market lines since 1990 has been estimated to have cost some £3bn to accomplish – but also opportunity costs – the time and energy devoted to administrative change instead of improving patient care. For this reason no one is keen to advocate further reorganisation. But the Sustainability and Transformation Plans (STPs) which are being drawn up to implement the aims of the Five Year Forward View (FYFV), are in reality a new large-scale reorganisation.

25. The FYFV's central aim is better integration of the NHS. But the provisions of the Health and Social Care Act of 2012 are aimed at promoting competition, the opposite of integration. In trying to achieve the aims of the FYFV commissioners and providers have to 'work around' the Act, working against its aims but in conformity with its legal provisions. Planning is thus being undertaken by ad hoc groups of local commissioners and providers working outside any legal framework⁴⁰⁹ and doing only what the Act does not explicitly forbid. Informal and unaccountable government of this kind tends to produce bad policies as well as being prone to conflicts of interest and corruption. To achieve the aims set out in the FYFV the Health and Social Care Act needs to be repealed and a rational and accountable area-based structure of management and planning put in its place.

ii) *PFI costs*

26. The annual cost of PFI schemes, which accounts for a large part of the overall deficit of the hospital sector, is £1.9bn.⁴¹⁰ The allocation of this cost to local health systems leads to serious unevenness in the level and quality of care that can be provided at the local level. The cost is also higher than if the hospital assets had been procured with public borrowing. However the PFI debt is dealt with, the excess cost needs to be lifted from individual hospital trusts, and to the extent that the cost cannot be reduced it should be shared nationally.

iii) *Cuts to social services*

27. Cuts in social care and other forms of social security significantly increase the demand for care from the NHS. Despite the announcement in the spending review that councils can

⁴⁰⁸ Paton C. At what cost? Paying the price for the market in the English NHS. Centre for Health and the Public Interest. <https://chpi.org.uk/wp-content/uploads/2014/02/At-what-cost-paying-the-price-for-the-market-in-the-English-NHS-by-Calum-Paton.pdf> (accessed 5th September 2016).

⁴⁰⁹ Leys C. Living with a zombie. The Commissioning Review. Summer 2016. Pp. 26-28.

⁴¹⁰ Hellowell M. The return of PFI – will the NHS pay a higher price for new hospitals? Centre for Health and the Public Interest. <https://chpi.org.uk/wp-content/uploads/2015/02/CHPI-PFI-Return-Nov14-2.pdf> (accessed 5th September 2016).

raise council tax by 2% to offset cuts to social care, research by the Kings Fund shows that real terms spending on social care is expected to fall over the next three years.⁴¹¹

28. The resulting scaling back of services to vulnerable groups, such as the closure of drop-in centres for pensioners and cuts to domiciliary care and other local social and mental health services, drives up attendances at A&E and hospital admissions, while cuts to residential and home care provision all lead to delayed discharges of patients who no longer need hospital care but need continuing care.

29. It is estimated that delayed discharges from hospital cost providers £145m in 2015/16. By July 2016 this equated to 184,188 days in hospital (the highest since records began in July 2010).⁴⁰⁴ ⁴¹² Even with increased funding from the Better Care Fund, and assuming that all councils raise the additional tax, the proportion of GDP spent on social care is still set to fall from its 2009 level of 1.2% to 0.9% by 2020.⁴¹¹ Moreover, councils with low property and business tax bases will raise lower levels of additional tax, yet are also those with the greatest need for social care. These policies and the proposed eventual abolition of central government funding of local authorities drive up the cost of the NHS.

30. Against this short-term backdrop, the tension between universal NHS care, free at the point of use, and means-tested social care budgets, will worsen if left unresolved, potentially leading to more unnecessary emergency attendances, admissions and delayed transfers. Besides the need to integrate the health and social care funding streams in such a way as to ensure that the principle of free care is not jeopardised, the deleterious consequences of the privatisation of adult social care also need to be tackled with new forms of regulation and consideration of steps to expand public provision.

iv) Raising the share of primary care in NHS spending

31. With more patients living with multiple long-term conditions there is good evidence that a greater investment in generalist medicine and primary care will provide better value for money and limit additional healthcare costs in the future.

32. Around 50% of all GP appointments are with patients living with long-term conditions,⁴¹³ and the active management of patients in the USA has been found to reduce the cost and average length of stay for patients. The value of a generalist (whether a GP or in a hospital) is the ability to co-ordinate specialist care and provide holistic care for patients. There is strong evidence that health systems which invest more heavily in generalists (such as the UK and The Netherlands) have better outcomes and lower costs than countries which spend more on specialist physicians (such as Sweden and the USA).⁴¹⁴

⁴¹¹ The King's Fund. Where does the spending review leave social care? December 2015.

<http://www.kingsfund.org.uk/publications/articles/where-spending-review-leave-social-care> (accessed 5th September 2016).

⁴¹² NHS England. Monthly delayed transfers of care data, England. Statistical Press Release. July 2016.

<https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2016/06/July-16-DTOC-SPN.pdf> (accessed 5th September 2016).

⁴¹³ Kirkham N. The pathologist in the 21st century: generalist or specialist? A jack of all trades and master of none? (millennial review editorial). *Journal of Clinical Pathology* 2000; 53: 7–9.

⁴¹⁴ Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *NCBI. Milbank Quarterly*. 2005;83(3):457-502. <https://www.ncbi.nlm.nih.gov/pubmed/16202000> (accessed 5th September 2016).

v) *Raising the share of mental health in NHS spending*

33. Poor mental health is closely linked to poor physical health. About 30% of patients with a long-term physical health condition also suffer from a mental health condition, which can exacerbate physical illness and increase the costs of treating it by 45%. An estimated 12-18% (£8-13bn a year) of all NHS expenditure on long-term health conditions is linked to poor mental health.⁴¹⁵

34. People who live in areas of high deprivation are disproportionately likely to have a long-term chronic condition coupled with mental illness.⁴¹⁵ In order to control the costs of long-term conditions more must be invested in the treatment of mental health and in tackling its socioeconomic determinants.

vi) *Reducing economic inequality*

35. The UK has severe levels of socio-economic inequality, raising the burden of illness that falls on the NHS. Not only do those living in the poorest neighbourhoods in England die on average 7 years earlier than those in the richest, but they also spend an average of 17 years more of their lives living with disabilities. With the estimated annual costs of health inequalities (lost taxes, welfare payments, and costs to the NHS) estimated at £36-40bn in 2010 there is a large scope for savings.⁴¹⁶

36. An economic policy directed to reducing inequality through improved levels of secure employment combined with a more progressive tax system would have a profound impact in reducing NHS costs through the reduction of the leading causes of ill health.

vii) *Prevention*

37. Sir Michael Marmot recommended that 0.5% of GDP should be spent on public health prevention and promotion measures.⁴¹⁶ In 2014/15 the share of spending on all aspects public health stood at 0.3%. A commitment to meeting Sir Michael's target is needed.

38. A clear example of the impact of public health on NHS costs is the increasing prevalence of obesity. Currently 1 in 4 adults and 1 in 5 children are obese and by 2050 it is predicted that 1 in 2 adults and 1 in 4 children will be obese. Obesity leads to increased health risks such as type 2 diabetes, cancer, osteoarthritis, and vascular disease. The direct costs of obesity to the NHS are currently estimated to be £6.3bn a year. By 2050 it is predicted that the direct costs will be £9.7bn, and the indirect costs £50bn.⁴¹⁷ A substantially more demanding government intervention to address the obesogenic environment is called for.

⁴¹⁵ Naylor C *et al.* Long term conditions and mental health – the cost of co-morbidities. The King's Fund and Centre for Mental Health. February 2012. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf (accessed 5th September 2016).

⁴¹⁶ Marmot M *et al.* Fair Society Healthy Lives. The Marmot Review. 2010. <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review> (accessed 5th September 2016).

⁴¹⁷ Public Health England. 'About Obesity'. https://www.noo.org.uk/NOO_about_obesity (accessed 5th September 2016).

New models of care

39. It is possible that new models of care, such as the Multi-specialty Community Providers and Primary and Acute Care systems promoted in the Five Year Forward View, will offer both cost savings and better care, but there are reasons to doubt it. First, there is serious lack of evidence. The Chief Executive of NHS Providers has stated that ‘There is little evidence that moving to new care models will release rapid or sufficient savings’, and observers well placed to judge have expressed doubts whether in circumstances of financial stringency they will improve patient care.⁴¹⁸

40. Second, experience with new care models tends to show that they may seem to work when initially tried out, especially when primed with extra funding, but not when rolled out on a wide scale without such support. Yet most of the £8bn Sustainability and Transformation Fund allocated to the NHS is being spent on covering providers’ accumulated deficits, with little left to pay for the capital, training and re-organisation needed to transform service delivery systems.⁴¹⁹

41. Third, the focus on new models of care tends to distract attention from the fundamental need to trust and respect the judgement of the professionals concerned, and ensure their commitment.

42. The way forward to greater efficiency and better patient care lies rather in providing sufficient funding to take the NHS out of its current crisis-management mode, endow it with a legal basis for rational and accountable planning, and ensure that new models of care are introduced at scale only on the basis of independently evaluated evidence.

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⁴¹⁸ Chris Hopson, quoted in the Health Service Journal, 12 September 2016, <https://www.hsj.co.uk/topics/finance-and-efficiency/hopson-new-care-models-a-15-year-journey/7010500.article>; and Williams D, McLellan A and West D, ‘A reality check for new care models’, Health Service Journal 19 September, 2016, <https://www.hsj.co.uk/7010620.article>

⁴¹⁹ The 2016/17 Sustainability and Transformation Fund: Why is it not enough and what are its implications for the provider sector?, Centre for Health and the Public Interest, June 2016.

Centre for Mental Health – Written evidence (NHS0079)

Centre for Mental Health is an independent national mental health charity. We aim to inspire hope, opportunity and a fair chance in life for people of all ages with or at risk of mental ill health. We act as a bridge between the worlds of research, policy and service provision and believe strongly in the importance of high-quality evidence and analysis.

We encourage innovation and advocate for change in policy and practice through focused research, development and training. We work collaboratively with others to promote more positive attitudes in society towards mental health conditions and those who live with them.

Our response to this Call for Evidence is based on research we have previously carried out. We have only addressed the questions for which we are able to offer an evidence-based view.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

The new NHS strategy for mental health, the Mental Health Five Year Forward View, and its implementation plan, set out clear plans for improvements to mental health services. If these are delivered according to plan, and this path is continued to 2030, there is the potential to deliver not just improvements to people's health and wellbeing but efficiencies across the NHS and beyond.

It is essential that by 2030 there have been not just specific service improvements, but improved transparency about funding levels and their output, where funding is targeted, and how the workforce is developed to meet people's needs. The commitment to parity between mental and physical health has been enshrined in law but is still far from being realised, including in terms of spending, outcomes and research. Poor mental health increases mortality rates, physical health morbidity, and comes at a significant cost to the NHS and economy as a whole. Real action on mental health must be taken if the health and social care system is to cope by 2030 and beyond.

One of the most effective changes which could be made would be towards more integrated and collaborative working across agencies in different sectors for people with mental health needs, including education, employment, housing and criminal justice.

Including mental health and wellbeing education in schools and providing family support and help at the first signs of difficulty has been shown to set firm foundations for children's mental health.⁴²⁰ For adults, there is evidence that people who are not in work make more use of mental health services than those who are, irrespective of the severity of their illness. Schemes such as Individual Placement and Support (IPS) have shown cost savings of around

⁴²⁰ Missed opportunities: children and young people's mental health <https://www.centreformentalhealth.org.uk/missed-opportunities>

£3,000 per person per year because of the reduced use of mental health care.⁴²¹ Housing should be recognised as a health intervention by mental health services; having access to stable housing has been shown to reduce the costs of hospital stays for people who would otherwise require inpatient care.⁴²² Initiatives such as the Sheffield Mental Health Citizens Advice Bureau, which provides welfare advice in mental health services, should be learned from and replicated in other areas.⁴²³

In the criminal justice sector, there is evidence that liaison and diversion schemes can improve health, as well as reducing the risk of re-offending and cut the costs of crime. It is vital that liaison and diversion services are made available in all police stations for both children and adults, and that mental health support is available at every stage of the criminal justice pathway. Offenders with mental health problems outside custody should be offered all possible support to make use of community mental health services.⁴²⁴

Within the health care sector, more must be done to act on mental ill health associated with long-term conditions. We know that mental health problems can exacerbate physical illnesses and so substantially increase the care costs for each person by about 45%. Changing demographics and the predicted increase in long term conditions between now and 2030 will concurrently increase costs of associated mental illness - £1 in every £10 of the entire NHS budget is linked to poor mental health among people being treated for physical illnesses.⁴²⁵

Building on the direction set out by the Mental Health Taskforce, health services must become much more integrated, including the better integration of mental health support with primary care and chronic disease management programmes, collaborative care arrangements between primary care and mental health specialists, cost-effective liaison psychiatry in acute hospitals, and improved support for the mental health aspects of physical illness.⁴²⁶ For physical conditions such as diabetes and chronic respiratory problems, the savings in physical health care costs would be more than sufficient to cover the costs of a structured collaborative care model as well as dramatically improving outcomes for patients.⁴²⁷

Centre for Mental Health's report, *Priorities for mental health*, has set out nine priority areas for service improvement where there is good evidence of cost-effective interventions, covering prevention and early intervention, better mental health care for people with physical health problems; and improved support for people with severe mental illness.⁴²⁸

⁴²¹ Priorities for mental health: Economic report for the NHS England Mental Health Taskforce <https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report>

⁴²² More than shelter: supported accommodation and mental health <https://www.centreformentalhealth.org.uk/more-than-shelter>

⁴²³ Welfare advice for people who use mental health services <https://www.centreformentalhealth.org.uk/welfare-advice-report>

⁴²⁴ Liaison and diversion <https://www.centreformentalhealth.org.uk/liaison-and-diversion>

⁴²⁵ Parity of esteem <https://www.centreformentalhealth.org.uk/parity-of-esteem>

⁴²⁶ Long term conditions and mental health: the cost of co-morbidities <https://www.centreformentalhealth.org.uk/long-term-conditions>

⁴²⁷ Priorities for mental health: Economic report for the NHS England Mental Health Taskforce <https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report>

⁴²⁸ Priorities for mental health: Economic report for the NHS England Mental Health Taskforce <https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report>

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

The future workforce in mental health services will need to be more diverse, encompassing specialist roles such as peer support workers, IPS specialists, liaison psychiatry services in acute hospitals and liaison and diversion teams working with the police and courts. All of these specialist roles have the potential for substantial cost-savings, as well as improved outcomes for people using services.

In order to move towards truly recovery-oriented services which help people to build meaningful and satisfying lives, the workforce will need to change the skill mix and balance between traditional mental health professionals and people whose expertise comes from 'lived experience'. The potential benefits of peer specialists to people being supported (as well as to teams and providers) are huge, and workers can make a significant contribution to enhancing the experience of care.⁴²⁹ The evidence available, while limited, suggests that the financial benefits of employing peer support workers exceed the costs, in some cases by a substantial margin, through significant reductions in hospital bed-use.⁴³⁰

We know that being in paid work can play a vital role in recovery for many people with mental health problems, and supporting people into employment should be a key priority for health and social care providers and commissioners. There is strong evidence that IPS is the most effective method of helping people with severe mental health problems to achieve sustainable competitive employment. One of the most crucial aspects of the IPS approach is the quality of joint working between employment specialists and mental health teams. Employment specialists should be integrated, and preferably co-located, with clinical teams. Commissioning of IPS services should be targeted and clear, ensuring one full-time employment specialist is available for each clinical mental health team.⁴³¹

Psychiatric liaison services provide mental health care to people being treated for physical health conditions in general hospitals. The co-occurrence of mental and physical health problems is common in the inpatient population, often leading to poorer health outcomes and increased health care costs. Every general and acute hospital should have a sustainable, dedicated in-house liaison psychiatry service that can meet local needs. An attainable objective for a liaison psychiatry service in a typical general hospital would be to generate savings of up to £5 million a year. There is also a major role for liaison psychiatry teams in improving services in community settings for people with co-morbid physical and mental health problems, and potentially also in perinatal care.⁴³²

The size of the prison population has doubled in the last 20 years and many people in the criminal justice system have complex mental health needs which are poorly recognised and

⁴²⁹ Peer Support Workers: Theory and Practice <https://www.centreformentalhealth.org.uk/peer-support-workers-theory-and-practice>

⁴³⁰ Peer support in mental health care: is it good value for money? <https://www.centreformentalhealth.org.uk/peer-support-value-for-money>

⁴³¹ Doing what works: Individual placement and support into employment <https://www.centreformentalhealth.org.uk/briefing-37-doing>

⁴³² Liaison psychiatry in the modern NHS <https://www.centreformentalhealth.org.uk/liaison-psychiatry-nhs>

inadequately managed. Liaison and diversion services which identify people who have mental health problems and learning disabilities when they come into contact with the police and courts can improve health, reduce the risk of re-offending and cut the costs of crime. While effective diversion requires some up-front investment in dedicated liaison and diversion teams working in police stations and courts, most if not all of the direct costs are likely to be covered by short-term cost savings in the criminal justice system.⁴³³

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

All staff, working across all service types must have at least basic mental health training and competencies. In general and acute hospitals, psychiatric liaison services should have the training and supervision of staff as a core function.⁴³⁴

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

b. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

Better primary mental health care and early intervention are both key to shifting mental health care from hospital based settings to the community and from crisis management to prevention and promotion. In both hospitals and the community, people's mental and physical health needs should be addressed through services which are joined up and recognise the impact that one can have on the other.

For people with complex needs, investing in primary mental health care, including GP training, can have a significant impact on outcomes. The Primary Care Psychotherapy Consultation Service, run by the Tavistock and Portman NHS Foundation Trust in the London Borough of Hackney, has improved mental health outcomes for patients, and reduced the number of GP consultations, A&E visits, outpatient appointments and hospital admissions, by offering training and support to GPs and a range of psychological therapies to patients.⁴³⁵

As detailed above, improved provision of liaison psychiatry services will cut costs and reduce hospital bed days. To date, such services have developed in an ad hoc fashion, resulting in a postcode lottery. Every hospital should have a comprehensive liaison psychiatry service as standard.⁴³⁶ About half of all patients being treated for physical health problems in acute hospitals have a co-morbid mental health problem such as depression or dementia. Most of these cases of mental illness go undetected by medical staff, leading to poorer health outcomes and substantially increased costs of care, equivalent to around 15% of total expenditure in each acute hospital. There is growing evidence that a dedicated proactive liaison psychiatry service working with medical staff can substantially reduce these extra costs, particularly among elderly inpatients, who should be a priority group for intervention.⁴³⁷

⁴³³ Liaison and diversion <https://www.centreformentalhealth.org.uk/liaison-and-diversion>

⁴³⁴ Liaison psychiatry in the modern NHS <https://www.centreformentalhealth.org.uk/liaison-psychiatry-nhs>

⁴³⁵ Helping patients with complex needs <https://www.centreformentalhealth.org.uk/complex-needs>

⁴³⁶ Liaison psychiatry in the modern NHS <https://www.centreformentalhealth.org.uk/liaison-psychiatry-nhs>

⁴³⁷ Priorities for mental health: Economic report for the NHS England Mental Health Taskforce <https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report>

In the community, the extension of liaison psychiatry would contribute to the management and treatment of mental health problems among people with long-term physical conditions such as diabetes and chronic respiratory or cardiac problems. Outpatient treatment clinics should be opened up to referrals from GPs and other community-based providers, where this is not already the case.⁴³⁸

For specific groups, there is even greater need for early identification of mental health needs. Perinatal mental health problems are very common, affecting up to 20% of women at some point during the perinatal period. As well as the adverse impact on the mother, they have been shown to compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences. The current provision of services is highly variable around the country, although there is widespread agreement about what services are needed from NICE and other national bodies.⁴³⁹

Centre for Mental Health has identified a number of changes that are needed to improve services, including reducing the pressure on general practice to enable longer consultations where necessary, improving the focus on mother and infant wellbeing by health visitors and practice nurses, joint working between Health Education England (HEE) and the RCGP Clinical Champion to support specific perinatal mental health training provision for qualified GPs, ensuring that local IAPT services fast track mothers with common perinatal mental health difficulties into treatment, and the adequate commissioning of parent-infant interventions.⁴⁴⁰

For people with serious mental illness, accessible and comprehensive crisis resolution teams in the community can provide effective support for people experiencing crises, lead to greater patient satisfaction and reduce hospital admissions. Economic analysis suggests that every £1 invested in crisis resolution teams yields savings in the NHS of £1.68.⁴⁴¹

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

Last year Mind reported that only 1% of public health spending by councils is clearly dedicated to mental health.⁴⁴² Mental health and wellbeing should be a major priority in twenty-first century public health. Above all, there must be recognition that a good public health strategy must be about the prevention of poor mental health as much as poor physical health. Such a strategy should take a cross-government approach, and include recognition of the key determinants of good mental health: early interventions at school and with families, stable employment and housing, as well as early access to health and care services when necessary.

⁴³⁸ Liaison psychiatry <https://www.centreformentalhealth.org.uk/liaison-psychiatry>

⁴³⁹ Costs of perinatal mental health problems <https://www.centreformentalhealth.org.uk/costs-of-perinatal-mh-problems>

⁴⁴⁰ Mental health during and after pregnancy <https://www.centreformentalhealth.org.uk/maternal-mental-health>

⁴⁴¹ Priorities for mental health: Economic report for the NHS England Mental Health Taskforce <https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report>

⁴⁴² Mind reveals 'negligible' spend on public mental health <http://www.mind.org.uk/news-campaigns/news/mind-reveals-negligible-spend-on-public-mental-health/#.V-T2kygrLcu>

At the outset, schools should be supported to promote good mental health and emotional literacy among children, backed up with better, faster and more attractive help for children with risk factors for poor mental health and those who become unwell. Evidence-based parenting programmes should be provided to families who need them to prevent or manage behavioural problems in children up to the age of 11.⁴⁴³ In addition, the identification and treatment of maternal depression and anxiety during the perinatal period would significantly reduce the likelihood of the development of mental health problems in children. The Coalition Government's taskforce report on children's mental health, *Future in Mind*, set out a broad range of recommendations which, if implemented effectively, could transform preventative mental health care for children, and translate into significant social and economic benefits.

For people with a mental illness, investment must be made in reducing the mortality rate, currently 3.6 times higher than the general population and resulting in a reduction in life expectancy of some 15-20 years. Contributing factors include smoking, obesity, poor diet, the iatrogenic effects of psychiatric medication, illicit drug use, and physical inactivity, and any public health efforts in these areas must consider and target the specific needs of people with mental illness.⁴⁴⁴

Some local councils have already found innovative ways of promoting good mental health, preventing mental illness and improving the life chances of people with mental health problems. The Centre's report on the 'zero suicide' initiative in the East of England found that it showed great promise.⁴⁴⁵ This approach seeks to minimise the risk of suicide through a range of activities including training for GPs in suicide prevention, taking action to reduce risks at 'hot spots', engaging with communities to raise people's confidence to talk about their mental health, and working with people at high risk and their families.

Other local authorities have used their JSNAs to understand the mental health needs of local people and focus action to address them more effectively. These include Blackburn with Darwen Borough Council, whose Integrated Strategic Needs Assessment for children's emotional health and wellbeing has identified what supports and what undermines young people's mental health in order to focus activity on reducing adverse childhood experiences.⁴⁴⁶

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

b. What is the role of 'Big Data' in reducing costs and managing demand?

There is a clear need for more robust data about mental health from early childhood to later life. Every Joint Strategic Needs Assessment should include such data, and use it to identify priorities for improved promotion, prevention, early intervention and recovery support. *The*

⁴⁴³ What we want to happen in mental health <https://www.centreformentalhealth.org.uk/what-we-want-to-happen-in-mental-health>

⁴⁴⁴ Priorities for mental health: Economic report for the NHS England Mental Health Taskforce <https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report>

⁴⁴⁵ Aiming for 'zero suicides' <https://www.centreformentalhealth.org.uk/zero-suicides>

⁴⁴⁶ Children and Young People's Emotional Health and Wellbeing: ISNA Lite <https://www.blackburn.gov.uk/Lists/DownloadableDocuments/CYP-Lite-ISNA-FINAL.pdf>

Mental Health Challenge has identified ten key data areas which should consistently be included to promote good mental health and to prevent and treat mental health conditions in local areas.⁴⁴⁷

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⁴⁴⁷ The mental health challenge: Ten questions for your council http://www.mentalhealthchallenge.org.uk/wp-content/uploads/2013/08/LA_Challenge_10_questions.pdf

Mr Adam Chaffer – Written evidence (NHS0144)

EXECUTIVE SUMMARY

1. This written evidence draws on my experience as a Public Governor and through my research during my Masters in Law dissertation looking at the rights to resource allocation in the NHS.
2. The National Health Service (**NHS**) is very much a national treasure for Great Britain; it is a concept which despite our cultural, regional and national differences we can all associate with and is equally the envy of the world. No other nation has truly managed the concept of universal healthcare free to the point of use. Notwithstanding the special place the NHS is held in the mindset of the British public the organisation nationally is facing challenges which if not tackled in an expedient manner are likely to severely undermine the long term sustainability of the organisation.
3. The underpinning points are contained in the next three numbered paragraphs.
4. The Executive Agencies of the NHS (in particular NHS England and NHS Improvement) have become too powerful and run contrary to their intended purposes. This power needs to be returned to the Department of Health so that decisions can be challenged appropriately through Parliament.
5. The second point which this paper considers is the fact that Foundation Trusts do work as a sustainable delivery model. However, the commissioning and tariff structure of the NHS is causing chronic financial problems to develop which if they continue will manifest in significant shortfalls in accessing the best level of care for patients.
6. This report will finally conclude that the future of the NHS involves tough decision making which Parliament, the Department of Health, NHS England and NHS Improvement need to make but cannot do so in the current climate. It is appropriate for Parliament in the current climate to convene a Royal Commission to consider the future of the National Health Service before we reach point of no return.

INTRODUCTION

7. The National Health Service (**NHS**) is currently at a crossroads the decisions which the Government makes in the coming years will have a significant impact on the future existence of the organisation. In order to balance the competing needs of patients both now and in the future the Government needs to take bold and decisive steps which are made with the full engagement of Stakeholders and the general public. In light of the prevailing situation within the NHS the House of Lords Select Committee is presented with a unique opportunity to shape the future and perhaps very survival of the NHS; it is truly an opportunity not to be missed.
8. I understand that the terms of reference for this Select Committee is to investigate and consider the, '*long term sustainability of the NHS*' and to report to the House of

Lords by Friday 31 March 2017. To that end this evidence is drafted to support the Select Committees objective. Drawing on my experience which I have outlined in paragraphs 9 to 11 I shall comment on the following areas of the Select Committees work:

- 8.1 resource issues, including funding, productivity and demand management;
- 8.2 models of service delivery and integration;
- 8.3 prevention and public engagement; and,
- 8.4 in addition to the above terms of reference I will also comment on additional points of relevance to the long term sustainability of the NHS.

INTRODUCTORY COMMENTS

9. My name is Adam Chaffer I am a Trainee Solicitor in Durham. Alongside my full time role I also serve as a Public Governor on the Board of Governors at the Newcastle upon Tyne Hospital's NHS Foundation Trust. Within this role I sit as Vice Chairman of the Business Development Working Group and an elected member of the Nominations Committee.
10. I hold a degree in Law (2012) from Northumbria University and also hold a Masters in Law (2016) with a dissertation that considered the fairness and methods of challenge to the current resource allocation model in the National Health Service.
11. From the outset can I be clear that this evidence is submitted in my professional capacity and therefore any opinions made herein are my own views and opinions and should not be taken to be representations or opinions of my employer or any other organisation which I represent.

POINT 1: THE FUTURE HEALTHCARE SYSTEM

12. Before considering how the NHS will cope in 2030 it is first important to appreciate where the NHS has come from. The NHS is built on a core precept that it meets the needs of everyone; it is free to point of delivery and based on clinical need, not the ability to pay. These core principles continue to survive to this day and remain a key cornerstone when considering future decisions making within the NHS. Another important point to appreciate is that the structure of the NHS is based within a framework set down by Parliament in successive Acts of Parliament from the National Health Service Act 1946 through to the Health & Social Care Act 2012. This framework debate and endorsed by Parliament has indecent times been eroded by the delegation of significant decision making to executive agencies.
13. Since the NHS was founded the health service as a corporate entity has undergone significant amount of structural reform following the amendments made by the Health and Social Care Act 2012.

14. At the time of writing the current model of the NHS can be broadly broken down into the following simplistic components:
 - i. The first tier of NHS service relates to the ‘first contact’ of the patient; normally this contact will be made to a General Practitioner, pharmacist, dentist or optician, however, emergency cases will be dealt with either at an Emergency Department or through a minor injuries ‘walk in centres’.
 - ii. The second tier of contact that the patient will come across is referral from the first tier (above) to a Consultant for diagnostic referral, outpatient, clinical services or surgery. Separate to this Emergency Department patients and minor injuries units can refer patients for non-elective care.
 - iii. The third tier concerns specialist care and long term treatment such as cancer care, cardiology and neurosciences.
 - iv. Running concurrently to these components (tiers one to three) there is support in an outreach capacity specifically by community nursing, social workers and other allied health professionals.

Deficiencies in the current NHS service model and the impact on the NHS by 2030

15. For secondary care; services are provided through NHS Foundation Trusts and NHS Trusts. Commissioning of these clinical services is provided by Clinical Commissioning Groups (CCG's) and for specialised services NHS England as the NHS Commissioning Board. The commissioning model which is currently utilised is a working model to an extent. The reliance of local knowledge to steer provider services works. However, the system of commissioning services has three major flaws which inherently weaken the entire financial structure. First the system no longer practices under the principle that the money follows the patient and therefore local commissioning falls down, if the model refocuses on this point it will be greatly strengthened. Secondly, there is scope to argue that the CCG model creates conflicts of interest and is an expensive model to operate. Further there is scope to argue that the previous model of Primary Care Trusts amalgamated into units covering a large geographic area functioned without any overriding conflict of interest. If this model could be transferred into a CCG model which mirrored the Primary Care Trust success then significant improvement will be made. At the same time this proposal would greatly reduce the administrative cost and duplication of services. The commissioning of specialised services from a central point does work as this remains a niche market which requires co-ordination from a central point.
16. The decision by the Coalition Government to introduce localised commissioning is a point which should be praised, it creates a market place which drives up standards. In the previous paragraph the failings of commissioning from an operational aspect were considered. In this paragraph reference is made to the funding aspect. The tariff structure which currently exists does not work and its failure creates a direct correlation to the budget deficit within the NHS. In order to rectify this flaw the

Department of Health and its executive agencies will need to undertake comprehensive reform of the tariff system. This is a point which can be easily reformed and if done expediently will greatly benefit the wider NHS.

17. A recurring theme which a future health system will need to manage is the discharge and community support for patients leaving hospital. The current system of post hospital support is not fully integrated which means there is gaps between hospitals and the community. In some parts of the NHS this is creating chronic delays which by default incurs cost and a shortage of beds for incoming patients. By reforming the system to ensure there are clear patient pathways is a workable solution. Understandably at peak times such as during the winter the lack of joined up health and social care creates pressure on the service. In time this is an issue which will become more compounded especially in the directorates of Emergency, Elderly Care and those which work on long term conditions such as cardiology.

Can the NHS become sustainable in the long term?

18. The first question that anyone approaching the question of the future NHS should ask is does the current model work in a sustainable and competitive manner and if the answer is in the negative why not. Before answering this question it is beneficial consider the rationale behind this question. Elements of the NHS clearly work well but they are let down by poorly constructed procedures which if rectified would strengthen and allow the NHS to prosper. Steps should be taken nationally to identify the elements which work well and those which do not. By identifying the element which works and those elements which are damaging the sustainability of the NHS the system can be reformed accordingly without the waste, expense, or upheaval of wholesale reform which is introduced ad hoc or without sufficient consideration.
19. Within the NHS structure there remains a significant degree of waste in terms of financial resources; if the organisation is to become sustainable then steps need to be taken to look for efficiencies in resources. At this stage it is perhaps beneficial to draw on one sizeable cause of financial inefficiency in the NHS; that of the executive agencies NHS England and more recently NHS Improvement. With respect of NHS England; the original intention of executive agencies was to act as lean support organisations ensuring that the NHS delivered. Such a support function is clearly needed to enable the NHS to develop consistently across the country and in the original construct of NHS England the idea worked. However, in reality what has developed is large bureaucratically complex organisation which pulls funding from front line services.
20. Turning to NHS Improvement, this organisation is again incurring significant financial resources but this organisation also gives cause for concern as it is unclear what the mandate of the organisation is and indeed why it has been created. Further it is fair to note that the organisation is created without Parliament having considered the matter which raises constitutional questions as to whether the organisation should exist at all.

21. In order for the future of the NHS to remain accountable to the public steps need to be taken to divert executive decision making back to the Department of Health and responsibility removed from NHS England and NHS Improvement.

POINT 2: RESOURCE ISSUES

22. One of the questions which this Select Committee is reviewing is whether the societal model of the NHS exceeds the current cost remit. The answer to this question is yes; indeed it is trite to think any other answer would be possible in the current financial environment. However, it would be more appropriate if the question was phrased to consider whether as a nation we would be prepared to continue to support the NHS even if it exceeds its cost target. This question is entirely subjective and depends on the views of the general public; as a rule of thumb the current public view appears to hold the NHS in extremely high regard and this in turn could be an indication of long term support for an organisation which is free to the point of use.
23. What this question truly highlights is something which transcends health economics; it is a question of morality and crucially what we as a country should be doing for the NHS; is balancing the books an objective or should we be striving to achieve a healthcare system which is true to Bevan's principles and protects the vulnerable. This question cannot be answered by professionals, interested parties or politicians it is a question which necessitates a national conversation and debate.
24. Another resource issue concerns competition within the NHS. The competition model introduced through the Health and Social Care Act 2012 is a workable model but it needs to be matched with strict financial controls to ensure failing organisations are dealt with promptly. The competition model also works well with the independent nature of Public Benefit Corporations but the system needs to recognise that independent means independent and that in creating organisations under this concept will create some organisations who flourish under dynamic and innovative leadership. Such organisations should not be criticised but praised and their work emulated across the wider NHS. By operating in a true meritocracy the NHS will flourish but for those organisations which are underperforming the Department of Health ought to be able to provide a turn-around team comprising of experts with public backgrounds supported by professional advisors from the private sector.
25. A clear resource problem is the continued and relentless need to continue to reinvent the NHS. This causes significant financial waste if every few years the model of providing clinical services is changed; such a zealous need to reform the NHS so regularly is not a sustainable way of operating.

POINT 3: MODELS OF SERVICE DELIVERY AND INTEGRATION

26. Integrated healthcare means ensuring the patient is treated in a metaphorical flight path to recovery; from diagnosis to discharge the care plan of the patient should be planned out. In considering this model it is important to remember that for a NHS patient one size does not fit all. The care model which suits the demographic in

Newcastle upon Tyne will be radically different to that in rural Norfolk. In order to tackle the relationship between hospital, general practice and community services monthly Quad Meetings should be introduced at a regional level to co-ordinate care between the hospital and community setting. By creating a forum of joined up thinking the challenges that exist

27. The practical change which the Committee have asked for direction on is simple. First the health budget set by Parliament needs to be improved. The simple fact is NHS is unsustainable on the current budget allocation and if the Government are committed to improving the NHS steps need to be taken to increase this. This may be achieved through a special tax levied exclusively for the benefit of the NHS. It is likely that if such a tax was created there would be public support but there would be an expectation that improvement will be seen within the NHS.
28. This point specifically relates to hospital care. There is a current school of thought that the model of delivering NHS care needs to be improved. Such improvement naturally incurs cost and in the past two decades the amount of structural reorganisation in the NHS has reached a rate which is a clear cause for concern. Effectively the constant change of reform is creating a plaster over a gaping wound which is the problems of the NHS; at this stage in proceedings the NHS needs a period of stability rather than further reform.

POINT 4: PREVENTION AND PUBLIC ENGAGEMENT

29. Within the NHS and the wider perspective of the general public the concept of prevention is one of the best methods to ensure that the public can ensure that the NHS is in a long term sustainable position. As things stand there is an understandable gulf between the current attempts at prevention and what is needed to ensure that the public support and partake in prevention measures.
30. On a national level there are entrenched health problems which have a profound impact on the resources and operational efficiencies of the NHS. By way of example let us consider obesity. The effect of obesity is creating clear pressures on the National Health Service. It is likely that without a level of preventative action these pressures will become exasperated.
31. The current model of prevention rests largely with Public Health England. Since the devolvement of public health work to Local Government there has been a marked decline in the available expenditure to finance prevention campaigns. In order to achieve prevention as a sustainable concern within the NHS the Government needs to ring fence the current public health budget and thereafter commit to an annual rise in expenditure each year thereafter.
32. The Government through Public Health England need to empower people to improve their health and well-being by creating a framework to inspire communities. Depending on the specific needs of a geographic community the framework could include subsidised sports programmes to allow people to get fit, weight loss clinics, and healthy eating through community allotments and farms. In order to improve Public Health engagement the Government could consider creating Public Health

Panels made up of ordinary people to achieve best practice within a designated community. Such an engagement approach would ensure that Public Health is relevant to each community rather than taking a *'one size fits all approach'*.

33. The introduction of the sugar tax by the last Chancellor of the Exchequer is a significant step in tackling childhood obesity. However, there is more which can be done for instance there is a general failing amongst the public to understand the causes and effects of obesity and the general need to lead healthy lifestyles.
34. Another useful example is the work undertaken in some German companies where incentives exist to empower employees to make lifestyle changes. For instance an employee may wish to take up running for health reasons; as the employee hits certain mile stones the employer rewards the employee for example with baby vouchers or department store vouchers.

POINT 5: ACHIEVING SUSTAINABILITY

35. The challenges which the NHS faces can be overcome, however, to do so will involve the Government taking a divisive step which will enable the NHS to develop a long term future. Until now although reform has been made there has been a lack of progression on key points. This pivotal step would be to create a Royal Commission on the Future of the National Health Service. The benefit and indeed logic of a Royal Commission would be to temporarily elevate the question of the NHS outside the bailiwick of the political arena and into a forum which can then be deliberated by a panel of associated professionals in the fields of medicine, economics, social theory and the associated legal provisions around healthcare..
36. It is perfectly understandable for the Government to be cautious in commissioning such a progressive idea as a Royal Commission; not least because of the length of time they take and the cost. However, notwithstanding these concerns it is imperative that the future of the NHS is properly deliberated and steps are taken to ensure that engagement in this programme draws in medical and allied health professionals, along with politicians (in particular former Secretaries of State for Health) and the public to ensure that a broad spectrum of information and opinion is correlated.
37. Should the Government implement a Royal Commission and then after scrutiny of the findings decide to enact into law the recommendations it is vital that such reforms are given chance to develop without the fear of continued reform for the sake of reform. One of the problems with the NHS today is not that the organisation is devoid of energy but that the institution is faced with continued, sustained and systemic patterns of structural reform to its funding and management structure. The problem with these reforms, however well intended, is that with each attempt is merely a sticking plaster over the question of the future of the NHS. Continued and unchallenged reform to the NHS of this kind has the effect of eroding the identity of the NHS which the public both know and have come to rely on.
38. Turning to the term 'sustainability' is relevant to ensuring a long term future of the NHS. The first step the NHS needs to establish is what does the term mean. Within the

ambit of the private sector, 'sustainability' means achieving a competitive future, adding value and ensuring that employees carry the moment of the organisation with them in their work. Establishing what the term means in the NHS should not just be a matter for the executive agencies but rather a conversation with the NHS staff as a whole. Each NHS Trust and NHS Foundation Trust should have a Sustainability Strategy which establishes what the term means but also how the organisation can achieve sustainability through engagement with the private sector. Most private companies have corporate social responsibility policies which the NHS can benefit from whether within their local communities.

CONCLUSION

39. The NHS cannot continue to provide the level of service it has done unless radical change is undertaken in the funding and operational capacity of the organisation on a national level. To achieve a sustainable health service there are a number of conclusions which this paper recommends the House of Lords consider. The first is that steps need to be taken to reduce the Executive Agencies role in terms of power, control and financial turn over. Concurrent to this first point a significant proportion of the power vested in these organisations needs to be returned to Parliament to ensure that those decisions which need to be made are made in a democratic manner. The second point is that the Foundation Trust model is a sustainable delivery model but the tariff system and commissioning model which underpins the NHS is not fit for purpose and inherently undermines the ability for Trusts to either break even or make a surplus which can be invested into the organisation to ensure it is a sustainable concern. Finally, the future of the NHS involves tough decision making which Parliament, the Department of Health, NHS England and NHS Improvement need to make but cannot do so in the current climate. Instead this paper concludes that the only proposed course of action is to refer the entire matter to a Royal Commission to consider the future of the National Health Service before we reach point of no return.

23 September 2016

Sir Cyril Chantler –Written evidence (NHS0187)

Summary.

1. NHS spends a similar amount on health care as comparable OECD countries but social care spending has fallen.
2. Political change as well as professional change is needed but radical reorganisation is not.
3. The care and treatment of people with chronic illnesses, the improvement of health and reduction of health inequalities should become the responsibility of local councils working with the NHS with joint commissioning of primary care, social care, and community nursing based on the Buurtzorg neighbourhood model.
4. General Practices should be linked to community hubs serving populations of circa 50,000 to 100,000 as joint enterprises with local councils, supporting social care, community support and voluntary services, diagnostic centres with specialist input and emergency medical centres etc.
5. Political responsibility for the service should be shared between national and local government as in Scandinavia and future investment should be targeted at this local level so that the pressure on hospitals can be relieved.
6. A major initiative should be undertaken by politicians, and the medical profession, to redefine professionalism, and replace contracts with compacts. The emphasis on regulation should be reduced by agreeing compacts at the local level, on what service can be provided and on the outcomes for patients that can be achieved. The aim must be to promote trust.
7. The training and support of specialists in training should be radically changed in line with the Greenaway report on the Shape of Training. The length of training should be reduced and should be similar to other countries in Europe. Rationalisation of acute hospital services should be supported as necessary to provide a consultant or trained specialist provided service whilst not necessarily assuming that this must imply closure of hospitals in any particular locality at this time.

Introduction.

It is interesting to reflect that many people of my age, including myself, would not be alive today given the knowledge of medicine that existed when I qualified. Life expectancy for a male in 1948 at the start of the National Health Service was 66 years and it is now nearly 80 years. During this period infant mortality has fallen from 34 deaths per thousand live births down to 5 deaths. These changes are partly the result of improvements in public health and nutrition but the advances in biomedical science and technology have played an important role as indeed has the National Health Service (NHS).

It is paradoxical that as a result of improvements in treatments and wealth the burden of disability and illness has increased. According to the Department of Health the treatment and care of those with long term conditions accounts for 70 percent of the primary and acute care budget in England. Many of them have multiple conditions. In Scotland the majority of those over 65 years have two or more chronic conditions. People in more deprived areas are worst affected than those in more affluent areas. Mental health problems are strongly associated with the number of physical conditions and people with multiple problems have considerable difficulty with the coordination of their care (1).

The NHS has grown to become the world's largest publicly funded health service. It currently serves 62 million people. The NHS employs more than 1.7 million people. In 1948 when it was launched it had a budget equivalent to £9 billion at today's value. In 2014 it cost £179.4 billion a rise of 4.2% over 2013 or 9.9% of GDP. This is comparable with other OECD countries (2,3). In contrast the amount spent on social protection has fallen; the UK spent 28% of GDP on social protection with three quarters of the expenditure on old age and disability in 2013 (4).

The Archbishop of York, Dr Cyril Garbett, commented during the debate on the NHS bill in 1946 that the National Insurance Act and the NHS bill would prove to be by far the greatest social reforms that had ever been passed by Parliament. I agree and think an adequate publicly funded healthcare system is the mark of a civilised society. The NHS is rightly loved by the British people but it is not perfect. Amenable mortality, defined as premature death from causes that should not occur in the presence of timely and effective health care, is higher in the UK than in a number of developed countries such as France, Italy or Sweden (5). Outcomes for children are even worse (6). The European Health Consumer Index places the UK 14th of 28 countries criticising in particular poor accessibility to health care and an autocratic top-down management culture. Each year its author suggests that social insurance funded health systems are more effective in meeting patients' needs than central government tax based systems though not necessarily as efficient (Bismark outperforms Beveridge!). An exception to this appears to be the Scandinavian systems where an element of locally raised taxation is combined with local accountability (7). A recent report suggested that errors in hospitals are the third commonest cause of death with perhaps as many as 8000 per year occurring in England (8).

The politics of the NHS have always been controversial. Aneurin Bevan in a speech to the Institute of Hospital Administrators in 1946 observed "the medical profession is not an easy one to handle. It is composed of eminent men and women who have devoted themselves and dedicated themselves to it, but who do not appear to bring the same collective sagacity to bear upon the profession as they do upon their individual patients". In 1950 he observed that "the NHS is a novel experiment. It is an attempt on the part of British society to reconcile two normally conflicting interests, centralised financial responsibility and decentralised administration at the periphery." This, I suspect, is a core problem.

One of our most distinguished ministers of health over the last 60 years was Mr Enoch Powell, a man sadly remembered largely for other reasons. In 1966 he wrote a pamphlet titled "A new Look at Medicine and Politics" which is available on the internet (9). It is 80 pages long and so well written that it is difficult to put down once you have started. A few quotations from his pamphlet:

“The universal exchequer financing of the service endows everyone providing as well as using it with a vested interest in denigrating it so that it presents what must be the unique spectacle of an undertaking that is run down by everyone engaged in it”.

“If an improvement or expansion of the service with which one is professionally concerned depends on government spending more upon it then it becomes a positive ethical duty to proceed to bombard the government and force or shame them into providing more money.”

“The un-nerving discovery every minister of health makes at or near the outset of his term of office is that the only subject he is ever destined to discuss with the medical profession is money.”

And finally “I have made no secret of my opinion that the National Health Service is inherently unsuitable for administration by a political minister. However the plain rule is that wherever the taxpayers money is being spent a minister must be held responsible for how it has been spent.”

Bevan’s decision to nationalise the hospitals led to the government supplying virtually all healthcare as well as paying for it. The one group of people who were not to be employed by the state were the general practitioners who, and this is often forgotten, are privately employed. The amount of funding for health care from private insurance or personal payers is amongst the lowest in Europe. There are strong arguments, in my view, in favour of funding from taxation but the debate concerning how to pay for it is bound to reopen over the next few years as the difficulties of maintaining the service without increasing the proportion of national wealth devoted to it, become apparent. The only comparable period in the previous history of the NHS was in the early 1980s when the country was recovering from the near bankruptcy that led to the winter of discontent.

In a paper presented to the mid Staffordshire NHS foundation trust enquiry Nigel Edwards wrote “the history of the NHS, conceived as a hierarchy in which authority and power resides at the centre casts a long shadow.” The Socialist Health Association has pointed out that since 1974 the NHS has been in an almost continuous state of what some people call re organisation. The report of the management enquiry undertaken by Sir Roy Griffiths, managing director of Sainsbury’s, at Mrs Thatcher’s behest in 1983 was in the form of a letter. In it he observed “If Florence Nightingale was carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge”. To Roy management was not a profession it was a job. It needs to be undertaken by those who wish to do so and have the capacity. To those who accept responsibility is given authority and the absolute requirement is to accept accountability.

My view then was that my professional responsibility was to be an advocate for my patients whilst the government’s responsibility was to provide the cash. I was a visiting professor at the John Hopkins Hospital in Baltimore around that time and began to think I was wrong. The Hopkins in 1972 had changed its system so that the senior clinicians had strategic responsibilities, managed budgets and delivered their services within the resources that could be made available. I returned to Guys hospital and with my colleagues argued that clinicians in a publicly funded healthcare system needed to accept that profligacy in the care of one patient could lead to the denial of adequate care to another. It is an ethical

responsibility to encourage efficacy, effectiveness, efficiency, equity, economy, and excellence or quality.

I became the general manager of Guys hospital for a period of three years between 1985 and 1988 with a group of 12 clinical directors working closely with our colleagues in nursing and administration charged with the task of reducing expenditure by 15% and maintaining the service. There were massive increases in efficiency which demonstrated to me how much can be achieved when the clinical staff, not just doctors, and the administrative staff work together to the benefit of patients. Just before he died Roy said he feared he had indeed invented a new profession called management. In 1992 he wrote “I have a genuine horror that managers and the various professions will go down parallel routes, barely touching each other and with very different objectives”. We can argue why this has happened but we cannot doubt that it has and it is in the interests of all, most importantly our patients that it must be changed.

One of the first acts of the incoming Labour administration in 1997 was to establish the National Institute for Clinical Excellence that in my view has been a great success. For the first time there was an impartial body that could determine whether new treatments and to a lesser extent current practice represented good value in terms of outcomes for patients. It has not been without controversy and some of the decisions have not been universally appreciated. Nonetheless it is widely regarded internationally as making a major contribution to the sensible allocation of health care resource. There are few if any nations in the world that do not have to restrict the provision for the public funding of health care in some way. This is either in terms of what is provided, when it is provided or to whom it is provided. To my mind it is a matter for national pride that in this country we tend to restrict or ration services more in terms of what and when rather than who.

Enoch Powell in 1966 wrote “I cannot but reflect sardonically on the effort I myself expended as Minister of Health in trying to get the waiting lists down. It is an activity about as hopeful as filling a sieve.” It would be interesting to hear a conversation between him and his successor Alan Milburn concerning how the reduction and control of waiting lists was achieved. There is no doubt the increase in capacity engendered by increased spending contributed to the reduction in waiting lists. Many believe that that the introduction of independent sector treatment centres was important. They created competition for the NHS, although their size was never sufficient to greatly affect the number of people waiting, the NHS began to treat more patients. However the acceptance that the private sector should provide services to NHS patients was critical in managing waiting lists and today around 25% to as much as 80% of private hospital cases are NHS patients.

Since 1989 British and later English governments have sought to decentralise the management of the NHS. Most recently we have had the Health and Social Care Act of 2012 that so far has had mixed results. It has involved Primary Care and General Practice more, indeed largely for the first time, in the management of the NHS but has left overall strategic uncertainty. NHS England is stimulating new models of care and the 5 year forward view seeks to coordinate these ambitions. The government made the intention to improve hospital services at weekends a key manifesto commitment and sought to fulfill this by changing the junior doctors contract. This led to a dispute that damaged patients, the profession and maybe the government. The answer to the weekend problem and indeed

issues of quality in care does not lie with junior doctors' contracts alone but requires strategic change.

Problems and Solutions.

What then are the problems of our current system? In 2006 I was one of a group of clinicians chaired by Lord Darzi to review healthcare in London (10). I accept that London is a special case but it is a large one. We noted that London has major health problems, and that Londoners were less satisfied with the NHS than citizens in the rest of the country and particularly so in relation to GP services. There were big inequalities in health status with a seven-year disparity in life expectancy between the Westminster and Canning Town that is just eight stops on the Jubilee line. Basically our conclusion was that the problem was fundamentally overall poor primary and community care. Hospitals were under huge pressure with high occupancy rates leading to problems with the standard of care. The only way to improve hospitals was to invest in better care in the community. Put simply you could not get into hospital because you couldn't get out and maybe you would not need to go there anyway if you had better care.

The model for chronic disease management recommended by the Royal College of Physicians and the Royal College of General Practitioners is based on the work of Dr Ed Wagner in Seattle (11). He says his model is based on the best of UK general practice. Following his model we suggested investing in primary care, encouraging general practitioners to come together in networks serving populations of between 50,000 and 100,000 so that some services currently only to be found in hospitals could be provided from the community. This did not necessarily mean closing down neighbourhood practices but rather that groups of practices should develop community hubs or hospitals that we termed (unfortunately) polyclinics. This is not a new idea. It was proposed in 1967 in a paper by Dr. Peter Draper in the *Lancet* (12) and recommended in a White Paper in 2006. Although not supported by the government initially or by the BMA, such facilities are now being established by groups of GP's. Such hubs could become the focus for urgent care out of hours, provide a range of diagnostic facilities, and most importantly allow specialist services to be situated alongside primary care to improve diagnosis and chronic disease management. They can also be the focus for a number of other services such as social care, community nursing support, hospital at home services and pharmacies and healthy living centres. They should become the hub for community maternity services (14) and for mental health services. They should contain academic centres to facilitate undergraduate and postgraduate education and research. There is an urgent need to get specialists like I used to be out of the hospitals to work alongside their colleagues in the community as in the Wagner chronic disease model. We need to recognize that it is only in the UK that specialists are confined to hospitals and this is the result of a trade dispute between the physicians and the apothecaries in the 19th century. Too often the argument is around closing hospitals. My view is that we should not be discussing closing hospitals until we have improved primary care services so that we can see whether the hospital is needed and if so in what form.

Modern medicine is complicated and requires multidisciplinary team work of a high order. If value, that is outcomes per pound spent, is to be maximized then high technology services

will need to be concentrated in fewer centres. A recent survey by NHS London (13) suggested that hundreds of people are dying every year in London due to lack of consultant staffing at weekends and out of hours. The strategy we expressed in the Framework for London report in 2007 is to “localise where possible and centralise where necessary.”

Centralise where necessary can also refer to the creation of integrated networks and the provision of specialised services. Examples in London concern trauma, heart attacks and strokes. If you have a stroke in London now you'll be taken within 30 minutes to one of the eight hyper acute stroke centres where you will immediately have a CT scan and if appropriate an injection (thrombolysis) to dissolve the clot in the brain. London has gone from being one of the more dangerous capital cities in which to have a stroke to perhaps the safest. Mortality has fallen by over a third, thrombolysis results are amongst the highest achievable and significant cost reductions have occurred through reduced morbidity and length of stay in hospital. I may point out that this initiative was developed by clinicians and managers working closely together.

There are great concerns about the quality of care provided in some parts of the NHS. The events at mid Staffordshire NHS trust have caused great distress and anger. But there are sadly other examples which appear almost on a daily basis, of a lack of compassion and care in institutions that seem to be overwhelmed by the difficulties that they face. In 2008 Lord Darzi invited two highly respected internationally based health policy organisations to review the English NHS. These were the Joint Commission International Consulting (JCI) and the Institute of Health Improvement (IHI). Both reports were critical of the top-down culture of the NHS. To quote from the JCI report “a shame and blame culture of fear appears to pervade the NHS and certain elements of the Department of Health. This culture generally stifles improvement”. The IHI report stated that a culture of fear and top-down control rather than shared learning and participative improvement are significant barriers to improvement.

As has been pointed out by Jennifer Dixon there are two parts to the NHS. One part provides elective treatments but only accounts for a quarter of the expenditure. I can see no reason why the patient (who pays for the service!) should not have a choice of providers. Commissioners and regulators should ensure that all providers who are funded through the NHS give good value, as defined earlier. Their results should be available for scrutiny and, in the words of the government, any willing and qualified provider should be able to compete in this area of the service.

Most of the NHS however is concerned with the treatment and I hope prevention of chronic illness and with the provision of complicated and expensive treatments such as transplantation or complex therapy for cancer or cardiac disease etc. It should also be concerned with the promotion of health. Public health is an important specialty and is rightly linked to communities. However the health of the public needs to be addressed at family and neighbourhood level as well and the average size of a general practice at around 10,000 people is ideal for this. The management of chronic disease should be led from primary care with health and social services and voluntary sector working together within local communities. There is a case for the commissioning of health and social care from a single budget at local level. Good quality chronic disease management requires a care plan developed by the patient and the carers, a key worker charged with working with the

patient to deliver the plan, an electronic care record shared by all involved including the patient and a multi-skilled group of carers who can learn to share skills. Over the last 18 months I have been chairing a general practice in outer North East London that has confirmed these principles.

The NHS, in terms of how it is provided as opposed to financed, does need to be decentralised. The 2012 act was a further move towards this if somewhat confused. CCG's are responsible for commissioning hospital services whilst specialist services and primary care are the responsibility of NHS England who are also required to audit the effectiveness of CCG's. NHS England have recognised that hospitals now serve larger populations than the "old" district general hospitals and as such CCG's need to come together to commission these services. During the National Maternity Review (14) we reached a similar conclusion when we recommended the establishment of Local Maternity Systems (LMS's) for the commissioning of maternity services which are more or less coterminous with the Sustainability and Transformation Plans (STP's). LMS's will each be part of around 11 maternity and neonatal regional networks that can become the focus for provision of specialist services and for learning and outcomes improvement. However and in my view very importantly it needs to be recognised that these arrangements are unsuitable for the organization of primary, community and social care and indeed most STP's have been drawn up without much input from local councils or indeed in many cases primary care.

Social care is the responsibility of local government. The coalition government in 2010 decided that whilst PCT's would not be elected local government would for the first time become involved with the NHS through Health and Wellbeing Boards. It is almost as though Morrison has finally got his way as part of Bevan's NHS! This decision has two very important results. First it provides democratic accountability for part of the health service at local level (rather like, but of course not identical with) Scandinavian countries. This should serve to ameliorate the top down culture of the NHS that is so damaging. Second it means that services for the chronic sick, those with disabilities and the improving of health and well being can be organized locally through cooperation between the local council and the NHS, indeed with joint commissioning. In Newham services for children with chronic illnesses such as diabetes, asthma and epilepsy are now being jointly commissioned. The Mayor of Newham has stated his intention to co-invest with the GP federation in general practice premises and in the creation of community hubs.

Most of the attention in the NHS has focussed on hospitals not recognising that as many as 29% of beds are occupied by those with chronic illnesses who would be better and safer out of hospital. Our hospitals are dangerously over occupied. In 2006 the Netherlands faced with the same challenges determined to organise the care of people with chronic illness as a separate "compartment" of their health service (15). They provide excellent coordinated community care not least through their very impressive model of neighbourhood (Buurtzorg) nursing that serves populations of around 10,000 people (16). Their hospitals have occupancy rates of around 85% and they are safe. They do not have problems with cross infection. In Holland it is difficult to get into hospital and easy to get out in contrast to us. My contention is that we need to use any new money that can be found to invest in this model.

However fundamental changes are required in hospitals too. People admitted to hospitals nowadays are sicker and have more complicated illnesses than before at least in terms of more complicated options for treatment. All such patients need to be seen on admission by trained specialists working alongside those doctors who are training to be specialists. This would be in line with a comprehensive report on the Shape of Training published in 2013 (17). Specialists in training need to be better supported and have time for a proper work and life balance as well as time out to support a family. The period of training could also be shortened in line with other European countries if they spent more time learning whilst being supervised and less providing the service. Maybe if this report had been implemented we would not have faced industrial action. Maybe also patients would be safer in hospital all days of the week not just at the weekends.

One of the safest hospitals in the world is the Virginia Mason Hospital in Seattle (18). As well as introducing new patient safety systems some years ago they replaced their doctors contracts with compacts; arrangements that recognised the importance of professionalism with doctors taking responsibility for organising as well as providing care with appropriate authority and accountability. The top down managerialism of the NHS, developed over the last 15 years, has been widely criticised by friends from abroad as well as here, and the doctors' contracts that resulted need to be replaced by compacts. Every effort should be made to increase professionalism and trust whilst reducing regulation and the need for it

The NHS needs strategic assessment and incremental change. It does not need further massive reorganisation. Central politicians have to let go and they now have the democratic legitimacy to do so to a reasonable extent especially in relation to operational matters. We need urgently to develop services for people with chronic illnesses on a local basis. The medical royal colleges, the BMA and the profession need to facilitate change and accept more responsibility whilst the government should, in return, act to reduce the climate of top down management and overwhelming regulation that has contributed to the present problems. Everyone needs to encourage clinical leadership, professionalism and the involvement of clinicians in the organisation and management of services.

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29 November 2016

The Chartered Institute of Public Finance and Accountancy – Written evidence (NHS0041)

About Us

CIPFA is one of the leading professional accountancy bodies in the UK and the only one, which specialises in the public services. It is responsible for the education and training of professional accountants and for their regulation through the setting and monitoring of professional standards. Uniquely among the professional accountancy bodies in the UK, CIPFA has responsibility for setting accounting standards for a significant part of the economy, namely local government.

CIPFA's members work (often at the most senior level) in public service bodies, in the national audit agencies and major accountancy firms. They are respected throughout for their high technical and ethical standards, and professional integrity. CIPFA also provides a range of high quality advisory, information, and training and consultancy services to public service organisations. As such, CIPFA is the leading independent commentator on managing and accounting for public money.

Response

We are in a turbulent period for health and social care in the UK. Changes in demand due to a growing and ageing population, combined with advances in available treatments, are placing increased pressure on public sector budgets. The early part of the century saw a significant leap in the proportion of national income (GDP) spent on healthcare –increasing from 7 to 10% in the first decade⁴⁴⁸. The changes caused by subsequent austerity, however, will see this to fall back closer to 8% by 2020, a figure that can be contrasted with over 11% in Germany, France and the Netherlands⁴⁴⁹.

In 2015, CIPFA in its Health of Health Finances briefing concluded that the NHS's medium term financial position was not viable. The Government acknowledged the issues by providing the NHS with additional financial support in the November 2015 Comprehensive Spending Review; and there have also been subsequent policy developments, notably around integration and devolution, which are promising. However, CIPFA's follow-up paper *More Medicine Needed*, released in May 2016⁴⁵⁰, predicted a £10bn shortfall in the NHS budget by 2020, implying that the funding assumptions lying behind the NHS Five Year Forward View are not achievable. This is due to difficulties in achieving the assumed £22bn of efficiency savings required by 2020 combined with a number of additional spending pressures, including the policy to provide 24-7 services, which have been added subsequently. These estimates were made prior to the Brexit vote and take no account of its potential impact on the economy, such as the predicted contraction of public finances and the increased strain on the available workforce.

⁴⁴⁸ The 3% increase is clear, but the government has since changed the definition used to assess health and social care spend, here back-converted

⁴⁴⁹ See, for example, <http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/health-care-spending-compared>

⁴⁵⁰ See the full publication *More Medicine Needed: The Health of Health Finances Revisited* at www.cipfa.org/cipfa-thinks/insight

The NHS Five Year Forward View, issued in October 2014, was widely welcomed as setting a new tone for the management of health and social care. It provided a much broader view of the determinants of health and placed emphasised longer term planning and investment in prevention as key to ensuring the sustainable delivery of effective services. Rightly, it incorporated expectations of significant efficiency and transformation as well as increased resources. Unfortunately the severe financial pressures experienced across the public sector and within the NHS specifically during 2015-16 signalled a retrenchment to shorter term responses designed to resolve the immediate issues. This is coupled with the ongoing failure by all governments – despite the welcome positives of precept flexibility and the Better Care Fund - to fund social care and public health consistently with the same demographic demands as fall on the NHS, so limiting the scope for preventative spend. Overall, then, there has been no significant move yet to break out of traditional short term thinking and healthcare funding remains something of a political football, a game in which the players are much more focussed on the results of the latest match than on prospects for the following seasons.

Against this background, the achievement of a healthy future involves a leadership challenge as much as a financial one, and CIPFA concludes that the Government must consider the following:

- New methods of prioritisation will be needed if the necessary savings are to be made without affecting services unacceptably. That might, for example, include reviewing the level and range of services which are provided free at the point of care by the NHS, sometimes referred to as the ‘NHS offer’. Pressures on local government finances have led to overall reductions in the numbers receiving social care (from 1.7m in 2009 to 1.3m now ⁴⁵¹) and changes in how social care is delivered. Is there an appetite for something similar to be achieved in the NHS?
- The Five Year Forward View is based on predicted pressures of £30bn. CIPFA feels more analysis and honest assessment is needed to update and address this figure, including in the light of the Brexit decision, and to assess the timing of pressures and planned savings. We believe that the £30bn assessment is understated, and that the NHS will be unable to react fast enough in the early years to make the productivity gains required to achieve even the £22bn target, leaving a severe shortfall in the medium term.
- To prepare for the predicted larger and older population of the future, the Government should return to the Five Year Forward View, review its assumptions and set aside more funds to encourage long-term preventative investments which will generate savings in the future. If this could deliver ‘productivity gains’ there would be a case to fund this investment through borrowing or even via bespoke taxation.
- The additional resource provided for the NHS from 2015 has not changed the underlying position, especially when combined with real term resource reductions for those areas outside the NHS ring fence (social care, public health, staff education

⁴⁵¹ According to the Health & Social Care Information Centre

and training). It will be necessary either to add further to the health and social care budget, charge users, or reduce services. To do nothing is not a realistic option.

It is vital that the coming financial shortfall is addressed as part of realistic long-term future planning for health and social care. CIPFA calls on the Government to take a serious look at the balance of demand and available supply of health and social care in order that the needs of the current and future population are acknowledged and provisioned. There are a number of ways in which this could be achieved but, building on our conclusions in *More Medicine Needed*, CIPFA proposes that an independent Commission should be set up to seriously examine the alternative options available to balance demand and supply for health and social care into the future:

- The Commission would need to consider the type and levels of services provided, look at the balance between short term and longer-term trends, and plan expenditure to match. This would be the first stage in a realistic public debate of funding available versus expectations of the services provided. The Commission would then need to recommend the best means, however radical, of achieving this new balance of funding and expenditure.
- To help remove questions about the level of resources available from the short-term political cycle, it would be helpful to link the expenditure requirements in a formal way to GDP. We suggest that a 'Golden Ratio', which commits government to a minimum investment in health and social care, would be best way to increase the certainty with which the NHS and local government can plan. Such a ratio would reduce the unpredictability of politically-driven annual settlements, while relating spending logically to what the country can afford. Looking at international comparisons a ratio of 10% of GDP would be achievable yet impactful, and is similar in magnitude to the findings of the Barker Commission. More work is needed on the exact percentage, both in terms of what is needed and the political recognition of the changed priority across all public spending. The resulting figure need not represent a 'cap' and should be subject to regular review by the Independent Commission.
- To ensure adequate funding is available, the Government may need to consider increasing the range of funding sources used, so that in addition to the current funding - which is almost entirely from general taxation - there might be increased charging and co-payments for NHS services, bespoke taxes, and greater freedoms for health and social care bodies to raise additional funds for capital investment

The predicted surge in demand for health and social care cannot be avoided. Difficult choices need to be made, and as a society we must face up to decisions regarding the extent to which we are willing and able to provide publicly funded health and social care. Decisions of this magnitude need the serious consideration which will be afforded by an Independent Commission and its findings should be implemented in a way which reduces the uncertainties caused by the vagaries of short term politics, such as via a 'Golden Ratio'.

21 September 2016

Chartered Society of Physiotherapy – Written evidence (NHS0055)

About the physiotherapy profession

The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the UK's 54,000 registered physiotherapists, physiotherapy students and support workers.

Physiotherapists are autonomous practitioners, able to independently assess, diagnose and prescribe medicines. The contribution of physiotherapy can be seen at many points of a care pathway as physiotherapists work as clinical leaders and multi-professional team members, to support patients in hospital, home, community, work and leisure environments.

Summary of CSP evidence

There are ten areas action is required to increase the long-term sustainability of the NHS

1. Giving clear political commitment to health services remaining free at the point of need and use, funded through general taxation
2. Reversing the decline in funding across health and social care
3. Taking national accountability for the 10k workforce expansion target for allied health professions and nurses training places that was indicated from the last CSR
4. Developing and investing in the workforce in line with future need and system transformation objectives and providing fair pay to maintain morale and motivation
5. Utilising all parts of the workforce at the height of their capabilities
6. Redistributing funding to develop out-of-hospital care and services that rehabilitate, prevent, educate and empower self-management and healthy life styles
7. Pursuing integration policies to achieve transformation goals and improving quality of care,
8. Overcoming the transactional barriers to system change, including how services are funded and issues of organisational accountability
9. Building a national consensus on the need for changes to the health and care system and the role of individuals and communities within this
10. Developing IT systems that can provide all parts of the health and care system seamless shared access, communication across boundaries, in a common language with shared standards

1. **Resourcing issues – including funding, productivity and demand management**

Is the current funding model for the NHS realistic in the long-term? Should new models be considered? Is it time to review exactly what is provided free-at-the-point of use?

1.1 The CSP strongly supports the principles of the NHS, that it is tax funded and free at the point of use, and that individual wealth should not be a barrier to accessing necessary health care services. This is a principle strongly backed by public opinion, with 89 per cent

saying that this is what they want their government to support.⁴⁵² The CSP also believes that the UK's universal health system is the most realistic system to deliver the changes required to be sustainable in the long-term. The comprehensive review of different funding models by Lord Wanless in 2002 supports this view.⁴⁵³ “

- 1.2 International evidence suggests where charges have been introduced there is a significant decline in access to services, specifically people's use of preventative services, but it has little impact on overall health expenditure.⁴⁵⁴
- 1.3 Insurance-based systems are not inherently more sustainable, stable or affordable, and the evidence suggests the contrary is the case. A comparison with the insurance-based system in the US is useful, where only one third of the population are covered by publically funded programmes (Medicare and Medicaid). The burden of this system on US taxation is twice that of the universal system in the UK – in 2013 it stood at 17.1 per cent of GDP in the US, while it was 8.8 per cent in the UK. The public cost of health services in the US is higher again when one takes into account the tax exclusion for employer-sponsored health insurance. At the same time, the private cost of health care to individuals in the US far exceeds that of taxpayers in other OECD countries and this cost is the primary reason for personal bankruptcy and mortgage repossession. Conversely, it also leaves public health vulnerable to changes in the economy (e.g. unemployment, wages). This has clear detrimental consequences not just for individuals, but the economy. Furthermore, in spite of high levels of both public and private expenditure, health outcomes in the US do not compare favourably to the UK.⁴⁵⁵
- 1.4 What is required for the long-term sustainability of the NHS is the modernisation of the health and care system - how services are organised and joined up with attention to the wider determinants of health, the relationships between service users, carers and professionals; the role of individuals and communities in improving public health and the redistribution of resources so that a greater proportion is targeted at prevention, health management and rehabilitation services outside of hospitals.⁴⁵⁶ There is already strong consensus among policy makers, political parties, clinical and professional leaders and frontline staff around this transformation agenda.
- 1.5 This is being undermined by the decline in health and care spending. Spending on social care services for the elderly has fallen by 17 per cent since 2009/10.⁴⁵⁷ Overall spending on health has been declining since 2009 as a proportion of gross domestic product, falling to less than both the European and OECD average and as average spending per head of population.⁴⁵⁸ ⁴⁵⁹ Major system change requires investment in

⁴⁵² 2014 British Social Attitudes Survey, undertaken by NatCen Social Research <http://www.health.org.uk/publication/public-attitudes-nhs#sthash.jf8DL2i.dpuf>

⁴⁵³ Securing our Future Health: Taking a Long-Term View” Wanless 2002

⁴⁵⁴ The impact of user fees on access to health services in low- and middle-income countries http://apps.who.int/rhl/effective_practice_and_organizing_care/cd009094_waiswaw_com/en/

⁴⁵⁵ <http://cohealthinitiative.org/sites/cohealthinitiative.org/files/attachments/warren.pdf>

⁴⁵⁶ University College London. The Future of Healthcare in Europe. London: University College London. https://www.ucl.ac.uk/european-institute/events-view/reviews/healthcare/FHE_FINAL_online.pdf

⁴⁵⁷ NHS in a Nutshell, Kings Fund 2016 <http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell>

⁴⁵⁸ NHS in Numbers, Nuffield Trust 2016 <http://www.nuffieldtrust.org.uk/nhs-numbers-0>

time and an adequate level of funding. The policy of transformation and the policy to reduce public spending on health and care are not aligned.

- 1.6 The productivity agenda sometimes confuses effective and efficient care with rationing of care and can be narrowly focussed on inputs rather than on patient outcomes. It also tends to look at short-term savings, inhibiting the move to more affordable and sustainable models of care. This is seen in physiotherapy where too often the number of physiotherapy sessions that patients receive is the starting point when looking at efficiency. This is crude and means that some patients receive more sessions than they need and others not enough. Getting in front of the problem at an early stage is the way to reduce the number of sessions required.
- 1.7 Under-resourcing is creating inefficiencies – pushing more service users into the most expensive parts of the health system, insufficient spending on health services pushing up social care costs, and insufficient spending on social care support is resulting in higher demands on health.

2. Workforce – including supply, retention and skills

How can an adequate supply of appropriately trained healthcare professionals be guaranteed? Are enough being trained and how can they be retained? Do staff in the NHS have the right skills for future health care needs?

- 2.1 **In the last Comprehensive Spending Review the government said that the change in student funding would enable an increase in student places for nurses and AHPs by 10 thousand by 2020, which in turn should help address current workforce shortage issues. Predictions of future population needs show the growth areas of need are for caring, rehabilitation and support activity to manage long-term conditions.⁴⁶⁰ As well as nurses, the parts of the workforce that need to be grown and developed to meet these needs are support workers and AHPs, including physiotherapists.**
- 2.2 **But against evidence of current and future need, the numbers of physiotherapists to be trained in 2016/17 was cut by 6.7 per cent. There is now a shortage of registered physiotherapists, creating difficulties in recruiting to posts. Services are focussed on delivering current contracts with staff shortages, which is a barrier to innovation and service redesign. A survey of practicing CSP members in March 2016 found that 89 per cent of those who responded (440 members) agreed that insufficient posts result in their service being overstretched. There needs to be a minimum increase of 500 physiotherapists being trained every year for at least the next three years to close the gap with growing demand.⁴⁶¹**

⁴⁵⁹ Staffing matters; funding counts. The Health Foundation, July 2016

⁴⁶⁰ Future Demand for Skills – initial results. Horizon 2035, Centre for Workforce Intelligence. August 2015 URL: <http://www.cfw.org.uk/publications/horizon-2035-future-demand-for-skills-initial-results>

⁴⁶¹ The Chartered Society of Physiotherapy. Workforce data modelling tool. London: The Chartered Society of Physiotherapy; 2015. URL: <http://www.csp.org.uk/professional-union/practice/evidence-base/workforce-data-model>

- 2.3 The CSP has supported the removal of bursaries to physiotherapy students on the condition that, if implemented properly it allows for the necessary expansion to happen. Currently there is a lack of clarity over who is responsible and accountable for delivering the 10k nursing and AHP training numbers expansion commitment. This urgently needs to be addressed, and both Health Education England and NHS England mandated by the government to achieve this.
- 2.4 It is critical that England starts to address sustainable workforce supply through domestic workforce production, rather than the current heavy reliance on overseas-qualified health care staff, particularly now in the context of Brexit and the impact of visa changes.
- 2.5 The workforce across health and care need to be fully utilised. The OECD earlier this year published a survey of doctors and nurses in 22 countries. This showed that 76 per cent of doctors and 79 per cent of nurses report being over skilled for parts of their work⁴⁶². The UK health workforce reflects this picture, including how physiotherapists and other AHPs are under-utilised.
- 2.6 Enabling all parts of the health workforce to work to the height of their capabilities and scope of practice means: registered physiotherapists and other AHPs not doing tasks that can be performed just as adequately by support workers; support workers not doing the tasks that carers or volunteers could do; and doctors not doing tasks that can be done just as well – or in many situations better – by an advanced practice physiotherapist or nurse. Taking this approach across the whole workforce frees up staff to concentrate on doing what only they can do.
- 2.7 This can be seen very clearly in the care of musculoskeletal health in General Practice. Physiotherapists are autonomous, regulated practitioners. They have the same high safety record as GPs, and considerably lower levels of complaint. They don't require supervision or delegation from medical colleagues or others. Many physiotherapists have advanced practice skills, and can independently prescribe and carry out injection therapy. An advanced practice physiotherapist costs £54.11 per hour, a GP £130.71,⁴⁶³
- 2.8 Musculoskeletal (MSK) health problems are the biggest cause of disability in the UK, are the most common cause of repeat appointments and account for between 20 and 30 per cent of the GP caseload, yet it is an area GPs commonly say they are not confident in managing.⁴⁶⁴ MSK problems are the most common cause of sickness absence from work and are a major barrier to physical activity. Physiotherapists have the most advanced expertise in MSK of all health professionals with the exception of

⁴⁶² Health Workforce Policies in OECD Countries: Right Jobs, Right Skills, Right Places, Ch 6
Skills use and skills mismatch in the health sector: What do we know and what can be

done?<http://www.oecd.org/publications/health-workforce-policies-in-oecd-countries-9789264239517-en.htm>

⁴⁶³ Chartered Society of Physiotherapy. Physiotherapy Cost Calculator. London: The Chartered Society of Physiotherapy. 2016. URL: <http://www.csp.org.uk/professional-union/practice/evidence-base/physiotherapy-cost-calculator>

⁴⁶⁴ Goff I, Wise E, Coady D, Walker D. Musculoskeletal training: are GP trainees exposed to the right case mix for independent practice? *Clinical Rheumatology* 2014;Sept 6 (Epub). <http://www.ncbi.nlm.nih.gov/pubmed/25190366>

orthopaedic consultants, and they can safely and effectively manage 85 per cent of a GPs MSK caseload.

- 2.9 GPs and policy makers are recognising the potential to utilise this expertise and the new role of General Practice Physiotherapists is being piloted in a number areas. Physiotherapists with advanced practice skills are contracted to provide the same first point of contact service for MSK patients as a GP would. The evidence from these pilots show high patient satisfaction, reduced costs and reduced pressure on GPs and secondary care – in particular significantly reducing unnecessary orthopaedic, MRI and xray referrals. In the longer term it could improve musculoskeletal care in communities, with significant benefits to public health and supporting people to be fit for work.
- 2.10 One of these is 'Physiotherapy First', a joint initiative between two NHS providers, Cheshire and Wirral Partnership NHS Foundation Trust and the Countess of Chester Hospital Foundation Trust. 36 GP surgeries in the West Cheshire footprint now provide their patients with the choice of seeing a physiotherapist when they first contact the practice with MSK symptoms. They see around 1000 patients per month – roughly a quarter of the GPs MSK caseload. Just under 3 per cent are referred back to the GP for medication review or for non-MSK conditions, while over 60 per cent are discharged after one appointment with the General Practice physiotherapists. This service was set up in addition to an already successful orthopaedic and pain triage/CATS service. Therefore areas with no such provision are likely to see more dramatic pathway changes and savings from reducing unnecessary referrals. The service has achieved all of their objectives:
- Saved GP /locum time – 84 per cent of patients seen by the physiotherapist would have been seen by the GP – value £540k / year
 - Decreased plain x-ray referrals 5.9 per cent - value £28k / year
 - Decreased MRI referrals 4.9 per cent - value £83k / year
 - Decreased orthopaedic referrals by 12 per cent - value £70k / year
 - Reduced referrals to physiotherapy services by 3 per cent - after a year-on-year increase of 12 per cent over the previous 5 years
 - High patient satisfaction – 99 per cent rated the service good or excellent, 97 per cent had their issues addressed.
 - High GP satisfaction - 91 per cent rated the service as being 8 or over for how beneficial they felt the service is to their practice with 45 per cent scoring them a maximum 10. Dr Chris Steere, GP at Neston Medical Centre told the CSP *'Physiotherapy First really complements how our GP's work in practice. Patients with MSK problems no longer need to see a GP first. Our patients are very impressed with the quick access and very few need a re-referral to see a GP.'*
- 2.11 There needs to be a rebalancing of investment in the training and development of the existing workforce. Approximately 60 per cent of the NHS's training budget is spent on just 12 per cent of the workforce (doctors) and there is no national training budget for support workers. What is required is an inclusive approach to workforce development and investment. This must be in line with changing patient, service and workforce needs and support advanced practice development across professions,

optimise the contribution of support workers, and enable strengthened skill mix and inter-professional and cross-sector/-agency working.

- 2.12 A sustainable health system requires staff to receive fair pay for the work they do in order to maintain morale and motivation. Since 2010 £4.3 billion has been cut from the salaries of NHS staff by the government restraining of public sector workforce pay below inflation⁴⁶⁵. The CSP supports the UK pay framework as set out in the Agenda for Change agreement and believes a Pay Review Body, independent from Government, is the most appropriate way of delivering this.

3. Models of service delivery and integration

How can the move be made to an integrated National Health and Care Service? How can organisations in health and social care be incentivised to work together?

- 3.1 **The experience from the Vanguard sites suggests that the barriers for scaling up new models of care are not the workforce but transactional issues relating to contracts, organisational accountability and sharing of risk, coupled with lack of time for service development.**
- 3.2 The current payment systems create perverse incentives and act as a barrier to a better use of resources overall – for example, activity-based payment in the acute sector that discourages a shift of care outside of hospital settings.⁴⁶⁶ This is only exacerbated by the current financial circumstances of providers. The bringing together of commissioners and providers into common partnerships (the STPs, devolved authorities) and the efforts to reform funding (towards capitation funding and commissioning for outcomes) offer a major opportunity. However, if these partnerships are principally presiding over cuts to services to balance the books in the short term, they are less able to lead the transformation of the system needed for long-term sustainability.
- 3.3 Community rehabilitation reduces the number of people becoming needlessly disabled and minimises restrictions in their leading active lives. It is essential for people to manage long-term conditions successfully. Teams are multi-disciplinary – integrating care around patient needs, as they move from one sector or setting to another, working in partnership with service-users to achieve the goals that are important to them.
- 3.4 However, too often people might receive intensive rehabilitation in hospital but then have long waits for rehabilitation in the community⁴⁶⁷, if it is available at all. While patients wait their recovery is halted and can reverse – often causing lasting disability and deterioration of health. This impacts terribly on people’s lives and drives up costs in both health and social care.

⁴⁶⁵ Forthcoming submission by health unions to the pay review body for 2017/18

⁴⁶⁶ NHS payment research report, Nuffield Trust 2014

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140220_nhs_payment_research_report.pdf

⁴⁶⁷ The Chartered Society of Physiotherapy. Unpublished data from a freedom of information request on community rehabilitation services. London: The Chartered Society of Physiotherapy: 2016

- 3.5 To stop this, a patient's rehabilitation should be continued from hospital to home. This is both a question of expanding rehab services in the community and integrating them with the rest of out of hospital care (including GPs).
- 3.6 Furthermore the model of access needs to be modernised. Requiring people to either go to see their GP or go back to secondary care for a referral builds in delays and duplication. A modern and more efficient model of care within communities puts more power into the hands of individual service users with long-term conditions to refer themselves to see the right professional at the right time.
- 3.7 Allowing patients direct access to physiotherapy is tried and tested. It cuts costs by up to 25 per cent compared to a GP referral.⁴⁶⁸ It has been evaluated fully and recommended by NICE for musculoskeletal patients, but in spite of this is only available in 3 in 10 CCG areas in England⁴⁶⁹. In trials in 2014/15 it was actively marketed to 10 000 adults registered in the intervention practices. There was no increase in referral to physiotherapy or waiting times and the number of inappropriate referrals was slightly lower among the self-referrers than it was among those referred by the GP.⁴⁷⁰ The Health Select Committee report into primary care recommended a timetable for the implementation of self-referral to physiotherapy as an urgent immediate reform.
- 3.8 There is also undoubted waste and inefficiency caused by duplication of care and delays across health and social care. Local evaluations of integrated approaches show the potential to reduce costs. For example, the NHS Greenwich Integration Pioneer brings together teams of nurses, social workers, occupational therapists and physiotherapists to provide a multidisciplinary response to emergencies they are alerted to within the community at care homes, A&E and through GP surgeries. They handle those that can be dealt with through treatment at home or through short-term residential care. In two and a half years over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team; there were no delayed discharges for patients over 65 and over £1m was saved from the social care budget.⁴⁷¹
- 3.9 However, evidence from integration initiatives overall suggests that integration may not achieve short-term savings. On the contrary, the experience of CSP members suggests that the current pressures to achieve efficiencies and squeezing of budgets is undermining the success of integration. The March 2016 survey of CSP members found that 75 per cent of members agreed that lack of funding was a barrier to

⁴⁶⁸ Holdsworth L, Webster V, McFadyen A. What are the costs to NHS Scotland of self-referral to physiotherapy? Results of a national trial. *Physiotherapy*. 2007;93(1):3-11.

⁴⁶⁹ Chartered Society of Physiotherapy. *Physio Works: self-referral*. London: Chartered Society of Physiotherapy. 2015. URL: <http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works/self-referral>

⁴⁷⁰ Keele University 2014/15. Awaiting publication

⁴⁷¹ Department of Health. *Integration pioneers leading the way for health and care reform*. 2013. URL: <https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2>

successful integration. Their experience echoes the evaluation of the Better Care Fund by the Public Accounts Committee in 2015.⁴⁷²

- 3.11 In the long term, care costs may be reduced (or at least the rise in care costs mitigated) if the health and care system was better able to support patients and carers to be more actively involved in their care and reducing levels of need.⁴⁷³ This requires an approach to integration that goes beyond integration at the level of organisations and an approach to care that goes beyond the limited medical model that dominates the health system.
- 3.12 The CSP is concerned that there has been a narrowing of focus in the implementation of integration policies as a means of achieving short-term savings. As well as doubting this as a means to save money, our concern is that decoupling integration from the longer-term goals on quality and the transformation agenda for long-term sustainability serves to undermine these aims. Successful integration requires a significant investment of time and resources in IT systems, system changes, cultural change, developmental work to provide services in different ways and the training and education of the workforce.

4. Prevention and public engagement

How can people be motivated to take greater responsibility for their own health? How can people be kept healthier for longer?

- 4.1 **Motivating people to take greater responsibility for their health requires a shift in all our thinking about what health and care services should be prioritised and how they should be delivered. The NHS is dominated by a narrow medical view that looks at illness as single events, often in isolation from the context of an individual's life. Given this, it is not surprising that the public too view their health as isolated issues that need to be 'fixed' by the professionals.**
- 4.2 Medical intervention and advances are of course vital. But far more attention needs to be given to those services that support, rehabilitate, prevent and educate people to manage conditions and lead healthy lives, and support carers to do the vitally important work that they already do. This is currently not the case for most areas.
- 4.3 Furthermore, the traditional approach in social care has been to manage and support the existing mental and physical condition of services users. What is required is a far more rehabilitative and preventative approach to care that empowers and enables people to manage themselves, and maximises their abilities to do so.

⁴⁷² Planning for the Better Care Fund report, Public Accounts Committee 2015
<http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news/report-planning-for-the-better-care-fund>

⁴⁷³ Hibbard JH, Peters E, Dixon A, Tusler M. Consumer competencies and the use of comparative quality information: it isn't just about literacy. *Med Care Res Rev.* US: Sage Periodicals Press. Aug 2007; 64(4):379-94.

- 4.4 Falls prevention is a good example of preventative health care services. Half of all people who suffer a hip fracture are left with a permanent disability and can no longer live independently. Group exercise programmes reduce falls by 29 per cent and individual exercise programmes by 32 per cent. Every year 160 000 serious falls would be prevented if everyone 65+ at risk of falling was referred to physiotherapy, which would save the NHS £252 million.
- 4.5 There are many excellent services that empower service-users and build social capital by reconnecting with communities. For example, the Hope Specialist Service in Grimsby is part of social enterprise, Care Plus, and provides rehab programmes and support for patients with COPD and older people at risk of falls. The team is made up of physiotherapists, occupational therapists, generic technical instructors, rehabilitation assistants and 80 volunteers – made up of former patients and carers, who act as motivators, role models and community educators. When the service was established it took over Hope Street Medical Centre, a GP surgery in an area of high deprivation. The centre was run down and used to be a target for vandalism - costing £3500 every month. Using Neighbourhood Renewal Funding, they turned it into a modern rehab centre. Since then they have raised money locally to develop a gym, outdoor exercise facilities, a garden and a café – with gardening forming part of people’s rehabilitation and produce from the garden is used in the café. In order to fundraise, they established a charity The Hope Street Trust, with volunteers on the board. Results from the service include: One hospital admission prevented per patient on the 8-week programme – saving £2600 per patient; hip fractures have been substantially reduced; volunteer led smoking cessation courses have a 62 per cent higher quit rate than the national average; patients report significantly reduced levels of anxiety and depression with higher confidence and ability to undertake daily activity; and a valued community asset has been created
- 4.6 Furthermore, a new public consensus needs to be built around what a modern, sustainable health service could look like, the role of the public and the unpaid workforce in this and the relationship between service users, communities and service providers. Services like Hope have a great deal to tell us about how we can go about this.
- 4.7 However, building this consensus is dependent on the public being able to trust that the NHS is going to continue to be free at the point of need and that adequate funding of health out of general taxation will continue to be a priority for whoever is in government.

5. Digitisation, big data and informatics

How can new technology be used to ensure sustainability of the NHS?

- 5.1 A major barrier to integration at a service level is the lack of investment in technology and systems to provide seamless shared access, communication across boundaries, in a common language with shared standards. This is required for example for booking and record keeping systems. The March 2016 CSP member survey found that 85% per cent of CSP members agreed that different IT systems are

a barrier to integration in their experience. One member in the South West summed this up: *“Fundamentally our IT services are all completely different: The acute trust, community trust, social services, mental health trust and GP practices all have systems that don't talk to each other. This wastes so much time, effort and money!”*

- 5.2 Digital technology has a rapidly increasing role to play in supporting people to self-manage conditions and motivate behaviour change, as well as modernising how patients access services. AHP Suffolk, a social enterprise, has run a successful self-referral service in primary care for the past seven years. It has driven down waiting times to 1-2 weeks for most patients and reduced secondary care referral rates by 20 per cent. Central to its success is an online portal, which 85 per cent of patients use to self-refer. This has significantly increased capacity by reducing triaging time by the physiotherapist to three minutes and freeing up time at the first appointment. It scores 97 per cent on the friends and family test and 88 per cent on patient satisfaction. West Suffolk CCG is now working with AHP Suffolk to pilot GP Physiotherapists in two GP surgeries, with a view to rolling this out to 22, in order to reduce orthopaedic referrals and save GP time. After consulting with patients, the service has gone further in using digital technology to support self-management by developing an exercise app. As well as receiving a tailored exercise sheet, patients will receive a video on their handheld device that shows how to do their exercises, sends reminders and invites them to record what they have done. The results are automatically put on their records. The purpose of the app is to reduce the number of appointments patients need and help people to get better quicker.

22 September 2016

Professor Kath Checkland - Written evidence (NHS0022)

Demand Management: notes for House of Lords Select Committee on the Long Term Sustainability of the NHS

Thank you for giving me the opportunity to give evidence. This note provides a summary of my testimony before the committee. I have included at the end a list of references with links to the source documents. I have also supplied to the Clerk to the committee with copies of the key texts.

1. The Committee asked about the **difference between demand management and rationing**. My understanding of this is that demand management represents attempts to influence levels of need or want for care in the population, whilst rationing represents control of the supply of care. Whilst the two are clearly linked, they are not the same.
2. The Committee asked about **perceptions of a failure of the NHS to successfully manage demand**. It is my belief that expectations of demand management have probably been too high. Research evidence suggests that many of the assumptions underlying demand management initiatives – that care outside hospital is cheaper, for example, or that integration saves money – are rarely borne out when tested. Thus, for example, evaluation of so-called ‘hospital at home’ schemes which put in place intensive home support to keep people out of hospital have been shown to be acceptable to patients, but not necessarily cheaper than hospital alternatives (Munton, Martin et al. 2011).
3. There are a number of ways in which demand might be managed. These include:
 - **Better prevention of ill health**. The evidence suggests that, whilst many preventative initiatives are cost effective, and are desirable in themselves, only a small proportion reduce costs overall (Owen, Morgan et al. 2012). In part this is because successful prevention only postpones death, and NHS costs are driven as much by proximity to death as they are by age; lifetime NHS costs for individuals will only be reduced if ill health at the end of life is experienced for a short time. In addition, monetary gains from preventative interventions will tend to accrue to other budgets, such as reducing welfare payments and increasing taxation income, rather than providing payback to the NHS. A report for NHS Scotland (copy attached) (Craig 2014) looked at the most cost effective preventative measures, and concluded that prevention should focus upon reducing income inequalities, increasing secure employment, providing early years interventions and taxing unhealthy behaviours.
 - **Improving citizens’ ability to manage their own health**. Most of the evidence in this area comes from studies of self-management for those suffering from long term conditions. Evidence suggests that such programmes can improve

quality of life, but only in a small number of conditions can they reduce use of hospital services (Panagioti, Richardson et al. 2014). Thus, better self-management by patients with respiratory diseases (such as COPD) seems to be associated with reduced rates of hospital admission. There are few studies which focus on the more general empowerment of individuals to manage their own health. A recent review by Prof Ray Pawson from Leeds University (copy attached) highlights that fact that empowered citizens may increase or reduce their use of services (Pawson, Greenhalgh et al. 2016).

- **Ensuring that those using NHS services are treated in the right place and that the care they receive is appropriate.** There is a general assumption that care provided outside hospitals will be cheaper than that in hospital. However, research evidence suggests that this is not necessarily the case. It is particularly difficult to measure this, because there is so little good data available about either the cost or volume of services provided by community nursing services, and we have little or no data about who is receiving privately funded social care. There are a number of high quality evidence reviews which look at these topics. Examples include: reviews of schemes to reduce referrals to hospital by GPs (Pawson, Greenhalgh et al. 2016); reviews of schemes to move outpatient services into the community (Winpenny, Miani et al. 2016); reviews of schemes to reduce emergency admissions to hospital (Munton, Martin et al. 2011, Purdy, Paranjothy et al. 2012); and reviews of integrated care initiatives (Nolte and Pitchforth 2014). **In general all of these reviews reveal a paucity of high quality studies of the potential for cost savings. Initiatives may improve outcomes, or may be cost effective, but few have been shown to reduce overall demand or costs.** Integrating between health and social care has not been shown to reduce overall demand for services or costs, although it is likely to improve patient experience. Multidisciplinary case management of high risk patients in particular has been shown not to reduce hospital admissions (Stokes, Panagioti et al. 2015). Our own research suggests that the provision of extended hours of services in general practice can reduce attendance at Emergency Departments, but the cost of the intervention was high, and cost-effectiveness was not examined (Whittaker et al 2016)

4. **Changing the skill mix of frontline staff** is sometimes suggested as a means of reducing overall costs, by ensuring that patients with less complex problems are seen by less highly qualified (and therefore cheaper) staff. The best evidence about this comes from work done by Sibbald et al (Sibbald, Bojke et al. 2003), which showed that nurses in primary care can provide high quality care and are acceptable to patients. However, they do not reduce costs overall because nurses take longer to carry out the same tasks. Study of NHS Walk-in Centres reinforced this finding, suggesting that nurses in Walk-in Centres could safely manage minor illness, but they took considerably longer than GPs (Salisbury, Chalder et al. 2002). In addition, there is some evidence that telephone triage of those seeking care may be more cost-effective if done by more well-qualified staff (Campbell, Fletcher et al. 2014)

5. Some studies of approaches to demand management, in particular those seeking to **support GPs to manage patients without referring them to hospital**, suggest that priority should be given to relationships and continuity of care, allowing appropriate care to be negotiated between patients and doctors, and between primary and secondary care staff who know and trust one another. Structural integration is thus likely to be less important than functional integration, in which communication between all those involved in a patient's care is prioritised (Pawson, Greenhalgh et al. 2016).

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12 September 2016

Children and Young People's Mental Health Coalition – Written evidence (NHS0058)

Summary

- Preventative approaches represent best value for money. Strong economic and moral case for investing in these approaches for both mental and physical health
 - Requires a fundamental shift from an illness to a wellness mind-set, with significantly more financial and workforce resource given to prevention.
 - Essential to have a whole systems approach at both national and local level. At national level we need joined-up, evidence based and values based approach to preventing ill health, especially mental health. At local level, we want to see all partners working together to plan and implement this policy in a way that meets local needs.
 - Essential to ensure parity between physical and mental health. The cost of not fully addressing children and young people's mental health is destroyed lives, wasted opportunities and a diminished society.
 - Increase taxation on products and services where the evidence suggests a negative impact on children and young people's health and wellbeing, and invest in preventative approaches
 - There is a recruitment and retention crisis regarding the NHS mental health workforce - especially in children and young people's mental health
 - We need a shift in thinking regarding the workforce. It is essential we utilise the skills of the voluntary and community sector, and also other agencies such as schools.
 - Essential that citizens, including children and young people are more health literate and responsible for their own health
1. The Children and Young People's Mental Health Coalition (CYPMHC) brings together over 100 leading organisations from across England, to campaign on behalf of and with children and young people to effect change in policy and practice that will improve their mental health and wellbeing.
 2. **The future healthcare system**
 - 2.1. As a Coalition we strongly believe that the key to unlocking a sustainable NHS is working in partnership with young people, who are the future – including the future workforce. This needs to be part of a whole systems approach, at both national and local level, which includes health and social care, and the education sector.
 - 2.2. Investing in a preventative approach– for both physical and mental health is in everyone's best interest. There are many good reasons for why this is important, especially for mental health. For instance, according to the World Health Organisation, depression is likely to be the leading global burden of disease by

2030.⁴⁷⁴ The impact on the individual and their family is immense; but specialist mental health services are expensive. So preventative approaches represent best value and value for money because it enables people to flourish and have healthier and more productive lives, and have less need of specialist services. For instance, investment in health literacy from early childhood would result in the next generation being better able to self-manage their own health, and be primed to become a valuable informed future health and social workforce. This can result in improved sense of self-worth and self-esteem, leading to improved well-being, resilience and mental health across the population.

3. Resource issues, including funding, productivity and demand management

- 3.1. The CYPMHC suggests increased taxation on products and services where the evidence suggests a negative impact on children and young people's health and wellbeing e.g. alcohol, cigarettes, fatty food, sugary drinks etc. This could be used to help fund a preventative approach.
- 3.2. The CYPMHC is firmly opposed to anything other than free at the point of use. Wherever a means test is drawn this will lead to a major fear and concern in young families that they will be unable to afford treatment for their children, or to remain healthy to care for their children.

4. Workforce, especially supply, retention and skills

- 4.1. The CYPMHC has specific and serious concerns about the current challenges in recruitment into the mental health workforce, especially in children and young people's mental health. We are having a recruitment problem at the same time as an increase in the number of the NHS mental health workforce leaving the NHS⁴⁷⁵⁴⁷⁶. This is unsustainable.
- 4.2. We pose the question are we bringing the right young people into the medical profession to match population based needs? We need more primary care prevention and support for long-term conditions including children and young people with complex needs, learning disabilities, neurodevelopmental needs and early onset serious mental illness. Is the current workforce equipped for this?
- 4.3. We need a shift in mind-set which goes across the board, so every citizen including young people are part of the health workforce e.g. being more health literate and more responsible for their own health. It is also essential to utilise the skills of the voluntary and community sector (VCS) and ensure they become a more integrated and respected part of the workforce. Education also has a role to play. Teachers are often the first person young people turn to regarding health issues, especially mental health. With the right training and support, school staff, can be a valuable part of the primary prevention workforce and be able to identify and signpost pupils who may have health issues. This is particularly valuable for mental health issues.

⁴⁷⁴ World Health Organisation (2012) Depression: a global crisis.

http://www.who.int/mental_health/management/depression/wfmh_paper_depression_wmhd_2012.pdf

⁴⁷⁵ BBC (2016) <http://www.bbc.co.uk/news/health-35667939>

⁴⁷⁶ Henfrey, H. (2015) Psychiatry – recruitment crisis or opportunity for change? <http://bjp.rcpsych.org/content/207/1/1>

5. Models of service delivery and integration

- 5.1. The CYPMHC's work which reviewed joint strategic needs assessments (JSNAs)⁴⁷⁷, and local transformation plans (LTPs) for children and young people's mental health, highlighted the importance of understanding the needs of any given community as a starting point and engaging with children and young people. It is essential that local agencies come together to jointly plan how to transform services in order to provide the full spectrum of services needed to promote mental health and also support those with mental health problems.
- 5.2. We are concerned about how strongly children and young people's mental health will be incorporated into wider Sustainability and Transformation Plans (STPs). The fear is that the needs of this group of people, most of whom can't vote, will be lost in this wider plan. Lobbying and campaigning organisations such as ourselves need to have data on these plans so we can be a constructive critical friend to both local and central government.
- 5.3. It is essential that schools are included in the local transformation of the child and adolescent mental health system. As mentioned above, schools have a key role to play in prevention and early intervention, but currently, schools are often not included as a key partner. National policy regarding children and young people's mental health, 'Future in Mind', highlights schools as being a key partner, but the reality is often quite different.⁴⁷⁸ So we need a new model that brings together all key partners, both at national and local level. At national level, we need to see a cross government, evidence based and values based approach to preventing ill health, especially mental ill health, with Department of Health working with Department for Education etc. At local level, we want to see all relevant partners working together to plan and implement this policy in a way that meets the needs of their local population.
- 5.4. Values based learning and practice, (which refers to understanding and embracing different value systems) is the only way likely to deliver sustained collaborative working, and make local communities real partners. It is essential to grow social scaffolding across local communities in order to deliver healthy group behaviours, so citizens including young people and the workforce have a sense of meaning, purpose and identify in their lives. The alternative is what we often have now, which are toxic social identities which come about because of a lack of support to local communities and the health workforce.
- 5.5. Young people with mental illness live their lives in the community, rather than in hospital. Hospitals for all of health care should be places of last resort to restore health and allow recovery in the community, or as a centre for specialist procedures. Where hospital care is needed for children and young people with mental illness, the links to home and community, education and peers should be maintained to aid the step down care required following being hospitalised. So

⁴⁷⁷ Children and Young People's Mental Health Coalition (2013) Overlooked and forgotten.

<http://www.cypmhc.org.uk/resources/overlooked-and-forgotten-review-how-well-children-and-young-peoples-mental-health-being>

⁴⁷⁸ Department of Health & NHS England (2015) Future in Mind. <https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>

hospitals have their place, but need to be part of the whole system of care, and be a last resort.

- 5.6. There is legislation regarding parity of esteem between mental health and physical health, but the CYPMHC is concerned about the progress, especially with regards to children and young people's mental health.⁴⁷⁹ The cost of not fully addressing the mental health of children and young people is destroyed lives, wasted opportunities and a diminished society.
- 5.7. When austerity hits, we know that mental health services are unfortunately still an easy target for cuts and can rapidly drop down the priority lists for CCGs. In recent years, we know that child and adolescent mental health services saw cuts to budgets and services, which resulted in children and young people with mental health needs, not getting the help required. This would not be allowed to happen if it was cancer. These cuts resulted in a crisis in these services, which triggered a Health Select Committee review,⁴⁸⁰ a review of tier 4 inpatient beds,⁴⁸¹ and for the then Coalition Government to form a taskforce, which produced their current policy document Future in Mind⁴⁸².
- 5.8. Despite all of this, and announcements of additional funding, we still hear frontline services say that they are not receiving the money from CCGs. Very recently the Public Accounts Committee stated that parity of esteem between mental and physical health is a laudable ambition, but pressures in the NHS budget make it difficult to achieve.⁴⁸³ This was backed up by data from the Labour Party which suggests that CCGs are diverting money away from mental health to plug holes in funding in acute services.⁴⁸⁴ NHS Providers and the NHS Confederation have reported similar findings.^{485 486}
- 5.9. We still hear that some children and young people are not able to access mental health services when they need it. Not providing support when needed is likely to result in problem which could be effectively addressed, becoming chronic and enduring problems that continue into adulthood. We know that about 75% of adult mental health problems have their roots in childhood; and having mental health issues results in outcomes such as poor physical health, more likely to have poor education, lower paid jobs, problems with relationships, if in work, more likely to be on sick leave etc.⁴⁸⁷

⁴⁷⁹ Health and Social Care Act 2012 - <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

⁴⁸⁰ House of Common Health Committee (2014)

<http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf>

⁴⁸¹ NHS England (2014) Child and adolescent mental health services tier 4 report. <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

⁴⁸² CAMHS Taskforce reports (2014) <https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>

⁴⁸³ Public Accounts Committee (2016) Improving access to mental health services.

http://www.publications.parliament.uk/pa/cm201617/cmselect/cmpublicacc/80/80.pdf?utm_source=80&utm_medium=module&utm_campaign=modulereports

⁴⁸⁴ Berger, Luciana (2016) How much longer will the Government's betrayal of mental health continue. Huffington Post.

http://www.huffingtonpost.co.uk/luciana-berger/mental-health-spending_b_12132886.html

⁴⁸⁵ NHS providers (2016) Funding mental health at local level: unpicking the variation.

<https://www.nhsproviders.org/resource-library/reports/funding-mental-health-at-local-level-unpicking-the-variation>

⁴⁸⁶ NHS Confederation (2016) Mental health funding not reaching frontline services.

<http://www.nhsconfed.org/news/2016/05/survey-finds-mental-health-funding-not-reaching-frontline-staff>

⁴⁸⁷ Chief Medical Officer (2013) Annual report of the Chief Medical Officer 2012: Our children deserve better: prevention pays.

- 5.10. There is an economic argument as well. The Centre for Mental Health found that there are measurable economic benefits to providing evidence based interventions. For instance, group parenting programmes for conduct disorder in young children accrues at least £3 for every £1 invested; and group behavioural therapy for anxiety in adolescence accrues £31 for every £1 invested.⁴⁸⁸ So ensuring that existing legislation is adhered to would help reduce costs and make the NHS more sustainable by not creating health problems which require specialist services.
- 5.11. This applies across both clinical and academic psychiatry. There is less investment mental health research.⁴⁸⁹ For instance, why has so little investment in genomics been focused on mental illness in young people? Investment in the epigenetics of young people with early onset psychosis would enable doctors to work with young people to choose wisely regarding their use of medication combined with psychological interventions. Epigenetics would help by informing us which young people would experience the most toxic side effects, leading to weight gain, diabetes, heart disease which is likely to shorten their lives. We ask that funding for children and young people's mental health is significantly increased as a matter of priority, and in accordance with the legislation on parity of esteem; but also as an investment that would rapidly delivery cost savings.

6. Prevention and public engagement

- 6.1. The health service, in its present state, can best be described as a 'crisis junkie'. Investing in youth in all senses would lead to informed citizens, better able to choose wisely about their health care through shared decision making. Key to this is how we deliver health education to all children and young people, but also how we educate and train medical students to embrace and see it as their duty of care to participate in shared decision making. Rather than thinking what can I do, but rather what should I do in partnership with my patient, however young that patient may be.
- 6.2. It truly beggars belief the meagre amount of financial and workforce resource we give to prevention in the early years, in order to provide real place based health. Unless we make a fundamental shift from an illness to a wellness mind-set, the future of the NHS is unsustainable as is any other hybrid self-part payment system.
- 6.3. HealthWatch are a vital part of public engagement and have told the CYPMHC that the public priority is children and young people's mental health. Are we bold and positive enough to start a national conversation about what a health service is there for, led by young people? Can we have an honest conversation about our current dilemma? An open all hour's system where we have not had the conversation with the 'customer' about each part of the system and when it is open, how to access it and what outcomes should you expect. So there needs to be a discussion about what is a realistic 'offer' and what is the contract between public and professionals.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255237/2901304_CMO_complete_low_res_accessible.pdf

⁴⁸⁸ Centre for Mental Health (2015) Investing in children's mental health.

<https://www.centreformentalhealth.org.uk/investing-in-childrens-mental-health>

⁴⁸⁹ Crossman, S. (2015) Why are we failing to fund mental health research. http://www.huffingtonpost.co.uk/sam-crossman/mental-health-research-funding_b_7827792.html

7. Digitisation of services, Big Data and informatics

- 7.1. Young people would and do embrace these new technologies. But new technologies need to be understood in the context of the whole pathway of care into which they should be safely embedded.
- 7.2. Young people understand the significance of big data and could be ambassadors about why this matters.
- 7.3. Children and young people are receiving education about IT and understanding data and statistical evidence. Education and training of medical students and in particular life-long learning for 'trained' professionals is lagging behind.

Appendix

Work of the Children and Young People's Mental Health Coalition – www.cypmhc.org.uk

The Children and Young People's Mental Health Coalition campaigns to ensure children and young people are happier, healthier and more confident about their future. Following is a summary of our work:

- Co-sponsor of Values Based Children and Young People's Mental Health System Commission (Due to be published in November)
- Developing 3 key principles required to improve children and young people's mental health within schools (In progress)
- Reviewing local transformation plans for children and young people's mental health to assess how effectively they are involving schools (In progress)
- Involved in development and writing of Government policy document, Future in Mind
- Developed a framework to help schools implement a whole school approach to promoting mental health and wellbeing in schools - <http://www.cypmhc.org.uk/schools>
- Regularly write blogs including Huffington Post Blogs - <http://www.huffingtonpost.co.uk/author/prof-dame-sue-bailey>
- Reviewed Joint Strategic Needs Assessments to assess priority given to children's mental health - <http://www.cypmhc.org.uk/resources/overlooked-and-forgotten-review-how-well-children-and-young-peoples-mental-health-being>
- Resilience and Results – guidance for schools about importance of promoting children and young people's mental health - <http://www.cypmhc.org.uk/resources/resilience-and-results-how-improve-emotional-and-mental-wellbeing-children-and-young>
- Influence policy via our campaigning and lobbying work – successfully encouraged Government to commission a new children and young people's mental health survey.
- Critical friend to Government and policy makers to be helpful, but also highlight problems.

22 September 2016

The Christie NHS Foundation Trust – Written evidence (NHS0157)

Questions	Comments
<p>1. Taking into account medical innovation, demographic changes and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?</p>	<p>NHS Wide:</p> <ol style="list-style-type: none"> 1. Greater involvement of patients and their carers in managing long term care at home will be essential. Ensuring they have practical and rapidly responding support for daily living requires strong relationships between all sectors, communicating with each other to provide a seamless service – this is not new but not all areas have such a cohesive approach nor is it applied consistently across the country. 2. 24 hour access to support will give assurance and confidence to people living at home that they can cope but back up is rapidly available. Care for people dying at home – making this the assumed placed and transfer into hospital / hospice being regarded as the exception. 3. For routine care, enabling patients to ring up and talk to a doctor / nurse rather than attend appointments should be more available. <p>For cancer care:</p> <ol style="list-style-type: none"> 4. Although prevention strategies are key to the improvement in public health and health care financial sustainability it is inevitable that cancer incidence will increase as the age profile of the population changes. Not only will more people require treatment but due to improvements in earlier diagnosis and treatments greater numbers of patients are living longer with and beyond cancer. Many require on-going further care to live with the consequences of the cancer and the associated treatment. Indeed those that have been treated with cancer are more likely to have further cancer episodes. 5. To ensure the very best of care continues to be delivered within the context of greater numbers of patients, cancer care needs to utilise a hub and spoke model where highly specialist care is delivered at nominated centres and relatively standard care is delivered at local sites under the clinical governance of the specialist centres. This will provide necessary facilities to specialist centres to deliver the most complex of care whilst

	<p>providing the support required for local providers to deliver relatively simpler treatments closer to the patients’ home. The Christie employs this approach in many services already across Greater Manchester but it is anticipated that this approach should be further expanded across wider geographies for some therapies.</p> <p>6. Funding mechanisms must adapt to allow and indeed promote this wider engagement.</p> <p>7. Furthermore, reconfiguration of screening and diagnostic services across areas to ensure consistency of quality of care, aligned within very clear clinical pathways overseen by cancer pathway boards across wide geographic areas will ensure that the appropriate resources will be put in the right place. Buy-in of Trusts within reconfiguration will need to be mandated to ensure that services are provided to deliver the best efficient care to patients and not in the interests of Trusts’ finances. This will require some form of independence to ensure the process is fair and is seen to be fair.</p>
<p>2. To what extent is the current funding envelope for the NHS realistic?</p> <p>a. Does the wider societal value of the healthcare system exceed its monetary cost?</p> <p>b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might</p>	<p>8. Every day we experience the warmth of the public’s view towards the NHS, and indeed The Christie is strongly supported within the community through the Christie Charity. Because of the excellent care we provide, and the number of people across Greater Manchester that have some relationship with The Christie we are the second largest hospital trust charity in the country. The experience of The Christie would suggest that people do value the care provided in excess of the monetary value of the care, but we recognise that cancer is highly emotive and other parts of the NHS may not be so strongly supported.</p> <p>9. Some form of capitation is required to enable those managing the whole care pathway to allocate funding to the right place. Each locality needs a commissioner with responsibility for the whole pathway.</p>

<p>best be spent?</p> <p>c. What is the scope for changes to current funding streams such as hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxed and expansion on co-payments (with agreed exceptions)?</p> <p>d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means tested basis, or could continuing care be made means tested with a Dilnot style cap?</p>	<p>10. Explicit tax amounts of everyone’s tax should be identified as being spend on NHS – this will hopefully encourage people to understand the costs associated with the NHS and promote efficiency within the NHS. Rather than co-payments there could be some approach of publicising how much each drug / procedure cost. This might get people to better understand the cost of their treatment and value it more, better taking care to ensure the prescribed treatments are follow more thoroughly. Funding though, in our opinion come from general taxes, as we need everyone to feel they have contributed to the NHS to continue to feel ownership of this national organisation.</p> <p>Sin taxes should be in place to reduce demand for alcohol and cigarettes but the NHS funding should not be directly linked to this income; this could promote a sense of entitlement of some over others due to the additional resources drinkers and smokers have put into the health service over time.</p> <p>11. There are already a number of procedures that are no longer funded by the NHS and others identified as being of limited clinical value. A public debate on the priorities for funding in the NHS is needed.</p>
<p>3. What are the requirements of the future workforce going to be and how can supply of key groups of healthcare workers such as doctors, nurses and other healthcare professionals and staff be optimised for the long term</p>	<p>12. The workforce will need to be multi skilled, flexible able to work across different boundaries both internally and externally, as we move towards an integrated health and social care model of services.</p> <p>13. Patient led care will be a focus, to ensure we are representative of the communities we serve and able to shift capacity from the hospital into the community and primary care services.</p> <p>14. This could impact on reducing the number of specialist roles to create generic roles that</p>

<p>needs of the NHS?</p> <p>a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?</p> <p>b. What effect will leaving the European Union have on the continued supply of healthcare workers from overseas?</p> <p>c. What are the retention issues for key groups of healthcare workers and how should these be addressed?</p> <p>4. How can the UK ensures its health and social care workforce is sufficiently and appropriately trained?</p> <p>a. What changes such as the use of new technologies can be made to increase the agility of the health and social care workforce?</p> <p>b. What are the cost implications of moving towards a workforce that</p>	<p>can work across boundaries, and to develop a service that focuses on self-directed care and patient centred planning. In addition, requirements around 7 day services will impact on the future workforce. Improved management of systems and use of technology including Health Roster and Job Planning software will enable this.</p> <p>15. We need to focus on ensuring the models of care are adapted to meet future challenges relating to changing healthcare needs, the demographic future of the workforce within the UK and Greater Manchester and the forecasted numbers of qualifying staff.</p> <p>16. There will be a requirement to succession plan and enable internal talent, to grow our own experts. This will involve best use of apprenticeship levy, working closer with higher education providers to create new training roles and higher advanced level apprenticeships that suit new models of care, for example the nursing Associate role. There may be a requirement to develop overseas schemes like our MTI scheme. However, the impact of the external political environment could result in the UK being a less attractive option for work. It will be essential that our recruitment is more strategic to attract world class talent.</p> <p>17. There is a need to develop career pathways for professional groups, expand the use of health professionals such as pharmacists and physiotherapists for assessment and treatment and establish methods to increase our development and use of non-medical prescribers.</p> <p>18. It is key to therefore focus on strategic recruitment to ensure appointments are made on technical expertise, potential for development and the values and behaviours of our workforce to enable leadership at every level.</p> <p>19. We must ensure our workforce are developed to maximise their potential to enhance to perform excellently, within a changing environment by offering development opportunities that are rewarding for staff as well as enabling the progression of the organisation. Structured management of our talent will require more flexible approaches to recruitment and will enable more strategic planning.</p> <p>20. It is necessary to carry out a training needs analysis across the organisation to understand the develop requirements of our workforce and to capitalise on training options.</p> <p>21. We must therefore also focus on ensuring engagement from our workforce and ensuring</p>
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<p>is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?</p> <p>c. What investment model would most speedily enhance and stabilise the workforce?</p>	<p>that they are healthy and well. Some key challenges will include the implementation of the junior doctor contract and retaining high performing staff. Improved total reward systems will need to be considered. Effective planning and new models of care will also support the sustainability of service, acknowledging the forecasted retention of staff owing to their demographics and large numbers potentially approaching retirement or the desire for flexible retirement.</p> <p>22. Sharing of common workforce systems and taking advantage of best practice, economies of scale and</p> <p>23. IT systems integration with partner organisations will enable greater efficiencies and consistent approaches to healthcare.</p>
<p>8. How can new technologies be used to ensure the sustainability of the NHS?</p> <p>a. What is the role of technology such as telecare and telehealth, workable technologies and genetic and genomedicine in reducing costs and managing demand</p> <p>b. What is the role of “Big Data” in reducing costs and managing demand?</p> <p>c. What are the barriers to industrial</p>	<p>24. The question isn't framed properly in our view. Technology is a tool - it is the change of how we deliver healthcare and application of technology to assist in this change. Technology investment is not a silver bullet.</p> <p>25. Telehealth definitely has a place. It provides savings and better patient experience. As home/remote diagnostics capability becomes more feasible (i.e. cost), then it will play a very important part. Specific wearable technology advice should be clinically led but the technology to move the information between the patient and health providers securely exists today. Genomics is a clinical question not technical.</p> <p>26. Immensely important. We have to leverage the data to understand existing clinical outcomes, which in turn inform change of clinical practice to improve. Data currently sits in silos (providers or worse, vendor locked in clinical systems within providers) and the scaremongering about data sharing and ownership is the main blocker to leveraging this incredibly valuable information. Evidence based change off the back of big data is essential for improved patient outcomes and targeting preventative healthy lifestyle programmes.</p> <p>27. Financial, security, political (provider silo's 'owning' the data, software vendors locking</p>

<p>role out of new technologies and the use of “Big Data”?</p> <p>d. How can health care providers be incentivised to take up new technologies?</p> <p>e. Where is investment in technology and informatics most needed?</p>	<p>data within their systems or not opening sharing) and managing the national message. Citizens share inordinate amounts of personal information daily through use of technology and financial services, however the thought of sharing data for improving clinical outcomes is seen as selling patient information to private sector for gain. The perception of the 'sell' to the public is the biggest challenge in our view but in reality people will be prepared to do it as long as the benefits are clearly defined.</p> <p>28. Pushing funding via providers instead of locality based approaches results in silo'ed solutions. The investment should be strategically planned across provider boundaries to ensure more integrated solutions and less duplication in the system. Benchmarking capability via Digital Maturity and targeted investment to benefit the population centres would be more cost efficient and replicable across the NHS.</p> <p>29. This is a case by case basis and although a simple answer is requested, the landscape across the NHS is incredibly fractured and no one answer is appropriate. The main challenge is the CIOs generally have very defined role within their organisation and therefore the coordination of IT across providers is not always delivered; there needs to be direction provided at a health economy level.</p>
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23 September 2016

Dr Stephen Clay – Written evidence (NHS0151)

My name is Dr Stephen Clay. I am writing this submission as an individual GP; however, I currently educate Primary Care teams in how to improve patient care by improving their productivity. In particular I specialise in helping practices improve access. Previously I was The Clinical Chair of the Improvement Foundation for the East Midlands and I was the Primary Care Advisor to the Strategic Health Authority NHS East Midlands. I will primarily concentrate my evidence on Primary Care though many of the ideas and innovations are equally applicable to secondary care services.

The future healthcare system

1. The longevity of the NHS and its resources are utterly dependent on the existence of a highly efficient, cost effective Primary Care Service.
 - a. Primary Health Care works best in teams. Each team needs a leader. In most cases the most appropriate leader is the most experienced and highly trained clinician, the GP.
 - b. Demographic changes will predominantly result in older people with more long term conditions. Whilst GPs are needed for complicated scenarios and exacerbations, most long term condition care can be managed by other members of the team e.g. nurse practitioners, physicians' assistants. The problem is that there aren't enough of them and so practices constantly poach them from one-another, driving up costs. Many of the ones that are there are nearing retirement. **Currently in the UK there are no training courses accessible for nurses to train as Practice Nursing unless the nurse is already employed as a practice nurse!** Madness. We need a national Clinical Assistant training programme and a national Practice Nurse training programme that doesn't require a nurse to already have a Practice Nurse job. This will provide a supply of suitably trained staff.
 - c. For years in both Primary and Secondary Care we have spent more and more time and money putting barriers between the patient and the most skilled clinician who can help them with their care. The theory being to 'filter demand' and thereby protect the precious resource that is the clinician. This has cost a huge amount of money and made accessing care harder for patients.

It has now been shown that **the most efficient and cost-effective way to achieve high quality patient care is to put the patient / carer in contact with the most senior clinician as soon as possible** and then let that clinician direct the patient to the most appropriate source of medical or social help be that the clinician them self, another member of the team, the wider medical or social community or just understand how best to care for them self.

Similar beneficial outcomes have been shown in Emergency Departments (EDs) and Acute Medical Units (AMUs). In Primary Care the best person to do that is

the GP. In Secondary care; a consultant. There are a number of examples of how to do this available e.g. Dr First. Such systems allow many more people (around 50%) to be helped in a given period of time and because of the improved access to Primary Care have **reduced ED attendance by ~20%** in those practices where it has been used.

- d. Patients monitoring their own care at home has proven very useful e.g. home blood pressure, peak flow and glucose monitoring. However, just because technology exists does not necessarily mean it should be used. For example, Skype or similar video consultations have a small place in aiding diagnosis in some cases but the widespread use of it has proven little more efficient than the standard face-to-face consultation.
- e. E-mail consultations have a place but can be intrusive to clinicians and cannot generally be used in the acute setting as patients do not have immediate feedback that their issues have been read and dealt with by a senior clinician and the necessary interaction between clinician and patient can be painfully slow compared to oral communication if typed 'live chat' is used.
- f. **The biggest danger to healthcare by 2030 in the UK is the availability of doctors and nurses at an affordable rate.**

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

- a. The most efficient use of resources was in the days of fundholding. Each fundholding practice was given a budget and the software to track its use. We knew how much we had spent, how much was accrued to be spent and the balance of the budget left on a daily basis in real time.

Practices were responsible for negotiating the contracts with the providers and policed the waiting lists knowing exactly how long each patient had been waiting for treatment. Practices knew exactly how much a procedure or outpatient appointment should cost (it showed on their computer every time a referral was made) and could easily claim back money that was inappropriately charged. Payments could be linked directly to the quality of service. Providers competed for work based on quality and cost. Any savings made could be reinvested into the practice to improve patient care.

This way of working was abandoned with the election of the New Labour government; however, a subsequent change of heart saw a more widespread but completely pale imitation of fundholding reinstated. This goes on to today. In real time no-one knows how much a procedure costs and so cannot choose the most cost effective, GPs do not have the software to track individual patient's journey's through the system and be alerted if delays occur. Practices may be told how much they have spent about 9 months later and there is little or no chance of any financial errors ever being corrected and even if it were that money is not available to the

practices to directly re-invest in patient care. The cost of administrating the systems is a complete waste of NHS resources. It is unfit for purpose and should be abandoned immediately with the cost savings reinvested in direct patient care.

b. The best funding model would recognise that the lions-share of patient consultations takes place in primary care and that it has become clear that much of the work currently undertaken in secondary care could be moved to primary care if the resources were available. This will need a considerably larger slice of the budget than the current 8% Primary Care currently receives. We need however, to look at which way of delivering primary care is the most efficient.

If we continue down the current path in Primary Care its costs will rocket. We are about to lose the most cost effective jewel in the crown of the NHS, the GP Partner. This is in part the fault of the GP's themselves and in part the policies of the current and previous governments.

At present Primary Care broadly works like this: The tax payer, via the government, via the NHS gives each Partnership an amount of money for caring for a set number of patients. Additional money can be earned by giving high quality care or additional services (e.g. via QOF and other enhanced services) but in essence the pot is limited. It is then down to the partnership to spend that money wisely on caring for its patients by employing staff.

Until the new contract of 2004, partnerships were the prime way new GP's entered the world of General Practice. After training, most GP's settled down in a partnership and worked their way up to parity over, say, 3 years to dedicate their working lives to a given set of patients becoming 'The Family Doctor' that we all know.

The increased income of the 2004 Primary Care contract encouraged doctors to join practices and Primary Care was seen as a good career path with its improved income and prospects for a portfolio career for those who wanted it. There were plenty of trained GPs about. For Partners the increase did include a sting in its tail; GP partners became the only people who were asked to fund their entire pension contributions (both personal and employer's contributions) from their declared income further distorting perceptions of their pay.

Then two things happened to destabilise the system;

- i) GP partners realised that if they took on salaried doctors rather than other partners they could in-effect earn more themselves because salaried doctors earned money at a set rate and that rate was lower than a normal partnership share of the remaining money left in the partnership after all of the bills were paid. Partnerships became hard to come by and so more young doctors were channelled into being salaried doctors or locums.
- ii) The government then thought better of its generosity toward Primary Care and there was an orchestrated slurring of 'greedy GPs' in the press. The government decided that it would slowly erode the pay increase and

consequently every year since then has seen an reduction of what was left in the Primary Care pot once the ever-increasing costs were taken out until a tipping point was reached when the hourly cost to practices of partners became outweighed by the hourly costs of salaried doctors and locums.

Based on published figures in 2011 the **hourly cost to a practice including all on-costs of a GP partner was ~£47. With that came the full responsibility of maintaining the primary care service of general practice for their registered patients. The hourly cost of a salaried GP was ~£63 with some, but considerably less, responsibility. The hourly cost of a locum was ~£100 with very little responsibility for the running of the practice.** Since then the situation has worsened.

It did not take long for newly qualified GPs to realise where the best income for the least responsibility lay. By the time the partners realised what was happening the die was cast and the number of doctors wanting to become partners fell through the floor. Moreover, those GP's who were partners began to realise the situation and so they have started retiring from partnerships in ever larger numbers. Many become locums or salaried doctors.

As we have already started to see partnerships are folding leaving third parties to pick up those fallen practices. The problem is that there are not enough doctors available to fill the gaps and so the ones that are available can charge more and more for the service they provide; a service which in no way is comparable to that of a partner. We have experienced locums refusing to undertake visits or sign prescriptions amongst many other normal GP partner duties. The equivalent hourly cost of salaried and locum doctors far exceeds that of partners and so, as a nation, we will pay more money for a worse service. The current trend for 'super-practices' does not address this issue; rather it will potentially make it worse.

So how could we incentivise the more cost-effective option of partnerships? The answer lies in the rules and regulations of how the NHS is funded and in particular what a GP can and cannot do for their registered patients. GP partnerships are small businesses. The more they can show their entrepreneurial skills the more they flourish. Examples include primary care computerisation, Read codes and telephone consulting to name a few. Reducing red tape and allowing that entrepreneurial flare will allow future developments to occur naturally.

One specific problem in Primary Care that needs rapidly addressing is premises. The problem is this: previously the NHS specified what was needed as a minimum specification for premises. Doctors would build the premises be it via grants or loans from banks, the new premises would have a market rental value and that rental value was predictable based on the proposed plans. Practices could approach banks who would lend the money based on the predicted income. Then the NHS property rental pot of money was cash limited. Now the situation in many areas of the

country is that even when it has been shown that an area needs improved facilities, NHS England will not agree to pay any increase in rent for the better facilities. Therefore, the banks won't lend the money, Section 106 money cannot be used because of the refusal to pay any increased rental by the NHS on the premises EVER. Partnerships cannot risk building a building that no-one will want to take on as the partners' retire because the rental won't cover the costs of buying in.

This has got to change. **It is unreasonable for the NHS to expect to pay the same rental despite requiring better premises.**

Many services that were once available on the NHS no longer are. An example of this is treatment of 'cosmetic' lesions such as cysts, warts and other skin lesions on the face or other parts of the body. Other services have never been available such as certain vaccinations. Whilst many have the skills to deal with these problems GPs are not allowed to undertake them either on the NHS or privately for their NHS registered patients. Patients find this restriction very upsetting and confusing as the only doctors who are not allowed to treat them are the ones they know the best at their own practice and whom they would prefer to undertake the procedures. Provision of such private work would allow increased income to practices without cost to the tax payer and it is likely that the cost to the patient would be less than private work done elsewhere and certainly more convenient. It could also act as another incentive for GPs to become partners.

c. The NHS delivering free care at the point of service is a precious thing. However we should not confuse need and want.

The budget is finite but everyone should receive a basic level of free service. That should include being able to have access to a GP within the standard hours of the GP contract (Monday to Friday 8:00 am to 6:30pm). In addition everyone should have access to free emergency Primary Care outside of those times 24 hours a day, seven days a week.

d. For those that want routine healthcare services outside of these hours it does not seem unreasonable to allow patients to pay for such services themselves or via their employer. Previously governments have shied away from allowing patients own GPs to charge for services available on the NHS but in fact it would be a way to drive GPs to offer a similar level of service to that described above. If only those GP's that already offered patients an appointment on the day of their choice within the contracted hours were allowed to offer a private convenience service then, given the entrepreneurial skills of GPs, **it would not be long before most GPs were offering the desired quality of NHS service without it costing the NHS a penny.**

We developed **Doctor First** where patients have rapid telephone access to their GP within contracted hours, having spoken to their GP they can then have a face-to-face consultation on the day of their choice (~90% choose the same day) if they wish (even if the doctor doesn't feel it necessary). What we have found over the 12 years we have been running the system is that only about 1/3 of patients choose to have a face-to-face

consultation and, because of the time the system frees up, they can have it on the day of their choice for the time they need. Because the GP books the appointment directly they can accurately judge the length of appointment needed and so reduce their own stress and see patients on time. It is a win-win situation. Studying the effect of this complete meeting of demand has also enabled us to predict how many patients will call for help and want appointments on any given morning or afternoon of the year. That ability to predict means that we can staff surgeries much more appropriately and thereby save money by directly managing supply and demand.

So far we have helped around 300 other practices and enabled CCGs to predict and have an accurate overview of supply and demand of patient need enabling them to plan ahead and be alerted to potential hotspots with the ability to warn EDs. There has been a **~20% reduction in ED attendance** from practices that use this methodology. If all practices in the UK achieved this it would **save the NHS budget about £1billion per annum in ED attendance costs.**

In the 12 years we have run this system I am yet to find a patient from any social class or job that was unable to access our services within standard working hours at their convenience for a non-emergency problem.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

See 1b

There are plenty of Doctors being trained they are just haemorrhaging from the system. Many newly trained doctors do not wish to remain in the NHS and in the UK. The cause of that is manifold but it seems that all of the incentives at present are not to stay working in the NHS. In addition to the poor work-life balance, **the system currently incentivises newly qualified doctors to leave the UK** as to do so means that they do not have to pay back their tuition fees.

Would a sensible option for the tax payer not be to make fees immediately payable if the student leaves the UK (unless on an educational sabbatical) whilst offering to write off of the fees if the doctor remains in the NHS for the first say 10 years of their postgraduate working life?

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

Regulation has gone way beyond the bounds of common sense. It is hugely costly in terms of paying for the regulation directly and in clinical time lost. At a time when both money and clinical time are in such short supply, reducing such things as annual clinical appraisals, CQC regulation, CCG regulation, etc are complete overkill. What we do not need is constant and

repeated assessment of clinicians who are providing a good service with years of experience in procedures.

- a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

The absolute number 1 priority is to make it a condition of supply to the NHS that all computer systems e.g. EMIS Web and System 1 can interchange information. Encourage other companies to enter the market. Do not make the mistake of having a single supplier unless you want costs to rocket.

23 September 2016

Clinical Council for Eye Health Commissioning – Written evidence (NHS0071)

1.1. The Clinical Council for Eye Health Commissioning (CCEHC) welcomes the Select Committee's inquiry into the 'Long-term sustainability of the NHS'.

2. About us

2.1. The CCEHC brings together the leading patient and professional organisations involved in eye health to offer united, evidence-based clinical advice and guidance to commissioners and providers in England on issues where national leadership is needed.

2.2. It consists of the following organisations in the sector:

- Association of Directors of Adult Social Services
- Association of British Dispensing Opticians
- British and Irish Orthoptic Society
- The College of Optometrists
- Faculty of Public Health
- International Glaucoma Association
- Macular Society
- Optical Confederation (including the Local Optical Committee Support Unit)
- Royal College of General Practitioners
- The Royal College of Ophthalmologists
- Royal College of Nursing (ophthalmic section)
- Royal National Institute of Blind People
- VISION 2020 UK

3. Future health care system

3.1 Lack of NHS capacity, compounded by funding constraints, exacerbated by rapidly growing need linked to the ageing population and combined with the impact of new technologies mean that the pressures identified for the period to 2030 as set out in this consultation are in fact already with us in eye health. Anti-VEGF treatment for wet macular degeneration, untreatable a generation ago, now cost an additional £244m⁴⁹⁰ a year alone.

3.2 Eye health services involve many professions and pathways, crossing many organisational boundaries, providing services in clinical, high-street and domiciliary care settings. Fragmentation of commissioning plans based on too small geographical footprints is

⁴⁹⁰ [Health and Social Care Information Centre. Hospital Prescribing England 2013–2014. Health and Social Care Information Centre. 12 November 2014, quoted in](#) The Pharmaceutical Journal, 6/13 December 2014, Vol 293, No 7839/40, online | DOI: 10.1211/PJ.2014.20067182.

leading to fragmented services and a waste of resources. Localism may bring helpful perspectives for service implementation but it cannot be sensible for Trusts, commissioners and primary care providers to have to manage multiple separately commissioned pathways for their populations. An agreed national approach is urgently needed to save much time and resource.

- 3.3 Eye health commissioning strategies are needed for larger populations, above Clinical Commissioning Group (CCG) level. The London Stroke Strategy, for instance, provides an evidence-based model, focusing all services on delivering the same positive outcomes. Similar radical culture, policy and management change is needed in eye health. There is potential for taking this forward through Sustainability and Transformation Plans (STPs) but, despite there being a national eye health indicator and the fact that poor eye health is a major contributor to loss of independence, depression and loneliness in older age, eye health is not high on the NHS's priority list. Eye health Clinical Quality Review Groups (CQRGs) at regional level would be a great step forward in monitoring data, quality, and clinical risk across the pathways.
- 3.4 Duplication of effort is endemic in fragmented services. Right Care needs to start in primary care, with patients seen again in these settings for follow-up and double-checking rather than referral to hospital just for irregular results. The NHS sight test funds only one domiciliary/high street/clinical appointment in England, whereas 'follow ups' are integral to the Scottish and Welsh NHS eye examination models.
- 3.5 Addressing the current and future capacity issues in Hospital Eye Services (HES) is critical. Optimising all available skills across the eye health sector is needed in order to deliver new models of care⁴⁹¹.

4. Workforce – optimising all available skills across the eye health workforce

- 4.1. Retention is a big issue for all types of health and social care staff. The pressure of working in unsustainable HES services could lead to some clinicians looking for alternatives outside the NHS. There needs to be some enablers to retain health and social care staff.
- 4.2. Optimising the use of all available skills across primary, secondary and social care is essential to ensure that patients are seen and treated most efficiently. More eye care professionals are undertaking training and using their new skills for extended roles in the HES but, owing to weak commissioning, there seems to be less opportunity to use these skills in primary care and this needs to change.
- 4.3. The ophthalmologist workforce in the HES is constrained by medical workforce planning, despite the growing public need for eye health services, and physical capacity in many hospitals is at a premium. On the other hand, the core skills of optometrists, orthoptists,

⁴⁹¹ <http://www.college-optometrists.org/en/EyesAndTheNHS/devolved-nations/england/clinical-council-for-eye-health-commissioning/ccehc-framework.cfm>.

opticians, ophthalmic nurses and others in the community create a flexible and ready workforce which can be upskilled in both the short and long term.

- 4.4. Universities and providers are currently supporting expanded clinical roles through further training and post-graduate qualifications including introducing students to multi-disciplinary team working and first-line prescribing.

5. Models of service delivery and integration – radical re-design of services is critical

- 5.1. Key objectives in reorganising services must be to achieve: better integration between primary care, community services, hospitals and social care; greater efficiencies; better management of patient flows; as well as freeing up capacity in the HES.
- 5.2. Whatever service models are commissioned, there need to be solid links between service delivery (including funding), education and research.
- 5.3. The lack of connection, communication and flow between primary care, community services, hospitals and social care – largely unaltered since the foundation of the NHS – presents a barrier to coordinated and personalised health services the Government is trying to achieve. The solutions are both cultural and physical, e.g. IT connectivity and common standards.
- 5.4. To tackle this, the CCEHC has developed new models for delivering more joined-up care through:
- a primary eye care service model to manage and monitor patients before referral, and
 - a community ophthalmology service model to manage patients with low risk conditions, and patients with stabilised disease discharged from the HES.
 - a low vision framework is in development.

6. Prevention and public engagement – promoting eye health as part of personal health regimes

- 6.1 As in many related areas, prevention needs to focus on broader, more consistent, evidence-based messages about healthy living, healthy and independent ageing, risk factors and life style choices. The media also have a role in responsibly disseminating these messages.
- 6.2 The opportunities for eye health are in secondary prevention through general health care services. We should aim to achieve a higher level of awareness of the dangers relating to eye health from smoking and diabetes (related to obesity).

7. Digitisation of services, Big Data and informatics – collecting and using data for health improvement and targeting

- 7.1 The lack of connectivity between primary eye care and the rest of NHS builds inefficiency into the system and is a major barrier to improving eye health efficiency, access and patient outcomes. Proper investment in IT is needed to improve the quality, speed and effectiveness of referrals, shared care and discharge between community optical practices, community ophthalmology and hospital care, by enabling electronic transfer of records, data and images.
- 7.2 Improved IT links will enable the collection and effective use of data for epidemiological analysis, public health purposes, service planning, research, and to provide a basis for identifying the information the public needs to encourage participation. This type of feedback mechanism improves the quality of services provided and decreases the risk for patients and providers.
- 7.3. We need to make better use of health information and intelligence to plan and develop better services, e.g. VISION 2020 UK's Public Health Committee portfolio of indicators⁴⁹².
- 7.4 One of the VISION 2020 UK indicators is for the measurement of delays due to hospital initiated cancellations and delayed follow-ups. This is not being collected nationally, and is just as important as the 18 weeks target for seeing and treating new patients. Those patients who remain in the HES are more at risk of sight loss if not seen on time because of disease progression than are those who have yet to access services within a reasonable timeframe based on risk. About 20 patients a month are losing sight because of delays caused by lack of capacity.

23 September 2016

⁴⁹² <http://www.vision2020uk.org.uk/vision-2020-uk-ophthalmic-public-health-committee-portfolio-of-indicators-for-eye-health-and-care/>

Coeliac UK – Written evidence (NSH0153)

1. About Coeliac UK

- 1.1. Coeliac UK is the national charity for people with coeliac disease with a mission to improve the lives of those living with the condition. We campaign, commission research and offer support and advice to people with coeliac disease and those who support them. Our current membership is approximately 65,000 people.

2. About coeliac disease

- 2.1. Coeliac disease is a serious medical condition where the body's immune system attacks its own tissues when gluten is eaten. This causes damage to the lining of the gut and means the body cannot properly absorb nutrients from food. It is not an allergy or simple food intolerance.
- 2.2. Coeliac disease is an autoimmune condition that occurs in people who have a genetic propensity. It is more common among people with other autoimmune diseases, such as Type 1 diabetes and autoimmune thyroid disease. The long-term health complications associated with untreated coeliac disease include osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency. Currently, the only medical treatment for coeliac disease is strict adherence to a gluten-free diet for life.

3. Introduction

- 3.1. Recognition of coeliac disease across the UK is low, with just 24% of those with the condition benefiting from a medical diagnosis.⁴⁹³ For the 150,000 patients diagnosed with coeliac disease the support offered by the NHS to manage their condition is becoming increasingly fractured across the UK. The need for improved and earlier diagnosis, the increasing variation of NHS support and the exacerbation of health inequalities have been central to our work over recent years. Our work in these areas has identified some issues that we believe have the potential to impede the long-term sustainability of the NHS.
- 3.2. Our evidence to the Health Select Committee is limited to structural funding issues, specifically short-term budget cycles and procurement processes, service delivery and integration, particularly the decentralisation of commissioning regardless of scale and its effect on long-term efficiencies, and prevention and public engagement, focusing on service change.

4. Resource issues, including funding

- 4.1. One of the principal pillars of NHS support for patients with coeliac disease is the provision of staple gluten-free foods, accessed from GPs by FP10 prescription. In around a third of Clinical Commissioning Group (CCG) areas across England this front-line support service for adherence to the gluten-free diet has been

⁴⁹³ West, J., et al., (2003) *Seroprevalence, correlates and characteristics of undetected coeliac disease in England*. Gut 52:960-5.

significantly restricted or removed over the past 12-months. In stark contrast, support services in Wales and Northern Ireland have remained unchanged, while in Scotland, significant service change has been introduced through the community pharmacy led Gluten-free Food Service (GFFS). The evaluation of the GFFS 18-month pilot reported overwhelming support from both patients and GPs, and was able to carry a 31.6% increase in volume with just 4.6% increase in costs, and has supported “better demand management on members of the healthcare team”.⁴⁹⁴

- 4.2. The annual cost to NHS England for gluten-free food supplied on prescription was £26.8m in 2014, this was 0.27% of the total prescribing budget of £8,852m for 2014.^{495,496} The NICE Guideline on coeliac disease cites the annual cost of gluten-free prescribing as £194.24 per patient per year.⁴⁹⁷ This is a net ingredient cost (NIC) calculation, and does not take into account income from prescriptions charges or costs associated with dispensing. Strict adherence to the gluten-free diet is the only way to avoid the more serious health complications associated with coeliac disease. Poor dietary adherence, or untreated coeliac disease is associated with health complications, one of the most common being osteoporosis.
- 4.3. Almost universally the reason given for service restrictions or cuts has been the need to find savings in an attempt to meet annual budgets. The longer term financial implications for the NHS appear to be secondary to the need to meet spend reduction targets, this means that front line services are being cut in order to find the “efficiency” savings sought by NHS England.
- 4.4. Our contention has been that this is a false economy. For example, the cost of gluten-free food over a 40-year period is approximately £7,770 (£194.24 per year), aiding adherence to the gluten-free diet and preventing long term complications such as osteoporosis. The cost of treatment for a hip fracture £12,170 (increasing by £70,000 per patient if cases become more complex).^{498,499,500}
- 4.5. Central is the importance of properly assessing how low-cost support can prevent long-term complications and the associated healthcare costs. While prevention seems to be an NHS priority, short-term budget cycles appear to be driving short-term decision making.
- 4.6. Adherence to the diet amongst those with coeliac disease varies from 42% to 91% and is influenced by a number of factors such as economic access, availability of products and the physical access to shops where gluten-free food is sold.⁵⁰¹ While the cost of gluten-free substitute foods remain significantly higher than gluten-

⁴⁹⁴ The Scottish Government, *Review of the Gluten-free Food Additional Pharmaceutical Service*, September 2015.

⁴⁹⁵ Figures are Net Ingredient Costs (NIC)

⁴⁹⁶ Prescriptions Dispensed in the Community, England 2004/14, Health & Social Care Information Centre, July 15

⁴⁹⁷ NICE NG20 Guideline, *Coeliac disease: recognition, assessment and management*, Appendix G, Full Health Economics Report, p.20, September 2015

⁴⁹⁸ Based on NICE Guidance NG20 Appendix G: Full Health Economics Report, 2015 annual cost of £194.94 for 40 years, figures not adjusted for inflation. Typical age at diagnosis 30-35yrs, average age span in the UK 70-75yrs.

⁴⁹⁹ Falling Standards, Broken Promises National Audit. RCP, May 2011

⁵⁰⁰ NHS Standard Contract for Specialised Orthopaedics, Schedule 2 – The Services, A. Service Specifications, NHS England, D10/S/a, 2013.

⁵⁰¹ Hall, N. J., Rubin, G. & Charnock, A., 2009. Systematic review: adherence to a gluten-free diet in adult patients with coeliac disease. *Alimentary Pharmacology and Therapeutics*, 30, 315-30.

containing equivalents e.g. gluten-free bread is three to four times the cost, improvements in the availability of gluten-free substitute foods has meant that CCGs have been rightly considering how best to support patients with coeliac disease and challenging historical policies in this area.⁵⁰² However, when proposing restrictions or cuts one of the reasons stated by CCGs is that gluten-free food is now available to purchase in large supermarkets at a lower cost than the cost to the NHS.

- 4.7. The total UK market value of gluten-free foods in 2014 in England was £211m, making the NHS England annual spend of circa £27m on gluten-free food around 13% of the total gluten-free food market.⁵⁰³ It seems reasonable to expect that such a significant market share provides sufficient purchasing power to negotiate prices equal to those paid by commercial retailers.
- 4.8. The list of prescribable gluten-free products is controlled by the Advisory Committee on Borderline Substances (ACBS). Manufacturers submit applications to the ACBS for product listing, which includes submission of a product price which is uprated each year for inflation. This means there is no negotiation on price and the number of products available is supplier driven. The NHS should consider competitive tendering for the supply of these products, which would help to secure competitive prices for gluten-free food products and continue to allow for reasonable patient choice. Patient support services should not be cut before this type of efficiency saving is explored.
- 4.9. The cuts to the prescribing of over the counter medicines (OTC), which seem to include gluten-free food, is also challenging the assumption that the NHS is “free at point of use”, as GPs now seem to be assessing a patients’ ability to pay for OTC medicines before writing a prescription for an OTC medicine.
- 4.10. This is likely to impact most significantly on those with low incomes, particularly those on pensions or benefits, who would normally receive a prescription product free of any charges. While this appears to be small and appropriate response to lowering costs, these small changes combine to further exacerbate health inequalities across England. GPs have reported to us the growing pressures:

“One of the pressures has been to advise us that we should not prescribe anything that is available without prescription over the counter. Working in poorer areas, this can give GPs a moral dilemma because some treatments can be very expensive indeed and we know some won't get it, while others in a different area will get it on prescription - inequality. Nevertheless, there has been a steady increase in GPs ‘refusing’ to prescribe OTCs of all sorts, but this has recently been thrown into doubt by the Local Medical Committees who have told us that if we feel that a patient needs a treatment and had reasonable grounds to suspect that

⁵⁰² Singh, J. and Whelan, K., (2011) Limited availability and higher costs of gluten-free, *J Hum Nutr & Diet Vol 24:5: 479-86*

⁵⁰³ Total value of gluten and wheat free market (excluding products on prescription) 2014 estimate, Mintel, Free Foods UK, November 2014, total was £184m (including VAT).

they wouldn't get it if we did not prescribe it, then we'd be on very shaky ground in not prescribing.”⁵⁰⁴

4.11. While over prescribing is an issue that needs to be addressed in the UK, it should not be assumed that because a product is available over the counter that it is not a necessary treatment or an effective strategy for the prevention of long-term health complications. The impact of such strategies on those on the lowest incomes should also be properly assessed if health inequalities are to be reduced.

5. Models of service delivery and integration

5.1. A further issue regarding the structure of budget streams has arisen when advocating alternative models of service delivery for the supply of gluten-free food. The Scottish GFFS model, if adopted in England, would require individual CCGs to commission a pharmacy-led service to replace FP10 prescribing.

5.2. However, CCGs have stated that this approach would mean additional expenditure as the CCG would be responsible for any new community pharmacy service fees required to deliver the service. Whereas under the FP10 model, administration and clinical costs are absorbed by fixed GP primary care budgets. Therefore, CCGs feel that there are no below the line savings to be made from adopting a pharmacy led model and instead see it as adding expenditure, even though there are savings in GP time resources to be made, and potential savings in NIC through a more personalised community pharmacy service. Commissioning specific services in community pharmacy to replace GP prescribing is seen as unviable for the relatively small number of patients with coeliac disease in each CCG area.

5.3. We have suggested to NHS England that this issue could be tackled through commissioning a national pharmacy-led service. This would provide scale so that new service design, administration, piloting, evaluation and any IT infrastructure was cost effective. The response from NHS England was that only those services included in the National “pharmaceutical services” under the terms of the Pharmacy Contractual Framework (CPCG) can be commissioned nationally.

5.4. Online ordering with pharmacy or retail store collection is also possible (i.e. electronic voucher or smart card scheme), and suitable for a large number of patients. However, setting up such a scheme would require IT system development and the establishment of partnerships with retailers or pharmacy groups. This type of IT infrastructure and supply contracting would require initial investment and development, which CCGs feel incapable of taking forward for small numbers of patients, but would be a cost effective viable alternative if considered on a national or regional scale.

6. Prevention and public engagement

6.1. Coeliac UK has engaged in a considerable number of CCG consultations over the past 12-months and encouraged members to respond to proposals to amend the NHS support services they receive.

⁵⁰⁴ Personal details of the GP quoted available to the Health Select Committee on request.

- 6.2. Our experience has been one of significant variation in the quality and level of engagement in consultation on service change. Some of the main issues include leading survey questions with questionable weighting of responses, the grouping of all OTC medicines without the engagement of specific patient groups who would be directly impacted, not giving appropriate consideration to clinical or peer reviewed research, and statements which imply that services at risk could only be continued at the expense of other patient services.
- 6.3. Specific examples of these experiences include NHS CCG Ipswich and East Suffolk CCG, both did not hold a full patient consultation. Coeliac UK staff and one member were invited to attend one meeting with the CCG, which included a gastroenterologist by phone from the local hospital. A decision to end support though gluten-free prescribing for all adults was then taken by the CCG Board. The issues of lack of patient engagement before implementing significant service change was raised with the local Healthwatch who agreed that there was a lack of notice or consultation with patients in their reply.
- 6.4. NHS CCG Enfield held a public consultation but did a weighting exercise with the data where the eight people who responded and did not have coeliac disease were weighted as 99.8% of the response, and the 121 people with coeliac disease that responded were weighted as 0.2%. The CCG also completed an equality impact assessment before the consultation which highlighted that some patients would find it difficult to afford the higher priced gluten-free foods. Even with clear patient support and evidence that the change was likely to increase health inequalities the decision was taken to end prescribing support.
- 6.5. NHS CCG Blackpool did not consult with patients before removing access to prescriptions. We have had no response from the Healthwatch in this area following our letter to highlight that significant change had taken place with no patient engagement.
- 6.6. Patient engagement is an important exercise to ensure that care and support services are patient-centred, they are based on the best possible evidence, alternatives and innovation can be considered from a wide variety of sources, and that unforeseen issues can be identified and addressed. Engagement is also essential to ensure that CCG Boards are accountable to all those who rely on the NHS. Well-developed consultation processes have the ability to deliver long-term and sustainable service improvement, while poor consultation processes can cause significant frustration among affected patients if not delivering long-term service improvement but potentially poorer health outcomes, can be viewed as simply a waste of resources or a “box ticking” exercise.

23 September 2016

Professor Jonathan Cohen and Sir David Bell – Written evidence (NHS0020)

Professor Jonathan Cohen and Sir David Bell – Written evidence (NHS0020)

[Submission to be found under Sir David Bell](#)

The College of Optometrists – Written evidence (NHS0013)

Written evidence submitted by the *Clinical Council for Eye Health Commissioning*

7.1. The College of Optometrists welcomes the Select Committee's inquiry into the 'Long-term sustainability of the NHS'.

8. About us

8.1. The College of Optometrists is the professional, scientific and examining body for optometry in the UK, working for the public benefit.

8.2. Supporting its 14,000 members in all aspects of professional development, the College provides pre-registration training and assessment, continuous professional development opportunities, and advice and guidance on professional conduct and standards, enabling our members to serve their patients well and contribute to the wellbeing of local communities.

9. The future healthcare system – The status quo is not sustainable

9.1. More than **two million people in the UK have reduced vision** and this is predicted to double by 2050. At least **20 patients per month** are losing their sight. Loss of vision can contribute to depression, falls among the elderly and reduced mobility which have financial consequences for the UK and for the NHS and social care. The direct and indirect costs of blindness in the UK are **£8 billion per year**.

9.2. Nearly **9 million people** are treated in hospital eye services (HES) annually representing 10% of all hospital outpatient attendances. Ophthalmology accounts for the second highest number for any speciality. The HES is overwhelmed and new treatments and an ageing population mean that the HES will continue to be under increasing pressure.

9.3. Addressing the current and future capacity issues in HES is critical and this could be done by optimising all available skills across the eye health sector in order to deliver **new models of care**. But, for new solutions to be sustainable, improved Information Technology (IT) connectivity between primary care, community services, and hospitals is key.

10. Workforce – Optimising all available skills across the eye health workforce

10.1. The workforce in the HES is limited and will be so for the foreseeable future. The **core skills of optometrists**, orthoptists, opticians, ophthalmic nurses and others in the community creates a more flexible and ready workforce which can easily be increased in both the short and long term.

10.2. Universities are currently supporting **further clinical opportunities** through post-graduate qualifications and, together with clinicians and regulators, they will reconsider the

necessary scope of traditional background subjects. They will also consider introducing students to multi-disciplinary team working, and teaching on therapeutic prescribing.

- 10.3. A universally recognised **national scheme of qualifications** for each profession will provide assurance to both the patient and the clinician discharging the patient, and a standard level of competencies across England.
- 10.4. To this end, the College of Optometrists has a suite of **higher qualifications**. Universities and other course providers apply to us to accredit their courses. The framework promotes a flexible system of accredited qualifications that can be used by optometrists who have a need or desire to further their knowledge. The courses are quality assured by the College and meet its standards. These qualifications are nationally recognised and have been developed to meet the growing demand for specialist skills, and recognise the highest standards of professionalism.
- 10.5. To support optometrists, the College of Optometrists also provides its members with two tools to help them to provide safe and effective services to patients. First, the College provides **Guidance on professional practice** to define good practice and the standards that patients can expect. Secondly, **Clinical Management Guidelines** provide a reliable source of evidence-based information on the diagnosis and management of eye conditions.

11. Models of service delivery and integration – Radical re-design of services is critical

- 11.1. The traditional separation between primary care, community services and hospitals – largely unaltered since the foundation of the NHS – can be a barrier to the personalised and coordinated health services.
- 11.2. Therefore the College of Optometrists is working closely with the Clinical Council for Eye Health Commissioning to design **new ways of delivering eye care** through a Primary eye care service to manage and monitor patients before referral, and a Community ophthalmology service to manage low risks patients and stable conditions out of the hospital eye service.
- 11.3. The key objectives in reorganising services is to achieve **better integration between primary care, community services, and hospitals**, efficiencies and a better management of patient flows as well as freeing up capacity in the HES.

12. Prevention and public engagement – Promoting patients responsibility

- 12.1. We can encourage a more preventative approach to eye disease by ensuring that patients are seen on time. **Early detection of sight threatening** and other health conditions through the eyes is essential to reduce avoidable sight loss.
- 12.2. It is essential that eye health services are easy for people to access if we are to encourage individuals to develop personal responsibility for their eye health and sight and therefore to enable the NHS to shift to a more preventative approach. This is why it is essential to

promote understanding and knowledge of optical practices as a core part of NHS primary care.

12.3. Properly evaluated public health campaigns jointly developed with patient groups are required **to raise awareness of the need to look after eye health** and to inform the public that sight tests can identify early stage eye disease, which can often be effectively treated. We should aim to achieve the same level of awareness of the dangers relating to eye health from smoking, diabetes (related to obesity), and UV light –plus awareness of genetic factors.

13. Digitisation of services, Big Data and informatics – Collecting and reporting data

13.1. IT links between community optical practices and the rest of the NHS as well as **improved systems in hospitals are key** to improving eye care services, outcomes for patients and NHS efficiency. Improved IT links will also enable the collection and effective use of data for epidemiological analysis, public health, service planning and research and will support patient information and participation.

13.2. The lack of connectivity between primary eye care and the rest of the service builds inefficiency into the system and is a major barrier to improving eye health efficiency and patients outcomes. **Proper investment in IT** would improve the quality and effectiveness of referrals, shared care and discharge between community optical practices, other primary carers and hospital care by enabling electronic transfer of records, data and images.

13.3. VISION 2020 UK's Public Health Committee has developed a **portfolio of local indicators, underpinning the national eye health indicator**, to help the commissioners to address the current gaps in information about the effectiveness of eye health and sight loss services. This data should be more systematically collected and shared with clinicians, managers and commissioners to inform and develop services to meet local needs.

30 August 2016

Mrs Gaynor Collins-Punter – Written evidence (NHS0044)

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

b. What is the role of 'Big Data' in reducing costs and managing demand?

Thoughts around this include classification of data, who it belongs to, any information sharing agreements, how easy / difficult it is to join datasets together to maximise insight. To give an example, the Care Act meant that local authorities needed to start to maintain records on clients' care costs and a key factor in joining together datasets was the lack of a suitable primary identifier, which was a national problem. The NHS Number had been identified as the best option but I am not sure whether this managed to move forwards. Clearly, if this type of dataset, including the type of care clients had e.g. in a residential home specialising in dementia care, other datasets drawn from within the NHS could then be used as an aid to the design of service provision across local authorities, partners and the NHS.

c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

Prior to my current role, I was actively involved in the rollout of iPads to social workers to help realise efficiency savings in undertaking client assessments in clients' homes. Although the studies using LEAN+ for analysis of business processes clearly identified areas of non-value add work, hence waste, it took some time to persuade some staff to embrace the new technology and to work with it. In some cases, staff involved UNISON to try and prevent the changes from happening and this all made for a delay to the planned rollout. I think there are key lessons that can be learned from this that could be applied to any technology rollout which are these:

- **the time needed for business process definition 'As Is' and 'To Be' must never be underestimated**
- **the 'people' side of the rollout programme for the new technology needs to appreciate individual perceptions and resistance to change and hence be factored into plans**
- **in the design of pilot projects for new technology, it is critical to the success of the pilot to set fit evaluation criteria up front and to monitor these throughout the pilot and at the end as input to wider rollout activity**

21 September 2016

Dr Brendan Cooper – Written evidence (NHS0132)

Personal Response from Dr Brendan G Cooper, Consultant Clinical Scientist in Respiratory & Sleep Physiology, QEHB.

Introduction

I am a Consultant Clinical Scientist and Hon. Senior Research Fellow in a large university hospital in the UK with over 30 years' experience as a healthcare scientist in respiratory & sleep physiology. I have held several senior leadership roles as DH Scientific Champion in Respiratory Physiology, Chair/President of my professional body and President of the Academy for Health Care Science (who are responding to this consultation independently) and I have a good insight into the clinical delivery of scientific diagnostic and therapeutic services in several clinical/scientific areas. These are my **personal** views and are not linked with any organisation.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

There needs to be better team work amongst clinical professionals where the “best team at the right time doing the right care in the right place” is adopted widely. This will require the acceptance by all clinical professionals that scientists and allied health professionals are equally as important as medics and nurses in delivering and leading healthcare. There are good benchmarking examples of integrated teams throughout the NHS.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

a. Does the wider societal value of the healthcare system exceed its monetary cost?

The public's perception of “free at the point of care” often means they take no responsibility for the cost of their care (losing expensive monitoring equipment, abusing ambulances and A&E, etc.). There needs to be a change in public perception that we are all responsible for the resources of the NHS at all times.

b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

Central taxation has sufficed for the NHS so far. Perhaps a referendum/census of the options to the public may indicate if they wish to pay more taxes on healthcare. The decision should be taken out of party politics and given to the public to decide.

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

Free care should be limited to patients agreeing to abide by the terms & conditions of the NHS (responsible for equipment, charged for failing to cancel appointment if not attending,

abolish prescription charges for patients/public who maintain good health and look after themselves.)

d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

Yes. Cosmetic and lifestyle type procedures/treatments should incur realistic charges. Emergency and chronic illness should remain free at the point of care. However, criminal and alcohol related injuries and related healthcare use by those responsible (after any legal trials) should be made to reimburse the NHS as part of their sentences. As a society we need to recoup indiscriminate waste/theft of resources at the point of that waste, linked to the legal system as a part of judicial sentencing.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

Much more team working with shared responsibility and leadership is required. The politicians need to grasp that it's not just doctors and nurses that make the NHS so successful!

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

Immigrants with healthcare training/experience should be allowed to fast track entry and subsequently be trained to deliver best practice. They should work in the NHS for a 3 year period after training.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

There is a serious risk of loss of excellent European staff to fill essential frontline posts. Research funding for EU healthcare researchers is likely to be affected and this must be protected in any Brexit deal.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

Several groups of healthcare scientists have retention issues linked to retirements (e.g. clinical neurophysiology, clinical cardiology, medical physics staff, etc.) and insufficient workforce planning and enough training opportunities for endangered healthcare scientist roles. There needs to be a balance of national and local planning of workforce requirements linked to appropriate professional bodies input.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

Innovation can improve flexible working and outreach services but will require hubs of innovation procurement in regions across England. Staff must be trained in multiple tasks to acceptable quality standards, with overlapping professions at lower levels where patient facing care is maximal.

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

Short term it will be expensive to train more adaptable staff, but the long-term benefits will prove cost-effective. However, politicians need to commit to strategy beyond the 5 year electoral cycle for this to work to be successful.

c. What investment model would most speedily enhance and stabilise the workforce?

A core of protected training post funding should continue, but much more staff investment in their careers to subsidise NHS training budgets. However, such personal investment should attract tax breaks. Private healthcare provision should pay a levy towards NHS training budgets instead of just “poaching” NHS trained staff.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

a. How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

Abolish the purchaser-provider model and utilise the savings on training clinical staff locally. This should remove the unnecessary and futile primary/secondary care divide and the costly healthcare management required to maintain this inefficiency.

b. How can local organisations be incentivised to work together?

More “Devo-Manc” type arrangements for healthcare to deliver local priorities cost effectively in relation to local needs across the primary/secondary care barrier. Breaking down Trust “loyalties” and sharing best practice will drive up standards and quality.

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

Abolish purchaser-provider models and work in integrated care teams to fixed budgets. Local needs should dictate which services are delivered beyond a basic core of emergency and chronic conditions care.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

The individual’s responsibility for both their health and lifestyle should be at the centre of future NHS healthcare delivery. Furthermore, once people become patients, there needs to be a shift of responsibility for their treatment and well-being to the individual /their carers and away from the healthcare system. The NHS and healthcare system must provide reliable evidence based best practice (through NICE?), since this will incentivise patients to adhere to treatment pathways and healthy lifestyle choices.

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

Personal responsibility for key areas of personal health to include; healthy diet, appropriate weight management, reduction in use of alcohol, recreational drugs and smoking and the regular practice of increased daily activity, exercise and good hygiene. Clear education of the risks to the public's health from risky activities (sports, hobbies, household work, DIY, etc.) should be considered.

b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

There needs to be some sort of incentive for individuals that adhere to healthy practices, follow treatment plans or avoid health risks. Perhaps some form of "disadvantage" to people who refuse to follow proven treatments and clinical advice. Whilst free at the point of care is important, there should be incurred charges if pathways are not followed. The problem will be having an effective way to implement charges – but this may be possible through the tax system and use of digital innovations.

c. Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

Patients receiving long-term medicines should have exemption only for those drugs relevant to their condition. Currently, exemption for somebody say with hypothyroidism, should not receive prescription exemption for medication for an unrelated medical condition (e.g. antibiotics for a throat infection or painkillers for a sprained ankle, etc.). Guidance based on clinical evidence is available.

d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

Yes, there should be key legislation that raises awareness of health issues like the "sugar tax". The tobacco laws have had a major impact on public health so there is good precedent to adopt similar strategies for combatting obesity, diabetes and subsequent cardiovascular disorders. Like the seat-belt campaign, it is a change of public attitude and personal responsibility that industry has to embrace. However, this needs to be cooperative to avoid driving sugar use "underground", like a form of prohibition.

e. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

Education and encouraging personal responsibility for health should be central in providers care pathways. Providers who deliver in this way could be prioritised for funding new or expanded services, provided the technology is in place to record the sustained improved/lower level of healthcare provided.

f. What are the barriers to taking on received knowledge about healthy places to live and work?

The perceived economic barriers of living in unhealthy places should be converted into local control by communities of the risks to their health. Examples include petrol and diesel bans at weekends, local industry forced to invest in cleaner air measures, local council and parish groups to promote and encourage greener living strategies, less stressful environment, less fast-food outlets, more control of offending risks that cause pollution, noise, and bad environments for health.

g. How could technology play a greater role in enhancing prevention and public health?

Examples could include;

- i. Use of clean air detectors and smartphone apps in local neighbourhoods linked to national networks to produce clean air maps.
- ii. Food intake and personal activity monitors to raise awareness of food intake:energy expenditure balance
- iii. Encourage most of the public to have their own “Health file” which records their key indicators (weight, BMI, waist circumference, resting heart rate, blood pressure, any blood tests they may have, sleep time/quality measures, activity (steps), a simple calorie intake log (using barcodes, etc.) and recording health events (colds, infections, injuries, GP visits, hospital admissions, etc.). The patient should truly own their own health records

7. What are the best ways to engage the public in talking about what they want from a health service?

Perform a National Health Census every 5 years? Different age groups will inevitably have different needs, but most people who reply will highlight the priorities. Currently the media and politicians tell us what the public want – both are famously unreliable!

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

There is a need to embrace these new technologies and make them relevant and more standardised for people’s lives. They should enable better targeting of healthcare so the right treatment is given to the patient who responds to it at the right time.

b. What is the role of ‘Big Data’ in reducing costs and managing demand?

This is immensely powerful if the public are educated that their data cannot be traced back to them – but of course this requires that systems must be in place so that data is totally secure/anonymised. The NHS is best placed to utilise and provide this helpful information.

c. What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

There is a lack of standardisation and independent assessment of new technology. Competition limits sharing of data and can sometimes side-line the best solutions for purely

commercial interests and financial gain. There is a need to exploit the procurement/evaluation skills of NHS healthcare scientists more.

d. How can healthcare providers be incentivised to take up new technologies?

Proven technology with independent reliable evidence (and not manufacturer's wild claims) should be available for providers to make informed judgements on which of the technologies actually make a significant improvement to health. A NICE Innovation Group should be the vehicle for this.

e. Where is investment in technology and informatics most needed?

Innovation in diagnostics and therapeutics (non-pharmaceutical) should be maximised to ensure greater adherence with treatments which is monitored in real time. Deliberate avoidance of treatment should result in withdrawal of treatment with perhaps payment back to the health service for costs incurred.

I welcome this opportunity for the House of Lords Select Committee to ask for these specialist views from experts within the NHS.

23 September 2016

Lord Crisp – Written evidence (NHS0176)

1. Overview

Thank you for the opportunity to provide evidence for the committee.

The Committee has a unique opportunity to re-shape thinking about the NHS. I suggest here that this re-thinking needs to be based on:

- the economic role that the NHS plays in the UK and its contribution to future prosperity
- the NHS's intimate links with the wider social sector and its role in society
- The need for major changes in the way the NHS operates and services are delivered to make it fit for purpose in the future
- The necessity of involving all sectors – employers, educators and designers as well as citizens, government and health bodies – in supporting healthy and resilient communities and individuals

This paper describes the conditions needed for sustainability and draws on research and examples from around the world. Whilst it is critical of the NHS, we should remember that the NHS is one of the highest performing and cheapest health systems in richer countries - and that its problems are very similar to those elsewhere. There are no models to copy or easy answers to find.

2. The transition underway in health and social care

The pressures in the health and care system and the uncertainties of Brexit point to the need for change. Even more important, however, is the need to recognise that the current hospital and illness-based model of service provision – which has served us so well in the past – is simply no longer fit for purpose.

Put simply, the UK, like every other western country, suffers from using a 20th century model of service provision to deal with the needs and opportunities of the 21st century. This is inherently inefficient and ineffective - as can be seen every day in hospitals and communities around the country.

Report after report in the UK and other western countries have described how the nature of the illnesses we suffer from has changed and that services need to change too, so that many more are provided in communities and homes and there is far greater emphasis on disease prevention and health promotion. These reports have all in their different ways described the need to transition to a health-based and person-centred system where patients and communities are fully engaged as partners and where full use is made of modern science and new technologies.

This transition is already underway in the UK with new practices and services being developed but it is slow, patchy and disjointed and doesn't capitalise on the UK's world class capabilities in research, science and technology. This transition needs to be given new impetus and accelerated.

It is the new and emerging NHS that needs to be sustained not the current one.

3. Sustainability

The sustainability of a health system is a health problem and cannot be reduced, as sometimes happens, to being a purely financial or economic problem. Moreover, it is a systems issue where changes in one part of the system impact, in often unintended ways, on all other parts. Recent experience in the Netherlands provides a salutary example, where

finance and insurance-based reforms designed to manage costs and improve services led to improved access but also had the unintended consequence of producing far higher overall costs.⁵⁰⁵

In 2014 I was privileged to chair a Commission on the Portuguese health system “*to look forward 25 years to create a new vision for health and health care in Portugal, describe what this would mean in practice and set out how it might be achieved and sustained.*”⁵⁰⁶ Its main recommendations have since been accepted as Portuguese Government policy.

That Commission concluded that achieving sustainability was dependent on 3 factors internal to the system itself (how the system operated; the availability of sufficient numbers of well-trained health workers; and the costs and economic implications of the system) and 3 external ones (building the health and resilience of the population, having strong informal caring and informal networks of care; and integrating health policy and practice with other sectors.)

Underpinning all these other factors is the need for any health system to have public and political acceptability and support. The Commission understood that the changes needed in Portugal would only be achieved with sustained political will and good public support. There are many international examples of how political will has produced change including post war Europe’s establishment of welfare states and, elsewhere, the massive improvements in current day Iran and Rwanda. President Obama’s struggles in the US show just how difficult this can be. These 7 factors are shown in Box 1 and discussed very briefly in turn in the following sections.

Box 1: The conditions for the sustainability of a health system

The sustainability of a health system depends on 7 main factors

Internal factors

1. The efficiency and effectiveness of health care provision
2. The availability of well-trained health workers
3. Costs and economic implications

External factors

4. The health and resilience of the population
5. The strength of informal caring and informal networks of care
6. The integration of health policy and practice with other sectors

Overall

7. Public and political acceptability and support.

4. The NHS - internal factors for sustainability

4.1 The efficiency and effectiveness of health care provision.

As already noted, the NHS operates a service model largely based on the health and service needs of the last century. The biggest single issue affecting its efficiency and effectiveness is how well chronic diseases are managed. These diseases (also called non-communicable diseases or long-term conditions) are now the greatest burden on the NHS and a small

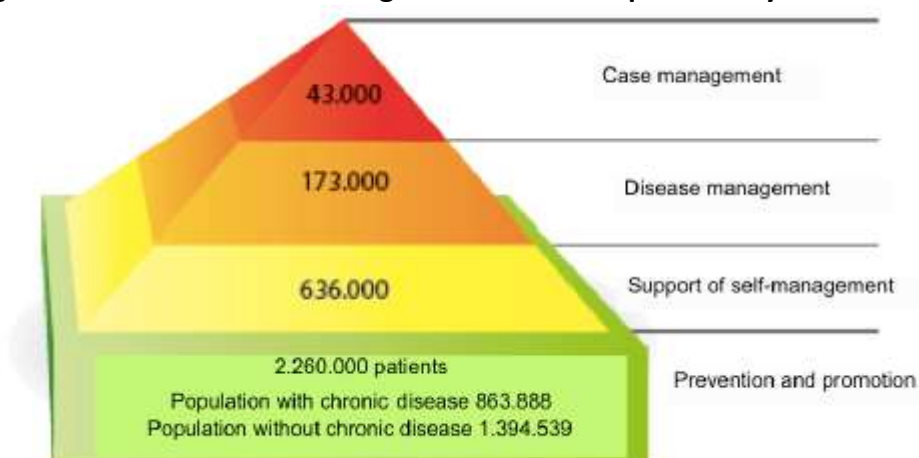
⁵⁰⁵ <http://blogs.lse.ac.uk/europpblog/2013/01/30/health-reforms-netherlands-ilaria-mosca/> Accessed 18 October 2016

⁵⁰⁶ Calouste Gulbenkian Foundation: The Future for Health in Portugal; Lisbon September 2014.

percentage of the population – mostly older people with more than three chronic diseases – use a very large proportion of the overall budget. In most western countries the figures are in the order of 5% of the populations using 40% of resources or 10% using 70%.

Figure 1 below shows the health care needs of the entire population of the Basque country as estimated by the Regional Government in 2010. A small number, here under 2%, need very intensive case management while another 8% need specialist disease management. The Basque government has attempted to orientate its entire health system around these needs. Similar stratifications of need and risk have been done in the UK with local health organisations seeking to implement similar changes.

Figure 1: Chronic disease management in the Basque country 2010 ⁵⁰⁷



Many of these high-burden patients need care from different specialists and services and the traditional linear model of GP- hospital specialist-tertiary centre doesn't work efficiently for patients with complex needs and multiple morbidities. New models for dealing with Parkinson's disease, mental health and the deployment of home nursing for dementia are described in section 5

All these new services use resources and knowledge in new ways. There is good access to evidence and protocols, technology is used (biological, engineering and ICT), people – both professionals and patients – take on new roles, community assets are used (as in the developing field of asset-based health care), methodologies for continuous quality improvement are employed, and funding is used to reinforce good practice.

These changes all require flexibility and are difficult to make in the current system which is beset by rigidities. There are, for example, difficulties in funding new services that use telephone or video consultations. There are even greater rigidities in how health workers are deployed with big differences in how consultants and GPs work and even greater demarcations between the professions.

This same lack of flexibility applies to acute services. Leading examples globally as described in section 5 include Aravindh and Naryana in India where inspirational innovators without our resources – and crucially without our baggage and vested interests - are "breaking the rules" and inventing new practice. The Government and the NHS need to find ways of doing this in order to accelerate the transition that is underway.

⁵⁰⁷ Vasco G: *A strategy for tackling the challenge of chronicity in the Basque county*; July 2010:Table1.1,31.

These criticisms of the NHS should not obscure the fact that it is a leader globally. It has many features from NICE to Public Health England to being a single-payer system which put it ahead of its competitors and mean that it regularly tops the Commonwealth Fund's league table of countries. Moreover, like any incumbent - rather than disruptive incomers - it has to continue to run the current service whilst introducing changes. This double running of the old services while introducing the new saps energy as well as increasing costs.

4.2 The availability of well-trained health workers

There is a global shortage of health workers which is getting worse as middle income countries and emerging economies build up their health services.⁵⁰⁸ This is a major challenge to the sustainability of the NHS particularly if Brexit makes it harder to retain health workers from outside the UK and/or encourages a "brain drain". Health workers are the largest element of costs for any health system and in the NHS amount to more than 60% of the total.

These shortages need to be tackled globally by a combination of training more health workers, extending their roles with technology, "task shifting" so that less trained workers can take on work previously only done by professionals with higher skills (and at a higher cost), and enabling or "activating" patients and communities to take on more themselves. The examples given in section 5 illustrate all these approaches. All are important but I will only look at one here – the way in which health worker roles need to change. The Lancet Commission on the future education of health professionals advocated an approach in which professionals were "agents of change" leading teams to accomplish tasks and always seeking to improve. In this model health professionals do not need to do everything themselves but are responsible for quality and improvement.⁵⁰⁹

At the same time there have been important developments in "task shifting" or "skill mix change" with, for example, Lord Willis's review for Health Education England *Raising the Bar, review of the future education of registered nurses and care assistants* showing how this could be achieved in nursing.⁵¹⁰ Similarly the APPG on Global Health has advocated a greater role for nurses which allowed them to work to the full extent of their competences.⁵¹¹

In an earlier study on skill-mix change the APPG identified the success factors which led to successful change. These are shown in figure 2. The way that nurse prescribing was introduced in England in 2003 was an excellent example of successful change; however, the widespread introduction of health care assistants without adequate training, support and supervision in many UK hospitals more recently has, sadly, been an example of failure to apply these factors and led to failures in patient care.

Figure 2: Success factors in skill-mix change⁵¹²

⁵⁰⁸ Crisp N, Chen L: Global supply of health professionals, *N Eng J Med*, 6 March 2014, 370:10 p 950-956

⁵⁰⁹ Frenk J, Chen L, Bhutta ZA, et al: *Health professionals for a new century: transforming education to strengthen health systems in an interdependent world*; *Lancet* 2010;376:1923-58.

⁵¹⁰ <https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf> Accessed 27 October 2016

⁵¹¹ APPPG on Global Health: *Triple Impact*; October 2016. <http://www.appg-globalhealth.org.uk/reports/4556656050> Accessed 27 October 2016

⁵¹² APPPG on Global Health: *All the Talents*; July 2012. <http://www.appg-globalhealth.org.uk/reports/4556656050> Accessed 27 October 2016



There are similarly examples of good and bad programmes of patient engagement which I have not described here.

4.3 Costs and economic implications

I touch briefly here only on 4 major areas and try to pull out some of the key points – and I am sure that the Committee will be exploring all of them in far greater detail.

There is a close two way relationship between health and the economy

As countries grow richer they spend more on health. In recent decades roughly every 1% increase in GDP in a country has led to a 1.1% increase in health expenditures. Moreover, public expenditure almost always increases as a proportion of total health expenditure as countries grow richer. This means that several rich countries including the US subsidise their health systems from public sources to a far higher extent than the NHS does. In 2015 the OECD recorded that the UK spent 7.8% on health from public sources while Germany spent 9.4%, France 8.6%, Sweden 9.3%, Japan 9.5% and the US 8.3%.⁵¹³

Not only is total health expenditure in all these countries far higher than in the UK but public expenditure is also far higher. In the UK this is simply – and cheaply – funded through tax and national insurance contributions but in the US it comes from many different subsidies, for example for medical education, and separate provision for different groups.

Expenditure on improving the health of the population is not simply a cost, however, but contributes to a healthy workforce and its productivity. Many studies have estimated the value to western economies of improved health in the workforce and, conversely, the costs of ill health and epidemics. Southern Africa, for example, has grown by at least 1% per annum slower due to HIV/AIDS. This year the UN's High Level Commission on Health Employment and Economic Growth set out the evidence for the impact of improved health on the economy and argued further that employing people in the health sector had a positive impact on the economy through a variety of different mechanisms.⁵¹⁴

One of the routes for beneficial economic impact is through the way in which research in the bio-medical and life sciences and associated technology benefits from a good health

⁵¹³ This analysis comes for the latest OECD figures and groups together tax based subsidy with compulsory contributions – ie the equivalents of the UK's national insurance. http://www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics/system-of-health-accounts-health-expenditure-by-function_data-00349-en Accessed 17 October 2016

⁵¹⁴ UN: Report of High Level Commission on Health Employment and Economic Growth; New York, September 2016

service and contributes to the strength of the economy. As noted in section 10 the UK could do more to capitalise on the comparative advantage it has in this area because of its access to the NHS, the largest integrated health system in the world.

Cost pressures

Costs have been driven up in OECD countries for many years due to ageing populations, the availability of new treatments and changing government policies but have slowed recently. The OECD's report on projected health and long term care expenditures to 2060 sets out different scenarios and suggests expenditure on average for OECD countries will rise by between 3.3% and 7.7% of GDP between 2010 and 2060.⁵¹⁵

The financial crisis of 2009, however, led to a slowing of growth in expenditure as countries took action to reduce costs. Some of this reduction came from short-term one-off measures such as pay-cuts or freezes, changing stock levels and restricting price rises and some from service cuts but others provided long-term recurring benefits. As well as looking at this report, the Committee may wish to consider how these reductions were managed and what can be learned from this period.

New approaches to cost control and payments systems

New approaches to cost control, financial management and payment systems are important. Here again, there are no simple and universal answers and changing financial flows can lead to increased transaction costs and to unintended consequences as noted earlier in the case of the Netherlands.

Competition has a place. Several studies have shown that introducing an element of managed competition into the English NHS not only improved efficiency but also improved quality. A 2010 LSE report, for example, concluded that. "Using AMI mortality as a quality indicator, we find that mortality fell more quickly (i.e. quality improved) for patients living in more competitive markets after the introduction of hospital competition in January 2006. Our results suggest that hospital competition in markets with fixed prices can lead to improvements in clinical quality."⁵¹⁶ The position is, however, less clear-cut with primary and community care services or in dealing with chronic disease management and the problems of managing patients with complex co-morbidities. Moreover, competition in markets without fixed prices can lead to a race to the bottom in quality terms.

Fee-for-service payments have been largely discredited in health care and identified as major cost drivers in many systems. Payment systems such as PROMS which take account of patient reported experience and others which pay uplifts for implementing best practice protocols, however, seem to have their place as systems try to move towards outcome costing and pricing. Similarly, approaches which make payments for a whole package of care which may last over several different episodes and involve different providers, are more effective and efficient than payments per episode or activity. Personal budgets and direct payments particularly for people with long-term conditions have an important part to play here as well – and, I understand, are likely to be extended in England.

⁵¹⁵ <http://www.oecd.org/economy/public-spending-on-health-and-long-term-care.htm> Accessed 1 November 2016

⁵¹⁶ <http://eprints.lse.ac.uk/28584/1/WP16.pdf> Accessed 1 November 2016

The Portuguese Commission looked at these sorts of examples in some detail, as I am sure the Committee will, and concluded that it was important for a health system to keep developing these methodologies. However, it also noted that more often than not these systems lagged behind service developments so, for example, inflexible payment systems got in the way of innovation rather than payment systems promoting service innovation. It considered that for the foreseeable future at least policy-led changes in service design were likely to have a much more significant effect on overall costs and quality than innovation in financial flows and payment methods.

Alternative financing systems

Broadly speaking there are three main ways of paying for health care globally:

- Out of pocket – as happens in most poorer countries
- Through tax and compulsory national insurance programmes which may have elements of direct patient charges or co-pays
- Through private insurance with direct patient charges or co-pays

Most high income countries employ their own mix of these three. There are others such as the Singapore system with its personal budgets which are probably too culturally specific to be of direct interest to the UK.

The UK system with its reliance on general taxation is the simplest and cheapest method with very low overheads. Competing private finance systems as in the US have the highest overheads.

The introduction of “co-pays” or patient charges into systems is often promoted as a way of increasing funding and improving efficiency but has some serious limitations. Studies such as the RAND one of 1983 show that increased charges reduce patient use of effective and ineffective health care in equal proportions, reminding us of the problems of market failure in health.⁵¹⁷ Reducing usage of health services for richer parts of the population in the US, where there is over-use, may be good for their health. However, poorer people who in the US make far lower use of services may miss out on services they need.

The problem as others have subsequently argued is that introducing exemptions for poorer and older people who are the biggest users of the service in the UK – as we do for prescription charges – mean that the charges on the remainder of the population have to be very high in order to generate any material amount of extra money.

These arguments don't apply in quite the same way to proposals to raise extra funding through the types of compulsory social insurance scheme used in much of Europe. These are generally progressive rather than regressive and can raise significant amounts by being in effect an additional tax. They also maintain the important principle of pre-payment for health care so that it remains free at the point of need.

A hypothecated NHS tax is often proposed as a way of securing extra funding for the NHS and showing people how much they are paying for the NHS and thereby making a link between payment and services. Critics, however, argue that funding from general taxation is more flexible and better able to reflect changing levels of need.

There is more consensus about the need to bring health and local authority budgets together, particularly in social services but also in housing and other areas to achieve

⁵¹⁷ Brook RH, Ware JF, Rogers WH: Does free care improve adult's health? Results from a randomised control trial; N Eng J Med. 309:1425-1434, 1983

synergies and improve overall usage of public funding. Experience in Northern Ireland shows that whilst this is a useful measure it is not in itself enough to secure better efficiency and quality but needs to be accompanied by other policy and management measures.

New sources of funding need to be considered particularly in raising capital and there are powerful arguments advanced both for local authorities being able to raise local taxes for health and care services and for public bonds of different sorts.

Another approach which has some promise but would involve a radical change in the UK is the example of the Accident Compensation Corporation of New Zealand. This is a public body, funded through government and from levies on employers, which pays for the health cost of anyone who has an accident of any sort – on the roads, for example, at work or as a consequence of health care itself. It provides about 14% of the funding of the New Zealand health system and has become over time an active proponent of better health promotion and more interventionist in demanding efficient and effective health care. It is another way of making a direct link between those who use the service and its funding.

5. Examples of leading practice internationally in health service provision

The examples described briefly here are only a few of many from around the world which give an insight into what future service provision might look like.

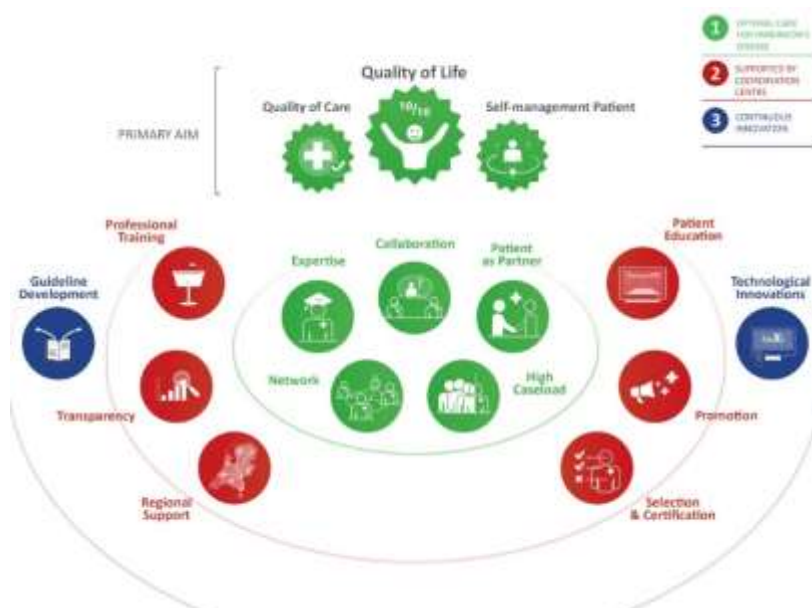
Parkinsonnet.org is an excellent and innovative example of chronic disease management.

⁵¹⁸ It brings together over 2,700 health professionals into regional networks with patients and carers to provide information and services throughout the Netherlands and into neighbouring countries. They are supported by a coordination centre and academic specialists at the Radboud University Nijmegen Medical Centre.

Parkinson's syndrome is a generic term for a very complex disorder which may lead to a wide range of different problems needing attention from different carers. This network ensures that patients are able to reach the appropriate professionals and, by having access to all the information and protocols in the network, to play a full role in their own care. The model breaks down all the rigidities of the traditional system described earlier with new roles for professionals and patients, home and community based care and extensive use of IT. Figure 3 shows the main components. Similar model could be developed for other chronic diseases.

Figure 3: The Parkinsonnet.org model

⁵¹⁸ <http://parkinsonnet.info/> Accessed 18 October 2016



Buurtzorg⁵¹⁹ is a home care provider in the Netherlands which involves teams of front line staff who lead the assessment, planning and coordination of care. The model consists of small self-managing teams of a maximum of 12 professionals (made up of nurses and other allied health professionals). These teams provide co-ordinated care for a specific catchment area, typically caring for between 40 to 60 patients. Overall they now look after 70,000 patients, about half of whom have dementia, and deal with health promotion as well as treatment.

Aravindh and ⁵²⁰ **Naryana Health**⁵²¹ are two examples of the innovation underway in India. Both use modern production management techniques to streamline and improve specific services – for eye care and cardiac surgery and other specialities respectively. Staff are deployed in different ways – ignoring many traditional western demarcations, patients and carers are co-opted to help and technology is used extensively. Both organisations provide very high quality services.

Sangath, an NGO working on mental health, child development and related services in Southern India, is equally impressive but works in a very different way.⁵²² It was founded 20 years ago by a small group of highly trained professionals who deliver services in the community by working with community workers and local groups. Using clear protocols and well-organised training and supervision it has been able to run successful randomised clinical trials on delivery methods as well as providing services to large numbers of people who would not otherwise be reached.

In America the **Mayo Clinic**, a not-for-profit organisation, is one of a number of good examples of organisations which are placing the individual experience at the heart of their

⁵¹⁹ https://www2.rcn.org.uk/_data/assets/pdf_file/0003/618231/02.15-The-Buurtzorg-Nederland-home-care-provider-model.-Observations-for-the-UK.pdf Accessed 18 October 2016

⁵²⁰ <http://www.aravind.org/> Accessed 18 October 2016

⁵²¹ <http://www.narayanahealth.org/> Accessed 18 October 2017

⁵²² http://www.sangath.com/details.php?m_id=2 Accessed 18 October 2016

services – empowering patients with data, offering choices and explicitly tailoring services to meet the needs and preferences of individual patients.⁵²³

It is interesting to note that **City Health Works** based in Harlem has explicitly copied the principles and methods of African community health worker programmes to “bridge the gap between the doctor's office and the everyday lives of patients diagnosed with life-threatening chronic illnesses.” Peer support workers contact and work with people where they live.⁵²⁴

It is perhaps not too fanciful to imagine that a combination of the methods employed by Pakinsonnet for chronic diseases, Aravindh and Naryana for acute specialities, Buurtzorg and Sangath for community care, and the Mayo for patient-centeredness might replace our current model of GP-hospital-tertiary centre with its multiple rigidities.

6. Health and wider society – external factors for sustainability

“Modern societies actively market unhealthy life styles.” This quotation from WHO Europe sums up the problem which places ever-increasing pressure on the NHS. The NHS will not be sustainable without reversing this current set of trends and, ultimately, building a society that helps create health by supporting healthy and resilient communities and individuals. There is a traditional African saying which equally simply describes the situation: “Health is made at home, hospitals are for repairs”.

The NHS and politicians cannot do this by themselves – all sectors of society need to be involved. This section touches very briefly on some of the key ways this needs to happen.

6.1 The health and resilience of the population

The Government, NHS England, Public Health England and other authorities are beginning to play a stronger role in disease prevention and health promotion and need to do more. Some of this requires legislation in tackling, for example, tobacco, air pollution, sugar, alcohol and road safety. In other areas they can lead on campaigns and by example in how they support their employees to be healthy.

Individuals and their families play the most important role in looking after their own health and adopting healthy lifestyles. There is not yet, however, sufficient recognition in policy and practice of the important role that the social determinants play in health and of the fact that social support, housing, employment, education and many other sectors need to play their part in strengthening the health and resilience of the population – and that government policy needs to be shaped to enable them to do so. There is evidence that recent austerity-inspired policy has damaged health and reduced resilience in the UK and elsewhere.⁵²⁵ Moreover, it has become more difficult for some disabled people to live independently as benefits systems have changed.

Global policy on the control of non-communicable diseases and the ambitious Sustainable Development Goals both focus heavily on prevention and on recognising and working on the social determinants of health.⁵²⁶

6.2 The strength of informal caring and informal networks of care

⁵²³ <http://www.mayoclinic.org/> Accessed 18 October 2016

⁵²⁴ <http://cityhealthworks.com/> Accessed 18 October 2016

⁵²⁵ Stuckler D, Banju S: *The Body Economic: why austerity kills*; Basic Books, London, 2013

⁵²⁶ http://www.un.org/ga/search/view_doc.asp?symbol=A/69/L.85&Lang=E Accessed 18 October 2016

The importance of a population “fully engaged” in its own health to controlling costs and improving quality was pointed out by Wanless in *Securing our Future Health: Taking a long-term View in 2002* and remains true today.

It is equally important to ensure that local informal caring and informal networks of care are strong and effective. It is estimated that the value of individual unpaid carers work alone is £132 billion annually, almost exactly the same as the UK wide spend on the NHS.⁵²⁷ Where these carers get weaker the burden falls on the NHS and local authorities; where they are strengthened the NHS becomes more sustainable.⁵²⁸ Similarly policies that encourage and support local caring networks and voluntary organisations will help take the strain off the statutory services.

6.3 The integration of health policy and practice with other sectors

Integration of government policy and action across sectors is essential for the reasons given earlier but so, too, is the involvement and leadership of people and organisations outside government.

The creation of Health and Well-being Boards in England and the current development of Sustainability and Transformation Plans are both attempts to achieve integration across sectors. The devolution of health budgets in Manchester and the bringing together of health and social care budgets elsewhere are designed to have the same effect.

These government-led programmes, however, need to be accompanied by employers, educators and others living up to their responsibilities for the health and well-being of the people they employ, teach or otherwise work with. There are some excellent examples where this is starting to happen and others such as the St Paul’s Way transformation project described in Section 7 where wide partnerships have come together to improve neighbourhoods and, inter alia, improve health. They are the exemplars of the health-creating society of the future.

7. Examples of leading practice in health-creation

Effective practice in health-creation is generally less advanced than innovation in service delivery but there are interesting examples – and many low and middle-income countries, with weak health services adopt policies which align poverty elimination with environmental, economic and health improvements.

Finland was the first country explicitly to adopt a Health in All Policies approach by recognising that farming and other practices influenced health and subsequently developing cross-sectoral policies to improve health.⁵²⁹ This approach emphasises the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making. This is now policy in many European countries and advocated by WHO Europe.

⁵²⁷ <http://si.easp.es/derechosciudadania/wp-content/uploads/2009/10/4.Informe-Wanless.pdf> Accessed 2 November 2016

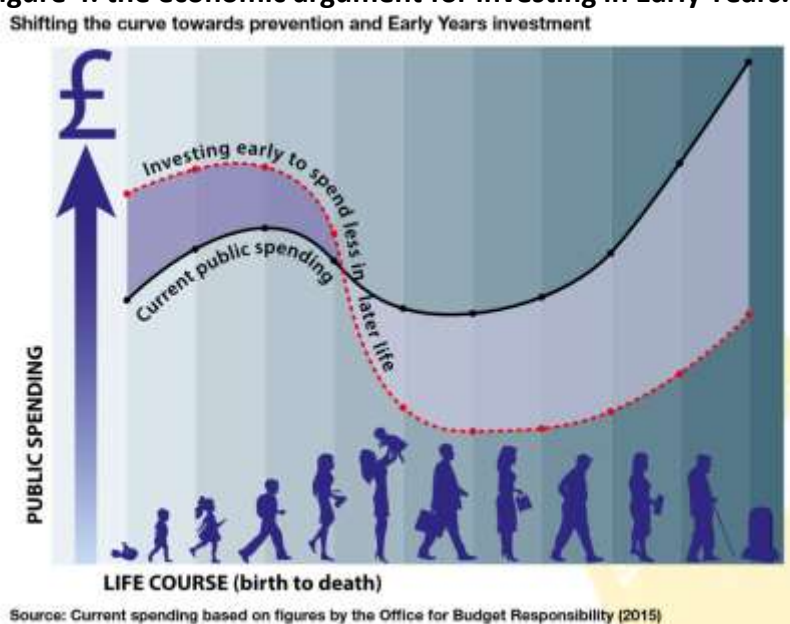
⁵²⁸ Buckner L Yeandle S; Valuing Carers 2015 – the rising value of carers’ support; Carers UK, London, 12 November 2015; <http://www.carersuk.org/for-professionals/policy/policy-library/valuing-carers-2015> Accessed 27 October 2016

⁵²⁹ http://www.euro.who.int/_data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf Accessed 18 October 2016

The Scottish Government's Early Years initiative is designed to make Scotland the best place in the world to grow up in. The Early Years Collaborative is the world's first multi-agency, bottom up quality improvement programme to support the transformation of early years. Launched in October 2012, it involves all 32 Community Planning Partnerships and a wide range of third sector partners. Its focus is on strengthening and building on services using quality improvement methodology, enabling local practitioners to test, measure, implement and spread new and different ways of working to improve outcomes for children and families.⁵³⁰

Wales, similarly, is developing a new strategy and illustrates the economic argument for its approach with Figure 4.⁵³¹

Figure 4: the economic argument for investing in Early Years.



The Early Intervention Foundation, an NGO, adopts a similar approach in England but does not have the reach that comes from being a government programme.⁵³²

Mexico, Brazil and several other low and middle income countries use “conditional cash transfers” – policies which attach conditions such as the requirement to have children vaccinated or attend school to social benefits – to improve health and life chances. The largest programmes, such as Brazil’s Bolsa Família and Mexico’s Oportunidades, cover millions of households. The World Bank has evaluated these and identified the benefits they can bring.⁵³³

BRAC in Bangladesh works with the ultra-poor providing health services, micro-finance loans and education and thereby breaking down barriers between the sectors and improving

⁵³⁰ <http://www.gov.scot/Topics/People/Young-People/early-years/early-years-collaborative> Accessed 18 October 2016

⁵³¹ CHEME: Transforming Young Lives across Wales: The Economic Argument for Investing in Early Years; 2016

⁵³² <http://www.eif.org.uk/> Accessed 3 November 2016

⁵³³ http://siteresources.worldbank.org/INTCCT/Resources/5757608-1234228266004/PRR-CCT_web_noembargo.pdf accessed 18 October 2016

This brief survey has shown that the sustainability of the NHS is not a simple issue nor is the NHS simply a deliverer of health services. Moreover the NHS needs major change to be fit for service for the future. There are examples in the UK and elsewhere which show the ways in which the NHS could develop both in service terms and as a partner with others in health-creation.

Fundamentally, the NHS needs to be seen as having important roles both in underpinning the economy – and the future prosperity of the country – and in supporting the development of a healthy and resilient society in the UK.

This paper ends with a manifesto written by some of the leading clinicians and health scientists in the country as well as a number of social entrepreneurs and members of the cross-benches. It is an attempt to spell out the direction that the NHS and the wider health and care sector needs to take in this country and to start the creation of a future narrative for a sustainable and high quality NHS.

10. A Manifesto for a healthy and health-creating society

The manifesto has 4 aims and sets out actions that follow from them. The aims are described here and the full document can be accessed from the Lancet online for 7 October 2016.

Aim 1. The UK should strengthen its role as a global centre for health and the bio-medical and life sciences.

Health, bio-medical and life sciences need to be at the centre of the UK's industrial strategy and vision for the future as an outward facing country, networked globally, building on the country's great traditions and values – and helping shape the future health, prosperity and security of the UK and the world. This will require all sectors: the commercial life and bio-medical sciences as well as the NHS, academia, government and voluntary organisations to build closer and more productive links to achieve synergy and impact.

The UK has the enormous comparative advantage that the HNS is the largest integrated health system in the world and is the ideal platform for developing still further the science and technology vital to health and to the country's economy.

At the same, time, however, as described in Aim 2, the NHS needs to modernise – with the help of the UK's science and technology based industries.

Aim 2. The transformation of the health and care system from a hospital-centred and illness-based system to a person-centred and health based system needs to be accelerated and funded.

This will require a massive increase in services in homes and communities and new ways to empower front-line staff, enabled by technology, to manage the complex needs of patients across different services and organisations. It will also require the involvement of many different partners and providers and the development of new infrastructure. Above all, however, there needs to be the far greater engagement of patients and carers in decision making and care – and enabling them to live as independently as possible.

The NHS, however, cannot do it by itself but needs every sector of the community as described in Aim 3 to fulfil their responsibility for improving – and not damaging – health.

Aim 3. The UK needs to develop and implement a plan for building a health-creating society – supported by all sectors of the economy and the wider population – and which addresses health inequalities.

Current plans for health promotion and disease prevention are too small scale and fragmented and need to be replaced by a much larger-scale and society wide effort. The NHS spends very little on prevention and while there are calls to increase it, it is clear that this cannot be done by the NHS, health professionals and politicians alone. Achieving real impact on the health of people throughout society requires leadership and action from all sectors.

The founding of the NHS in 1948 was a great national coming together around the shared purpose of providing health services for everyone. An equally bold initiative is needed today to bring together the expertise and resources of all the parts of society which impact on health – employers, teachers, designers, manufacturers as well as citizens, community groups and government - to improve health for all and build a health creating society. A health creating society can only be built in a society which itself is healthy and health and science institutions as described in Aim 4 have a role to play in this.

Aim 4. Health, care and scientific institutions should help develop and restore a healthy society in the UK.

The UK's health, care, science and broader academic communities embody values of social solidarity and have a crucial part to play in developing and restoring a healthy society in the UK. They are smaller versions of UK society with the same diversity of population, culture and skills. Tackling racism, promoting equality in all its forms and celebrating innovation and creativity are vital to the sector - and to the country as a whole.

2 November 2016

Anne Marie Culpan – Written evidence (NHS0190)

1. Background

The introduction and development of medical imaging over the last century has brought significant advances in both diagnosis and treatment of disease. In 2015-16 (the last year for which statistics are available) nearly 23 million conventional x-ray examinations, 9 million ultrasound and nearly 7.5 million CT / MRI scans were performed. The number of imaging investigations performed rises by approx. 2% per year, demand is further expected to exacerbate because of the need to diagnose and monitor disease in:

- an increasing number of people expected to access NHS services (population growth);
- an increasing number of elderly people, people with long term conditions and people with more than one condition;
- expansion of preventative (screening) programmes involving imaging.

Increases in the number of imaging investigations performed is also driven by technological development – innovations in digital image acquisition and molecular medicine for example, heralding examinations of increasing complexity that are time consuming to both perform and interpret. A typical CT or MRI scan may generate 300 and 500 individual images to be reviewed before a diagnostic conclusion can be reached.

Traditionally responsibility for performing imaging examinations, that is positioning patients and acquiring images, has been the responsibility of non-medically qualified allied health professionals – radiographers, and responsibility for interpreting imaging examinations, that is making the image-based diagnosis, has been the professional domain of medical doctors – radiologists. However, as demand for and range of imaging examinations has increased, and at a faster rate than the clinical capacity of radiologists has increased, the role of radiographers has expanded to incorporate some image interpretation. Radiographers have also expanded their role to perform some image-guided diagnostic (tissue sampling – biopsy) and therapeutic (musculoskeletal local anaesthetic injection) procedures that traditionally were only performed by doctors.

With over a quarter of a million people waiting more than a month for imaging investigations to be performed (2015) and 99% NHS Trusts failing to meet demand for image reporting – sustainability of the NHS going forward requires investment in both additional radiology (medical) resource, additional non-medical imaging (radiographer) resource and investment in medical imaging technologies that have the capacity to improve the efficiency (timely) and the quality (accuracy) of image based diagnosis and treatment.

There is evidence that the quality of care, in terms of diagnostic accuracy interpreting images, provided by radiographers is at least equivalent, if not in some instances better than that provided by radiologists. In terms of financial sustainability, radiographers are approx. 33 – 50% cheaper to train and employ than radiologists. Unlike radiology, which has trouble recruiting, in particular to specialties such as intervention and breast imaging, recruitment to radiography training programmes is healthy.

Over the last 30 years radiographer role development has emerged as a solution to radiology medical workforce capacity problems. To date this has been somewhat piecemeal and localised and has been contingent on the support of a few insightful and progressive local managers and radiologists. With a more strategic approach, selective investment in continued career progression of the non-medical imaging workforce, alongside further investment in expanding the medical radiologist workforce, offers potential to transform the current workforce into an integrated labour force that has the best the potential to realise sustainable transformation of imaging services for the future.

I would like to draw the Committee's attention to the following specific examples related to the terms of reference of the review and my own particular field of expertise and interest.

2. Medical innovation

Technical innovation in medical imaging has introduced examinations of increasing complexity that are time consuming to perform (require more radiographers) and to interpret (require more radiologists).

In order to address this:

- the non-medical profession have introduced the '**assistant radiography practitioner**' role – this requires a one-year training programme to become competent to perform a limited range of straight forward uncomplicated conventional radiographic (image acquisition) examinations - appendicular skeleton (upper and lower limb), 2- view (screening) mammography, for example, on cooperative adult patients. Removing this workload from the remit of registered radiographer practitioners frees up capacity for them to undertake the more complex examinations. Introducing a lower grade more narrowly trained worker into the image acquisition role is also associated with cost savings – equity which can be transferred to fund the increased demand for imaging;
- some radiographers have undertaken postgraduate M-level training incorporating qualifications which **up-skill** them to undertake image interpretation. Substituting a radiographer to interpret less complex conventional radiographic investigations such as appendicular skeleton and straightforward acute head CT scans, in turn releases consultant radiologist capacity to interpret more complex examinations and perform image-guided interventional procedures of a more clinically complex nature. **Telemedicine** capability, with the ability to view images remote from where they are acquired, enables an expert (radiologist) opinion to be sought instantly, for any unexpectedly difficult cases the radiographer might encounter. As above – the substitution of a (lower paid) non-medical worker is associated with cost efficiencies that might be deployed elsewhere to fund additional activity;
- industry (e.g. Siemens partnership with IBM Watson) is developing big data and machine learning innovations that have potential to introduce **computer assisted detection/diagnosis** into the discipline. Prototypes for pulmonary nodules, bowel polyps and breast lesions have all demonstrated the potential to improve the discrimination of cancer and non-cancer image abnormalities. Over the next 20 years machine learning is expected to play a central role in radiology service provision - its

routine incorporation into workflow will offer the potential to pre-analyse the large data sets from more complex imaging examinations, and create draft reports – diagnostic support in this form should alleviate time pressures on radiologists. Although initial investment in such innovation is likely to be expensive, long term return on this investment is likely to generate efficiency gains such as improved demand management (individualised care reducing blanket referral for multiple examinations), cost reduction (fewer but targeted examinations, reduced investigator performance time, more thorough analysis of complex imaging examinations and in a shorter time frame) and improved quality (greater accuracy and fewer human errors).

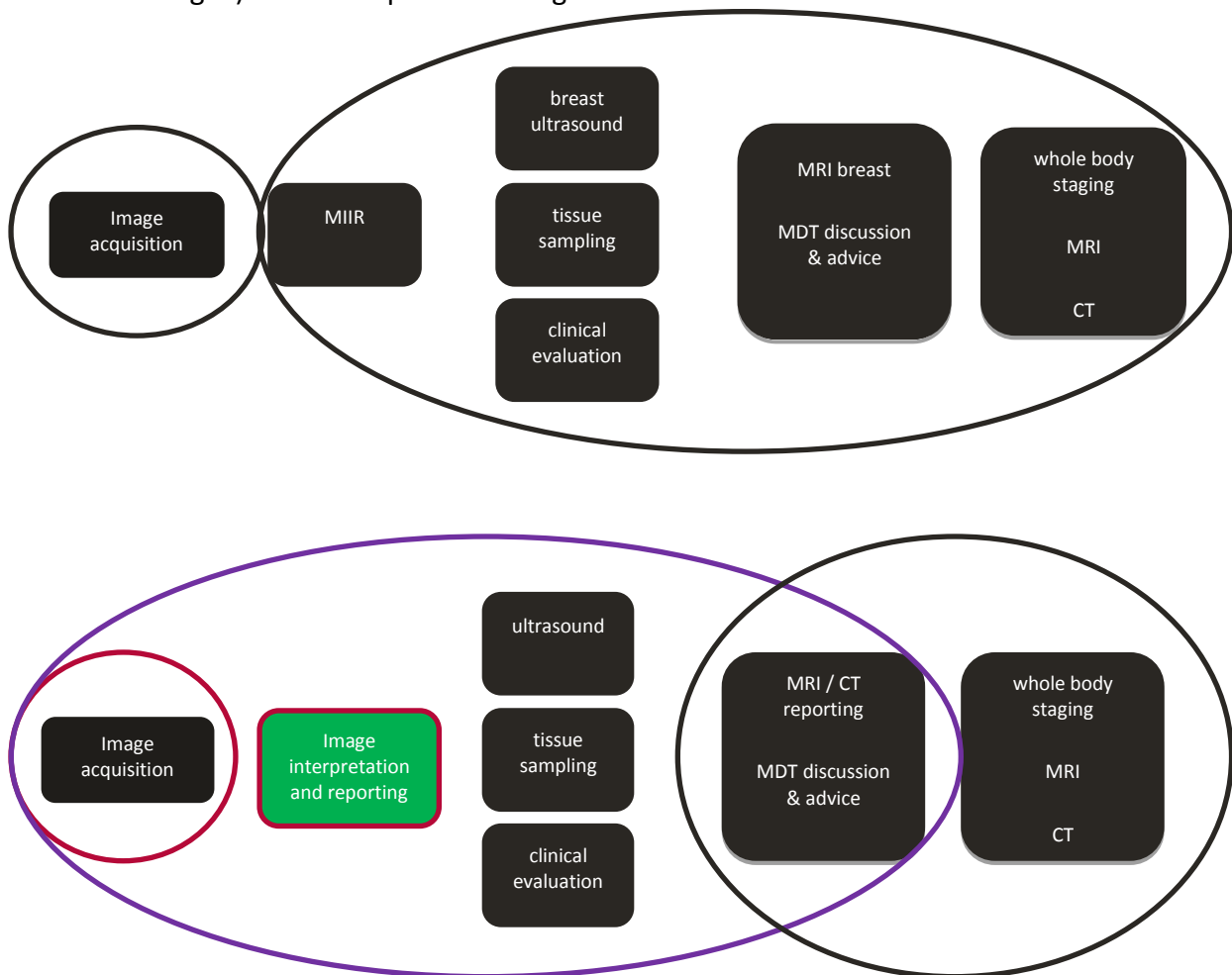
3. Demographic change

In the UK, change in population demographics and disease, for example increased prevalence of long-term conditions and increased numbers of people with more than one condition, add further pressure to imaging services because they increase the need for screening, diagnostic and monitoring investigations.

For example, in my area of clinical interest – breast cancer screening and diagnosis:

- Breast screening is based on population mammography (breast x-ray imaging). The NHS breast screening service images more than 2 million women every year and its reach is expanding. As the **population ages** and people with breast **cancer survive longer** due to a combination of early diagnosis and better treatment, more women will be eligible for screening and surveillance (annual follow up mammograms to detect recurrence). **Expansion of mammography screening** has been facilitated by the introduction of assistant practitioners, to do some of the work performed traditionally by radiographers. Assistant practitioners take only 1 year to train to undertake (routine 2 view) mammography (on cooperative able women) and are paid at Band 4 (£19 - 22K), in comparison to a radiographer who must undertake a 3 year BSc (in radiography) followed by a 1 year postgraduate certificate (in mammography) and is paid at Band 6 (£26 – 35K).
- In turn this has freed up experienced radiographers to expand their role to take on some of the duties in the traditional domain of the medically qualified radiologist. Following pioneering studies in the early 1990s, and the establishment of bespoke HEI postgraduate training courses, radiographers now have an established role interpreting screening mammograms in 'double reading' schemes of work alongside radiologists. The latest research has demonstrated no risk associated with double reading by pairs of radiographers. Double reading improves care quality **by improving sensitivity** (detecting more cancers) and **improving specificity** (reducing anxiety and further investigation in women who do not have cancer). Double reading by radiographers **reduces demand on radiologist resource** and / or releases them to perform clinically demanding interventional or interpreting more complex (MRI / PET-CT) scans.

- In symptomatic breast imaging services, those services that address the need for urgent referral and investigation of people with clinical signs and symptoms of breast cancer, radiographers have expanded their role beyond the interpretation of radiographs (mammograms). Where services have had particular **difficulty recruiting radiologists** to the sub-speciality, they have not been able to deliver care without this radiographer skill development. The first diagram below shows the traditional scheme of work where a radiographer (purple) only acquired images and the radiologist (blue) was responsible for the rest of the patient pathway. The second diagram compares the new skills mix model which focusses the radiologist's role (blue) on interpreting complex whole body cancer staging examinations (CT / MRI) and advising multidisciplinary medical colleagues (surgeon / pathologist / oncologist) on clinical patient management.



Quite clearly transforming the workforce to include assistant practitioners (green circle - to undertake image acquisition [purple box]) and **advanced clinical practitioner radiographers** (purple oval - to undertake image interpretation [green box], ultrasound performance and interpretation and tissue sampling – biopsy [orange boxes] and involvement in additional modality interpretation and MDT meetings [red box]), reduces the amount of work radiologists (blue circle) have to do in this service. Typically an Advanced Clinical Practice radiographer would take 6 years to achieve competence and be paid £31 – 41K, in comparison to a Consultant Radiologist who would take at least 12 years to train and be

paid a minimum of £76K (up to £102K + up to £76K in ‘excellence’ awards) to undertake the same tasks.

- Expanding the role of radiographers in breast services has improved the quality of care delivered in terms of individual **patient experience** and in terms of **access to care**. In the traditional skills mix model a patient referred to the breast clinic might be examined by a surgeon or nurse and then sent to a radiographer who would position them and acquire their mammogram images; a radiologist would then interpret the images at an office based workstation and might request an ultrasound scan; this could be performed and a preliminary report offered by a sonographer (post graduate qualified radiographer); the radiologist might then look at a few representative still ultrasound images and the provisional report and decide to do a biopsy. The radiologist then might spend 5-10 minutes injecting anaesthetic and taking tissue samples leaving a health care assistant to undertake aftercare – the patient is cared for by at least 5 different practitioners. By contrast in the new model the advanced clinical practice radiographer has an adaptable skill mix and can perform all the routine diagnostic examinations required in the clinic. The advanced clinical practice radiographer’s competencies give them a holistic overview of the entire patient journey – the patient’s experience is enhanced because they only need to undress and be examined by **one health care practitioner** and they **benefit from continuity of care and communication**.
- Advanced Clinical Practice radiographers who have specialised in breast imaging tend to spend all of their time in this single clinical domain unlike radiologists who often only do a few sessions a week in any one speciality. As such radiographers can be **deployed across the service more flexibly** to respond to fluctuating demand to meet referral to diagnosis targets. Clinical specialist advanced practice radiographers are more easily available in the right place at the right time to better meet the needs of individual patients, than radiologists are.

The above examples, from my own area of clinical expertise and research, demonstrate how service delivery (capacity & access) and patient care (satisfaction) can be enhanced if the traditional role of the radiographer is transformed at the lower end to support increased numbers of assistant practitioners and at the upper end to support up-skilling career progression into advanced clinical practitioner roles. This model is not confined to the breast imaging application illustrated above but is transferable across the imaging service.

4. Sufficient and appropriate training

Following the CSR postgraduate medical education (radiologist specialty training) is still funded and managed centrally. The non-medical imaging workforce training system has changed and is no longer supported by HEE funded commissioning. The radiography profession has **concerns about how moving the non-medical imaging workforce training to the ‘student loan’ system** will affect recruitment, retention and career progression to undergraduate radiography BSc programmes and postgraduate MSc advanced practice (ultrasound, image interpretation, breast imaging, CT and MRI) courses.

Potential exists in the new **health apprenticeship scheme**. On the face of it, this might be an attractive route to attract assistant practitioners. Workplace based training on the job, whilst receiving a salary and having a guaranteed post at the end of training mirrors what exists typically now, where Trusts attract new people into the healthcare workforce or capitalise on the experience of existing health care support workers, to train as assistant radiography practitioners using HEI Certificate in Higher Education or Foundation Degree programmes, to give them competence to undertake a limited scope of examinations.

The new apprenticeship scheme also has potential as an alternative route into radiography for people who cannot, do not want or are unable to access traditional 3 year full time student loan funded BSc degree programmes. **Higher apprenticeships**, incorporating MSc degrees, also have potential to support the development of Advanced Clinical Practitioners. The contribution that these radiographers can make to addressing the medical radiologist workforce shortage and increasing demand for imaging should be **recognised and prioritised for funding** / support. Specific and targeted **support for the career development** of the current non-medical imaging (radiographer) workforce could be crucial to their retention in the NHS – they are motivated and have untapped competence capital, the most cited reason for leaving radiography and / or leaving the NHS is because they feel unsupported and undervalued.

Direct entry MSc programmes (with registration) have the potential to increase supply of non-medical professionals into the imaging workforce. **Changing entry systems** for imaging healthcare providers will require changes to **statutory registration** arrangements. The Society of Radiographers has a voluntary register for assistant radiography practitioners and sonographers (non-medical health care providers who perform and interpret ultrasound scans) but this does not afford the public the same quality assurance as state registration. As has been suggested for nurse associates (to be regulated by the NMC), the regulation of new imaging health care providers (by the HCPC) needs to be prioritised.

5. Summary

Population demographics and developments in medical technology are expanding the capacity, role and remit of imaging for diagnosing and monitoring disease, guiding minimally invasive interventional treatment and promoting health and wellbeing through preventative screening. Big data and the advent of genetic and genome medicine herald a new paradigm of personalised medicine which will invariably change the way that imaging services are delivered. The roles of imaging professionals, both medical and non-medical will need to continue to change so that they can meet increased demand and deliver individualised person centred imaging.

The NHS employs just over 3,500 medical radiologists and over 16,000 non-medical radiographers. The examples above demonstrate unequivocally that this workforce needs to be considered as a single inter-dependent entity. Imaging services require a combination of medical and nonmedical healthcare providers all working at the upper limits of their competence skill sets. No imaging professional should be doing work that can safely be undertaken by a lesser / more narrowly qualified practitioner. Removing professional funding silos, selectively targeting short term efforts at maximising the potential of the non-

Anne Marie Culpan – Written evidence (NHS0190)

medical workforce will allow the NHS to bridge the current medical workforce skills crisis until more radiologists can be trained. Investment in technology infrastructure will help the imaging workforce manage increasing demand and implement Big Data, Machine Learning and genomic medicine solutions to prioritise allocation of its resource.

11 December 2016

Dell EMC – Written evidence (NHS0070)

Introduction

1. Dell EMC welcomes the opportunity to contribute evidence to the Select Committee on the Long-term Sustainability of the NHS. This response begins with an executive summary followed by a short introduction to Dell EMC, its expertise, and capabilities. It then addresses some of the committee's specific questions.

Executive Summary

- Better use of data and technology in the NHS can bring huge efficiency savings and fundamentally transform how care is delivered. A recent report by the economic consultancy Volterra Partners examined the productivity and financial implications for the NHS of making more widespread use of current best practice with regard to the use of information and analytics technology across the NHS. This report found that doing this would improve efficiency in the healthcare sector by between 15% and 60%, resulting in savings to the NHS of between £16.5 billion and £66 billion per year.⁵³⁷
- There is an opportunity to respond to the challenges posed by an ageing population and rise of long term conditions by using data more effectively to move to a more proactive, preventative, and personalised system – the Wellness Model.
- This can be achieved by focussing on:
 - Interoperability of patient records, enabling them to be accessed and updated at any point in the healthcare system.
 - Greater use of data analytics, to enable risk stratification and prevention, and improved treatment outcomes.
 - Using mobile technology to enable health professionals to work more efficiently and make patients more engaged in their care through use of e.g. apps and health monitors.
- To deliver this vision the NHS needs to invest in workforce skills, technology, and encourage greater collaboration between. There are also organisational changes within the NHS which would accelerate this.

About Dell EMC

2. Dell EMC, a part of Dell Technologies, enables organisations to modernise, automate and transform their handling of data using industry-leading converged infrastructure, servers, storage and data protection technologies. Dell EMC services customers across 180 countries – including 98% of the Fortune 500.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

⁵³⁷ *Sustaining universal healthcare in the UK: Making better use of information; Volterra Partners; 2014;*
<http://volterra.co.uk/wp-content/uploads/2014/09/Final-EMC-Volterra-Healthcare-report-web-version.pdf>

3. A number of organisations have identified that the ageing population and rise of long term conditions are placing significant strain on the NHS budget. According to the latest figures published by NHS Improvement, NHS trusts recorded a £461 million deficit in the three months to June, despite the additional £1.8 billion of extra spending allocated for the current financial year to reform services and stabilise hospitals' budgets.⁵³⁸ Research also suggests that without reform the health service as a whole could face a £20 billion funding shortfall by 2020-21.⁵³⁹
4. Making more effective use of technology and data offers a way of avoiding major cuts to NHS services. It offers an opportunity to deliver huge efficiency savings while also fundamentally transforming and improving how care is delivered. How to deliver on this vision was explored in the 2014 report by the independent economic consultancy Volterra Partners entitled *Sustaining universal healthcare in the UK: Making better use of information*,⁵⁴⁰ which was supported by EMC and accepted by the Royal College of Physicians and NHS England. This report found that technology can support collaboration and the sharing of information between different parts of the health system to create a more joined up system and enable healthcare to be delivered in a more proactive, personalised, and preventative fashion – a “Wellness Model” – as opposed to the current, system based on acute care. This is because early identification and treatment significantly increases the chances of a successful outcome and results in lower overall costs.
5. A key component of this would be using technologies like genome sequencing and targeted medicine to determine appropriate care pathways, minimise waste and cater for changes in the way services are provided. For example, more effective use of patient data can improve after care through the use of targeted drugs, remote monitoring technology feeding directly in to patients' electronic records, and better links between the health and social care system, to prevent hospitalisation. It can also reduce the cost of in hospital care by reducing complications, unnecessary diagnostic tests and streamlining treatment to reduce the amount of time patients stay in care.
6. To achieve this vision and achieve gains in efficiency and cost effectiveness, there needs to be appropriate investment in the NHS workforce and technology systems, as well as structural reforms to encourage collaboration. The latter should include abolishing the provider-commissioner split and returning to a system in which a central intelligent customer can coordinate healthcare commissioning across the country. This would put an end to unnecessary competition between and duplication of services and functions among CCGs and Providers. It would also enable skilled staff to be deployed more efficiently across health economies, resulting in lower management and service costs, reducing waiting times and improved quality of care and access to treatment for patients.
7. This can be achieved by centralising the management of money and allocating funds on a health economy level, using real time data to apportion funds and support the development and approval of business cases. Instead of CCGs, local health economy

⁵³⁸ *Hospitals plan cuts in services as NHS budget deficit continues*; Financial Times; 25 August 2016;

<http://www.ft.com/cms/s/0/d414ec22-6ace-11e6-a0b1-d87a9fea034f.html#axzz4Kh7Pzcyp>

⁵³⁹ *NHS plans closures and radical cuts to combat growing deficit in health budget*; The Guardian; 26 August 2016;

<https://www.theguardian.com/society/2016/aug/26/nhs-plans-radical-cuts-to-fight-growing-deficit-in-health-budget>

⁵⁴⁰ <http://volterra.co.uk/wp-content/uploads/2014/09/Final-EMC-Volterra-Healthcare-report-web-version.pdf>

management boards, including representatives from primary and secondary care, social care, and mental health, should be created. These would ensure that services are located in the right place and avoid duplication of services within individual healthcare economies. They would also enable coordination of staff, patient services, and more efficient procurement, while significantly cutting management costs. As the former head of the NHS Sir David Nicholson has acknowledged, the internal market reforms have run their course and now is the time to put a governance structure in place to manage resources and drive performance while avoiding internal politics and wasteful competition and duplication.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

b) What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

8. As highlighted above, a single management team above would be better placed to achieve best value and avoid duplication.
9. As part of this there would be more emphasis on demand management, using demographic and patient data to coordinate where services are needed and how they should be designed and delivered. Instead of simply tracking activity and patients treated, outcome data should be used to create an incentive for wellness. This would also allow the system to take account of changing demographics, the rise of long term conditions, and make the best use of new health technologies reliant on better use of data such as genome sequencing and translational medicine to tailor treatments and care pathways, target drugs and limit negative side effects, and reap the benefits of remote sensors to monitor patients at home instead of caring for them in expensive hospital settings.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

10. There must be investment in appropriate skills throughout the health workforce to enable the benefits of technology and data to be realised. Key elements will include data handling and coding. Analytics will fundamentally change the nature of research and it is important that there are enough people with the appropriate data science skills to maximise the benefits.
- a. **What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?**
 - b. **What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?**
 - c. **What are the retention issues for key groups of healthcare workers and how should these be addressed?**

11. Brexit is likely to affect the ability of the NHS to recruit staff from other EU countries. However, it is important to remember that European training and standards do not always reflect those here in the UK, meaning that workers from EU countries often have to undergo training courses in order to be able to work here. In addition, the NHS recruits large numbers of staff from outside of the EU, primarily driven by cost.
12. A solution to both these issues would be to address the issues around the perceptions and status of certain jobs in the NHS, and create a system with more emphasis on on-the-job training, upskilling and progression. In such a system more people would be able to work their way up the system from more junior grades and vocational occupations to more senior clinical and management positions, reducing the need for foreign workers to fill key skills gaps.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

13. From a workforce planning perspective, data analytics can help predict and shape future healthcare demand and needs, and therefore enable managers to plan ahead and ensure they have the right mix of staff and skills.
14. Remote training technologies can also be used to accelerate the training process and make it more efficient. A Da Vinci surgery robot, for example, has a 3D remote console module that can be used to train surgeons on new procedures from anywhere in the world. The robots are also capable of running four or five training sessions per day, reducing the amount of time required to train a surgeon and make the whole process more efficient.
15. Removing the need for classroom based training would create an opportunity to minimise disruption and enable more people to train at a time and place suitable for them

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

16. A more adaptable workforce would reduce overall costs and help eliminate duplication. It would minimise the need for as many specialist roles and the use of external contractors on expensive short term contracts to fill skills gaps. Combined with more extensive use of sensor and monitoring technology, treatment can be supervised remotely and specialists can be placed where they are most needed.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

17. The key change required to deliver this is the application of technology to improve coordination and the handover of care between the health and social care systems. This will ensure greater continuity in care, and a much more seamless experience for

patients as social care workers are fully aware of the particulars of a given patient and all the treatments they have had.

18. Creating the integrated local health economy boards described earlier in this submission, covering the entire patient pathway and including representatives from health, social care, and other key services, will help deliver an integrated National Health and Care Service. This will end the duplication of services and enable the creation of a sustainable and truly integrated system. But this needs to come hand in hand with other key reforms including:
 - a. Moving away from activity-based to outcome based-funding;
 - b. Moving to the 'wellness model' of care, in which health is managed more proactively and patients are engaged in the treatment process, including via technology;
 - c. Creating teams with a wide range of skills and encompassing the full range of services needed to address the needs of local populations, including the elderly, and those requiring rehabilitation and mental health services;
 - d. Using technology to help design and shape change in service provision in conjunction with clinical reviews of service;
 - e. A recognition of the importance of technology in healthcare at both board and senior voting executive levels. Healthcare cannot be provided without technology yet there are very few technology leaders across the NHS and poor leadership coming from central departments.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

19. As highlighted above, using data in a fundamentally different way throughout the NHS will be critical to moving to a more preventative system. To deliver this a more skilled workforce will be needed to carry out risk stratification and predict which conditions individual patients are likely to develop in the future, and provide appropriate treatments. In addition, making more use of real time information to determine how services are planned and delivered will also be key.
20. Health boards need to recognise and embrace the use of technology to re-shape the provision of services. Technology needs to be at the heart of all service transformations and not implemented after service changes have been decided (usually without an understanding of the way services could change if the appropriate technologies were implemented).

g. How could technology play a greater role in enhancing prevention and public health?

21. There is an opportunity for a future NHS Choices service to provide public health advice in a fashion that is both much more dynamic and engaging to citizens, and more fully integrated with other key public services. Tailored advice could be provided to people in the format best suited to their individual needs and circumstances, as well as via other key services like Jobcentre Plus or social housing provision. For example, basic health and wellbeing awareness training could be

made a core component for anyone claiming welfare benefits, to help support the change in culture needed to support the wellness model

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

b. What is the role of 'Big Data' in reducing costs and managing demand?

22. As highlighted earlier in this submission, better use of technology and data can support collaboration and the sharing of information between different parts of the health system to create a more joined up system and enable healthcare to be delivered in a more proactive, personalised, and preventative fashion – a “Wellness Model” – as opposed to the current, system based on acute care.
23. A key component of this would be using technologies reliant on (big) data and analytics like genome sequencing and targeted medicine to determine appropriate care pathways, minimise waste and cater for changes in the way services are provided. For example, more effective use of patient data can improve ‘after care’ through the use of targeted drugs, remote monitoring technology feeding directly in to patients’ electronic records, and better links between the health and social care system, to prevent hospitalisation.

c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

24. In addition to the availability of the right data science and skills within the health service, there needs to be a greater understanding and awareness of examples among clinicians and commissioners about how technology, data and more intelligent use of information can shape services and patient outcomes.
25. The cost of analytics software and technology need not be a barrier: it is possible for health providers to work with partners and start small and scale up as and when required. Once use cases are proven,
26. providers can then think about building their own in-house or real time capabilities.
27. Whatever model is followed, analytics can also be implemented with appropriate safeguards to protect patient data. In our view the key features of a robust information governance framework should include:
 - a. Viewing information governance as an enabler for information sharing, the provision of better care, and research;
 - b. Ensuring dynamic and skilled leadership within health organisations, including a Director at Board level, who is formally responsible for information governance and who can oversee the safeguarding of personal confidential data; and another holding a suitable ICT professional qualification, charged with the responsibility for all Information and technology services within the organisation;
 - c. Developing clear policies, processes, access control protocols, and ways in which to get appropriate levels of support proactively applied;

- d. Harmonising and consistently applying guidance and processes across the organisation to enable staff to feel confident in applying them appropriately in a manner that helps to develop a dynamic and innovative environment;
 - e. Ensuring that everyone working with personal confidential data is aware of and understands their responsibilities;
 - f. Publishing in a prominent and accessible form information to let the public know what data sharing is taking place and why.
28. A key example of the potential application and benefits of data analytics in health is that of NHS Scotland, which has developed an integrated care model for the treatment of diabetes based on bespoke data analytics services developed in conjunction with the provider Aridhia, which has reduced the need for amputations by 30%, and significantly reduced costs.⁵⁴¹
29. The Volterra report cited above examined the productivity and financial implications for the NHS of making more widespread use of current best practice with regard to the use of information and analytics technology across the NHS. This report found that doing this would improve efficiency in the healthcare sector by between 15% and 60%, resulting in savings to the NHS of between £16.5 billion and £66 billion per year.

d. How can healthcare providers be incentivised to take up new technologies?

30. This could be achieved by linking investment in technology to turnover in the CQUIN or as a top slice of tariff. This would see full funding only being unlocked if a given investment in technology takes place. To be effective however technology would need to be separated out from medical equipment, similar to the Healthcare Information and Management Systems Society's 'Meaningful Use' requirements.

e. Where is investment in technology and informatics most needed?

31. Investment in technology will deliver the greatest effect in:
- a. Improving the commissioning of services and health economy planning via the use of internal Informatics and remote modelling;
 - b. Enabling the agile development of web-based systems to replace legacy applications;
 - c. Enabling services to be provided both inside and outside of organisations, and data to be re-used for other clinical applications;
 - d. Enabling SMEs and other third party organisations to support local health economies by identifying ways big data analytics and decision support can be applied to transform the delivery of services and provide specialist capability.

23 September 2016

⁵⁴¹ <http://www.aridhia.com/>. Information on Aridhia's work with NHS Scotland is detailed on p.31 of the Volterra report cited above.

Department of Health – Written evidence (NHS0018)

Dear Lord Patel

**LORDS SELECT COMMITTEE ON THE LONG-TERM SUSTAINABILITY OF THE NHS – ACTIONS
FROM THE ORAL EVIDENCE SESSION ON TUESDAY 12 JULY 2016**

Thank you for the opportunity to give evidence before the Lords Select Committee looking into the Long Term Sustainability of the NHS, on Tuesday 12 July 2016. In our session we said that we would write to you to clarify a number of points; I hope this letter and the covering sections answer all the questions you and your fellow committee members raised.

We have broken up the commitments to write into their constituent parts and attach sections as follows –

Section 1 – Finance

Section 2 – Workforce

Section 3 – Technology

Section 4 – Integration of health and social care

We trust that these responses answer the questions that the Committee raised and will of course provide any further evidence as requested. However, please do accept our sincere apologies for the delay in getting this letter to you.

Yours sincerely

Andrew Baigent, Director of Finance, Department of Health

Gavin Larnar, Director of Workforce, Department of Health

Tim Donohoe, Director, Informatics Delivery Management, Department of Health

Dr Edward Scully, Deputy Director, Integrated Care, Department of Health

Mark Davies, Director, Population Health, Department of Health

Section 1 – Finance

Finance Announcement for 2016/17 Plan

It was promised during the evidence session that the Department would send details of the finance announcements to be made in regards of plans for 2016/17.

NHS England and NHS Improvement wrote to providers on 21 July setting out the actions required to stabilise NHS finances in 2016/17, which we detail for the committee below – this will be a focus for the whole Government going forward.

In a wide-ranging seven-point set of actions NHS England and NHS Improvement have:

- 1) allocated an extra £1.8 billion to trusts (the Sustainability and Transformation Fund), with the aim set by NHS Improvement of cutting the combined provider deficit to around £250 million in 2016/17 and the ambition that, in aggregate, the provider position commences 2017/18 in run-rate balance;
- 2) replaced national fines with trust-specific incentives linked to agreed individual published performance improvement trajectories, so as to kick-start multi-year recovery against A&E and elective care targets;
- 3) agreed 'financial control totals' with almost all individual trusts and clinical commissioning groups (CCGs), which represent the minimum level of financial performance against which their boards, governing bodies and chief executives must deliver in 2016/17, and for which they will be held directly accountable;
- 4) introduced new intervention regimes of “special measures” which will be applied to both trusts and CCGs not meeting those financial commitments;
- 5) set new controls to cap the cost of interim managers and to fast track savings from back office, pathology and temporary staffing;
- 6) published the 2015/16 performance ratings for CCGs; and
- 7) launched a two-year NHS planning and contracting round for 2017/18-2018/19, to be completed by December 2016, and linked to agreed Sustainability and Transformation Plans (STPs).

Full details have been published in a “*Strengthening financial performance & accountability in 2016/17*” document on 21st July. This can be found on NHS Improvement’s website – <https://improvement.nhs.uk/resources/strengthening-financial-performance-and-accountability-201617/>.

In addition, NHS Improvement have placed five challenged NHS providers in financial special measures in order to bring about swift improvement in their finances and as part of this each trust will undergo a rapid review, and agree a financial recovery plan. Specialist teams, led by an improvement director, will oversee intensive, accelerated action to bring about financial improvement including support from peer providers where appropriate. Details can be found on NHS Improvement’s website - <https://improvement.nhs.uk/news-alerts/strengthening-trusts-financial-and-operational-performance-201617/>.

In recognition of the fact we need a whole system approach to retaining financial discipline, NHS England placed nine CCGs who are not meeting their financial commitments into financial special measures. Details can be found on NHS England’s website - <https://www.england.nhs.uk/2016/07/operational-performance/>.

Control Totals and the Methodology for their calculation

We also agreed to give you the methodology behind the control totals that have been set out. NHSI have calculated a 'control total' for each provider, which is the surplus or deficit that they expect providers to achieve, as a minimum level of financial performance.

Providers who achieve these totals will be eligible for a share of a £1.8 billion Sustainability and Transformation Fund (STF). A general element of 1.6bn is allocated to all providers of emergency care, who have been under the greatest pressure financially. It will also include a targeted element (£200m) to support providers to who have plans to achieve further efficiencies. This money will be allocated on a case-by-case basis where it can deliver the greatest benefits. To be eligible to access the targeted element of the STF providers must have accepted an agreed control total and the conditions of the fund. Individual control totals will be updated as required for those who receive additional funds.

The control totals are calculated from a starting point of an aggregate deficit of £1.8 billion for the NHS trust and foundation trust sector, adjusted for additional activity and cost growth as described in the published Sustainability and Transformation Fund Document (see below). The control totals reflect the minimum improvement in financial position that NHS Improvement expects each provider to be able to achieve in 2016/17, given their provisional allocation of the STF. This takes into account each provider's current financial position and opportunities for efficiencies. Given the final 2015-16 provider deficit is now known to be £2.45 billion, NHS Improvement has initiated further action to support providers to reduce the underlying deficits: efficiencies such as tackling excessive pay-bill growth, implementation of Lord Carter's recommendations on back office pathology consolidation, consolidation of unsustainable services; implementation of controls on agency spending. The control totals have been calculated using an impact assessment model developed by NHS Improvement. The model takes into account a range of known factors at an individual provider level. To see the full document that sets out further detail around the Sustainability and Transformation Fund and the mechanics behind how the control totals were calculated, see [The Sustainability and Transformation Fund and financial control totals for 2016/17: methodology](#).

Section 2 – Workforce

We said that we would send you the details of three long term strategic reviews in to the NHS workforce. The NHS workforce has of course expanded significantly under the current Secretary of State, which provides the backdrop to what follows.

Horizon 2035

The Department of Health (DH) commissioned research from the Centre for Workforce Intelligence (CfWI) to investigate what skills might be needed in 20 years' time. The resulting research is published as 'Horizon 2035'.

This horizon scanning and long term workforce planning research quantified and modelled multiple plausible future scenarios and the results provide intelligence on the demand pressures our health and care system and workforce face. This work took into account the following factors (amongst many others) up to 2035:

- population demand including physical and mental health long term conditions;
- the impact of technology and its effect on productivity;
- workforce flexibility;
- workforce mobility (including migration);
- the level of self-care; and
- the state of the economy.

This work found that:

Demand for workforce time is growing faster than population - We project that demand for health and care workforce time could grow more than twice as fast (+1.3 per cent as an annual average growth rate) as the rate of overall population growth (+0.6 per cent as an annual average growth rate) to 2035.

The significance of long-term conditions - Over 80 per cent of additional demand is driven by increasing healthcare and support needs which are associated with long-term conditions. This relates both to the ageing population and a projected increase in prevalence across age groups.

A different skill profile in 2035 - The initial Horizon 2035 results suggest that the future profile of demand may be profoundly different to the picture of demand today. For example, growth in demand for lower 'levels' of skill – such as those associated with unpaid care, support carers and NHS bands 1-4 – are projected to substantially outstrip growth in demand for higher skill levels associated with medical and dental professionals.

Stimulating new ways of thinking - Quantifying and projecting the whole health, social care and public health system in terms of the component workforce skills can reveal new insights for workforce planning. These insights can surmount notions of workforces and sectors and help to align the skill mix of the future with the case mix of the future.

This work is guiding further work at the strategic level with a longer term focus to support policy development as well as further investigating specific workforce issues working with ALBs such as HEE.

The report can be found at:

<https://www.gov.uk/government/publications/horizon-2035-future-demand-for-skills-initial-results>

NHS Improvement and NHS Employers retention study

NHS Improvement (NHSI) is undertaking a project to explore the key drivers of nursing turnover and how retention can be improved. The project is exploring what the key drivers of turnover in NHS trusts and foundation trusts in England, and developing case studies of trusts that have successfully improved nurse retention. NHS I is testing the findings with experts on nurse retention including HR Directors and Directors of Nursing in trusts with a good level of turnover, the Royal College of Nursing, Unison and NHS Employers. The project will support HR and Nurse Directors by informing their nursing workforce strategy. NHS I plans to present emerging findings to the NHS Improvement Clinical Advisory Forum later this year, followed by the final outputs. Following this work, NHS I plans to conduct a further review of the drivers of medical workforce attrition and how retention can be improved.

NHS Employers has worked with employers over the past year to raise awareness and understanding of the different approaches to recruiting and retaining talent. A range of guidance, tools and resources is available at the NHS Employers website to support employers in valuing and retaining their staff.

HEE strategic framework

Health Education England's 15 year strategic workforce framework – Framework 15 – was published in July 2013. It aims to:

- guide decisions made in the short term; and
- inform longer term planning and work plans.

You can find a copy here:

<https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Strategic%20Framework%20%202015%20Refresh%20Final%20document.pdf>

NHS skills mix

Horizon 2035 looks at health, public health and social care together; the 20-year timeframe; and thinking beyond current notions of workforces and sectors to consider the future demand for skills at a system wide level. For Horizon 2035, a 'skills and competence lens' has been developed. It provides a common framework to describe varied workforce activity within and between the three sectors.

The work considers the aggregate demand for 'wellbeing' skills for the next 20 years and identifies demand pressures by skill type e.g. in caring and prevention skills areas as well as changing mixes of skills by complexity and demand source.

In terms of addressing workforce gaps and shortages, DH works with the ALBs to identify workforces at risk and to develop appropriate responses. The key plans that describe a wide range of workforces across health and care are the HEE 10 to 15 year view and the longer term DH 20 years plus view.

We committed to providing you with names of officials who were considering this aspect of workforce planning. If you wish to make further enquiries on this subject, we would suggest that you contact Rob Smith, Director of Workforce Planning and Strategy, Health Education England, or Ian Cumming, Chief Executive Officer, Health Education England. We can happily provide contact details.

Flexible working

The NHS is one of the largest employers in the world and should be a role model for best employment practice. Around a third of NHS staff work part-time. Flexible working

legislation allows all NHS staff, not just those that work part-time, the ‘right to request’ flexible working arrangements to help them balance their work and personal lives, including the ability to take breaks from employment. Locally, NHS employers should have policies in place which support staff that need to work less than full time because of caring or other responsibilities. It is of course important that working patterns support the needs of patients as well as staff.

The increasing number of women entering the medical profession has informed the development of the new junior doctors’ contract and terms and conditions so that it better supports those that work less than full time.

There will be transitional arrangements over four years from 2016 for existing junior doctors which are informed by forecasts on the proportion of doctors that may work less than full time during the period of transition. The new juniors’ contract (and transitional arrangements) is specifically designed to ensure that those that need or want to work less than full time (mainly women) are not disadvantaged.

Section 3 – Technology

During the evidence session Tim Donohoe outlined the progress being made on the digitisation of health and care services. He agreed to provide data showing the progress that is being made.

There is no single, standardised measure of the progress of digitisation of services across the health and social care system. However, set out below are some of the currently available indicators. Whilst this is not an exhaustive list, it gives a helpful indication of the growth in the adoption and use of digital technologies. This is an abiding focus for the Secretary of State.

1 - National Systems

These are centrally provided systems, used in the delivery of care at local level and where transaction volumes and usage can be readily monitored:

Electronic Prescription Service (EPS)

The EPS allows prescribers such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. The number of GP practices using the EPS has risen from 222 (2.9 %) as at July 2012 to 6291 (82.1%) as at June 2016.

The number of prescriptions handled through EPS per month has risen from 0.6% (503,538 items) July 2012 to an estimated 44.2% (39,467,540 items) June 2016. The GMS contract aim is for GPs to be doing 80% of their repeat prescriptions by EPS by March 2017.

The average number of prescriptions issued per day is currently 1.7 million (note that on average each prescription is for 2.2 items).

Summary Care Record (SCR)

SCR is an electronic health record, which provides healthcare staff with rapid access to essential information about an individual patient in order to provide direct care and treatment to them.

The percentage of GP registered patients with an SCR available has risen from 0.4% as at March 2009 to 95.9% as at March 2016 and there is an upward trend in enablement across care settings, as shown in the table below.

Table 1 – % of care organisations enabled to view SCR.

Setting	% enabled to view SCR
Hospital Pharmacy	95
GP Out of Hours	68
A&E	51
Acute Assessment	45
111	88
Ambulance	82
Non-Hospital Urgent care	57
Community or Intermediate Care	70
Community Pharmacy	21

The NHS e-Referral Service combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. Patients can choose their initial hospital or clinic appointment; book it in the GP surgery at the point of referral, or later at home on the phone or online.

Table 2 – Targets for GP to 1st appointment referrals made via eRS.

<p><i>eRS Targets</i></p> <ul style="list-style-type: none"> • 60% by September 2016 • 80% by September 2017 • 100% by September 2018

GP2GP Record Transfer

GP2GP enables patients' electronic health records to be transferred directly and securely between GP practices. It improves patient care as GPs will usually have full and detailed medical records available to them for a new patient's first consultation.

Table 3 – GP2GP uptake and utilisation

Practices live with GP2GP	Utilisation (records sent via GP2GP which are integrated – enable practices)
75.6% as at April 2014	77% as at April 2014
98.4% as at April 2016	83% as at April 2016
<i>Forecast 99% end 2017</i>	<i>Forecast 86% end of 2017</i>

NHS Choices

The NHS Choices website is the UK's biggest health website where patient and users can learn more about what the NHS does and the services it provides.

Total number of visits to the site per year has risen from 115,847,398 during 2011 to 298,559,898 during 2016 (Jan – Jun).

2 - Local Systems

Local systems are those that exist in individual organisations delivering care. In many cases, these operate to common standards and are linked to the national infrastructure (e.g. the NHS broadband network). In terms of penetration and usage, over 99% of GP practices have a system provided under these arrangements and therefore hold patient records electronically and are able to perform common tasks such as prescribing drugs electronically (both locally and using the national EPS service).

The Patient Online programme has been working to drive up patient usage of online transactions with GP practices. This typically involves patients being able to link to their GP via the same GP practice system. The current position is set out below:

Patient Online as at June 2016

- Over 95% of practices offer online appointment booking, ordering of repeat prescriptions and access to detailed coded information in patients' records

- Figures for March 2016 show that 8.5 million patients have signed up for online booking of appointments with 1.4m appointments booked or cancelled during March – up over 100% from April 2015
- Appointments booked/cancelled in the months of March 2015 and 2016 – March 2015 - 671,000 and March 2016 - 1,351,533
- Up to March 2016 the number of ‘No show’ rates for appointments booked online was 35% lower than for appointments booked conventionally, saving significant time for practices
- As of March 2016, 8.4 million people have signed up of repeat prescriptions with 1.7m repeat prescriptions ordered online during March – up 43% from April 2015
- As at March 2016, 55% of practices have at least 10% of patients registered for online services, leaving 45% to be enabled by March 2017
- Prescriptions ordered in March 2015 and 2016 - March 2015 – 1,085,000 and March 2016 – 1,685,849
- At the end of March 177,666 patients were registered for detailed access to their records. This is an encouraging start as practices were only obliged to offer this service from April 2016. It is not expected that every patient will want to access their records – initially the expectation is that practices will target patients for whom this service would be of particular benefit e.g. those with long term or complex conditions.

Other NHS Providers

The position across other NHS providers is more difficult to summarise. In April 2016 NHS England launched the results of the digital maturity assessment for secondary care providers. The results are available on the [MyNHS](#) website, itself a key transparency tool amongst the best and most comprehensive in the world, (and these can be viewed at individual Trust level). The assessment identifies key strengths and gaps in healthcare providers’ provision of digital services at the point of care and offers an initial view of the current ‘baseline’ position across the country. We are confident of a broadly improving picture across the NHS, but of course there is more to do.

Table 4 – Digital Maturity Self – Assessment: Key Findings:

What percentage of respondents states positively⁵⁴² that

Healthcare professionals rely on digital records for the information they need @ the point of care	34%
Professionals have digital access to the information they need from other healthcare providers	23%
Professionals have access to a consolidated view of their patients’ health & care	15%

⁵⁴² Answered ‘Mostly Agree or Completely Agree’ or greater than 60% for quantitative responses. Counts based on full dataset (acute mental health, community & ambulance service providers)

records	
More than 60% of care summaries are shared digitally with GPs	64%
More than 60% of lab tests are ordered with GPs	52%
More than 60% of radiology tests are ordered digitally	49%
More than 60% of inpatient medications are prescribed digitally	19%
Healthcare professionals receive digital alerts to patient preferences	25%
Digital systems alert professionals to patients whose observations or EWS are deteriorating	29%
Remote/virtual clinical consultations and clinical advice are available to patients	11%
Staff rostering is managed digitally throughout the organisation	74%
Healthcare professionals have access to Wi-Fi throughout the organisation	82%
Wi-Fi is available in public areas throughout the organisation	50%

3 – Next Steps – Paperless 2020

The [NHS Five Year Forward View](#) published in October 2014, set out some of the key challenges facing the health and social care system. The subsequent creation of the National Information Board (NIB) has brought together stakeholders from across the system to look strategically at how technology, digital and data can help to address some of these challenges. Following the publication of the NIB's [Personalised Health and Care 2020 document](#), in late-2014, a programme of work has now been established to drive forward further digitisation across the health and social care system. This is the package of work announced by Secretary of State, Jeremy Hunt, in February 2016.

The programmes in this initiative range from establishing a modern and reliable infrastructure (e.g. by providing free WiFi across the NHS estate) to providing a framework to accredit apps, enabling patients to self-manage their care and integration across health and social care settings. The programmes are grouped in 10 transformation domains, aligned to the Five Year Forward View.

Summary

So whilst not yet a comprehensive picture, the evidence above suggests that digitisation of services across health and social care is proceeding well and in February 2016 a report from the Nuffield Trust ["Delivering the benefits of digital health care"](#) described the NHS as heading towards a digital "tipping point". This will remain a key area of focus over the next few years to ensure that we continue to build on the progress that is being made.

Section 4 – Integration of health and social care

We also promised to write regarding work happening in Vanguard sites around the use of capitated budgets and what evidence from other countries was being used to inform long term thinking on integration.

Population (Capitated) Budgets

There are already a number of actions being pursued by NHS England / NHS Improvement to ensure the policy and regulatory framework supports the integration of services. For example, whole population budgets (a form of capitation) are being developed by many Vanguard sites with intensive support, including:

- Northumbria
- Whitstable
- Dudley
- Tower Hamlets
- SE Hants
- Wakefield
- Modality – Sandwell & West Birmingham
- City of Manchester
- Stockport Together; and
- Mid-Nottinghamshire’s Better Together programme.

These sites are working intensively with NHS England / NHS Improvement to progress whole population budget development locally, and to co-produce a handbook to help guide remaining Vanguards and other areas. Across these sites, staff are working to deliver a whole system care approach through Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS) covering a range of hospital, community, social and primary care within a single outcomes-based capitation contract. NHS Improvement and NHS England are now working to support more commissioners in developing and implementing a capitated payments or whole population budgets, based on these initial experiences. For example, between April – July 2016, NHS England / NHS Improvement ran a series of webinars on the topic, and NHS England is now working to spread the learning and experience from the Vanguard sites to other areas.

Intensive work with Vanguard sites, and the production of the Whole Population Handbook, aim to provide the framework to enable sites to be payments ready for new contracts from April 2017. Both during 2016/17, and in 2017/18, NHS England / NHS Improvement intend to support shadow testing in sites to analyse and evaluate the potential impact of whole population budgets in supporting new models of care; in advance of the payments mechanism being used in contracts to support MCP and PACS new models of care.

There are also more targeted uses of capitation. For example, officials in Southend are working to create a capitated budget for a smaller cohort of high-need patients via a series of ‘early implementer’ sites. The Clinical Commissioning Group (CCG) there is preparing a tender for a new service that will work across health and social care for those with complex health and care needs. This new service will effectively establish new contracts and budgets with providers to supply services for the patient cohort. Issues around data linkages and IT interoperability are currently being resolved prior to wider roll-out. For more information,

see: http://www.nhs.uk/media/2781964/final_case_study_-_setting_up_to_manage_a_cap_budget_-_southend_31mar16.pdf

International Integration case studies

Northern Ireland

Northern Ireland has had a structurally integrated system of health and social care since 1973. While there have been few evaluations of the impact of integration in Northern Ireland, those that have been conducted have found the following:

- By dividing the system into ‘programmes of care’ - such as mental health or learning disability – it is well placed to meet the increasingly complex needs of services users, and fewer users are in danger of slipping through the net.
- The management structure allows professionals from a range of health and social care backgrounds to occupy the position of programme manager or team leader. This has promoted parity of esteem, and has helped to address some of the cultural barriers to integration.
- In integrated trusts, a single body is responsible for discharge and arranging care outside the hospital, and a single assessment system is in place. There are very tight targets in place for discharge, and they are generally achieved with a compliance rate of around 95 percent: 90 per cent of patients with ongoing needs will be discharged from an acute setting within 48 hours of being medically fit, and no complex discharge will take longer than 7 days. However, due to the way that data is coded and collected, it is not possible to make direct comparison with performance on discharge in England.
- However, the health agenda continues to dominate the integrated structure, both in terms of financial allocation and in terms of the targets set and monitored by Government; social care is considered by many to be the neglected partner.

“Northern Ireland has one of the most structurally integrated and comprehensive models of health and personal social services in Europe” (Heenan and Birrell, 2006: 48).

Heenan and Birrell’s studies of staff experience of integration in Northern Ireland produced broadly positive results. Importantly, interviewees (staff of service providers) “were at pains to emphasize that professionals here had ‘an integrated mindset’. Structures and administrative responsibilities were described as ‘secondary’ to a willingness and commitment to working together” (2006: 62).

The conclusion reached by Heenan and Birrell is that structural integration acted as a facilitator in Northern Ireland, removing crucial barriers, but that it was the senior leadership’s constant efforts to introduce creative and innovative practices that really produced integrated care: **“Integration was not really about structures or patterns of working; it was fundamentally a way of thinking”** (2006: 63). This is reflected in the principal negative identified by Heenan and Birrell: there remained lingering difficulties in the equality of health and social care functions within the system, with the health agenda sometimes dominating to the detriment of social care.

It is commonly accepted that two key barriers to the integration of care are ‘behavioural change’ and ‘organisational co-operation’. The experience of Northern Ireland suggests that ‘full integration’ can overcome difficulties in organisational co-operation, but that behavioural change is a more important prerequisite for delivering truly integrated care, and that it cannot be guaranteed by structural integration alone.

New Zealand

Since 2001, District Health Boards in New Zealand have held a single budget with which they are responsible for commissioning most aspects of both health and social care. However, “New Zealand’s health system has long been seen as providing highly fragmented, poorly co-ordinated services to service users” (Cummings, 2011).

In 2006, analysis by Canterbury District Health Board concluded that current operating models were unsustainable. The Board was running a deficit, admissions and waiting times were rising, and the population was ageing rapidly. Calculations suggested that Canterbury would need a new 500-bed hospital, 20 per cent more general practitioners and practice nurses, and another 2000 residential care beds by 2020. This served as the stimulus to reform the system.

From 2007 onwards, the Chief Executive of the Board pushed an agenda of service integration, labelled ‘One System, One Budget’. At its heart was an imagined health and care system organised around the individual, rather than the hospital:



Figure 1

In order to reach this goal, the Board signed off a new set of principles to be instilled across the health and care system as the drivers of transformation:

- Those in working in the system had to recognise that there was ‘one system, one budget’ in Canterbury;
- All organisations had to focus on getting the best outcomes from the resources possible, rather than competing for funding; and
- Everyone’s goal was to deliver the right care, in the right place, at the right time, by the right person.

The Board embedded these principles through a comprehensive programme of education for staff across the system, teaching new management techniques and using interactive events to bring the new vision to life. The principles were then turned into practice through the development of new initiatives such as HealthPathways and Acute Demand Management System (ADMS). HealthPathways brought GPs and hospital doctors together to determine ideal patient pathways for treatment of different conditions, agreed on by nurses, allied health professionals and funders. In 2011 there were 480, reviewed biannually. ADMS is a means for general practice to access funds to support patients outside of hospital. Funding allows observations, follow-ups, repeat home visits and carer education.

Results of the ‘One System, One Budget’ initiative have been impressive:

- Low rates for acute medical admissions, low average length of stay for medical cases, low acute readmission rate;
- Thousands more elective procedures being performed, with waiting times for elective surgery down;
- An increase in conditions being treated in general practice rather than hospital;
- Fewer patients entering care homes, and a rising curve of demand for residential care now flattened;
- Move from NZ\$17m deficit in 2007 to NZ\$8m surplus in 10/11;
- Changes in quality of care and value for money are harder to measure, as data is incomplete or non-existent. However, evidence suggests an improvement in both.

Canterbury “has moved from a position where, back in 2007, its main hospital in Christchurch regularly entered ‘gridlock’ – with patients backing up in its emergency department and facing long waits as the hospital ran out of beds – to one where that rarely happens” (Timmins and Ham, 2013: 4). This transition happened in the context where system, or ‘full’, integration was already the status quo, but which lacked service integration and its concomitant behavioural culture. Structural integration alone was insufficient to deliver improved outcomes.

Scotland

- Achieving integration – both within health and between health and social care – has been a significant policy priority in Scotland since 1997.
- A series of programmes aimed at delivering better, more co-ordinated community care for people with long-term conditions has helped to deliver a 13.5 per cent reduction in the rate of emergency bed days for LTCs between 2006/7 and 2010/11.
- The Reshaping Care programme aims to provide more proactive and integrated care and support at home to the over 65s, and helped to save an estimated 750 bed-days in 2011/12 (equivalent to a 9 per cent reduction).

- More recently, the Public Bodies (Joint Working) (Scotland) Act was passed in 2014, and came into force in April 2016. It requires the NHS and local council care services to be integrated in every area in Scotland, either by establishing a joint integration board, or by designating one body the lead commissioning partner. It is too early to determine what impact this has had.

USA – Kaiser Permanente

- Kaiser Permanente is a non-profit 'health maintenance organisation' serving well over 8 million people in eight regions of the US. Its mission is to 'provide affordable, high-quality health care services to improve the health of our members and the communities we serve'. It is comprised of three parts – the Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and Permanente Medical Groups. Combining the roles of insurer and provider, Kaiser Permanente directly provides care both inside and outside hospitals, enabling patients to move easily between hospitals and the community, facilitated by a model of multi-speciality medical practice in which specialists work alongside generalists.
- Kaiser Permanente is recognised as one of the top-performing health systems in the US and is one of the lowest-cost health care providers in most of the regional markets in which it competes.
- In a survey conducted for the California HealthCare Foundation, Kaiser members reported higher levels of collaborative goal-setting in their health management and reminders for preventive or follow-up care, compared with patients seen in other care settings in California.
- For 11 medical conditions studied, the NHS uses 3.5 times the number of bed days as Kaiser for those aged 65 and above. Part of the explanation is that Kaiser can deliver more care outside the hospital in large medical offices, similar to polyclinics.

USA – Program of All-inclusive Care for the Elderly (PACE)

- PACE's objective is to maintain frail elderly persons in the community for as long as possible by avoiding or postponing institutionalisation by providing comprehensive acute and long-term care services, which are co-ordinated by, and for the most part organised around, an adult day health centre.
- The day health centre is the primary setting for the delivery of most, if not all, covered services. In addition to offering social and respite services, the centre functions such as a geriatric outpatient clinic, with primary medical care and ongoing clinical oversight and management playing central roles. At the heart of PACE is the multidisciplinary team, which comprises nurses, physicians, therapists, social workers, personal care assistants, transportation workers, nutritionists, and so on. PACE provides case management organised in day care centres through multidisciplinary teams, including nurses, physicians, therapists, social workers and nutritionists.
- Quasi-experimental, non-randomised design was used to compare the experience of program enrollees in 11 PACE sites with the experiences of individuals who expressed interest in the program, but did not subsequently enrol. Enrolment in the program was found to be associated with a large decrease in hospital use, and fewer admissions to and time spent in nursing homes. Patients in the program also used substantially more ambulatory care services, including outpatient medical and

therapeutic care, as well as home- and community- based social care. The costs to Medicare under PACE were considerably lower than for the non-enrollee comparison group. The program also represented a cost savings to state Medicaid budgets allocated for long-term care in the order of 5%–15%. However, no empirical data to support this observation were found.

Valencia

- Valencia has an integrated care system that uses capitated budgets to fund care for the whole population across primary, ambulatory and acute care, representing approximately 50% of services. Providers have used the capitation to establish ambulatory care hubs, invest in integrated information systems and offer specialist support in the community. This has led to:
 - 25% reduction in net cost per head
 - 30% drop in emergency admissions
 - 90% service user satisfaction

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29 July 2016

Department of Health – Supplementary written evidence (NHS0175)

Introduction

1. The Department of Health leads the health and care system to ensure people experience a service that protects and provides safe, effective and compassionate care. A key part of this role is to provide the long-term vision needed to meet current and future challenges
2. Whilst the bulk of our work focuses on the medium term for which funding has been agreed (up to 2020-21), in managing this period, we make decisions that are consistent with latest thinking on emergent challenges to deliver a sustainable health service over the longer term. We discuss these below in context of:
 - Future funding;
 - Direction of thinking on workforce;
 - Approach to technology and digitisation;
 - Integration of health and social care;
 - Prevention and Public Engagement.

How must health and care systems change to cope by 2030 – Future Funding?

3. A simplistic way to try to answer this question is to distil to assess the scale of funding that might be needed by 2030.
4. The funding challenge for the NHS is similar to those faced by all major economies for the future. Similarly, the evolution of NHS spending and over the long run is not atypical of OECD countries. According to the new, internationally much more comparable, health accounts definitions, UK expenditure (including both government and private spending) was 9.9% of the GDP in 2014, similar to the EU-15 simple average of 9.8%.
5. In 2013 the OECD published a study on drivers of expenditure – between 1995 and 2009 growth in expenditure across OECD countries was an average of 4.0%. They found that demography accounted for only 0.5% each year, income effects accounted for 1.7% and a residual 1.8% (of which about 0.7% is related to new technology). Therefore, a rapid growth in a successful economy will impact on the scale of health and care funding much more than an ageing population.
6. Another way to assess a future funding requirement is by using the DH long term funding model. Put simply this model applies price, volume and efficiency offsets to the major components of NHS expenditure: staff (58%), non-staff consumables (17%), drugs (13%), social care and continuing health care (5%) and other (7%), to construct an overall funding pressure. As we approach the next spending period, we will distil this analysis to judge the appropriate forecasts for each key parameter.

7. However, a too rigorous quantification would not be sensible at this stage; for example, to guess what an appropriate pay settlement figure might be with only limited knowledge of the wider fiscal position in 2021.
8. However, we can conclude that the demographic challenge does not drive an unaffordable service, more that the rate of growth in funding, which is the choice for future governments and linked to wider economic growth, will instead determine the pace of adoption of new treatments and technologies.

Future Workforce

9. Effective workforce planning is critical to the delivery of affordable, high quality care. The Government's policy is that the country should be self-sufficient in respect of the health professional workforce. Health Education England was set up with this specific remit and they are mandated to reduce the number of professions included on the Shortage Occupation List year on year.
10. The Government has also embarked on contract reform. Its ambition is to agree changes that promote affordable, sustainable pay systems that reward high performance and support the recruitment and retention of the skilled, dedicated and compassionate staff that the NHS needs.
11. As well as expanding supply in the existing professions DH aim to lever a more flexible workforce in the future by introducing new routes into caring professions via the Government's expanded apprenticeship scheme, and the introduction of new roles, for example, the new Nursing Associate role, and the Physician Associate.
12. These actions will deliver a more flexible workforce that is better placed to adapt and respond to changes in the way health and care is delivered in the future.

Integrated health and care

13. The introduction of the 2014 Care Act puts social care on a new statutory footing. Building on the Care Act, the 2015 Spending Review cited the need to develop a modern integrated and devolved health and social care system by 2020.
14. Good progress has already been made to integrate budgets (currently the Better Care Fund). However, achieving a truly integrated health and care service will require further integration of budgets; greater collaboration of the health and care workforces; place-based approaches to workforce planning; a supportive regulatory regime; and, removal of barriers around information governance and IT.

Prevention and public engagement

15. An upgrade in prevention requires a shift in investment within the NHS (both in primary and secondary care); empowering local organisations, communities and individuals; and, simplifying structures and strengthening collaboration between

local partners. NHS has specific roles via Section 7A (vaccination, immunisation, screening, child health info systems, prison population public health, sexual assault referral centres).

16. Legislation by governments has a role (tobacco, alcohol, obesity). Linking across government – work, education, housing – will be needed to tackle health inequality, e.g. the joint Work and Health Unit.
17. Our strategy for enhancing population health and wellbeing, as signalled in the *Health and Social Care Act 2012* is to shift away from over-reliance on central control, to give local authorities the freedom, responsibility and funding to innovate and develop their own ways of improving public health in their area.
18. We recognise that responsibility has to be shared right across society – between individuals, families, communities, local government, business, the NHS, voluntary and community organisations, and the wider public sector.

Technology and Digitisation

1. The *Five Year Forward View* notes the role technology could play in a transformed NHS. A programme of work exists to align investment in technology with business transformation. There are a variety of technologies available (or emerging) that have the potential to transform the way in which services are delivered, many of which support more agile working both within and between hospitals and other care locations including the community. The formation of the National Information Board (NIB) has drawn together stakeholders from across the system to look strategically at how technology, digital and data can support change, and is setting a clear strategic direction for further digitisation of the health and care system.
2. Adopting digital health technologies has the potential to deliver better patient outcomes (better pathways of care, higher quality service) and increase the efficiency of the NHS (managing demand). Digitisation will allow greater use of data to see real outcomes and develop/evaluate models of care (wider population linked data, health management, self-care, diagnostics, treatments, research).

23 September 2016

Mr Bill Dickinson – Written evidence (NHS0074)

Mr Bill Dickinson – Written evidence (NHS0074)

Sustainability within the NHS

In my view all NHS hospitals should be looking at sustainability through one central purchasing hub for NHS England and all hospital 500 bed and above should be made to install CHP to become less reliant on the grid and more self-sufficient energy efficiency would increase if energy managers were made accountable for their actions.

Bill Dickson, Energy and Environment Manager, The Princess Alexandra Hospital NHS Trust

23 September 2016

Dispensing Doctors Association – Written evidence (NHS0062)

Long-Term Sustainability of the NHS

The Dispensing Doctors' Association (DDA) represents over 6,600 NHS GPs working in 1,335 practices across the UK. It is the only organisation that specifically represents the interest of dispensing doctors and their 8.8 million patients.

Dispensing doctors are NHS GPs who are permitted to dispense medicines in designated rural areas where a community pharmacy is not economically viable. They pre-date the NHS and can be traced back to the introduction of National Insurance in 1911.

It is our view that the NHS will be sustainable for as long as there are people of goodwill prepared to pay, fairly, for it. In addition, there needs to be an agreed definition of what constitutes NHS services with no 'postcode lottery'.

There have been a very large number of reviews into the NHS over the last ten years, the most impressive being the one undertaken by Sir Derek Wanless in 2002⁵⁴³. Many of the conclusions he reached are equally applicable today. Indeed health outcomes improved considerably following the publication of the Wanless report, and the commensurate increase in resources that accompanied it: from 6.3 per cent of GDP in 2000 to 8.8 per cent by 2009⁵⁴⁴. The Government of the day introduced an increase of one penny on the rate of employees' National Insurance Contributions in the Budget of that year.

Over the last six years, the rates of increase in NHS resourcing have been 0.8 per cent a year.⁵⁴⁵ This represents a much smaller rate of increase than in the years following the Wanless report until 2009/10. As a result, there ought to be no surprise that the NHS is suffering, compounded by the ageing population and the costs associated with new technology. It is a tribute to the efficiency of the system, and the hard work of its staff, that the NHS is managed to cope under the unprecedented levels of financial strain under which it now finds itself.

Since 2008, GP income has declined by 11%⁵⁴⁶ while there has in the same period been a 2.3 percentage point rise in the cost of running a practice (including the amount spent on keeping GP practice buildings in good repair, energy bills for GP practices and the amount spent on GP staff, including practice nurses and receptionists). The cost of running an average practice now accounts for 61.6 per cent of total GP income. The recent GP funding increase has been described as "not statistically significant".

⁵⁴³ Securing our Future Health: Taking a Long-Term View, Sir Derek Wanless, 1 April 2002, HM Treasury
<http://www.yearofcare.co.uk/sites/default/files/images/Wanless.pdf>

⁵⁴⁴ How does NHS spending compare with health spending internationally? John Appleby, King's Fund, 20 January 2016
<http://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally>

⁵⁴⁵ Did the government meet its pledge to increase real terms spending year on year? The King's Fund, 18 February 2015
<http://www.kingsfund.org.uk/projects/verdict/did-government-meet-its-pledge-increase-real-terms-spending-year-year>

⁵⁴⁶ Doctors' & Dentists Review Body Report 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/288697/Doctors_Dentists_42nd_report.pdf

Dispensing GPs' earnings fell by 11.3 % between 2005/06 and 2012/13⁵⁴⁷. As a result of this fall in income there are now many vacant GP posts in rural areas across the country.

The latest GP earnings report shows that dispensing GPs report a higher earnings to expenses ratio⁵⁴⁸, which is defined as the proportion of gross earnings taken up by expenses. For dispensing GPs this is 69.1 per cent, compared to a 60.8 per cent ratio for non-dispensing GPs. This suggests increased pressure on dispensing GPs' operational cash flow.

Given that General Practice is responsible for ninety per cent of the NHS' workload, for less than ten per cent of its budget, this demonstrates what a wonderfully efficient, cost-effective system we have in the UK. However, the high level of GP vacancies is now placing general practice under enormous strain, which has ramifications for the rest of the NHS.

There is, at last, a belated realisation that funding for General Practice, and the rest of the NHS needs to increase. However, it will take a significant period of time to repair the damage that has been done, not least in relation to recruitment and retention.

For dispensing GPs, the higher earnings to expenses ratio could be addressed if NHS England would focus on the problems relating to the reimbursement of drug costs within the GP contract. For last three years, the DDA has tried to engage with NHS England on this issue, to no avail. In our view, the current system of reimbursement is not working for patients, the NHS or practices. Some drugs are currently being reimbursed at less than the cost of buying them, creating perverse incentives in the system that must be addressed. Robert Francis said, in his first report, that "*...it should be the patients - not numbers - which counted.*"⁵⁴⁹ We believe that the current system of reimbursement is not adhering to that principle.

Moreover, NHS England's Five Year, and GP, Forward View documents pay no attention to the specific problems relating to the provision of General Practice in remote and rural areas. Federating practices into a variety of different structures might work well in urban settings, but they do not lend themselves to rural areas; the current system appears to be the most cost-effective.

This is not dissimilar to the situation affecting rural post offices over the last few years. Dispensing practices are even more central to the local community and are a 'one-stop shop' for the health and community care of the local population.

If the current state of affairs continues, we are concerned that some rural practices will cease to be economically viable. This concern is based on statistics from the Department of Health's own Cost of Service Inquiry published in 2010⁵⁵⁰. In addition, the Scottish Health

⁵⁴⁷ Investment in General Practice Report, September 2014, NHS Digital

<http://www.hscic.gov.uk/catalogue/PUB14900/inve-gene-prac-eng-wal-ni-scot-09-14-rep.pdf>

⁵⁴⁸ GP Earnings & Expenses 2014-15, NHS Digital, 14 September 2016

<http://www.digital.nhs.uk/catalogue/PUB21314/gp-earn-ex-1415-rep.pdf>

⁵⁴⁹ Robert Francis QC, Quoted in the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, Volume 1: Analysis and Lessons Learned, Part 1, p11, 2013.

⁵⁵⁰ Cost of Service Inquiry for Dispensing Practices, Department of Health, September 2010.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215502/dh_128817.pdf

Department has acknowledged that the cross subsidy from dispensing income ensures that rural GP practices are economically viable.⁵⁵¹

Where dispensing income has been lost, at least three Scottish practices have closed in the last two years. One Scottish Health Board is currently keeping a practice open through the use of locums, which is expensive for the NHS and not providing patients with the kind of continuity of care to which they are used, or deserve. A similar situation pertains to a number of practices in Wales. We would not wish to see this state of affairs to occur in England.

One of the aims stated in the GP and Five Year Forward View is to transfer care out of hospitals and into primary care. The DDA supports this policy, but is disappointed that the resources do not appear to be being transferred with the work. This adds to the burden for general practice set out above.

In addition, a number of rural areas appear to be losing the funding for important services like community hospitals. This seems to be counter intuitive and to short-change rural communities.

It is our view that the NHS cannot resolve the problems attributed to patient demand unless it is funded properly, focused and put centre stage.

There are a number of other actions that we will, undoubtedly, contribute to the sustainability of the NHS:

1. Enabling staff to be trained in rural areas, as well as urban areas will help recruitment and retention because rural areas command a different set of skills.
2. A period of stability to allow the recent reorganisation in England to become embedded; there has been so much change that the workforce is suffering from ‘change fatigue’.
3. IT systems that are ‘fit for purpose’ and that are designed to deliver better clinical care for patients.
4. ‘Superfast’ broadband must be available throughout the NHS; many remote and rural GP practices are experiencing painfully slow speeds.
5. The Electronic Prescription Service (EPS) must be made available to dispensing practices as soon as possible. Rural patients are being disadvantaged by the lack of access.

⁵⁵¹ David Thomson, Scottish Government to Health & Sport Committee of the Scottish Parliament, Tuesday 24 June 2014, Column 5732:

“...It is important to note that dispensing income for GPs is never intended to cross-subsidise the delivery of core services. That is in our Statement of Financial Entitlement and those directions are the financial basis for the regulations. *We do know that that is not what plays out on the ground. It is important that we recognise that, even if the rules state something slightly different.*”
<http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9278&mode=pdf>

6. The services to be provided by the NHS should be clearly defined then funded appropriately.

Thank you for the opportunity of submitting our contribution to your committee's work and we look forward to the final report.

22 September 2016

Doctors For The NHS – Written evidence (NHS0027)

Question 1

2. To what extent is the current funding envelope for the NHS realistic?

The current levels of funding are inadequate – the evidence is in the unmet need manifested by increasing waiting times for appointments in primary and secondary care, for elective procedures and A&E departmental waits.

The benefit of increased funding from 2002- 2009 is shown in improved performance at that time and the fall in performance since then. In addition to the waiting time figures mortality has also been affected as the Keogh report showed that hospitals that prioritised finance over quality of care had higher mortality.

NHS finances are too often viewed as a cost to the nation's purse and not as investment in essential services but the benefit of increased funding is shown through the economic multiplier effect*.

International comparisons demonstrate that our level of funding is lower than comparable countries whilst the Commonwealth fund data demonstrates that the NHS performs better than them – evidence that the NHS is highly efficient. Therefore the basic structure and philosophy of the NHS is sound and what it lacks is adequate funding.

Supporting evidence comes from the Commonwealth Fund's international comparisons with the NHS coming first in 9 out of 12 categories. We are spending progressively less on health as a nation and less than comparable countries . (From 9% GDP in 2013 to a predicted 6.8% by 2020). In comparison France and Germany spend 11.5% and 11.3% respectively . NHS funding has only risen 0.9% annually since 2010 but 4% is needed annually to keep pace with rising demand.

Recent policies of selling off NHS land and properties are not sustainable and can prevent or cause real problems to NHS activities e.g, accommodation and training facilities for key workers.

*(Public Health. 2006 Nov;120(11):994-1001. Epub 2006 Oct 4.The contribution of health to the economy in the European Union.

- a. Does the wider societal value of the healthcare system exceed its monetary cost?

Yes, it is a truly **great** British institution, a source of national pride and a unifying factor for the whole country. It embodies both a civilising force and a practical method of rationing a limited resource. Along with the law it is a major communal effort and proof that we care for each other, indeed care for the humblest, poorest most troublesome individual there is in our country.

All major religions support the principle of loving thy neighbour as thyself. This principle is applicable in every country in the world. Its very existence enhances the way citizens see themselves and reminds them of their duty.

- b. What funding model(s) would best ensure financial stability.....?

General taxation is the fairest and most practical source.

- c. What is the scope for changes....?

It is most important that the current tax system operates effectively, especially with regard to large multinational companies. A modest increase in taxation would be acceptable to the general population provided it was presented realistically with appropriate public consultation. The higher levels of taxation in Scandinavian countries and other parts of the world are evidence that most people are happy to pay for high quality services.

- d. Should the scope of what is free at the point of use be more tightly drawn?

The guiding principle must be that no-one should suffer ill health through inability to afford treatment. There could be scope for reviewing some items. The NICE guidance on what is affordable should be followed as this identifies treatments that are cost effective.

Workforce

3. What are the requirements of the future workforce.....

We need high quality staff capable of adapting to changing future needs. At present we import too many health professionals from abroad which causes two main problems. It deprives those countries of key workers and the resettlement issues are expensive, often a hospital with recruitment problems will have an employment initiative with overseas staff to find they move on to more attractive posts in a short period.

The most urgent matter is a detailed independent analysis taking account of developments in the health field e.g. with increasing elderly numbers there are more patients with cancers but few oncologists are knowledgeable in the field of elderly cancer patients and consequences of treatment in this age group.

- a. What are the options for increasing supply.....?

We should be self sufficient, with overseas staff visiting only for the purpose of specialist training to return to their countries.

Internal development can be increased e.g. many nurses can progress to be specialist nurses but the career pathways are not well developed.

- b. What effect will the UK leaving the EU have....

It is probable that there will be fewer EU health workers in the UK, depending on the outcome of the Brexit discussions.

- c. What are the retention issues for key groups of healthcare workers?

It is becoming clear that one of the greatest motivational factors for staff is to work for the NHS itself: for the pride and fulfilment that comes from working for the best known and most highly respected health brand in the world.

NHS workers are, or have been, seen as having a commitment that is admired by the public and it is the overriding sense that is publicly owned and publicly accountable that drives staff to deliver the best they can.

The quality of human resource (HR) management in the NHS has been varied with many examples of excellent person management but also some below an acceptable standard. Many managers have taken the commitment of professionals for granted and some staff have worked under difficult conditions with poor management out of a desire to do the best they can for their patients.

With many services now being outsourced we can see rapid turnover of staff as the new management lack the public service ethos and the motivation that comes with working for the NHS. I have seen outsourced services undermanned as staff have left because of unfavourable new terms and conditions. This has meant the outsourced services are unsustainable as they have had to rely on expensive locums.

In short, to recruit and retain staff it will be essential to restore the founding principles of the NHS and to value all working in it as dedicated professionals and public servants.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

This will require investigation with appropriate experts on higher & further education, Public Health and the relevant professional associations.

- a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

Technology has transformed most aspects of work and social life. Most young people are now familiar with using IT in the form of 'apps' on hand held devices to carry out many tasks and these skills can be used in IT at work. For older people training may be required.

Information sharing can improve efficiencies for staff and benefit patients but will need to recognise privacy and data protection issues.

Specific examples are given in section 8

5 Models of service delivery and integration

- a. How could truly integrated budgets for the NHS and social care work?

Whilst improved social conditions can lead to reduced illness there is a need to learn from pilot sites how best to invest in improvements in social care without reducing funding of the acute sector.

b. How can local organisations be incentivised to work together?

By reforming CCGs and providers into one health board with reciprocal representation on Local Authority Councils.

By making the core purpose of the organisations to honour the WHO definition of health “ a state of complete physical, mental, and social well-being ...” instead of the current situation where too many boards of Foundation Trusts see their role as maximising income from providing services through the internal market and commissioners lack the expertise to have sufficiently constructive dialogue.

At present there is an unequal distribution of expertise through the purchaser provider split and the division into purchasers and providers hampers co-operation. Commissioning has resulted in substantial waste of resources and needs to be replaced by integrated planning.

c. How can the balance between (a) hospital and community services (b) mental and physical health and care services be improved?

a) As in b (above) and including GPs, district nurses and all other community providers into one, locally managed board.

b) Whilst the report of the Independent Mental Health Taskforce to the NHS in England, February 2016 is welcome as is the increased but probably inadequate funding there is too much costly and inefficient use of the market as opposed to comprehensive planning.

6 Prevention and public engagement

a. What are the key elements of a public health policy to enhance a population’s health?

Implementation of the Marmot Review ‘Fair Society, Healthy Lives’

7. What are the best ways to engage the public about what they want from a health service?

Public engagement is currently patchy, only a small proportion take part in the process and important plans do not reach public awareness until they are well advanced, possibly because the local press do not understand the issues except when a local service is threatened.

The public in general would be more involved if local health boards had representatives from local councils and possibly directly elected members.

People with experience of local services could be elected onto user groups with representation on the boards.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

Technology enables improvements in many areas of healthcare and has potential for major benefits but many initiatives have failed through failure to understand the limitations of the systems and the training issues.

There have been too many IT failures in the health service, usually through the suppliers failing to understand the needs of the system and dazzling managers with performance statistics that relate to the hardware but not to the functionality.

Some approaches have used computers to do those tasks where they are more efficient e.g. calculations, retention and retrieval of information, others have allowed a complete redesign of a manual system.

Experience with virtual doctors and other professionals is accumulating and need further development. At present computer programs can interrogate a patient's symptoms and present this in summary form saving much clinical time and going into more relevant detail than the average primary care consultation.

Electronic clinical decision-support tools that integrate with clinical computer symptoms can add additional information beyond the knowledge of an individual doctor e.g. likelihood of cancer, speeding the referral to specialist care when necessary.

Some tasks can be completely redesigned to take advantage of computer's capabilities (e.g. the manual system of cross matching blood can now be largely replaced by an electronic system of screening and selection which enables system redesign with a 30% saving on an average approx £1million per hospital).

b. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

The biggest barrier is the credibility of the claims of benefit. Too many systems have failed to deliver benefits and a rigorous evaluation of new systems prior to roll out is essential.

d. How can healthcare providers be incentivised to take up new technologies?

Through demonstrating that they do, actually work in the real world of clinical practice, e.g. through service redesign make professionals' work easier and improve quality.

We now have computer-based chronic disease management systems that enable the health care team to make improvements in several areas e.g. reduce emergency admissions, increase quality of care, enable shared care across primary and secondary care, improve record keeping and audit procedures, gain better control of patients therapy, reduce administration time—achieve paperless working and improve reporting procedures.

e. Where is investment in technology and informatics most needed?

Connecting all the services necessary for co-ordinated care and through incorporating algorithms that expedite clinical decisions. Major benefits can be made in the care of patients with chronic diseases requiring monitoring i.e. both bringing care closer to the patient enabling specialist supervision of treatment. Examples include decentralised testing but centralised supervision for patients with diabetes or taking oral anticoagulants. Testing can be carried out in the community, including patients' homes and the results transferred immediately to specialists in centres with the expertise to modify treatments when necessary.

Monitoring and dose adjustments can greatly improve efficiency in other chronic diseases e.g in rheumatology, where biomarker monitoring can also be used to improve effectiveness. As described in d.

17 September 2016

Doctors in Unite (the Medical Practitioners' Union – Written evidence (NHS0102)

About Us

- i. Doctors in Unite (the Medical Practitioners' Union), a section of Unite the Union, is the only TUC-affiliated union formally party to the representative machinery of the BMA (by virtue of an agreement with the BMA in 1950), a progressive voice within the BMA and a medical policy think tank for health as a social goal.*
- ii. We played a major part in the development of the concept of clinical commissioning by advocating neighbourhood health committees in our evidence to the Short Committee in 1988, by persuading the Labour Party in 1992 to adopt locality commissioning as its policy for the replacement of fundholding, and by persuading the BMA of that same policy in the mid 1990s.*
- iii. This submission is supplementary to the full Unite the Union evidence and should be considered alongside it.*

Key Points

- We now believe that purchaser/provider separation has gone too far. Strategic commissioning has become dominated by legalistic procurement, and this process threatens the efficiency and equity of the health care system and the very existence of the NHS.***
- Given our roots as one of the founding advocates of locally-accountable clinical commissioning we ask you to take that statement seriously.***
- Believing that the solution to the problems of the NHS is the further development of commercialisation and competitive procurement in the NHS is like trying to save the Titanic by repeated attempts to ground it on the iceberg.***
- The NHS needs significantly more money for demographic reasons and because of the epidemics of obesity and alcohol. It is not a bottomless pit.***
- This money will be most efficiently raised and spent through general taxation and a publicly owned and planned NHS. It would be unfortunate if a less efficient system were adopted out of antipathy to taxation or an ideological commitment to a smaller state.***
- Investment in public health and social care is an important part of that need and would reduce, but not eliminate, the need for NHS investment. The failure to invest in social care and public health is like stripping the lead off the roof to make buckets to catch the rain.***
- Healthy ageing is essential to contain health and social care demand. The cost of a dependent older population arises from the difference between healthy life expectancy and life expectancy, not from age structure alone. As this gap is greatest in deprived areas, it compensates the wrong areas if we allocate resources according to age structure without taking this factor into account.***
- There is now considerable evidence that the Keynesian multiplier for health and social care spending is between 5 and 10, implying that increased health and social***

care spending will be fiscally self-financing (indeed more than self-financing) and economically beneficial.

- ***Markets are an inefficient way of distributing health resources.***
- ***Failure to address the wider determinants of health is socially irresponsible and financially imprudent given the burden it imposes on the NHS.***
- ***The financial burdens of the PFI schemes and the resolution of those problems should be removed from local communities and dealt with nationally***

1. The Need for More Money

- 1.1. The NHS needs more money. You will be overwhelmed by evidence to that effect. We agree with it.
- 1.2. The population is ageing. To the extent that this results from increased longevity there is scope to debate whether it will result in increased healthcare demand, as we discuss later in the section of this evidence dealing with healthy ageing. However to the extent that it is a demographic ageing it will undoubtedly result in increased need for health and social care spending. Demographic ageing began in the 1980s with the coming into old age of the generation of large families created by the fall in infant mortality around the turn of the 19th/20th centuries, continued with the coming into old age of the first generation of men to have lived their entire adult life in peacetime, and will continue until 2036 when those conceived on VE Night reach the age of 90.
- 1.3. NHS spending must increase with a demographically ageing population and it must respond to increasing longevity by a policy of healthy ageing, which itself requires some spending, albeit spending with a strong medium term payback.
- 1.4. To some extent the ageing of the population has been ameliorated by immigration. Immigration is a good thing because immigrants contribute to the system more than they take out. However they do need services, especially (as a younger population) primary care. The fact that they generate the taxes to pay for them doesn't help if the money isn't spent. NHS spending must increase with an increasing population.
- 1.5. Care is subject to the relative price effect, whereby it is easier to make technological efficiencies in manufacturing industry than in labour-intensive service sectors. This inevitably leads to spending on labour-intensive personal services rising as an economy becomes more affluent. The belief that services paid for collectively can be excluded from that process is an ideological belief without an underlying reality.
- 1.6. An epidemic of alcohol misuse has led to increased need for spending on A&E services and on services for liver disease and gastroenterological disease. This has been partly a general rise in alcohol consumption which now seems to be falling again. However the most important element of this epidemic has been pre-loading, the drinking of cheap alcohol at home before going out, so as to reduce the cost of getting drunk. Pre-loading has also affected the viability of the pub trade leading to a loss of a setting which contributed to local communities and provided a degree of social control over

drinking. We need to explore solutions to this problem in order to reduce the consequent need for NHS care that has materialised.

- 1.7. An epidemic of obesity has also occurred due to the excessive sugar consumption and reduced opportunities for physical activity, including active travel. This has led to increases in diabetes and heart disease which have been very expensive for the NHS and have added to the pressures on general practice.
- 1.8. The Health Select Committee of the House of Commons has criticised the fact that much of the “additional” investment in “the NHS” was found by cuts in other areas of the comprehensive health service, including public health and workforce development. It suggested that, instead of the figure of £10bn a year quoted by Government, the increase in health spending within this public spending review period will be only £4.5bn a year.
- 1.9. We agree with Lord Lansley when he said in your Lordship’s House on 8th September that the health and social care system is not sustainable without levels of spending growth significantly greater than the figure of under 1% a year that it will have received over nine years if these spending plans are maintained.
- 1.10. We would also draw attention to the significantly greater proportion of GDP spent on health in most other developed countries.

2. Investment in Public Health and Social Care

- 2.1. Investment in public health and social care will, by reducing demand, reduce the amount of additional money that is needed. If the public health and social care investment is well used it will reduce the extra NHS investment needed by more than the amount of the investment in public health and social care. But it will not eliminate it.
- 2.2. Reducing investment in public health and social care in order to generate a headline figure for new investment in the NHS is like stripping the lead off the roof in order to make buckets to catch the rain.
- 2.3. There is a considerable need for new investment in public health and social care which we discuss later.

3. An Ageing Population

- 3.1. If the dependency ratio is calculated by dividing the number of people over 65 by the number of people of working age, it is at its highest ever and is rising inexorably. If it is calculated by dividing the number of people within 15 years of life expectancy by the number of people actually working, it is at its lowest ever and likely to fall further, remain the same or rise very slightly.

- 3.2. This is because in the second calculation life expectancy affects both the numerator and the denominator whereas the denominator is increased by increasing levels of workforce participation by women and older people.
- 3.3. This emphasises the importance of healthy ageing to the viability of health and social care.
- 3.4. The need for services for a dependent elderly population does not therefore arise from life expectancy but from the difference between life expectancy and healthy life expectancy.
- 3.5. That difference is at its greatest in the least affluent populations. These are also the populations where people live shorter lives. They not only live shorter lives but they are dependent for longer at the end of those lives.
- 3.6. Expenditure formulae for local government and the NHS distribute the money to cope with an ageing population in proportion to the number of people who are chronologically old without accounting for the earlier dependency in deprived populations. They thereby distribute the money in exactly the opposite direction to the one in which it is needed.
- 3.7. It may seem paradoxical that the burden of an ageing population falls more harshly on those areas where fewer people live to be old. But it is true, since it is dependency, not age itself, which creates health and social care need.

4. Raising the Money:- the Keynesian Solution

- 4.1. When Iceland was faced with a major banking crisis it refused to cut social spending and invested in public services. People slept better and enjoyed better health. Predictions of economic disaster did not materialise. On the contrary Iceland experienced better economic growth than other countries.
- 4.2. The same was true of those Eastern European countries which refused to cut social spending in response to the collapse of the Soviet Union. They experienced better health and better economic growth than the countries which followed conventional economic prescriptions.
- 4.3. The repetition in Iceland of the situation already seen in Eastern Europe led some economists to review the assessment of Keynesian multipliers. They discovered that different kinds of expenditure had different levels of Keynesian multiplier. Overall, Keynesian multipliers may have been fractional or just above 1, as the IMF had always assumed. However some kinds of expenditure, including health, education, welfare, social care and cultural expenditure had fiscal multipliers far higher, even between 5 and 10.
- 4.4. This finding is capable of explaining why some Keynesian reflations have worked but others, like the Barber Dash for Growth under the Heath Government, were disastrous.

- 4.5. A fiscal multiplier for health and social care spending between 5 and 10 implies that spending more money on health and social care, within reason and subject to capacity limits, will reduce the deficit by raising more money in extra tax than is spent.
- 4.6. The caveat “within reason and subject to capacity limits” is important.
- 4.7. It has been plausibly argued, based on these fiscal multipliers, that the post war establishment of the welfare state and the NHS was a major driver of the economic recovery of Britain from post war austerity and that this is a driver which could be used again. The idea that social spending is a drain on the economy rather than a driver for its growth is fundamentally misconceived and is based on a misunderstanding of how an economy works.
- 4.8. We acknowledge the contribution to the thinking in this section of our evidence of Stuckler & Basu’s book “The Body Economic”, of a scientific session at the 2016 Annual Representative Meeting of the British Medical Association and of the work of the Economics Special Interest Group of the Faculty of Public Health.

5. Raising the Money – The Case Against Alternatives to Taxation

- 5.1. Even if the view expressed in the preceding section is rejected, it will still be better to raise money for the NHS from general taxation than from other sources.
- 5.2. Introducing charges for NHS services will be inequitable and will distort the care provided. Evidence has always shown that such charges often deter those most in need.
- 5.3. Introducing means-tested charges may or may not be inequitable but it increases transaction costs and it is based on the proposition that the more affluent members of society, those in professional and managerial occupations, won’t notice that, although their taxes have not gone up, they are getting less in return for them. If such financial lack of perception were widespread in those groups in society that we depend on for intellectual drive, our country would have more to worry about than the level of taxation. Luckily it isn’t.
- 5.4. Insurance based systems may or may not be inequitable but they have high transaction costs and are inflexible, whilst offering no real advantage over a tax-based system. For that reason they should not be considered to be a viable option.
- 5.5. We reject the idea that if a particular sum of money is paid for a particular service then, if it is called “tax” and collected by HMRC it is a drain on the economy, but if it is called an “insurance premium” and collected by AXA or Aviva it suddenly becomes a vibrant part of the service sector of the economy.

5.6. We agree with Lord Lansley in his comments to your Lordship's House on 8th September that the NHS should remain free at the time of use and funded out of general taxation.

6. Efficiency

6.1. Those health care systems which offer better care than the NHS spend more. We are unaware of any health care system which offers better care than the NHS by being more efficient.

6.2. There are health care systems, such as that of Cuba, which offer somewhat less good care than the NHS but much more cheaply, so that arguably they are better value for money. Those systems are single-payer systems with a planned managed health care system. They also constrain consumer choice and the freedom of health workers to a degree that would be unacceptable in Britain.

6.3. There are also health care systems which arguably offer better value for money than the NHS by placing more emphasis on primary care.

6.4. The NHS was more efficient than it now is when it was a planned managed health care system, driven by local interaction between health professionals and local people, and with its roots in primary care.

6.5. It would be foolish to pretend that there is no scope for further efficiency in the NHS, but it is limited and we have already reached the point at which so called "efficiency savings" are usually cuts in service quality.

6.6. Efficiency of the entire health and social care system could be increased by directing a greater proportion of the essential increased funding towards social care.

6.7. Efficiency of the comprehensive health service established under the NHS Acts, what used to be called the NHS before it was redefined in 2013 so as to exclude public health, would be increased by directing a greater proportion of the essential increased funding towards public health.

6.8. Efficiency of the s66(4) NHS, the NHS as it was redefined in 2013, would be increased by directing a greater proportion of the essential increased funding towards primary care.

6.9. These investments will help to reduce growing demand and hence reduce the increased expenditure needed to accommodate it. But because of the drivers of increased demand they will only reduce the growth of expenditure, not reduce current expenditure.

6.10. Efficiency of the hospital service would be increased by the reduced transaction costs and changed incentive systems that would result from abandoning competitive procurement and restoring the NHS as a managed system.

7. The Role of Commissioning & Markets

- 7.1. As outlined in paragraph ii we have considerable claim to be one of the main players in developing the concept of clinical commissioning.
- 7.2. Our concept of clinical commissioning derives from the Alma Ata Declaration and its declaration that health care should be organised from its base in primary care, with communities and their health professional advisers determining the pattern of support that the local primary care system needs from more specialist systems. Individuals can then be supported by their GP in navigating that system.
- 7.3. This is a system of strategic planning with its roots in local communities.
- 7.4. As commissioning has developed it has progressively departed from those roots and become a market-oriented system of procurement.
- 7.5. Instead of GPs and local communities, procurement lawyers determine the pattern of health provision.
- 7.6. If markets pay for activity the system is open to provider capture as providers aim to generate more activity. Diagnostic drift occurs in coding systems. Demand management is destroyed.
- 7.7. If markets aim instead to pay for quality the indicators of quality are not sufficiently coherent or comprehensive to be immune to distortion. There is a focus on the measurable at the expense of less measurable measures and at the movement of indicators without regard to the underlying reality they are meant to reflect.
- 7.8. These last two statements are amply justified by experience from around the world.
- 7.9. It may be that these problems could be overcome if the commissioning relationship was between professionally led democratically accountable local organisations making holistic judgments. But it isn't. Such sensible judgment is deemed anticompetitive and rendered illegal.
- 7.10. Lord Lansley said in his speech to your Lordship's House on 8th September that clinical commissioners should only use competitive procurement when it is the only way to achieve significant improvements in patient care. He seems still not to understand that the market structures which his own legislation imposed on the NHS do not permit such discretion.
- 7.11. Forced to use competitive procurement measures, judged primarily by their achievement of financial targets, and lacking the ultimate long stop of a power to provide the service themselves, clinical commissioning groups increasingly cease to be strategic commissioners and become bean counters.
- 7.12. Planning by targets which fail adequately to capture the underlying reality was one of the major problems of the Soviet economic system.

- 7.13. Forced to secure their income in such a market, NHS organisations are compelled to behave like commercial organisations and adopt the same tricks as their competitors.
- 7.14. Losing sight of purpose and concentrating on making money by financial distortions was one of the causes of the banking crisis.
- 7.15. We do not believe that combining one of the biggest errors of the Soviet system with one of the biggest errors of the Western banking system is the way to create a viable process for managing a public service.
- 7.16. Between these two pressures the NHS as a service coherently and strategically planned, professionally led and democratically accountable, simply ceases to exist.
- 7.17. The NHS has already legally ceased to exist as a socially owned mechanism by which society collectively pursues the health of the people as a social goal. Insofar as it retains many characteristics of such a system this is temporary and will be destroyed as competitive procurement continues to wreak harm
- 7.18. This system is not a solution to the problems of the NHS; it is one of the main obstacles to addressing those problems.
- 7.19. We outlined the minimum changes necessary to reverse that situation in evidence given to the Health Select Committee of the House of Commons in its enquiry into Europe. We repeat them at Appendix 1. As we said in that evidence we would ourselves go further than that appendix and would pursue the measures contained in the bills drafted by Peter Roderick and presented to the House of Commons by Caroline Lucas and by Margaret Greenwood.

8. The Role of Rationing

- 8.1. It is often said that there is a limitless demand for health care and that there will always be a need to ration it.
- 8.2. However for most health care this is not true. People do not enjoy receiving health care. They do not open brochures listing the illnesses they can suffer from and joyfully plan which one they would spend their holiday on if only they could afford it. The proposition that there is a limitless demand for health care is nonsense.
- 8.3. The BMA had said that there are some areas of healthcare where demand is limitless or at any rate far exceeds any level that a society could afford without diverting resources from other important contributors to health and well being. However they are a definable subset of the total.
- 8.4. We are in two minds as to whether we agree with that.
- 8.5. Some of our members believe that this statement is true and that understanding it is central to keeping rationing in its proper place and preventing it spreading to the rest of the system. They believe that in the specific areas in question it is right to have set

budgets and clinical thresholds which contain the demand to within those budgets. However outside those areas health care should simply be funded to meet need. Recognising and circumscribing those areas is important.

- 8.6. Others of our members have doubts about this idea. They believe that if the areas where need is said to be limitless are carefully examined they can be perceived to be areas where what is being considered is not a need (a health intervention which will deliver benefit) but a want based on inadequate information. They believe that more careful and supportive clinical practice could resolve the problem, for example by helping a person inappropriately demanding cosmetic procedures to understand and address their lack of self confidence. They believe that the time to work in that way is itself an unmet, but not limitless, need.
- 8.7. There is, of course, consensus that, if need is defined as a health intervention which will deliver benefit, ineffective treatment is not a need that should be met.
- 8.8. There is also consensus that it is impossible for everybody to be enrolled on research programmes delivering experimental treatment.
- 8.9. One group about which there is controversy includes expensive measures of limited benefit. If measures have no benefit at all they are quite simply not a health need at all and no health service ought to provide them. The problem arises when the benefit is very small but not zero. They include remedies which are expensive and have a small prospect of achieving a limited benefit. They include remedies which are fashionable but in fact of limited effectiveness or no better than cheaper established remedies. They include expensive drugs with some minor theoretical advantages over more expensive drugs. Most controversially they include last ditch measures to preserve life at all costs against all reasonable hope or to prolong it insignificantly. Reasonable to whom? Insignificant to whom?
- 8.10. Another such group includes attempts to treat things which are not illnesses but part of the normal vicissitudes and discomforts of human existence. In this group are the treatment of minor musculoskeletal aches and pains. It also includes measures which improve human beings instead of merely returning them to normal. This extends to cosmetic measures in those who rationally are not disfigured. It includes the treatment of normal unhappiness and distress as is it were an illness (although supporting people through the loss reaction is a valuable preventive measure which we do not do enough of).
- 8.11. A third group consists of preventive measures – screening, monitoring, treatment of risks, supporting changes to healthier behaviour. This is important and we should do far more of it. But we cannot do everything. Indeed if we tried to do everything we would create a neurotic iatrogenically hypochondriac society.
- 8.12. A fourth area is treatment whose purpose is to avoid the need for the adoption of healthy lifestyles. We are not referring here to treatment of the consequences of unhealthy lifestyles – how a person became ill does not affect their need for care. We

are referring to treatments in which a person could resolve their health problem by, for example, being more physically active, but insists on an alternative expensive treatment. The distinction is important.

- 8.13. Another source of limitless demand is the reassurance of people who lack the skills to manage their own health problems or those of their children. The initial solution is not to add this to the above list of items but rather to address the lack of skills and empower people to make sensible health choices. This is part of the concept of the fully engaged scenario, along with healthier lifestyles. However there does come a point at which everything reasonable has been done.
- 8.14. A final source of limitless demand is defensive medicine, treatments given and investigations carried out not because there is any real need for them but for fear of criticism if they are omitted.
- 8.15. Some of our members believe that such treatment will need to be prioritised against a budget. Others believe that what is needed in these areas is a more careful analysis of the underlying roots of the demand and the actual clinical benefits available. However this controversy affects only a small part of the total health system. Most health needs should simply be met.
- 8.16. It is important to emphasise that those of our members who advocate a limited circumscribed role for financially-driven clinical thresholds are not advocating that every treatment in the above list should completely cease to be provided by the NHS. Indeed twice in the above paragraphs we have added something to this list whilst also saying that more of it should be done. It is simply that in those areas there may be a need for clinical thresholds. Such thresholds are either unavoidable or are avoidable only by funding much more detailed, careful and supportive clinical practice.
- 8.17. It is a matter of deep concern that the NHS, for financial reasons, is currently applying clinical thresholds in areas which ought not to be in the above list, and is approaching some issues within the above list by applying a complete ban rather than by adopting clinical thresholds.
- 8.18. The NHS should be so funded that it should be able to meet all the needs that do not fall into the above categories and still have a sufficient budget left over to address the above areas, whether this is done by adopting reasonable clinical thresholds for the above areas of care or by funding a more careful, detailed and supportive clinical practice.

9. The History, Distortion and Future of the NHS

- 9.1. The NHS as established by Nye Bevan was a tripartite service in which local councils, acting as part of the NHS, provided public health and community health services, local Hospital Management Committees managed hospitals and local Executive Councils handled contracts with family health services contractors, including GPs whose practices had been nationalised and then franchised back.

- 9.2. The management of the system was fundamentally local and rooted in local communities, although accountable to the Secretary of State who had a duty to provide the service and was accountable to Parliament for doing so, thus ensuring strategic oversight and national standards.
- 9.3. The management of the system was rooted in the nexus of the relationship between health professionals and local communities.
- 9.4. Although the service was nationalised, this was not a Morrisonian nationalisation. It was much more accountable to Parliament, the professions and the people. Indeed in its working it was closer to a mutualised system than a nationalised one.
- 9.5. The system spanned the whole realm of health. It was a mechanism for addressing health as a social goal. It is sometimes said that the NHS has never addressed prevention and that Nye Bevan's statement that it would improve the health of the people represented a naïve belief in the power of medicine. This is simply untrue. In its first quarter of a century the NHS, through its local government wing, one of its three wings, cleared the slums, cleaned the air, removed the need for the TB hospitals, and eradicated diphtheria and polio from the UK.
- 9.6. In 1974 public health was moved from local government to the new health authorities, and environmental health remained with local government and was redefined as no longer part of the NHS. From that date onwards the NHS has been purely a treatment service. Nye Bevan who described health as the product of the struggle of the people against unhealthy conditions and said of its improvement over time "capitalism proudly displays the medals won in the battles it has lost" would have been appalled.
- 9.7. At first the new health authorities maintained the local involvement and the interplay of professionals and local communities that had been a feature of the NHS in its first quarter century. But in a succession of reorganisations over the next quarter of a century the management of the NHS became increasingly centralised and directive. It came to be much more Morrisonian than its original character.
- 9.8. The transfer of micromanagement from the Secretary of State to quangos in 2013 completed the centralisation of the NHS into a Morrisonian nationalised industry and, by the procurement processes that were set in place, commenced its privatisation.
- 9.9. There was an opportunity in 2013 to do something other than that. The Health & Social Care Act 2012 (implemented in 2013) could have been a major step back to the future if:
 - Health & Well Being Boards had been better structured and had been given real power and a small secretariat.
 - The new public health functions of local government had been seen as part of the NHS as they had been from 1948-74.
 - Environmental health had been returned to the concept of an NHS from which it was separated in 1974.

- There had never been introduced the absurd terminology which distinguished “the NHS” from “the comprehensive health service”, a terminology whose only utility was to allow the asset stripping of public health, the disengagement of NHS England from prevention and to provide cover for a Chancellor of the Exchequer to strip the lead off the roof to make buckets to catch the rain.
- Part III of the Act with its empowerment of legalistic procurement had never been passed.
- The duty to provide had remained vested with the Secretary of State and delegated instead of being turned into a merely exhortatory function.

9.10. We believe that the NHS should return to its roots. It should become again a mechanism through which society pursues the health of the people as a social goal. Power should pass out of the hands of bureaucrats, beancounters and business operatives and back into the hands of Parliament, the professions and the people.

10. The Role of the Commercial Determinants of Health

10.1. We cannot afford a population which ages unhealthily due to ever rising levels of obesity, alcohol-related morbidity and diabetes. Our failure as a society to appropriately regulate the food industry, to invest in walking and cycling, and to tackle alcohol abuse, is a major factor in the rising costs of health care. Government inaction on public health measures is financially imprudent and unaffordable.

10.2. If a drug were invented tomorrow which reduced heart disease, reduced blood pressure, helped prevent diabetes, improved mood, helped prevent the osteoporosis of ageing, and made people stronger and fitter, it would be hailed as a wonder drug, the share price of its manufacturer would soar and any suggestion that the NHS could not afford it would be overwhelmed by anger and protest.

10.3. Physical activity does all of those things. Walking and cycling are effective ways to integrate physical activity into everyday life with proven health benefits. The walking and cycling investment programme amounts to £1 per person per year. In Copenhagen it is £24.

10.4. We believe that it is important to consider health in all policies and to make health a material factor in all public decisions (including planning decisions and licensing decisions). As Disraeli said “the health of the people is the first concern of government”.

10.5. Neglecting this is like allowing people to play with fireworks in your house and expecting the insurance company to pay for the resulting fires without increasing your premium.

10.6. Neglecting health out of an ideological distaste for regulation is something we cannot afford. We can have two of an NHS, controlled levels of public expenditure and a neurotic antagonism to the mythological concept of a nanny state. We cannot have all

three. Current neglect of health-promoting social policies is socially irresponsible and financially imprudent.

11. Welfare Policy as a Cause of Ill Health

- 11.1. If life expectancy and healthy life expectancy in all parts of the country was the same as it is in the most affluent areas health and social care demand would be reduced significantly. One plausible analysis, albeit based on data from only one geographical area, has suggested 12.5%.
- 11.2. Welfare spending, like health spending, is self-funding due to the Keynesian multiplier. There is no financial reason to cut it. There is no financial reason not to have decent incomes for all who work, whether in paid or voluntary work. There is no financial reason not to have justice for the WASPI women, or for those unfairly deprived of occupational pensions due to their employer's insolvency, or for disabled people.
- 11.3. Whilst welfare reform, focused on reducing dependency, is beneficial to health and compatible with the concepts of the post-war welfare state, welfare reform focused on punitive stigmatisation and reducing welfare spending is health damaging and financially self-defeating. It is another example of stripping the lead off the roof to make buckets to catch the rain.

12. Raising the Money – The Issue of Tax

- 12.1. In our section on Keynesianism we argued that spending on health and social care and public health will be self financing through the fiscal multiplier.
- 12.2. In the section that followed we argued that alternative ways of raising money by methods other than tax will either be inequitable or inefficient.
- 12.3. We are aware that those who do not accept our argument about the fiscal multiplier will counter our argument in favour of tax –based systems by saying that there is a resistance to increased taxation.
- 12.4. There are those, such as the Conservative MPs Dan Poulter and Jeremy Lefroy who seek to square this circle by arguing for hypothecated tax.

We believe there is actually no circle to square as we have called for Keynesianism solutions to health funding.

- 12.5. It is however also important to understand more fundamentally the roots of the resistance to tax increases
- 12.6. As corporate multinationals have paid a decreasing tax contribution the tax burden has correspondingly fallen more heavily on small businesses and individuals.
- 12.7. Small businesses which pay their tax have to compete with multinationals which don't.
- 12.8. As the proportion of the tax burden falling on individuals increases the value for money of taxation to an individual declines.

- 12.9. This is resented, but probably no more than other situations where people believe corporate interests are increasing the cost of the basic necessities of life, such as fuel bills or commuting costs. People also resent the risk of losing their savings due to the costs of social care.
- 12.10. If we are wrong about the Keynesian self-financing nature of increased health and social care spending, we would advocate that the money be raised by taxing multinational companies for economic activity which exploits UK markets but is declared as profits elsewhere. If multinational companies pay these taxes then this would raise the money to fund the increased health and social care spending. If they choose instead not to exploit UK markets then they will create market niches which can be filled by small businesses which will pay their taxes and fund the increased health and social care spending.
- 12.11. If we are right that the Keynesian multiplier will fund the spending anyway, then the deficit can be correspondingly reduced. If we are wrong then at least the spending will have been funded.

13. Spending the Money - Social Care

- 13.1. The burden on the NHS is increased by the failure of social care systems to provide effective crisis intervention leading to people presenting to the NHS. This is well recognised.
- 13.2. Equally important but less well recognised is that the burden on social care is increased by failures of the NHS to intervene early to prevent the development of dependency – a process which is increasingly coming to be called iatrogenic ageing.
- 13.3. The following is a scenario which will be played out in a number of places in the country today and every day.
- 13.4. An old person who lives alone falls or feels unwell and is unable to look after themselves. They need no more than some temporary support but, being unable to arrange any form of crisis care, they or their neighbours or their out of hours GP, sends them to hospital.
- 13.5. The hospital admits them to a busy ward with overworked staff.
- 13.6. Their nutrition and hydration are neglected by busy staff and nobody has time to mobilise and walk them. As a result they lose mobility. Lacking mobility they are unable to be sent home.
- 13.7. After a period of time the hospital starts to say that they have no medical need and to demand that the social care system finds them a place in a care home so that they no longer “block a bed”. However there are no community social care facilities available

as they are either closed down or full. The patient remains in the hospital bed and other acutely unwell patients have to be kept in A&E or in corridors.

- 13.8. Failing to invest in crisis intervention and intermediate care options to keep people out of hospitals, in staff to pay attention to the nutrition and hydration of people in hospital and in staff to mobilise old people in hospital, is stripping the lead off the roof to make buckets to catch the rain.
- 13.9. When people start to become dependent they will initially want to support themselves at home. Support for this will slow the increasing dependency. Inadequate support will turn the home into a lonely place as constraining as any institution. Domiciliary support has been cut to this point already. Like failing to invest in hydration, nutrition and mobilisation in hospital, it is a false economy.
- 13.10. When people do become unable to maintain a satisfactory lifestyle at home they need to be cared for in a dynamic vibrant community (what Nye Bevan, referring to the service that private hotels in the first half of the 20th century provided to those old people who could afford them, described as “the private hotels for the working class”). As one of our members put it “one of the most awful things we see is an old, vulnerable and helpless person stranded in their own home, visited by professional carers four times a day, unable to get out of bed and completely at the mercy of whoever has the number for the key safe. What a terrible existence. I am going into a care home with a lot of other raucous old ladies. I don't want to moulder away unnoticed in my own home.”
- 13.11. Unfortunately year by year pressures on the unit cost of care homes means that they often have to reduce the features which make them a vibrant community. There is some reason to believe that social pressures which focus on looking after people rather than on promoting their independence add to this pressure, as do CQC inspection regimes which have that same mindset. There is a place, albeit probably a limited one, for co-residency, where groups with different needs live together in mutual support. We are concerned by the uncomprehending way in which the CQC approached such a situation at Botton Village in Yorkshire.
- 13.12. We need vibrant communities of old people and we need effective domiciliary care which delays the point at which people need to enter them. We are in grave danger, if current funding approaches continue, of having neither of these. If we do not have them the burden will fall on the NHS. We will once again have stripped the lead off the roof to make buckets to catch the rain.

14. Spending the Money – Public Health

- 14.1. The British Medical Association, explicitly speaking on behalf of the whole profession and not just of public health doctors, has argued for increased investment in public health as essential to the financial stability of the NHS. Four times in the last five years the Chair of BMA Council has written to Ministers, including once to the Chancellor of the Exchequer, urging such increased investment. One such letter said that £1bn of

such investment would do more to benefit the NHS than an equivalent investment in the NHS itself (as currently defined)

- 14.2. The Association of Directors of Public Health produced detailed proposals in 2012. They showed for example that an investment of £110million a year in stop smoking services and tobacco control could save £600m a year in NHS costs. They also suggested that an investment of £165million in NHS health checks could save 414 lives, prevent 1,018 strokes and heart attacks and 2,545 diabetes cases and save £1.8bn a year (although there is some controversy over this)
- 14.3. It is often said that preventive savings are long term and do not address immediate problems. This is true of some proposals, although it is necessary for us to take measures which address long term sustainability. However reductions in smoking, the prevention of strokes and heart attacks and measures which promote employment of people with mental illness are examples of programmes which have an immediate or early effect.
- 14.4. Investment will only produce these savings if the money is properly spent on a programme which fits the local health strategy and for this reason the BMA also proposed a greater involvement of the NHS and Health & Well Being Boards in the spending of an increased public health grant.
- 14.5. The Government's response to this considered advice from the profession was to cut public health grant and propose its inclusion in the business rates retention process, reducing even further the unity of the comprehensive health service established under the NHS Acts.
- 14.6. It appears that as a result cuts are being made in services which were previously expanded as priorities, such as health visiting, school nursing, and drug and alcohol services and in services which obviously help contain demand such as vaccination and immunisation, health protection, and sexual health.
- 14.7. We have already mentioned that the Health Select Committee of the House of Commons has criticised the fact that much of the "additional" investment in "the NHS" was found by cuts in other areas of the comprehensive health service, including public health.
- 14.8. The Health Select Committee of the House of Commons has also criticised public health cuts as a false economy adding to the costs of the NHS.
- 14.9. We agree with both of these comments by the committee and we describe the failure to invest in public health as stripping the lead off the roof to make buckets to catch the rain.
- 15. Spending the Money – Primary Care**
 - 15.1. General practice is central to cost-effectiveness in the NHS. It is in crisis. Funding has been cut year on year yet workload increased year on year. Morale is low. It is difficult

to recruit. Young doctors are increasingly choosing non GP career pathways. It is becoming particularly difficult to recruit doctors prepared to take on the risks of being profit-sharing partners. Early retirements are becoming normal.

- 15.2. DiU believes in a form of general practice which is linked to community leadership.
- 15.3. As MPU we have played an important role in shaping modern general practice through our role in initiating the Family Doctors' Charter and in initiating the idea of clinical commissioning.
- 15.4. It is often said that general practices are small businesses but it is important to recall that the business goodwill of general practice is nationalised. GPs tend to stay in their communities for a whole career – during good and bad times. Current trends to turn general practice into a commercial entity operated by commercial organisations, and to subject commissioning to rules which turn clinical commissioners into figleaves overseeing a tender process, threaten the whole basis of these systems.
- 15.5. The regulatory and bureaucratic burdens on general practice are significant and take clinicians away from direct patient care.
- 15.6. The Government insistence on moving to a 7 day NHS is driving GPs away from the profession. GPs are unable to provide a safe and sustainable 5 day service never mind looking to a 7 day GP service.
- 15.7. Funding cuts threaten many practices – that is why DiU played such a prominent role in the Save Our Surgeries campaign which succeeded in 2014 in obtaining some emergency resources from NHS England but this battle must continue and our members are at the forefront of it.
- 15.8. We have described already in this evidence a number of pressures that fall particularly on general practice.
- 15.9. General practice as we have known it over many years as a cornerstone of the NHS faces the prospect of complete obliteration. This will seriously damage the efficiency of the whole system.

16. Spending the Money – Pharmaceuticals

- 16.1. Pharmaceuticals have a downwardly sloping cost curve with high entry costs due to research and development.
- 16.2. Pigou's Theorem predicts that for such a product the market will clear with high prices, unmet need and substantial unused capacity (either actual or potential).
- 16.3. This is because the price needs to be kept high enough to pay the entry costs. If there is no market intervention to make this unnecessary, and there is no way to market unused capacity without competing with the main product (as when travel companies

market restricted or stand by deals which are sufficiently unattractive) the product can only be sold to those prepared to pay the price that meets the entry costs.

- 16.4. Pigou wrote extensively about the problem of the market clearing with unmet need coexisting with a potential to meet it at low marginal cost. He examined the implications of various ways of doing this. It is a shame his work is universally ignored in the delusional consensus that market solutions are always optimal.

We believe that these issues should be investigated further in order to improve outcomes for the NHS and wider society.

17. Spending the Money – Hospitals

- 17.1. Hospitals also have a downwardly sloping cost curve and are subject to Pigou's Theorem. Tariff systems fail to capture the opportunity of marginal costs, exaggerate the financial benefits to the system of demand management and can destabilise the core elements of a hospital.
- 17.2. It would be better if the hospital system was planned and its core costs separately accounted for.
- 17.3. There is a widespread belief that we need to have fewer larger hospitals in order to achieve economies of scale. There is little evidence for this. There are diseconomies of scale as well as economies of scale and evidence suggests that the range of size in which these balance out optimally is between 200 beds and 600 beds.
- 17.4. It is necessary to take account not only of economies and diseconomies of scale but also the need to maintain safe staffing levels and the need to have a sufficient degree of specialisation that hospitals do not dabble in complex tasks that they lack the experience to do well.
- 17.5. The virtual eradication of the cottage hospitals over the last quarter of a century has removed a facility which was useful to primary care in dealing with crisis situations not actually requiring specialist care.

18. PFI

- 18.1. Communities whose hospitals happened to need significant capital investment under the Major Government or the early years of the Blair Government suffer serious financial problems as a result of the PFI Scheme
- 18.2. The PFI Scheme is now universally recognised to have been a disastrous error.
- 18.3. There are political attempts to argue about blame but the reality is that both major parties are responsible. The Thatcher Government invented the scheme. The Major Government made it the only real way to get capital investment. The Blair Government early in its years substantially expanded its use but that is only because they were catching up with underinvestment and using established methods. Later the Blair and Brown Governments modified the scheme. The Coalition dramatically reduced it. The Cameron Government acknowledged it to have been an error but has

continued the policy. At no point during this sorry saga did any of the official Oppositions make an issue of it.

- 18.4. Politicians may not have recognised the error that was being made but that does not mean that it was not known, it simply means that politicians were not listening.
- 18.5. In the early 1990s Dr. Stephen Watkins, then President of the MPU, delivered the following speech at a BMA Annual Representative Meeting. “I would like you to imagine that you are buying a house. You have two options. One is to buy the house and borrow the money at a low interest rate from a building society which your family and friends have used in the past. The other is from a new provider, Innovative Financial Instruments of Grand Cayman – IFI for short. It is a more complex deal. IFI keeps an interest in the house, the managing director can sleep in one of the bedrooms and there is a risk share agreement under which they will pay to rebuild the house if it is destroyed by a meteorite. The interest rate is much higher than the building society but the big attraction is that they will tell your creditors you don't owe them the money. The good news is that only 50 people in the UK would choose the IFI deal. The bad news is that they are the Cabinet and the Shadow Cabinet”.
- 18.6. It is wrong that communities should be left to bear the financial consequences of this absurd political consensus amongst the political class. This distorts the pattern of hospital provision to the arbitrary detriment of communities which were unfortunate enough to need hospital investment during the period that this nationally-directed error was occurring. The financial burdens of PFI (i.e. the costs of PFI deals to the extent that they exceed the costs of rational financial arrangements) should be centralised and dealt with by the Treasury which made this disastrous misjudgement and initiated this absurd idea.

19. Workforce

- 19.1. The morale of NHS staff, including nurses, consultants, GPs and junior doctors, is very low.
- 19.2. The straw that broke the camel's back was an unrealistic attempt to turn a 5-day service into a 7-day service without extra resources and the cavalier way in which staff warnings about the dangers of this were ignored.
- 19.3. This added to a steadily rising burden of demands upon staff.
- 19.4. Medical and nursing staff are queuing to resign or retire early. Hospitals are then forced to recruit from expensive locum agencies. If the staff had been valued and looked after from the outset then the use of locum agencies would not be needed. Locums do not provide the continuity of care required in a workforce
- 19.5. It occurred in parallel with cuts in funding for workforce development.
- 19.6. It also reflected an inept misreading of evidence on weekend death rates which in fact showed the exact reverse of what the Secretary of State interpreted it to show. A

higher death rate at the weekend could theoretically be due either to deficiencies of care at the weekend or to a pattern of admission in which only more seriously ill patients were admitted at the weekend. In fact, as we explain in Appendix 2, the pattern fits the latter hypothesis not the former. However the Secretary of State stubbornly refused to listen to calm, considered explanations of this.

- 19.7. DiU believes that it is important to emphasise work/life balance, proper career structures and respect for equality and diversity. This involves tackling issues of specialist training as well as pay and conditions as the MPU did in its policy “Hospital Specialist Training and Examinations”.
- 19.8. It is also necessary to recognise that an expanding service requires an expanding workforce and to plan properly the training necessary for this.
- 19.9. Whilst we support career development of all members of the team and recognise scope to expand the contribution and standing of other professions, it is important to recognise the specific role of doctors (together with dentists, non-medical public health specialists and some senior scientists) as the health profession whose practice cannot be defined simply in terms of meticulously following guidelines and procedures but involves the making of holistic judgments about their applicability. This is essential and at times life-saving.

APPENDIX 1 THE MINIMUM LEGAL CHANGES NECESSARY TO HALT THE FORCED COMMERCIALISATION OF THE NHS BY PROCUREMENT LAW

This Appendix is based on evidence previously submitted to the Health Select Committee of the House of Commons.

1. We support the NHS Reinstatement Bill.
2. We understand the concern that this Bill will lead to reorganisation. We think that concern is misplaced as the continuation of the present competitive procurement process is forcing repeated reorganisation of front line services anyway – for example almost all health visiting services are being reorganised as a result of a legal duty on local authorities to pursue a procurement process.
3. If however fear of reorganisation holds Parliament back from adopting the NHS Reinstatement Bill then proposals to make Trusts and CCGs executive agencies of reformed Health & Well Being Boards are a possible alternative.
4. We have drawn up, and set out below an outline for a bill to implement such proposals. We still prefer the NHS Reinstatement Bill but the following Bill would be a workable second best alternative.

Clause 1 would redefine the Secretary of State’s duty as being “to provide a comprehensive health service, to be called the NHS which (add rest of current wording).

Doctors in Unite (the Medical Practitioners' Union – Written evidence (NHS0102)

Clause 2 would transfer to the Secretary of State all powers currently vested in NHS bodies, NHS Trusts, NHS Foundation Trusts, NICE, the CQC, NHSE, Public Health England, Monitor, CCGs, or local authorities insofar as they act as part of the health service,

Clause 3 would add NHSE, PHE, CQC, NICE, Monitor and local authorities insofar as they act as part of the health service to the list of NHS bodies

Clause 4 would add those bodies, CCGs and NHS Foundation Trusts to the list of NHS bodies open to direction by the Secretary of State

Clause 5 would provide that the Secretary of State would normally exercise his powers by delegation to NHS bodies, that exceptionally they may be arranged otherwise for purposes specified (essentially maintaining existing contracts until they expire, maintaining arrangements which work, making use of charities and entering into arrangements which carry clear benefits to patients), that until changed by statutory instrument they shall be deemed delegated to the body which held them prior to the enactment of clause 2, and that the Secretary of State shall be under a duty to promote non-commercial management of services.

Clause 6 would repeal Part 3 of the Health & Social Care Act.

(This makes the NHS again a centrally directed service for the purposes of the *Teckal* and *Hamburg* rulings of the European Court of Justice and it abolishes the distinction between the NHS and the health service which the current Government uses to not protect the funding of public health).

Clause 7 would provide that subject to a power to reserve certain matters to a national or regional body, all powers of the Secretary of State in the area of an upper tier local authority shall be delegated to the Health & Well Being Board of that authority

Clause 8 would modify the arrangements for composition of a Health & Well Being Board to provide a better balance between different interests – the BMA has advocated each of three groups having at least a quarter and not more than half of the seats on the Board. These groups are health professionals with a duty to bring independent professional judgment to the board, representatives of patient or population advocacy groups and elected representatives of the people (including councillors, elected public governors of Foundation Trusts, elected members of the local governing body of Healthwatch, and individuals directly elected to serve on the Board itself). These groups are not necessarily exclusive, for example a health professional elected by the people would contribute to two of these groups.

Clause 9 would strengthen the professional independence of the Director of Public Health and provide for public health advice to all public bodies.

Clause 10 would provide that the purpose of CCGs, NHS Trusts and NHS Foundation Trusts would be to act as agents for one or more Health & Well Being Boards.

Clause 11 would confer on Health & Well Being Boards, or a number of such Boards acting jointly, the power to create new NHS bodies and to make orders transferring assets, staff and liabilities, provided that these orders affect only assets, staff and liabilities within the service for which the Boards making the order are responsible.

Such orders would require a public consultation and the approval of the Secretary of State.

There would also need to be transitional provisions and a short title.

If you want to integrate social care into the NHS you would just add it into the definition of the comprehensive health service in clause 1, and add local authorities insofar as they act as social services authorities into clauses 2, 3 and 4, but you would need to decide how to fund it.

If you want to reintegrate environmental health back into the NHS that it was removed from in 1974 you would add the Environment Agency and local authorities insofar as they act as environmental health authorities into clauses 2, 3 and 4

If you want to give effect to the ambition which Bevan had, and Bevin wrongly blocked, to include occupational health in the NHS you would add the Health & Safety Commission, the Health & Safety Executive, and local authorities insofar as they exercise functions under the Health & Safety at Work Act into clauses 2, 3 and 4 and add a new clause 12 requiring employers to procure an occupational health service from an NHS body or provide it themselves under licence from an NHS body.

APPENDIX 2 THE EXPLANATION OF EXCESS WEEKEND DEATH RATES

Definitive scientific studies are under way to identify whether the time pattern of occurrence of excess deaths in those admitted at the weekend supports the hypothesis that the excess deaths are due to poor care at the weekend or whether it supports the hypothesis that they are an artefact of admission patterns which lead to admitting only people who cannot wait until normal services resume.

The time patterns predictable from the two hypotheses are entirely different, virtually opposite to each other.

Under the hypothesis that the deaths are due to poor care, those admitted earlier in the weekend will have worse outcomes than those admitted later in the weekend due to a dose/response curve (although not necessarily a smooth curve as there may be more effect in a window just after admission). Those admitted as emergencies earlier in the week will have better outcomes than those admitted later in the week since they are more likely to have completed the major elements of the care by the weekend. The lowest death rates in emergency admissions will be in those admitted on Monday and the highest in those admitted on Friday. Those admitted overnight during the week will have higher death rates than those admitted as emergencies during the day.

Under the hypothesis that the excess is an artefact of patterns of admission, the greatest pressure to admit, and therefore the least serious cases admitted, and therefore the lowest death rates in emergency admissions, will be on Thursday when there is a pressure to admit before the weekend. Death rates in emergency admissions will then rise through the weekend as we get closer to normal services and therefore the pressure to admit less serious cases eases, and they will hit a high on Sunday when only those who cannot wait overnight will be admitted. Those admitted overnight during the week will have lower death rates than those admitted as emergencies during the day.

A proper study would take account of the time of admission rather than just the day of admission and it would account for case mix so as to adjust for variations in the occurrence of serious events over the week, such as those that can be predicted from differences between work-related and leisure related activities.

Such studies are under way, including that being conducted by Tim Doran in York. The question therefore arises as to whether those studies should be awaited before pursuing development of a 24/7 NHS, which carries a considerable investment of managerial time, service rearrangement, staff disruption and money. There are of course elements of a 24/7 NHS which are worth pursuing anyway for reasons of patient experience or to save costs associated with the admission of emergencies who could have been treated electively (which is, of course, the nature of the alternative hypothesis). However there is no doubt that the perception that people might be dying as a result of poor weekend care is an important factor in the extent, speed and determination with which the policy is implemented. Considerable damage could be caused, both by unintended consequences and by opportunity costs, if this perception is wrong but the error is not realised until the process is well under way.

A sensible answer to that question could be generated by looking at whether the pattern of crude rates day by day corresponds most closely to the predictions of one hypothesis or the other. Whichever hypothesis the pattern of crude rates most fits would be the best working hypothesis until the full scientific analysis is available.

This data is available in the work of Meacock,R, Doran,T, & Sutton,M “What are the Costs and Benefits of Providing Comprehensive Seven-Day Services for Emergency Hospital Admissions?” Health Econ. (April 2015) DOI: 10.1002/hec. The study sets out the English national crude death rates in emergency admissions by day of admission for 2010/11. The pattern that can be seen is the one that would be predicted from the hypothesis that the excess weekend death rates are an artefact of admission patterns. Instead of being lowest on Monday and highest on Friday, falling through the weekend, as they would do if the relationship was causal, death rates are lowest on Thursday, rise through the weekend and then fall through the first part of the week, as they would do if the relationship was an artefact.

In the light of this evidence there does not seem to be any case for proceeding at the moment with those parts of the 24/7 NHS programme which cannot be justified independently of the issue of excess weekend deaths. It would also seem to be right to allay the public alarm that has been caused. The definitive more precise studies should, of course, continue and they may unearth data that will change perceptions on the matter. At

the moment however the scientific data currently available suggests that the best working hypothesis is that the excess weekend death rates are a statistical artefact of admission patterns rather than a real health issue and that we should not devote resources to addressing them unless this picture changes when better data is obtained.

23 September 2016

John Eayrs – Written evidence (NHS0161)

1. In 1991 I got hit by a double decker bus. This road traffic accident eventually caused me to be unable to work fulltime. In learning to live with the after effects of the road traffic accident I had to obtain treatment options outside the NHS which I had to pay for.
2. My treatment regime at present is
 1. McTimony chiropractic every six weeks which is paid for by the NHS.
 2. Alexander Technique lessons which cost me £120 per month which I pay for from a PIP award.
 3. Body movement practice (T'ai chi) which helps me to move without over tightening the back.
 4. Meditation and mindfulness to help enable me to be sensitive to when I apply stress to the nerve roots in my neck.
3. An MRI scan shows I have extended discs in the neck which apply pressure on nerve roots. The treatment I receive as described in paragraph 2 above enables me to keep the pressure on the nerve roots as low as I can. I believe it is recognised that:
 1. Pain killers will not prevent pressure being applied on nerve roots in the neck.
 2. Medication will not help teach me how to manage my pain.
4. I have a long term health disability which can only be managed and there are many with long term health conditions which cannot be managed by the NHS regime of pain killers and surgical operations. I submit as evidence for consideration:
 1. the web site <https://healthunlocked.com/painconcern>
 2. "Cracked" ISBN: 9781848315563 a book written by James Davies Senior Lecturer Social Anthropology and Psychotherapy at The University of Roehampton (London UK) details some of the misleading and dishonest research results that have been presented in Professional Journals and conferences. (cannot send by email)
 3. "Bad Pharma" ISBN 978-0-00-735074-2 a book written by Ben Goldacre in 2012 details how drug companies mislead doctors and harm patients. (cannot send by email)
5. The evidence presented above suggests a new approach is needed. The present approach of the NHS pays for all treatment and is free is unsustainable. The NHS cannot pay for all the treatment that I need to maintain myself as an individual that can function reasonably well in society.
6. I have had to educate myself in how the body works, study biology and work out how scar tissue behaves and determine the effect of ten tonnes of force driving my upper arm into my neck would do. None of this can be done in a ten minute or 5 minute consultation by a GP, an orthopaedic consultant or a Rheumatologist.

7. There is a need for an educator to help a patient with a long term condition investigate their condition and to develop strategies to manage their long term condition. For example:
 1. If the patient develops the skills to manage their long term condition with reduced medication then the cost to NHS is reduced.
 2. If the patient develops the skills to investigate and understand the various mental health problems that come with their long term condition then there is a reduced demand for anti-depressants and anti-psychotics.
 3. Some long term conditions can make the patient highly suicidal. It is very expensive in resources to prevent a person deemed to be at risk and so sectioned from committing suicide.
8. The salary of an educator is far less than that of an experienced GP. An educator can take groups of patients at a time and teach the patients the needed skills of handling their health disability. For some, some Health disabilities that can take years.
9. An educator can facilitate the meeting of patients with similar health disabilities so that patients can teach each other effective strategies for handling their health disability. An educator can help patients learn useful coping tools such as meditation and mindfulness. Setting up meditation sessions for patients with health difficulties enable networking of patients so that that the isolation a health disability presents is reduced. This in turn produces less mental health stress which in turn reduces the need for expensive psychiatrist input.
10. I am suicidal on occasion. Feeling suicidal on a Sunday morning at 3am guarantees that no help is available. I have discovered that by having a goal that is important and is personal to me enables me to sit through the suicidal feelings. An educator can help a person with a long term health disability develop goals that enables a person with a long term health disability to hang on when emotions are very painful. Discussion of feelings makes feelings worse. Feelings and body posture are related. By engaging in strategies that change the body posture from one of emotion pain to one of non-emotion pain enables a person to function better and reduces a person's need for a mental health expert. This again is something an educator can engage in.
11. An educator should be able to learn the required skills in a one year course. This is in comparison to 4 year degree course for a nurse or 10 years as a GP.
12. The use of an educator will improve the mental health of those with a long term health disability. Reduce medicine costs to the NHS. Reduce the need of GP and specialist consultations. Same the NHS time as groups of people can be seen rather than individuals. The educator costs less than a fully trained medical person.

23 September 2016

Faculty of Public Health – Written evidence (NHS0154)

About the UK Faculty of Public Health

1. The UK Faculty of Public Health (FPH) is committed to improving and protecting people's mental and physical health and wellbeing. FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). Our vision is for better health for all, where people are able to achieve their fullest potential for a healthy, fulfilling life through a fair and equitable society. We work to promote understanding and to drive improvements in public health policy and practice.
2. As the leading professional body for public health specialists in the UK, our members are trained to the highest possible standards of public health competence and practice – as set by FPH. With close to 4,000 members based in the UK and internationally, we work to develop knowledge and understanding, and to promote excellence in the field of public health. For more than 40 years we have been at the forefront of developing and expanding the public health workforce and profession.

Headline Messages

- I. The NHS must remain a universal healthcare system; open to all, free to all, and funded by all through general taxation;
- II. Poverty is the major cause of inequality in health and in NHS service usage;
- III. Prevention of long-term conditions is far more cost effective than treating illness as it occurs;
- IV. The 20% cut to public health funding^{552, 553} must be reversed, and ring-fenced public health grant maintained beyond 2017/18;
- V. It is a false distinction and false economy to consider NHS and public health funding as separate;
- VI. The NHS must accept either a decline in quality and standards of patient care, reduce demand by restricting access to services and treatments – or increase health funding;
- VII. Public health expertise must be embedded by legislation within CCGs and NHS England, including at Board level;
- VIII. The specialist workforce dedicated to working with CCGs and the wider NHS on health care public health must be strengthened;
- IX. Rapid action must be made on the 12 upstream priorities of FPH's manifesto;⁵⁵⁴
- X. Hospitals will not cope with a fall in the numbers of doctors from outside the UK;
- XI. Better alignment between public health and clinical practice is needed if we are to achieve the necessary shift to prevention;
- XII. Efforts must be made to increase co-working and collaboration between the NHS, local authorities, employers, the voluntary sector, and communities in all their diversity;

⁵⁵² HM Treasury, Spending Review and Autumn Statement 2015: documents, November 2015, <http://bit.ly/1QHVv9k>

⁵⁵³ Department of Health, Local authority public health allocations 2015 to 2016, November 2015, <http://bit.ly/1UbECTG>

⁵⁵⁴ UK Faculty of Public Health, Start Well, Live Better A Manifesto, March 2015, <http://bit.ly/1wDfDv0>

- XIII. The Government must ensure that any trade negotiations post the EU Referendum include clear and strong public health exceptions and define health as broadly as possible.

Introduction – Prevention is better than cure

3. FPH welcomes this opportunity to provide written evidence to the House of Lords Select Committee on the Long-Term Sustainability of the NHS inquiry. Public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.
4. It is well established that the determinants of health – and ill health – cannot be influenced by health policy on its own, and are determined largely outside of the NHS. People with a higher socioeconomic position in society have greater life chances and opportunities to lead a flourishing life. The more opportunities and access to opportunities people have, socially and economically, the better their health.
5. This link between social conditions and health must not be a “footnote to the ‘real’ concerns with health” – but the main focus.⁵⁵⁵ It is absolutely critical that public health, which, under the Health and Social Care Act 2012, moved to local authorities from the NHS, must be seen as part of, and not distinct from, the comprehensive package of health and social care.
6. Prevention of long-term conditions is far more cost effective than treating illness as it occurs. Focusing on prevention can reduce high long-term treatment costs and improve health outcomes – avoiding premature deaths and ensuring a more sustainable NHS. In 2010, 70% of the NHS budget was spent on long-term conditions – yet only 4% cent of the health budget spent on prevention. This is rapidly decreasing as public health funding is being decimated.
7. Truly achieving a “radical upgrade in prevention and public health”⁵⁵⁶ requires more than reversal of cuts to public health funding alone. It requires a healthcare system grounded in public health principles and a public health framework with strong primary and community care relationships.⁵⁵⁷
8. It requires equitable, upstream social and economic policy at national and international level⁵⁵⁸ to address the unequal distribution of power, income, goods, and services – and consequent unfairness in the immediate circumstances of peoples’ lives – access to healthcare, education, work and leisure; homes, communities – and chances of leading a healthy life.

⁵⁵⁵ Fair Society, Healthy Lives, The Marmot Strategic Review of Health Inequalities in England, post-2012, 2010.

<http://bit.ly/1hs5CeE>

⁵⁵⁶ NHS England, *Five Year Forward View*, October 2014, <http://bit.ly/1lvuwY5>

⁵⁵⁷ FPH draws attention to efforts in Scandinavia to embed public health as a foundation block of the health care system

⁵⁵⁸ FPH notes the ground-breaking Welsh Government, Well-being of Future Generations (Wales) Act 2015, <http://bit.ly/1Q2zMtf> and also draws attention to the

9. FPH's manifesto, *Start Well, Live Better*,⁵⁵⁹ outlines 12 evidence and based practical actions that will contribute to securing the NHS's long-term sustainability, through commitment to preventative action – strongly aligned with the Five Year Forward View. FPH further supports:

- A tobacco levy – a cost-effective way to guarantee resources regardless of public finances.⁵⁶⁰
- Giving Hospital Trusts a £200million target to reduce avoidable procurement and agency staff commissioning costs.⁵⁶¹
- Giving NHS Trusts a £200million target to reduce 'interventions of limited clinical value'.⁵⁶²
- Addressing unacceptable country-wide variation in quality of care.⁵⁶³

Major cuts to public health and social care

10. Subsequent to the £200 million cut to the ring-fenced public health grant announced in 2015, the Comprehensive Spending Review 2015 (CSR) unveiled further real terms cuts by 3.9% each year to 2020/21 (a cash reduction of almost 10%). This follows the 12% already cut from the national social care budget since 2011;⁵⁶⁴ and estimated real-term reductions in local government funding and income of 37% and 25%, 2010-15. 32% is also to be cut from Department of Communities and Local Government funding by during this CSR.

11. Statutory public health functions may also change post-2017, with serious implications for critical health and public health services provided by local authorities, e.g. already fragmented sexual health services, health visitor services and fulfilment of new local responsibility for children 0-5 years. All of these non-mandated services are already at most serious risk, in turn placing risk to the sustainability of the NHS.

12. We cautioned in 2012 of the risks to adult and child safeguarding posed by the Act.⁵⁶⁵ Yet, as a consequence of the Act, today, in 2015 a key component of the very services designed to ensure safeguarding of vulnerable children from serious risk – is now itself not safeguarded. With 0-5 services now not mandated, FPH reminds the Select Committee of the 2011 Munro Review of Child Protection⁵⁶⁶ which outlined the

⁵⁵⁹ UK Faculty of Public Health, *Start Well, Live Better A Manifesto*, March 2015,

http://www.fph.org.uk/start_well%2c_live_better_-_a_manifesto

⁵⁶⁰ Action on Smoking and Health, *Smoking Still Kills: Protecting Children, Reducing Inequalities*, 2015, <http://bit.ly/1ICDuko>

⁵⁶¹ FPH draws attention to Lord Carter's Review of Operational Productivity in NHS Providers, 2015, <http://bit.ly/1fe92oU>

⁵⁶² FPH draws attention to the Academy of Royal Colleges report, *Protecting resources, Promoting value: A doctors guide to cutting waste in clinical care*, November 2014, <http://bit.ly/1kOOz6D>

⁵⁶³ FPH draws attention to the Dalton Review, *Examining new options and opportunities for providers of NHS care*, December 2014, <http://bit.ly/1G6AptI>

⁵⁶⁴ ADASS, *Budget Survey – Executive Summary*, July 2014, <http://bit.ly/1EPAnTw>

⁵⁶⁵ UK Faculty of Public Health, *Health and Social Care Bill – Risk Assessment Summary*, 2012, <http://bit.ly/14BaH2u>

⁵⁶⁶ The Munro Review of Child Protection: *Final Report A child-centred system*, 2011, <http://bit.ly/1mJRdAL>

importance of a child centred system. The recommendations of the Munro report remain relevant today.

13. We further strongly support the cross-party 1001 Critical Days manifesto.⁵⁶⁷ This important vision for the provision of services in the UK for the early years period, puts forward the moral, scientific and economic case for the importance of the conception to age 2 period, and should be a key consideration when considering the sustainability of the NHS.
14. Safeguarding does not end at 5 years. Local authorities have responsibility for children 0-19 and adults – responsibility across the life-course. This is about a coordinated, system wide approach, linked with social care and all of the other elements of the system. FPH urges Government to ensure that these important services are fully funded and protected.
15. FPH is also concerned that the CSR signals the grant's replacement with a retained business rate model. Eventual redistribution may particularly hurt deprived local authorities striving to address greater health needs and wider health inequalities. Should the ring-fence be removed, the National Audit Office warns PHE's ability to influence and support public health outcomes will be tested.⁵⁶⁸ We strongly advocate long-term maintenance of the ring-fenced public health grant beyond 2018.

NHS and public health funding must not be considered as separate

16. FPH welcomed the former Prime Minister's commitment to increase NHS spending in real terms every year in this Parliament, rising to at least an extra £8 billion a year by 2020. We further welcomed his recognition that the costs of obesity, smoking, alcohol and diabetes necessitate: "a completely new approach to public health and preventable diseases – prevention, not just treatment. Tackling causes, not just symptoms."⁵⁶⁹
17. The Secretary of State for Health affirmed that assurance. Alongside welcoming NHS England's Five Year Forward View's (FYFV) call for a "radical upgrade in prevention and public health",⁵⁷⁰ a "vision" is needed, he announced, "encompassing the move to prevention, not cure, with much bigger focus on public health."⁵⁷¹ That vision is critical to the NHS's sustainability.
18. It is a false distinction and false economy to consider NHS and public health funding as separate. FPH has previously expressed our deep concern that the Government, while pledging "to support financially [the FYFV],"⁵⁷² has limited that commitment to NHS spending. This contradicts not only the Prime Minister and Secretary of State's

⁵⁶⁷ The 1001 Critical Days Manifesto, 2013, http://www.1001criticaldays.co.uk/the_manifesto.php

⁵⁶⁸ National Audit Office, Public Health England's grant to local authorities, December 2014, <http://bit.ly/1NOZiLi>

⁵⁶⁹ The Prime Minister's Office, PM on plans for a seven-day NHS, May 2015, <http://bit.ly/1LwXk3>

⁵⁷⁰ NHS England, Five Year Forward View, October 2014, <http://bit.ly/1IvuwY5>

⁵⁷¹ The Rt. Hon. Jeremy Hunt MP, Making healthcare more human-centred and not system-centred, July 2015, <http://bit.ly/1HzUmrX>

⁵⁷² The Rt. Hon. Jeremy Hunt MP, Making healthcare more human-centred and not system-centred, July 2015, <http://bit.ly/1HzUmrX>

commitment and vision; but conclusion of the FYFV itself – that public health investment needs “explicit support from the next government.”⁵⁷³

19. It contradicts PHE’s evidence-based advice to Government that “it will be neither effective nor feasible to attempt to solve an epidemic of largely preventable long-term diseases, through risks e.g. obesity, poor diet, physical inactivity, smoking and excessive alcohol consumption, by ramping up spending on hospitals, clinicians and services.”⁵⁷⁴

20. These cuts will deliver substantial additional burdens on the NHS.^{575, 576, 577, 578, 579} The value for money, cost-effectiveness of public health, and case for increased public health investment, is well established.^{580 581 582 583 584 585 586} Severe cuts and the ring-fence’s removal, will:

1. Worsen significantly health and wellbeing of local populations;
2. Increase inequalities across the life course, including within hard to reach groups;
3. Compromise delegated health protection and health improvement functions;
4. Make harder provision of population healthcare advice, and will hence;
5. Increase the burden of preventable non-communicable disease, putting further pressure on the NHS (already spending 70% of its budget managing long-term conditions)⁵⁸⁷, and;
6. Contradict deficit reduction – it will increase the deficit. Every £1billion “saved” will generate at least £5billion additional NHS, social care and wider economic costs.⁵⁸⁸

The medical profession is united against cuts to NHS, public health and social care funding

21. The public health and medical profession were united in opposition to the £200million cut to the ring-fenced grant. The Academy of Medical Royal Colleges, representing 22 Colleges and Faculties and 200,000 members – and a broad cross section of professional bodies, including the Local Government Association and Society of Local Authority Chief Executives,^{589, 590} called for the £200million cut to be reversed and no further cuts to be

⁵⁷³ NHS England, *Five Year Forward View*, October 2014, <http://bit.ly/1lvuwY5>

⁵⁷⁴ PHE, *From Evidence into Action: Opportunities to protect and improve the nation’s health*, October 2014, <http://bit.ly/ZT2t3h>

⁵⁷⁵ DH consultation on public health allocations 2015-16, 2015, <http://bit.ly/1hulx0H>

⁵⁷⁶ CSR 2015 consultation, 2015, <http://bit.ly/1KCs2dB>

⁵⁷⁷ DH consultation on proposed target allocation formula 2016/17 <http://bit.ly/1NPRfTm>

⁵⁷⁸ Update on public health funding, 2012, <http://bit.ly/1Qm2aFK>

⁵⁷⁹ CSR confirmation, 2015, <http://bit.ly/1INQ63H>

⁵⁸⁰ European Journal of Public Health, *Cost-effectiveness research on preventive interventions: a survey of the publications in 2008*, April 2011, <http://bit.ly/1KVISpW>

⁵⁸¹ NICE, *Judging whether public health interventions offer value for money*, September 2013, <http://bit.ly/1NezdqF>

⁵⁸² Journal of Public Health, *The cost-effectiveness of public health interventions*, September 2011, <http://bit.ly/1Dv4Psi>

⁵⁸³ World Health Organization, *The case for investing in public health*, 2015, <http://bit.ly/1DgHeG7>

⁵⁸⁴ UK Faculty of Public Health, *The economic case for investing in public mental health*, <http://bit.ly/1MeYTGw>

⁵⁸⁵ Local Government Association, *Money well spent? Assessing the cost effectiveness and return on investment of public health interventions*, November 2013, <http://bit.ly/1W5GkYv>

⁵⁸⁶ King’s Fund, *Inequalities in life expectancy Changes over time and implications for policy*, 2015, <http://bit.ly/1gZMCZZ>

⁵⁸⁷ Department of Health, *Improving the health and well-being of people with long term conditions*, January 2010, <http://bit.ly/1FScD4l>

⁵⁸⁸ Professor Simon Capewell, University of Liverpool, 2015

⁵⁸⁹ Academy of Medical Colleges, Letter to the Chancellor of the Exchequer, October 2015, <http://bit.ly/1Me3gm9>

⁵⁹⁰ Signatories to the AoMRC letter included: The UK Faculty of Public Health, The Association of Directors of Public Health,

made. FPH's membership are again united in opposition to the CSR's decimation of public health funding.

22. Against this backdrop, FPH is concerned by the stark choice the Royal College of Physicians' (RCP) recent report, "*Underfunded. Underdoctored. Overstretched*", outlines. *The NHS in 2016*" – that the NHS must accept either a decline in quality and standards of patient care, reduce demand by restricting access to services and treatments – or increase health funding. It observes that:

- **Funding has not kept up with demand** – in 2015, NHS England estimated that if no action was taken the gap between demand and funding would leave a £30bn hole by 2020/21;
- In November 2015, the government committed to an £8.4bn increase in NHS funding by 2020/21 with £3.8bn front-loaded for 2016/17;
- To bridge the gap, NHS England set a target of £22bn in efficiency savings by 2020/21;
- In July 2016, an even more **ambitious efficiency target of 4%** was set for 2016/17;
- This is **unlikely to be achievable** – it's at least double the 1.5–2% that trusts have achieved over recent years, and considerably higher than the average historical saving of 0.8% per year;
- Lord Carter's comprehensive review of NHS productivity identified £5 billion-worth of savings that could be made across the NHS – short of the amount needed to close the funding gap;
- **It is likely to impact on patient care too** – already in 2015, more than eight out of ten doctors believed that efficiency savings had had a negative impact on staff-to-patient ratios;
- If the efficiency targets are met, providers will have an **underlying deficit of £2.35bn in 2017**;
- Even if hospitals achieve efficiency savings of 3–4% every year to 2020/21, they will only balance the books in 2020/21 if they also 'slow the pace of activity growth by 1% to 1.9%'.
- Missing the 3–4% efficiency target means **activity growth needs to be scaled back further**;
- Half of growth in hospital activity is due to the demands of a growing, ageing population;
- This is **now the largest sustained fall in NHS spending as a share of GDP since 1951**;
- Once adjusted for inflation, spending on the NHS in England will increase by an average of 0.9% per year, considerably below the 3.7% growth rate that the UK NHS is used to;
- Once adjusted for NHS-specific inflation, the real increase is just 0.2% per year;
- **UK public spending on health is expected to fall from 7.3% of GDP in 2014/15 to 6.6% in 2020/21** – increasing the gap between the UK and other major EU countries, e.g. Germany;
- Growth in health spending is also set to lag behind growth in the UK's economy;

- The King’s Fund calculate that if health spending kept pace with the growth in the economy by 2020/21 we would be spending £16 billion more than planned on the UK NHS.

23. Indeed, the RCP state that: “Cuts to the budgets of social care and public health services and recorded hospital deficits of £2.45 billion are already impacting on patient care: growing waiting lists, patients stuck in hospital because of discharge delays, emergency departments closing their doors, and the spectre of ‘rationing’ treatment.”

The economic impact of the EU Referendum

24. The Health Foundation further concludes that the impact of leaving the European Union will have a negative impact on the UK economy which in turn may result in an NHS budget £2.8bn lower than currently planned in 2019/20, if the government aims to balance the books overall. In the longer term, the NHS funding shortfall could be at least £19bn by 2030/31– equivalent to £365m a week – assuming the UK is able to join the European Economic Area. If this is not the case, the shortfall will potentially be as high as £28bn – which is £540m a week.

25. The Health Foundation assessment determines that if economic growth slows as predicted, funding no longer being paid to the EU would be more than cancelled out by the negative economic consequences of leaving. Therefore if the NHS were to receive an extra £100m a week from 2019/20, this would require: increased taxation of around 1p on the rate of income tax; adding £5.2bn to the expected public finance deficit; or making further cuts to other areas of public spending.

26. This would be compounded by Department of Health budget reductions of nearly £3bn in 2019/20 than currently planned, falling to £118.9bn from the planned spending of £121.7bn (2016/17 prices). This would be an average decrease of 0.4% a year in real terms between 2016/17 and 2019/20. It would see the health budget fall back to a similar level of spending to 2015/16.

The Health and Social Care Act 2012 (the Act)

27. In March 2012, FPH called for withdrawal of the Act and urged the Government to adopt an NHS stabilisation plan.⁵⁹¹ FPH’s professional, evidence based analysis made clear that the Act would harm patients, undermine the public’s health, lead to service fragmentation, worsen health inequalities and prevent effective health and social care integration.^{592, 593, 594, 595, 596, 597, 598}

⁵⁹¹ UK Faculty of Public Health, Action update, March 2012, http://www.fph.org.uk/action_update

⁵⁹² Our Strategy for Public Health in England, 2011, <http://bit.ly/1NPPxIO>

⁵⁹³ Transparency in Outcomes, 2011, <http://bit.ly/1Sp21iF>

⁵⁹⁴ Developing the Healthcare Workforce, 2011, <http://bit.ly/1O6XIYj>

⁵⁹⁵ Review of Regulation of Public Health Professionals, 2011, <http://bit.ly/1PFK0gH>

⁵⁹⁶ Funding and Commissioning Routes, 2011, <http://bit.ly/1ktOLin>

28. Regrettably, the risks to population health identified are now being realised. Detailed Evidence demonstrating realisation of these risks is found within FPH’s report on the Act’s impact.⁵⁹⁹ The Act’s scope and measures prompted concern from many professional bodies. FPH produced a risk assessment⁶⁰⁰ outlining six key concerns:

1. Loss of a comprehensive NHS and withdrawal of NHS services;
2. Increased competition and costs;
3. Reduced quality of care;
4. Widening health inequalities;
5. Risk to effective discharge of public health responsibilities;
6. Risk to the public health workforce.

29. In 2014, we conducted a membership survey to determine whether the concerns identified were warranted, and, if so, to grade and prioritise them. The 200 members responding reflected the demographic and work characteristics of FPH’s membership. Respondents reported substantial on-going concerns about the Act’s scope and implementation. Most consistently rated the risks identified as still ‘high’ or ‘extreme’. The following key threats emerged:⁶⁰¹

I. Infrastructure for public health:

- a. Short-term nature of ‘ring-fence’ for local public health budgets;
- b. Lack of access to information about the use of health services.

II. NHS Planning and delivery:

- a. Loss of insight on addressing population need, effectiveness and efficiency for NHS commissioners;
- b. Fragmentation of services and poor coordination of care.

III. Public health workforce:

- a. Concern about workforce fragmentation and the impact on patient and public safety because of changes resulting from Act.

30. The solutions to the challenges that we face are complex. FPH hopes this response offers a starting point for discussion. We would welcome the opportunity to present oral evidence to the Committee.

Consultation questions

The future healthcare system

⁵⁹⁷ Response to the Health and Social Care Bill committee, 2011, <http://bit.ly/1PcDvUq>

⁵⁹⁸ Response to the Communities and Local Government Committee inquiry on the future role of English local authorities in health issues, 2012, <http://bit.ly/1OtEhJo>

⁵⁹⁹ UK Faculty of Public Health, Membership survey report on the impact of the Act, 2015, <http://bit.ly/1FFfzlj>

⁶⁰⁰ UK Faculty of Public Health, Health and Social Care Bill – Risk Assessment Summary, 2012, <http://bit.ly/14BaH2u>

⁶⁰¹ UK Faculty of Public Health, Membership survey report on the impact of the Act, 2015, <http://bit.ly/1FFfzlj>

Question 1: Taking into account medical innovations, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

31. Efforts must be made to increase co-working and collaboration between the NHS, local authorities, employers, the voluntary sector, and communities in all their diversity. The challenges, beyond economic ones, facing all of these groups, not just the NHS, must be approached in a 'whole systems' manner.
32. Targeted prevention needs to be clearly defined as focused interventions that:
- i. Assess the risk to the individual;
 - ii. Provide early and timely intervention;
 - iii. Provide specific interventions according to the needs of the patient/user;
 - iv. Prevent unnecessary hospital admission and support timely hospital discharge;
 - v. Prevent unnecessary admission to residential or institutional care;
 - vi. Avoid dependency through targeted rehabilitation and recuperation;
 - vii. Focus on rehabilitation and help for people to improve their social functioning;
 - viii. Provide low-level support for people most at risk of losing their independence;
 - ix. Maximise independent living.
33. There must be a concerted, continuous, focus on prevention; health and care systems need to approach prevention in a sophisticated manner – Primary, Secondary and Tertiary prevention are all important to this aim.
34. Investment in maternity and family health needs a social, as well as a medical, focus. Targeted interventions must be designed to address the needs of the most challenged communities in a holistic manner and with a preventative focus.
35. There must be a greater understanding of the social determinants of mental and physical health and of the very high lifetime cost that result from exposure to deprivation, abuse and poverty. Emotional, psychological, and mental health need to be given equal weight to physical health and medical interventions. Medical interventions are likely to be less needed and more effective if the social, emotional and mental aspects are addressed together.
36. Health and social care systems must account for the UK's increasingly ageing population, and must respond with policies designed to encourage and facilitate healthy ageing. A Compassionate Communities approach ensuring that as far as possible people are prepared for and experience 'good death' will have positive mental and physical health benefits for families and communities in the short and longer term.⁶⁰²
37. Economically, health and social care systems need to better consider environmental and social sustainability as a highly supporting, not competing, mechanism. The most successful and ethical businesses discovered this years ago and have acted accordingly.

⁶⁰² <http://www.compassionatecommunities.org.uk/>

Health and social care systems like the NHS have even more to gain from systems such as the Triple Bottom Line Approach.

38. Health and social care services must decarbonise as soon as possible for financial and legal reasons, to be an example of good practice and for social reasons. The NHS and health and social care providers must reduce their carbon footprint and service costs. The Environmental efficiency of the NHS is a critical area that requires attention and focus. Action is required to address wastage through overprescribing, excess transport and buildings/energy costs. FPH acknowledges the role of fora such as the Academy of Medical Royal Colleges' 'Choosing Wisely' programme and also 'Realistic Medicine.'

Resource issues, including funding, productivity, demand management and resource use

Question 2: To what extent is the current funding envelope for the NHS realistic?

39. Please refer to the introduction.

Does the wider societal value of the healthcare system exceed its monetary cost?

What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

40. FPH recommends capitated place-based budgets for health and care, with mechanisms placed to incentivise local authorities to investment in prevention.

What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

41. FPH supports use of funds raised from sources such as Sugar Levy to be reinvested in public health and social care services.

Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

42. The NHS has its place in the UK psyche as one of the major pillars of our society. Founded to help address some of the nation's biggest inequalities, the NHS has become a national treasure. As society has changed, so too have the diseases that challenge us, both individually and collectively. Major killers like obesity, diabetes, and heart disease are influenced by our lifestyles and our environment. Inequalities persist and, in these austere times, are widening. It is still true today that where you live is a major factor in how long, and how healthily, you will live.

43. The NHS has also changed; evolving, innovating to meet those challenges – struggling at times, but in the main available to those who need it, irrespective of wealth or status.

However much it has changed, however much it needs to continue to change, fundamental to the NHS's ethos should be that it delivers the maximum public health benefit from every pound invested, that it ensures the highest possible standard of care, and that it remains a universal healthcare system; open to all, free to all, and funded by all through general taxation.

44. We underline the importance of social efficiency. It is more efficient to fund health through general taxation, and inefficient not to address poverty as source of inequality in health and in health service usage.

Workforce

Question 3: What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

45. Since the introduction of the Health and Social Care Act 2012, the public health profession has seen different employers trying to coordinate terms and conditions to cover seniority, pension arrangements, leave entitlement as well as salaries and incremental scales. It is important that public health leaders have experience of working across local government, the NHS and PHE. We need a single public health system with easy movement between employers.

2.

46. The biggest risk faced is not being able to attract medically qualified specialists to work in local authorities. Public health support to the NHS is provided by local authorities and doctors are needed in multidisciplinary teams to support acute service re-configuration, development of integrated primary care, and health and social care coordination. FPH is concerned by general reductions in public health consultant posts within some local authorities, movement of medically qualified consultants to PHE, and restructuring of smaller teams. Budget cuts place teams at greater risk.⁶⁰³

3.

47. FPH is concerned by the contraction of local and national PHE services generally, and, in particular, frontline health protection services. The Acheson report was clear on the need to ensure presence of one Consultant in Communicable Disease Control per 400,000 of the population. Yet, by 2012 this dropped to one in 500,000 and, unless arrested, could drop to 1 in 700,000. The capacity and capability to deliver, with depleted and disconnected public health workforce, for example, a level of response to pandemic influenza, as was the case in 2009, is at serious risk.⁶⁰⁴

What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

- The creation of opportunities for entry level health and social care training in the UK;

⁶⁰³ FPH is feeding into the long term review of the workforce commissioned by the DH, PHE and Health Education England, <http://bit.ly/1evAje>.

⁶⁰⁴ UK Faculty of Public Health, Staffing guidelines: Standards for Effective Public Health Teams, http://www.fph.org.uk/staffing_guidelines. FPH is happy to provide further evidence to substantiate on this point

- The development and or clarification of progression ladders from entry level to Post Graduate level in health and social care;
- The increased focus on making a career in health and social care attractive – in terms of workload, culture, values and work satisfaction;
- Appropriate remuneration and status for health and social care practitioners and professionals.

What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

48. FPH, in its recent report, *“The Health Related Consequences of the European Union Referendum”*, made clear the significant benefit to healthcare provision in the UK that free movements of health professionals around the EU, with mutual recognition of professional qualifications, is a significant benefit to healthcare provision in the UK. Up to 10% of the health and social workforce in the UK is of European Economic Area (EEA) origin, addressing existing shortages of skilled staff and able to work in the UK because of EU Treaty provisions.
49. At EU level there is an awareness of the shortages of health workers that exist in a number of countries. It is estimated that the EU will need one million additional healthcare workers by 2020, an increasing urgent issue. Since 2008, the European Commission has funded studies looking at health workforce planning issues such as skills gaps, staff retention strategies and ethical recruitment practices as well as joint actions which bring together member states to explore these issues in detail.
50. At present, there is easy access to skilled labour, and this free movement of health professionals benefits health professionals individually, and the UK generally as a net importer of health and social care professionals. This ensures that skills gaps in the UK workforce are filled quickly, and is particularly important in the NHS and for medical specialties, as well as e.g. home and institutional care for the elderly, as part of UK current efforts to increase domestic medical workforce supply.
51. The UK life sciences sector also benefits from free movement of skilled people within the EU. The UK currently acts as a hub for global researchers, attracting more university-educated EU citizens than any other member state, and resulting in 20% of the UK academic community being made up of EU nationals. The UK benefits from access to the Erasmus and Marie Curie schemes that provide mobility of early career researchers, as well as the EPIET programme, providing training in communicable disease control. The quality of UK science is strengthened and acts as a vital magnet for life sciences investment.
52. FPH notes with concern the recent findings of the Royal College of Physicians’ report, *“Underfunded. Underdoctored. Overstretched. The NHS in 2016”*, which concludes that hospitals could not cope with a fall in the numbers of doctors from outside the UK. The report outlines that:

- To cope with the shortage of doctors-in-training, the NHS has become increasingly reliant on doctors who qualified outside the UK;
- Doctors from outside the UK account for two in every five hospital doctors, with nearly one in five qualifying elsewhere in the European Economic Area;
- This is one of the highest levels of any OECD country, and higher than any other key EU country. It leaves the NHS vulnerable to the impact of changes to immigration rules;
- Increased reliance on older doctors, with increasing early retirement is a problem;
- This is a major issue for the GP workforce, which has lost large numbers of experienced and skilled staff. We must take action to avoid this pattern repeating in hospital medicine;
- Flexible models of working, including in acute and general medicine, are crucial if the system is to respond effectively to growing numbers of doctors who work less than full time;
- 40% of female consultants work less than full time compared with 4% of male counterparts;
- As the proportion of women in the medical workforce increases, training numbers must be sufficient to support the growing number of less than-full-time posts.

53. We support the RCPs' conclusion that we need joined-up action across government if we are to address the workforce challenges facing the NHS. The Department of Health, Treasury, Home Office, Department for Exiting the European Union, and Department for Work and Pensions need to work together with the health and social care professions and NHS organisations to find immediate and long-term solutions.

54. Migration rules and plans for exiting the EU must enable staff from outside the UK to work in the NHS; pension rules should not disadvantage doctors for staying longer in the NHS; and medical school and medical careers should be accessible across society

What are the retention issues for key groups of healthcare workers and how should these be addressed?

55. Stress, work overload and lack of control are frequently quoted issues. Addressing this means caring for the carers, ensuring that staff are supported in their wellbeing and work life balance and that they feel valued.

56. Flexible working options and flexible career options which recognise the stressful nature of some roles and enable staff to take breaks, move sideways or across the system.

Question 4: How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

57. High quality initial training supported by an ongoing culture of CPD.

58. Ensure all staff receive training in the emotional, psychological and mental health elements of their role – and that this is applied in practice. Greater focus should be placed on addressing the ‘work-life balance’ issues faced by staff.
59. The establishment of clear standards in training and practice, for example, ensuring that all health and social care workers are able to effectively treat and or refer people who are tobacco dependent (as yet there is no such requirement despite tobacco being the largest preventable cause of morbidity and mortality in the UK). Such a standard could be established and regulated by current authorities such as the GMC and NMC.
60. The adoption of a whole system approach, to ensure that where possible, staff are able to work across healthcare, social care and public health disciplines.
61. The establishment of a Royal College, or Chartered Institute of Social Work, in order to do for the social care profession what the Royal Colleges and Chartered institutes have done for other such as General Practitioners and Surgeons.

What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

62. New drugs and technologies have the potential to reduce the burden on the health and social care workforce, promoting a low-cost/ high population impact model.

What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

63. Costs should not be the driving factor in relation to the development of a skilled, adaptable health and social care workforce. FPH would recommend funding be directed towards:
 - a) Targeted efforts to recruit and build on the current workforce, to counter rates of attrition and account for demographic changes within the current workforce;
 - b) Funded education and training for health and social care from entry to post graduate level;
 - c) Incentivising staff to remain in the sector by making long-term career and professional development opportunities attractive;
 - d) Identifying and providing specific training in areas where there is a skill deficit.

What investment model would most speedily enhance and stabilise the workforce?

Models of service delivery and integration

Question 5: What are the practical changes required to provide the population with an integrated National Health and Care Service?

How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

64. FPH recommends:

- Establishment of a single capitated budget mediated through a place based approach;
- Integration of primary care, including GPs, into the public health and care system;
- Establishment of parity between emotional, social and mental health needs with medical/physical health needs;
- Establishment of Health Alliances – which include local communities.

How can local organisations be incentivised to work together?

65. Incentives and rewards for cooperation, not competition, can be put in place. A performance based incentive system could be applied in a whole system manner.

How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

66. The removal of the false distinctions between hospital and community services, and mental and physical health and care services. Such demarcation only places highly skilled and adaptable professionals in rigid silos, reducing their ability to work holistically with individuals.

67. Integration of primary care, including GPs, into the public health and care system.

68. The effective establishment of parity between emotional, social and mental health needs with physical or medical health needs across the whole system. This needs to include the emotional, social and mental health needs of staff.

69. Development of means to enable staff to move with patients across the system, rather than patients moving between, blocks within the system, creating a more holistic relationship between patient and health/social care provider.

70. The establishment of a Royal College, or Chartered Institute of Social Work, in order to give social work the professional status needed to effectively integrate with other healthcare disciplines.

71. Efforts should be taken to remove the blocks to better integration by improving the alignment of whole system objective and measurements (ideally linked to resourcing).

Prevention and public engagement

Question 6: What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

72. The whole system needs to be incentivised to invest in and deliver prevention. Prevention activity needs to be sophisticated and systematic. FPH recommends:

- Emphasis should be paid to promotion of healthy local, regional and national economies. For example, growth should be inclusive, with support being given to social enterprises, sustainable enterprises and local producers so that they, and the communities they operate in, benefit from national growth;
- Cuts to local authority public health budgets to reduce the deficit should be recognised as the ‘falsest of false economies’, as described by the Kings Fund, and reversed;
- Emotional, social and mental health should be addressed equally alongside physical health;
- A practical manifestation of this would be the continuity of health and social care provision so that clients receive the personalised care from professionals needed to build and maintain relationships. The present commoditisation of health and social care undermines this
- Thought should also be given to the short and long-term value of the provision of social prescriptions and welfare/debt advice in primary care settings;
- Plans should be made to improve the provision, and availability of quality, healthy hospital food – the NHS still has a long way to go before this fundamental provision is optimised (see Soil Association’s Food for Life Catering Mark for examples of health and sustainable catering);⁶⁰⁵
- The NHS should use its estate to promote active travel through provision of adequate cycle storage/showering facilities, and advocate closer public transport links;
- The NHS should use its estate to incorporate restorative green and blue spaces to promote physical activity, recovery and wellbeing (see NHS forests);⁶⁰⁶
- The NHS should invest in, and support Healthy Homes initiatives. For example, the Healthy Housing Hub in Derby is highly effective in reducing demand on health, social care and emergency services, maintaining independent living within vulnerable people’s own homes and facilitating timely hospital discharge.⁶⁰⁷ This is a good example where existing good practice in housing provision is not incorporated into health and social care systems planning strategies because there are only weak arrangements for this type of planning and the way that resources are distributed locally undermines ‘joined up’ policy. There may opportunities with the Devolution agenda to address these issues;

⁶⁰⁵ <https://www.soilassociation.org/certification/the-food-for-life-catering-mark/>

⁶⁰⁶ <http://nhsforest.org/>

⁶⁰⁷ <http://www.derby.gov.uk/housing/improvements-and-repairs/healthy-housing-service/>

- The NHS should mandate and enforce smoke-free hospitals (encompassing all heated tobacco and nicotine products);
- The NHS should properly use daylight/natural light to promote wellbeing and good sleep patterns in hospital settings;
- The NHS should promote widespread adoption of WHO health promotion hospitals approach;⁶⁰⁸
- Making Every Contact Count must be embedded across NHS and social care organisations;⁶⁰⁹
- Alcohol brief intervention/motivational interviewing should be offered in all hospitals.^{610 611}

What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

A strong specialist workforce

73. A strong public health specialist workforce provides leadership, capability and capacity that can:

- Ensure the delivery of public health functions;
- Provide a source of expert advice to political leaders and other policy makers;
- Provide high quality decision-making: the ability to bring in research and intelligence and integrate with community and other views;
- Improve health and social outcomes, ensuring the best use of scarce resources;
- Provide resilience: to lead in major events such as outbreaks and flooding;
- Anticipate changing environments and new hazards and threats;
- Reduce the burden of non-communicable diseases on health and social care;
- Ensure succession planning, including future DPHs and other key roles.

74. FPH feel very strongly that the future of high quality needs-based commissioning in the NHS will be compromised by a lack of specialist public health staff experienced and available to support GPs and other clinical leaders in that function in CCGs. In addition, as Integration and closer Health and Social Care commissioning models develop in a climate of increasing resource pressures, local health communities will require more rather than less support of this sort to maintain improving health outcomes.

75. FPH also emphasises the substantial and core role consultants in HCPH play in maintaining Joint Strategic Needs Assessment (JSNA) chapters – particularly those that

⁶⁰⁸ http://www.hphnet.org/index.php?option=com_content&view=category&id=10&Itemid=374&limitstart=20

⁶⁰⁹ <https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources>

⁶¹⁰ http://www.who.int/substance_abuse/activities/sbi/en/

⁶¹¹ <http://www.bmj.com/content/340/bmj.c1900>

relate to individual diseases and/or associated healthcare services – which are supposed to be a central support for health and wellbeing work. Many JSNAs are getting increasingly out of date – possibly due to lack of public health, and HCPH capacity within local authorities.

76. Whilst we recognise there are still public health teams that provide a superb and high quality service in the way envisaged in the Act, many are experiencing capacity or capability challenges as resource pressures and skill-mix change affects English public health departments. FPH recommends that an urgent review is undertaken on the current capacity for HCPH and whether Public Health England or NHS England need to take action to maintain a sufficient core of skilled practitioners to cover all healthcare commissioning organisations.
77. FPH further recommends, as it has done since the passage of the Health and Social Care Bill, that a public health presence should be embedded on a statutory basis on the Board of NHS England. FPH is committed to supporting this function and we are looking at ways of ensuring the best possible training experiences for future specialists but feel strongly that Public Health England and NHS England’s oversight, influence and support is vital in safeguarding this role for the future.
78. FPH attaches with this response some case studies of the value that Healthcare Public Health brings to the sustainability of the NHS.

Upstream legislative policy interventions

79. The Faculty of Public Health (FPH) draws attention to our 12-point action plan for public health. Start Well, Live Better is the culmination of an extensive consultation with our members about the top public health priorities for this government and the next.
80. From children’s health to climate change, Start Well, Live Better sets out 12 important and practical actions for anyone serious about giving our children the best possible chance of a healthy and happy life – and each intervention will make an important contribution to addressing the sustainability of, and reducing pressure on, the NHS.

Give children the best start in life

- Implement the recommendations of the 1001 Critical Days cross-party report
- Make personal, social, health and economic, and sex and relationship education a statutory duty in all schools
- Reinstate at least two hours per week of physical activity in schools

Introduce good laws to prevent bad health and save lives

- Stop the marketing of foods high in sugar, fat and salt before the 9pm watershed on TV, and tighten online marketing restrictions
- Introduce a 20% duty (per litre) on sugar sweetened beverages
- Introduce a minimum unit price for alcohol of at least 50p per unit of alcohol sold
- Implement standardised tobacco packaging
- Set 20mph as the maximum speed limit in built up areas

Help people live healthier lives

- Give everyone in paid employment and training a living wage
- Reaffirm commitment to a universal healthcare system, free at the point of use, funded through general taxation

Take national action to tackle a global problem

- Invest in public transport and active transport
- Implement a cross-national approach to meet climate change targets including a rapid move to 100% renewables and a zero-carbon energy system.

81. **Childhood obesity:** In August the Government published its childhood obesity plan. FPH welcomes the fact that the government has produced this plan to tackle childhood obesity, which includes measures for reformulation, the introduction of a sugar tax, an exercise plan for schools, a standard for public sector food procurement and the reinstatement of a healthy schools standard.

82. However, this plan lets down a generation of children by not going far enough to tackle childhood obesity. We are at a crisis point: if we are successful in tackling childhood obesity, we will give all children, particularly those from the most deprived backgrounds, the best start in life so they can grow up to be healthy adults.

83. If we fail, it is children and their families who will pay the price, as well as the tax payer, because of the estimated £4.2 billion costs to the NHS of treating obesity in everyone. We must not become blasé about the risks that obesity poses to the one in five children who are obese by the time they are 10. An obese child's weight can cause them significant health problems and make it more likely they will develop life-limiting diseases like Type 2 diabetes.

84. FPH remains fully supportive of a duty on sugary drinks a part of a wider strategy to tackle childhood obesity, and is very disappointed that the necessary, evidence based measures to make the duty a success are not included in the plan. These include tougher regulations of junk food marketing to children, particularly online, where there are far fewer restrictions.

85. No single measure will not combat childhood obesity. We are very disappointed that the sugar duty is the only one of 11 evidence-based measures that are included in this report, and that the government has failed to adopt the comprehensive evidence compiled by Public Health England.

86. We are disappointed that some in the food industry have been claiming that a sugar duty would lead to job losses: in fact, it would be good news for the wider economy as well as our health, because of the money saved from treating obesity-related health conditions. People living in the most deprived circumstances have the most to gain from the duty, because they are more likely to experience health problems caused by a poor diet that is high in sugar.

87. We know from independent analysis of the responsibility deal that five years of voluntary agreement with industry has largely failed to address this crisis. There is no evidence that voluntary approaches are effective. The previous Chancellor told parliament he did not want to duck the difficult decisions and tell his children's generation that we did nothing to tackle childhood obesity. We and the wider public health community want to see the new government show the same commitment to child health by taking bold action.

88. FPH is a member of the Obesity Health Alliance and we support its policy positions, which the Committee can read here <http://obesityhealthalliance.org.uk/wp-content/uploads/2016/08/OHA-Joint-Policy-Position-Statement-Aug-2016.pdf>.

Trade and Health

89. FPH has previously raised our strong concerns that the Transatlantic Trade and Investment Partnership currently under negotiation between the EU and United States risks increasing levels of competition in the NHS, fragment services and make it harder to give patients high quality, integrated care. It also risks increasing the cost of vital medicines, including cancer drugs, for patients across Europe.

90. As the Government consider their potential negotiations on bilateral trade agreements post the European Union Referendum, it is important that public health concerns override economic or trade concerns in any area where these priorities may conflict. This means:

- Including clear and strong public health exceptions, and;
- Defining public health as broadly as possible (e.g. not restricting the definition, explicitly or implicitly, to emergencies or to particular diseases).

91. We draw the Committee's attention to our detailed report on this issue:

- FPH, Trading Health? Executive Summary
<http://www.fph.org.uk/uploads/TTIP%20executive%20summary.pdf>
- FPH Trading Health? Full Report
<http://www.fph.org.uk/uploads/FPH%20Policy%20report%20on%20the%20Transatlantic%20Trade%20and%20Investment%20Report%20-%20FINAL.pdf>

92. We also note the recommendations of the Health Impact Assessment undertaken by the University of New South Wales on the regional equivalent Trans-Pacific Partnership Agreement <https://www.phaa.net.au/documents/item/494>

Mental Health and Wellbeing

93. Poor mental health brings with it costs to individuals and their families as well as to

society as a whole through costs to public services: health, social care, housing, education criminal justice, social security and the wider economy. People with mental health problems are more likely to experience physical health problems, smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty, and be overrepresented in the criminal justice system.

94. Productivity losses, benefit payments and cost to the NHS associated with mental health problems cost the English economy £70bn a year 59.
95. It is vital that public health (and other health and social care) practitioners become advocates for public mental health providing strong leadership and prioritising mental health within current public health practices. Here is a list of key actions that all professionals working in public health and beyond can take to promote mental wellbeing and prevent mental health problems:
 - Whether you work in a specialised public health role or generalist/general work force, consider what you can do within your sphere of influence to advance the public's mental health as a leader, partner and advocate;
 - Move, wherever possible, from deficit to strengths-based approaches and ensure you promote good mental wellbeing, address the factors that create mental wellbeing and tackle mental health problems;
 - Adopt a proportionate universalism approach, including universal interventions to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at risk groups;
 - As part of the universal approach, ensure that you are working towards your own mental wellbeing and that of your colleagues;
 - Move towards ensuring mental health receives the same billing and priority as physical health in your work;
 - Adopt a life course approach. The foundations of mental health are laid down in infancy in the context of family relationships. Place-based intervention in settings such as schools, workplaces and communities complements the life course approach and makes the most of existing opportunities;
 - Reduce stigma and discrimination by increasing mental health and wellbeing literacy across the whole population. Include interventions to improve understanding of the impact stigma and discrimination have on the lives of people with mental health problems;
 - Contribute to the expansion of the public mental health evidence base and focus on the interventions and activities that make the biggest impact;
 - Ensure that you build evaluation into everyday practice and monitor the effects of practice on mental health.
96. FPH draws attention to FPH's recent report, *Better Mental Health for All: A public health approach to mental health improvement* and is keen to discuss the recommendations and findings in further detail with the Committee.
<http://bit.ly/28LW9U9>

Welfare Reform, life chances and child poverty

97. Poverty is the major cause of inequality in health and in service usage. FPH provides the secretariat for the APPG on Health in All Policies. In February 2016, the APPG published its report into the impact of the Welfare Reform and Work Bill 2016-17 on child poverty.⁶¹² The report outlines that a generation of children who grow up in poverty and have worse health as a result.
98. We must have a successful and prosperous economy, but this APPG report clearly illustrates that the Government's attempts at an economic recovery may risk increasing the health inequalities faced by poor and vulnerable families and children.
99. There are 3.7m children in the UK living in poverty, the majority [60%] of whom have parents in low-paid work, and that the Welfare Reform Bill introduces measures that have the potential to increase the number of children growing up in poverty by 1.5 million by 2020. This is unacceptable especially when there is strong evidence that shows that eliminating child poverty in the UK would save the lives of 1,400 children under 15 every year.
100. Of the measures the Bill proposed six were found to directly and detrimentally affect child poverty. The seventh measure which looked at the impacts of the 1% reduction in social housing rent, appeared to have a short-term, positive impact on household incomes but in the longer term would reduce the availability of affordable housing, driving up rents and housing costs.
101. The APPG has made more than 30 recommendations to address the negative effects of the Welfare Reform and Work Bill, which we attach as an appendix below. We need a comprehensive, cross-government strategy to tackle child poverty, otherwise we are in danger of failing our children and creating a lost generation. The cumulative effects of this bill will in turn increase pressure on the NHS, and further compromise its sustainability.
102. In this context, FPH emphasises that it is disease free life expectancy which poor people lose more of so they may be living with long term conditions for more than 30 years. This is major cost to health service and why resource allocation should be redirected to areas with lowest disease free life expectancy. We also emphasise the use of disability free life expectancy as a means to more fairly reflect burden of inequality and long term conditions on health service demand.
103. It also means that 'preventive services' such as stop smoking need to be rigorously offered through clinical care for those already having long term conditions to prevent deterioration and aid recovery.

⁶¹² http://www.fph.org.uk/uploads/APPG_on_Health_in_All_Policies_inquiry_into_child_poverty_and_health_2.pdf

104. Related to this, FPH draws attention to the growing acknowledgement that those first early years of a child's life are absolutely crucial. Getting it right as parents with professional help and public resource to support where needed has the potential to make a huge difference to how that child will grow into an adult contributing to society.
105. FPH supports the recommendations of the 1,001 Critical Days Cross Party manifesto. It is a vision for the provision of services in the UK for the early years period, which puts forward the moral, scientific and economic case for the importance of the conception to age 2 period. This period of life is crucial to increase children's life chances. Society is missing an opportunity if we do not prevent problems before they arise and that it is vital that a focus on the early years is placed at the heart of the policy making process.
106. The Manifesto highlights the importance of acting early to enhance outcomes for children. Too many children and young people do not have the start in life they need, leading to high costs for society – for the NHS – and too many affected lives. Every child deserves an equal opportunity to lead a healthy and fulfilling life, and the 1001 Critical Days Manifesto supports this.

A Health in All Policies Approach

107. FPH supports the findings of the recent Health Select Committee report in public health post 2013:

“National system leadership is important to signal clarity of purpose and commitment to the local system when it comes to improving health and wellbeing. In order to demonstrate where national leadership for public health lies, and to avoid confusion and the risk of giving conflicting advice to the local system, the Government should produce a clear statement of who does what in respect of the main system leaders, namely, the Department of Health, Public Health England and NHS England.”

108. *Embedding health in all policies is important at both national and local level. But while there is evidence of progress locally, there is less evidence of such an approach becoming embedded across Government departments. We urge the Government to take bold and brave action through its life chances and childhood obesity strategies in order to improve public health and reduce health inequalities.*
109. *How most effectively to secure joined-up working across Government is a complex challenge to which there is no single or simple solution. The issue is not amenable to a simple structural fix—building sound relationships is a key step in the process.*
110. *A Cabinet Sub-Committee on Public Health is unlikely in itself to be the answer to securing more effective joined-up policy to improve health and wellbeing. We consider instead that the strengthened cross-departmental working which is required is more likely to be achieved by vesting responsibility for providing political leadership for public health at a national level in a Minister in the department responsible for coordinating cross-departmental work, the Cabinet Office. We recommend that a*

Minister in the Cabinet Office be given specific responsibility for embedding health in all policies across Government, working closely with the Minister for Public Health in the Department of Health.

111. *Since Public Health England was established, the interface between it and the DH has lacked clarity. We therefore urge the Government to review the relationship between the DH's Public Health Group and PHE. The 'tailored review' of PHE which DH is currently carrying out offers a good opportunity to do so.*
112. *Likewise we urge NHS England and PHE to clarify how the two organisations are seeking to pool their expertise and resources around public health in order to ensure that the local health system feels adequately supported and not conflicted by confusing messages or requirements.*

Air Pollution

113. FPH fed into and endorses the Royal College of Physicians' and Royal College of Paediatric and Child Health's report, *Every Breath we Take* (<http://bit.ly/1PUBD09>), which examines the impact of exposure to air pollution across the course of a lifetime.
114. The report sets out the dangerous impact air pollution is currently having on our nation's health. Each year in the UK, around 40,000 deaths are attributable to exposure to outdoor air pollution which plays a role in many of the major health challenges of our day. It has been linked to cancer, asthma, stroke and heart disease, diabetes, obesity, and changes linked to dementia. The health problems resulting from exposure to air pollution have a high cost to people who suffer from illness and premature death, to our health services and to business. In the UK, these costs add up to more than £20 billion every year.
115. FPH has also draws the Committee's attention to our recent report, *Local action to mitigate the health impacts of cars* which adds to the knowledge of the dangers from air pollution, and the urgency with which we must improve our air quality.
<http://bit.ly/2aoKT2m>

Public Health expertise embedded in commissioning

116. FPH expresses deep and ongoing concerns about the future of public health specialist input into healthcare planning and commissioning as a result of the Health and Social Care Act 2012 (the Act). Effective healthcare commissioning and meeting the challenges of NHS England's Five Year Forward View requires CCGs to deliver highly competent local commissioning of effective and efficient healthcare services based on need.
117. The value that public health specialists have traditionally brought to that CCG role was recognised in the Act, which made this service to CCGs a statutory part of the new public health role of local authorities in England.

118. Healthcare public health is one of the three core domains of specialist public health practice, alongside health improvement and health protection. Healthcare public health (HCPH) is concerned with maximising the population benefits of healthcare while meeting the needs of individuals and groups, by prioritizing available resources, by preventing diseases and by improving health-related outcomes through design, access, utilisation and evaluation of effective and efficient healthcare interventions and pathways of care.
119. FPH draw the Committee's attention to our recent definition of Healthcare public health⁶¹³ (<http://bit.ly/1lvNRqu>), which is also attached with this submission.
120. Since the Act, and subsequent severe resource reductions of approximately 20% for English councils, there has naturally been pressure on the public health functions that transferred to local authorities in that reorganisation. One consequence of this in many places has been a gradual reduction in the specialist workforce that is dedicated to working on HCPH with CCG NHS commissioners.
121. Whilst this is not universal, there are many examples we have come across where that function is substantially limited or even absent. This is a matter of ensuring that the right people, with the right skills – experts in population health – are in the right place and able to provide the population with assurance that their local (and national) services will be commissioned to the highest quality and represent the best value for money, and improving the efficiency of the NHS.
122. Naturally many English council public health departments focus on their direct health improvement roles, wider strategic public health upstream work and the commissioning of those limited health services for which the councils are now responsible. We have many examples where private consultancy has been used by CCGs or DPHs because of a lack of those necessary skills or limited capacity within their existing teams working on mainstream health services commissioning, suggesting there is unmet need developing.
123. Spending valuable funding on costly management consultancies, which may not be of the highest quality, to fill gaps left by public health does not represent the value for money the public would expect in addressing their population health.
124. There has also been a loss of more experienced specialist staff familiar with health services commissioning in many public health departments and although public health training is carefully overseen and comprehensive, many trainees and newly qualified Consultants now have limited experience of direct NHS work and familiarity with NHS datasets required in such work.

What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

⁶¹³ UK Faculty of Public Health, Definition of Healthcare Public Health, November 2015, <http://bit.ly/1lvNRqu>

125. Personal responsibility and self-management are important principals to be promoted through advocating improved health literacy, it is equally important to recognise that the state and its institutions have a responsibility toward the health and wellbeing of the populace. The most effective interventions are upstream legislative and regulatory interventions.
126. The State needs make decisions based on the best available and most up to date scientific evidence base in legislating for health. It needs to ensure local areas are properly and fairly funded. The current cuts to local authority budgets is, and will continue to be, very damaging to the prevention agenda unless this changes.
127. Local and / or regional bodies need to gather and analyse local data and evidence. They need to understand their people and their needs with a view to understand current and future prevention needs.
128. The establishment of a specific civil service position, responsible for monitoring trends in public health, noting when both self-reporting, and national statistics begin to highlight worsening morbidity and mortality. At present, no official, or body has commented on the rise in poor self-reported health in the UJ, and there have only been cursory investigations into the falling life expectancy of elderly people in 2012 and 2013, and the very large rise in deaths in 2015.^{614 615} FPH supports the Health Select Committee's recent proposal for cross department.
129. The state needs to actively monitor and regulate industries related to unhealthy lifestyles. For example, the state needs to:
 - e) Address the marketing of unhealthy foods high in fast sugar and salt, particularly to children,⁶¹⁶
 - f) Effectively monitor and regulate industries developing heated nicotine/tobacco products in line with other European nations
 - g) Reduce the threat of climate change to human and planetary health.

Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

130. Yes there is a mismatch, both in funding between treatment and prevention, and between different local areas due to different approaches of local authorities.

⁶¹⁴<http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2014-07-16>

⁶¹⁵<http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2015>

⁶¹⁶ https://www.sustainweb.org/publications/who_sets_the_agenda/

131. There is gross lack of investment in emotional and mental health, both in terms of treatment and prevention. For children, the Future in Mind programme has gone some way to address this, and facilitated investment in universal interventions and early intervention, as well as treatment, enhancing personal and community resilience.⁶¹⁷
132. The public health ring fence has been extremely helpful to date, where it has been honoured. The challenge has been managing a ring fence within a local authority system which is diminishing, resulting in cuts to provision which is essential to prevention.
133. Decarbonisation of NHS services can release economic savings, and help achieve shifts towards self-care, out of hospital care, and improved public health and wellbeing (see Sustainable Development Unit's research 'Securing Healthy Returns').⁶¹⁸

Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

134. Yes. "Upstream" interventions categorised as "Price" are most likely to decrease health inequalities, while "downstream" "Person" interventions appear most likely to increase inequalities. Please see section on childhood obesity.

By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

135. The most effective means would be the effective use of good quality evidence to build the, solid, business case for prevention.

What are the barriers to taking on received knowledge about healthy places to live and work?

136. Individual behaviours take place within a culture. For example, Smoke Free Legislation in the Health Act 2006 changed social norms and influenced individual behaviours.
137. Therefore the focus needs to be on shifting social norms and building healthy places, which enable and support healthy choices and behaviours.
138. Currently the implementation of measures to enhance positive health impacts of built environment / infrastructure developments are hindered by developers' viability concerns (e.g. unwillingness to include high proportion of affordable housing, or build to high sustainable homes standards).

How could technology play a greater role in enhancing prevention and public health?

⁶¹⁷

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

⁶¹⁸ <http://www.sduhealth.org.uk/policy-strategy/engagement-resources/fnancial-value-of-sustainable-development.aspx>

139. Technology needs to be easily and effectively integrated into people's everyday lives. In terms of primary prevention, there are already a number of mobile apps that are in use for supporting healthy behaviours, e.g. PHE's Sugar Smart app, and exercise/fitness apps. On a secondary prevention level, using effective technologies to support monitoring of health conditions can aid self-management and reduce burden on services.

Question7: What are the best ways to engage the public in talking about what they want from a health service?

140. Technology needs to be easily and effectively integrated into people's everyday lives. In terms of primary prevention, there are already a number of mobile apps that are in use for supporting healthy behaviours, e.g. PHE's Sugar Smart app, and exercise/fitness apps. On a secondary prevention level, using effective technologies to support monitoring of health conditions can aid self-management and reduce burden on services.
141. It is important to acknowledge that what patients and the public consider to be priorities within health services is not necessarily what professionals and providers consider as priority.
142. The patients that engage most with decision makers are not necessarily representative of service users as a whole. Those most in need of services are often the least able to engage. Care needs to be taken to ensure equitable representation of patients in consultations and the co-production of services. Communication should be both ways, with clear rationale for healthcare decisions and transparency of processes.
143. It is better to talk about how people want to live healthy fulfilling lives (reduce reliance on service provision / passive client model). An excellent model that engages with people to 'get a life not a service' is the Local Area Coordination (LAC) approach adopted in Derby.⁶¹⁹ LAC empowers people to improve their health and wellbeing through community solutions. It supports the wider transformational change for the NHS to ensure a sustainable health service by focusing on prevention, person centred and flexible care through local, joined up support.⁶²⁰
144. The promotion of individual behaviour change need to be reinforced by the promotion of a healthy culture; with key health messages from birth, through school and on through employment through employers. Direct means such as action to restrict the promotion and sale of unhealthy foods and drinks; investment in healthy towns and communities; and incentivising people to engage in all forms of active travel.

Digitisation of services, Big Data and informatics

145. Data linkage is life-saving. The public needs to be properly engaged in a discussion of how population health data enables better services and the connection of services

⁶¹⁹ <http://www.derby.gov.uk/health-and-social-care/your-life-your-choice/active-in-community/local-area-coordination/>

⁶²⁰ Ibid

throughout health and social care and enables us to understand more about the causes and solutions to health problems.

Question 8: How can new technologies be used to ensure the sustainability of the NHS?

What is the role of technology such as tele-care and tele-health, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

146. Technology has an enormous role in reducing costs and managing demand in the health and social care system, and will increasingly do so with a digital generation. If used appropriately, technology can be harnessed to improve diagnostic accuracy, support self-care and facilitate healthy behaviours and therefore reduce demands and costs for services. However, use of technologies in this context needs to be monitored and evaluated for cost-effectiveness, patient safety and unintended consequences.

What is the role of ‘Big Data’ in reducing costs and managing demand?

147. Big data needs to be produced in a timely manner. Facilitating data sharing within and between organisations can help to improve service planning and delivery; maximise outcomes for individuals with complex needs; and improve efficiency by reducing duplication of data recording and improving communication between health and related professionals. However, effective data sharing needs to be balanced with safeguards for patient confidentiality and appropriate usage. Local organisations should develop clear data sharing protocols, supported by national guidance.

What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

148. Apart from the application of the technologies – there will be ‘people dynamics’ to manage for staff, patients and public. There is a culture of caution when it comes to data sharing, due to concerns around confidentiality and appropriate usage on both sides (professionals and public). Systems for recording data are not always compatible within or between organisations.

How can healthcare providers be incentivised to take up new technologies?

149. Evidence gathered through robust evaluations of new technologies can and likely will be used to demonstrate their value for money

Where is investment in technology and informatics most needed?

150. Investment in technology and informatics would have the most impact in evaluative processes, to ensure the ability to build the evidence bases for effectiveness of new treatments and technologies, the review and development of clear systems, and the development of guidance and protocols for effective and safe data sharing

23 September 2016

Faculty of Sexual and Reproductive Health – Written evidence (NHS0098)

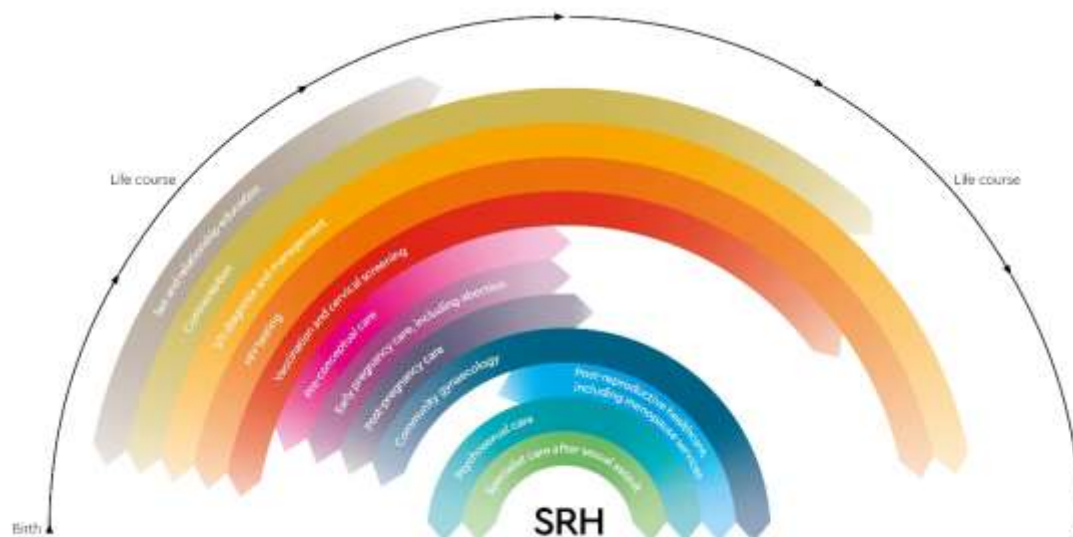
FSRH welcomes the opportunity to respond to this call for evidence on the long-term sustainability of the NHS.

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the representative body for over 15,000 doctors and nurses working in sexual and reproductive healthcare, supporting healthcare professionals to deliver high quality care. We provide national qualifications in sexual and reproductive healthcare, clinical standards and evidence-based clinical guidance to improve sexual and reproductive healthcare for the whole of the UK in whatever setting it is delivered.

Whilst FSRH acknowledges the broad scope of this call for evidence, in its capacity as a speciality sexual and reproductive healthcare (SRH) organisation, FSRH will be considering the theme of long-term stability in so far as it relates to sexual and reproductive healthcare and its role as a key healthcare intervention that is focused on prevention and health promotion.

Fundamentally, FSRH believes that the current health and care system must invest in public health and deliver on the NHS Five Year Forward View’s ‘radical upgrade in prevention’ to ensure the sustainability of the NHS. More specifically, we believe that the Government should invest in public health, including open-access and primary care based sexual and reproductive healthcare across the lifecourse in order to return wider health benefits and avoid significant future treatment and health costs.

Diagram showing the wide reach of SRH across the lifecourse:



Summary of recommendations:

- Funding models should be focussed on prevention rather than demand. The Government should invest in health promotion and public health in order to avoid excess treatment costs including unnecessary hospital based interventions.
- Public health should not be reliant on funding from business rate retention and should be afforded the same protection as NHS expenditure. The Government should ensure a centrally-controlled public health budget beyond the 2018/19 ringfence, as evidence suggests without this funds will be diverted to other areas.
- There should be investment in SRH in order to avoid substantial health and social costs incurred by unintended pregnancy, maternal/child health outcomes and costly gynaecological intervention carried out unnecessarily in hospitals.
- The Government should enact statutory PSHE education/ Sex & Relationship Education (SRE) and invest in training for education professionals to deliver high-quality PSHE education/SRE in order to improve life chances, reduce inequalities and reduce unwanted pregnancies .
- Health Education England should ensure there are adequate numbers of consultants in sexual and reproductive healthcare to secure long term SRH service quality and support to primary care and multi disciplinary teams.
- There should be shared core modular training between medical specialties to reduce silo-working. Other medical specialties should have the option to ‘buy-in’ to SRH training to ensure that the future workforce is equipped to confidently address the wider determinants of health and manage issues concerning SRH.
- Greater emphasis should be placed on multi-disciplinary working, and nurse training must be supported and developed to ensure that nurses’ roles are strengthened.
- The NHS should be enabled to move beyond traditional models of service delivery and upskill allied healthcare professionals in SRH, and other disciplines, to optimise the existing healthcare workforce.
- As 80 per cent of women access contraception in primary care, GPs and practice nurses must be adequately supported to gain the necessary competencies to deliver all available methods of contraception to reduce unintended pregnancies and support family planning and spacing of pregnancies.
- Local authorities and CCGs should be required and funded to support continued professional development in SRH service specifications to guarantee an appropriately trained SRH workforce

- SRH should be integrated into women’s health care pathways in the NHS, including abortion and maternity services.
- Integrated sexual and reproductive health services should be placed on one integrated tariff to avoid distortions in service provision, which currently impact on the availability and accessibility of contraception.
- In an enhanced public health strategy, SRH outcomes indicators should be updated to measure rates of unintended pregnancy, access and outcomes in primary care and reflect the SRH needs of women across the lifecourse including post reproductive health.
- In an enhanced public health strategy, at a national level there should be clearly set out responsibilities divided amongst, and clearly attributed to, national health system leaders, while PHE should have stronger enforcement powers to act on data findings.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope of the NHS realistic?

2.1 In the context of demographic changes, as well as drastically reduced public health budgets⁶²¹ and the forecast removal of the public health ringfence, the funding envelope for the NHS (and Local Authorities now responsible for clinical care in SRH) is not realistic. Not only will demographic changes increase the demand for long-term condition management, but lack of investment in the public’s wider health will further compound the frequency of long-term conditions; leading to more complicated, harder-to-deal-with conditions, increasing the demand for treatment and threatening the long-term stability of the NHS. This sentiment echoed and reiterated with the Health Select Committee’s recent report *Public Health Post-2013* which explicitly recommends:

‘The Government must commit to protecting funding for public health. Not to do so will have negative consequences for current and future generations and risks widening health inequalities. Further cuts to public health will also threaten the sustainability of NHS services if we fail to manage demand from preventable ill health.’⁶²²

2a. Does the wider societal value of the healthcare system exceed its monetary cost?

⁶²¹ Under the terms of the 2015 Spending Review public health budgets will be cut by 3.9% per year, representing a real-terms reduction of at least £600million in public health spending by 2020/21 (Nuffield Trust, King’s Fund, The Health Foundation: 2015). This is on top of the £200 million in-year cut announced in July 2015.

⁶²² Health Select Committee (2016) *Public Health Post-2013: Second Report of Session 2016-2017* Available at: <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/140/140.pdf>

2.2 There is strong evidence to suggest that there is huge societal value in the prevention of unintended pregnancy that far exceeds the cost of investing in contraception. For example, it is estimated that if current levels of provision of, and access to, contraception are maintained, unintended pregnancy is expected to cost the UK's social welfare, housing benefits and education budgets between £113 billion and £203 billion over the 2015-2020 period.⁶²³ This figure does not take into account cuts to the public health budget, which are likely to restrict access to contraception and may increase rates of unintended pregnancy, in turn increasing public spend, particularly to the welfare budget.

2.3 In addition, evidence suggests that health, educational and financial outcomes for teenage mothers, young fathers and their children are far worse than for young people who do not have an unintended pregnancy. For example, Public Health England's *Framework for supporting teenage mothers and young fathers* illustrates that children born to teenage mothers have a 63 per cent higher risk of living in poverty; men who were young fathers are twice as likely to be unemployed at 30; and teenage mothers have higher rates of poor mental health for up to 3 years after an unintended pregnancy.⁶²⁴ If this high public expenditure and worsened outcomes are taken into account, it is evident that the wider societal return of investment in contraception and education categorically exceeds its monetary cost and investment in contraception carries huge societal value.

2b. What funding model(s) would best ensure financial stability and sustainability without compromising quality of care? What financial system would help determine where money might be best spent?

2.4 Funding model(s) should be focussed on prevention as opposed to demand. Investment in prevention would have a profound impact on the financial stability and sustainability of the NHS, helping the health and social care system to avert excess costs. With regard to sexual and reproductive healthcare, FSRH believes that cuts to the public health budget are a false economy and the Government should invest in SRH (and other proven public health interventions) to save money for the wider health and care system. The widely cited Department of Health statistic that for every £1 invested in contraception saves the NHS £11 in averted outcomes⁶²⁵ succinctly illustrates how investment in high-quality SRH would bring a significant return to the healthcare system by freeing up valuable health and social care resources in the long term.

2.5 FPA's report *Unprotected Nation 2015*⁶²⁶, which estimates the financial and economic impacts of restricted sexual and reproductive health services, forecasts grave cost implications for the NHS if unintended pregnancies increase. If current access to

⁶²³ FPA (2015) *Unprotected Nation 2015* Available at: <http://www.fpa.org.uk/sites/default/files/unprotected-nation-2015-full-report.pdf>

⁶²⁴ Public Health England and the Local Government Association (2016) *Framework for supporting teenage mothers and young fathers* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524506/PHE_LGA_Framework_for_supporting_teenage_mothers_and_young_fathers.pdf

⁶²⁵ Department of Health (2013) *A Framework for Sexual Health Improvement in England* Available at: <https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england>

⁶²⁶ FPA (2015) *Unprotected Nation 2015* Available at: <http://www.fpa.org.uk/sites/default/files/unprotected-nation-2015-full-report.pdf>

contraception worsens, over the 2015-2020 period the expected increase in healthcare expenditure is estimated to amount to an additional £1.178 billion in health service costs. This figure only spans the maternity service costs associated with unintended pregnancy (abortion, miscarriage, still births, live births), not taking into account future health costs associated with maternal and child health outcomes.

2.6 These estimations are particularly pertinent given that we are already seeing evidence of restricted access to contraception following 2015's £200 million in-year cut to the public health budget – restrictions that are only set to worsen with the 3.9 per cent year-on-year cut to the public health budget announced in the 2015 Spending Review. Findings from the Advisory Group on Contraception (AGC)'s audit of local authorities reveal that more than one in ten of the audited authorities have closed sites delivering contraceptive care in 2015/2016 and 11 per cent of councils indicated that they are reviewing their plans to close sites, suggesting further restrictions in access in 2016/17 and beyond. Further, FSRH's own research found that one third of British women aged 18-24 (32 per cent) and a quarter of British women aged 18-49 find it difficult to get an appointment with their GP, nurse or clinician to talk about contraception⁶²⁷.

Integrated Tariff

2.7 FSRH believes that there should be a single mechanism for payment across all sexual health services (those providing GUM care – STI checks and HIV treatment - and contraceptive care). To ensure value for money, integrated care and unintended distortions in service provision, *all* sexual health services should be funded through the [Integrated Sexual Health Tariff](#)⁶²⁸.

2.8 The reason for this is simple. At present, genitourinary medicine (GUM) services and sexual and reproductive health services (SRH) often work on different funding mechanisms; GUM is on tariff whilst SRH services are usually funded by block contracts. Tariff contracts allow service providers to be paid for activity delivered - Payment by Results (PbR) - whilst block contracts pay a fixed sum of money to provide a service set out in a specification, irrespective of levels of activity. These disparate funding mechanisms can distort delivery of care and access to contraception in a way that is unrelated to need. This risks allowing distortions in provision between GUM and SRH services that are based on the desire to increase income, rather than providing a fully-integrated service driven by the needs of the patient.

Ringfence

⁶²⁷ On behalf of FSRH, ComRes interviewed 1108 British women of reproductive age (18-49 years) online between the 11th and 15th November 2015.

⁶²⁸ The Integrated Sexual Health Tariff was developed in partnership with the London Sexual Health Programme. Over a period of five years, a wide range of Sexual Health stakeholders have been involved in the development of a new integrated pricing mechanism including Providers, Commissioners, representatives from all the major London and National stakeholders, including the HPA, BASHH, FSRH and Department of Health PbR and more recently, regional evaluation and feedback from across England.

2.9 FSRH is also concerned by the Government's plans to scrap the ring-fenced public health grant and from 2019 replace this with public health funding through local business rate retention. As set out in the [Local Authorities Public Health Functions Regulations](#), all local authorities have a duty to maximise the wellbeing of the people living in their locality. However, we believe relying solely on business rate retention to fund public health will compound health inequalities in socio-economically deprived areas due to a variance in the yield of rates. Therefore, funding public health through business rate retention risks reductions in public health funding in areas with the most need; preventing local authorities from exercising their duty to take steps to improve public health and restricting the provision of, and access to, public health interventions, including contraception. Consequently, FSRH urges the Government to extend parity of esteem to sexual and reproductive healthcare, and other public health interventions, as healthcare spends that align with those of the NHS and directly impact on the long-term stability and expenditure of the NHS. As such, SRH funding and the wider public health budget should be ensured akin to the budget of the NHS (See answer to question 6c).

Investing in education to prioritise ill-health prevention

2.10 In addition, FSRH believes that the status and quality of Personal, Social, Health & Economics (PSHE) education must be improved, given the invaluable impact high-quality health education can have on health literacy and in turn the prevention of costly health conditions. In terms of improving sexual and reproductive healthcare outcomes and avoiding unintended pregnancy, investment in robust training for education professionals delivering PSHE education and/or SRE would ensure that young people are equipped with the health literacy skills to take charge of their own sexual and reproductive health and know how to navigate the public healthcare system to meet their own contraceptive needs. Not only is this a key empowerment tool to enable young people to exercise their sexual and reproductive rights, but it is a key preventative tool to help the NHS and the social care sector avoid incurring the associated health costs of unintended pregnancy.

2d. Should the scope of what is free at the point of use be more tightly drawn?

2.21 Access to contraceptive information and services is a fundamental human right, rooted in basic human rights protections.^{629, 630} It is also a vital healthcare intervention, which, irrespective of who it is delivered through (local authorities or NHS England), must remain free at the point of use. As such, women should never have to pay to have access to the full range of 15 contraceptives currently on offer across the UK. We are concerned that already many women have to pay very high costs to access some forms of emergency contraception – much higher than in other European countries.

⁶²⁹ The United Nations Population Fund and Centre for Reproductive Rights (2011) *The Rights to Contraceptive Information and Services for Women and Adolescents* Available at: <http://www.unfpa.org/resources/rights-contraceptive-information-and-services-women-and-adolescents>

⁶³⁰ World Health Organization (2014) *Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations* Available at: http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf?ua=1

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

SRH Consultant Shortage

3.1 In order to deliver high-quality SRH that can prevent unintended pregnancy and subsequent health costs there needs to be strong leadership of services that facilitates partnership working between different disciplines. A report from the Centre for Workforce Intelligence on Community Sexual and Reproductive Healthcare outlines that there should be 1 sexual and reproductive healthcare consultant per 125,000 people in order to adequately lead local systems to cater to population sexual and reproductive healthcare need.⁶³¹ However, at present there is a significant SRH consultant workforce shortage, despite the fact that Community Sexual and Reproductive Healthcare (CSRH) is a hugely oversubscribed medical specialty training programme. Therefore, to prevent this shortage from worsening in the coming years, FSRH calls for Health Education England to urgently address this issue and provide more subsidised training places on the CSRH specialty training programme.

Cross-medical Specialty Training and Working

3.2 High-quality sexual and reproductive healthcare spans medical disciplines (GUM, gynaecology, public health, primary care) and, as such, necessitates cross-boundary working in terms of patient pathways. Consequently, the supply of key healthcare professionals to support this type of working could be optimised through shared core or modular SRH training between medical specialties or credentialing.

3.3 The UK's population behaviour continues to change, with earlier expressions of sexuality and sexual activity, and a widening of the gap between when people start having sex and the age when they have their first child.⁶³² Women are therefore spending a longer period of time preventing unintended pregnancies, and sexual and reproductive healthcare as a wider determinant of the population's health is growing in importance. With this in mind, healthcare professionals will increasingly need to possess the skillset to confidently address the sexual and reproductive healthcare needs of the people in their care. FSRH believes that broad-based and basic training that covers women's health issues and sexual and reproductive health would be of great value to many clinicians at early stages in their training, especially those training in Obstetrics and Gynaecology, Genitourinary Medicine and General Practice. Indeed, this would require a collaborative and reciprocal support from different specialties to implement such multi-professional training.

⁶³¹ Centre for Workforce Intelligence (2013) Community Sexual and Reproductive Healthcare

⁶³² National Survey of Sexual Attitudes and Lifestyles – 3 (2013) Available at: <http://www.natsal.ac.uk/natsal-3.aspx>

3.4 In particular, we believe that the communication and consultation skills that are integral to the Community Sexual and Reproductive Healthcare curriculum would be of great benefit to other medical specialties allowing them to;

- develop greater awareness and acceptance of the diversity of sexual behaviour and expression of gender
- confidently include the issue of contraception in consultations with all women of reproductive age
- confidently deal with sensitive issues and sexuality
- manage discussions around reproductive choice, pregnancy planning, contraception, parenthood and abortion and risky sexual behaviour
- promote healthy behaviours and encourage prevention through affecting lifestyle change

Current issues with SRH workforce optimisation

3.5 Furthermore, it is concerning that local authorities do not have to stipulate or fund continued professional development for healthcare professionals in service specifications for sexual and reproductive healthcare services. Service providers are only required to maintain existing skills as opposed to furthering them and optimising the skillset of the workforce. FSRH believes that all local authorities should ensure that service specifications for SRH services are designed to include training requirements in their contracts and optimise the contraceptive services that the current SRH workforce can offer.

3.6 FSRH is also concerned that public health cuts are resulting in a 'dumbing down' of SRH service specifications (asymptomatic STI testing and pill prescribing), resulting in a deskilling of sexual and reproductive healthcare professionals able to provide the full range of contraceptive care (including long-acting reversible methods). Similarly, the decommissioning of long-acting reversible contraceptives in general practice is raising concerns regarding the deskilling of SRH clinicians across primary care. As 80 per cent of women choose to access contraception in primary care, it is paramount that women are able to access long-acting reversible contraceptives and that clinicians working in primary care have adequate opportunity to gain competencies in delivering long-acting reversible methods of contraception.

3.7 It is also important to note that SRH service delivery is increasingly multidisciplinary with a clear and rising role for nurse specialists in the delivery of care. In order to further the development of nurse competencies and strengthen their leadership role, FSRH believes that service providers should commit to actively supporting nurses to undertake further professional training.

3.8 Consequently, for the current skillset of the sexual and reproductive healthcare workforce to be maintained, and the most financially efficient, effective methods of contraception to be delivered, SRH funding must be ensured and workforce training stipulated as part of all local authority service specifications.

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

3.9 Whilst investment in the traditional SRH workforce is paramount to ensure sufficient and appropriate clinical competencies, creating a workforce with an adaptable skill mix that can be applied across care settings can be achieved without large cost implications and a focus on ‘Making Every Contact Count’. Small system changes such as upskilling allied healthcare professionals (for example, community pharmacists and midwives) by improving their sexual and reproductive healthcare literacy and skills to signpost to relevant services would ensure that they are able to optimise their interactions with the public, using their skills to the greatest effect to prevent unintended pregnancy.

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

5.1 Whilst FSRH acknowledges the need to better integrate the health and care services, we also believe that practical changes must be made to integrate public health interventions, as vital aspects of healthcare, into NHS care pathways. There is a particular need for contraceptive information, support and care to be integrated into women’s health care pathways, where current fragmentation is leaving many women at risk of unintended pregnancy. We see an example of this in maternity care pathways where the issue of contraception is often not raised until the 6-week postnatal GP check-up. However, evidence supports that there is a significant window between the birth of a child and the 6 week check-up where women are at risk of unintended pregnancy.⁶³³ In light of this, we believe maternity services and health visitors should be mandated to provide contraceptive information, support and care before postnatal discharge. Likewise, we are seeing that abortion services, commissioned by NHS England, do not align with local sexual and reproductive healthcare delivery, leaving vulnerable women unable to access contraception in current abortion service models.

5.2 This integrated approach to women’s health is advocated by the CMO, who, last year, framed her annual report with the overarching objective to achieve a broader vision of women’s health centred on individual patient need, as opposed to medical or commissioning silos. In it, the CMO states that we should be working to:

‘Strengthen commitment to integrating pregnancy prevention, pregnancy planning and pregnancy care.’⁶³⁴

5.3 Public health is widely seen as boundary spanning, and, as such, public health interventions such as contraception should be integrated into NHS service models and care

⁶³³ FSRH Clinical Effectiveness Unit (2009) *Postnatal Sexual and Reproductive Healthcare* Available at: <https://www.fsrh.org/documents/cec-ceu-guidance-postnatal-sep-2009/>

⁶³⁴ Chief Medical Officer (2015) *Annual Report 2014, The Health of 51%: Women* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/484383/cmo-report-2014.pdf

pathways. The recent Health Select Committee report *Public Health Post-2013* echoes this sentiment, making the recommendation:

*'There is a need to address the system boundary issues that have negative consequences and make sure that they are addressed in the best interests of patients'*⁶³⁵.

5.4 This approach would ensure a health and care system that is prevention-led at all points and centred on the health and wellbeing needs of the individual as opposed to traditional medical and commissioning silos.

Thinking beyond a treatment focussed model of healthcare

5.5 In addition, and as discussed in the response to question 2b, improving health literacy and public competency with regards to navigating the healthcare system to best meet individual needs is a crucial factor when it comes to promoting prevention and the sustainability of the NHS. With this in mind, health issues must be better integrated into the education system and the Government must think more broadly about a more holistic vision of healthcare that not only spans medical silos but also wider policy areas, such as education, that are also key determinants of health.

5.6 In regard to sexual and reproductive healthcare, taking this wider integrated approach to healthcare necessitates implementing the recommendation of the Education Select Committee, Women & Equalities Select Committee, Home Affairs Select Committee, and Joint Committee on Human Rights' recommendation that PSHE education be made statutory. Statutory status and investment in training for education professionals in the delivery of high-quality PSHE education/SRE will ensure that young people are equipped with necessary skills to address their own sexual and reproductive healthcare needs and protect themselves against unintended pregnancy and the NHS from the costs that unintended pregnancy incurs.

5.7 FSRH strongly believes that now is the time to implement statutory PSHE education/SRE, from both the perspective of empowering individuals and facilitating NHS Sustainability. This viewpoint has also been backed by the Chief Medical Officer, the Children's Commissioner, six medical royal colleges, and many other leading health organisations⁶³⁶.

5b. What changes would be required at national and local levels to make integrated budgets work smoothly?

5.8 In order to make integrated budgets work at a local level to ensure fully integrated sexual and reproductive healthcare, that is to say fully-integrated 'one-stop shops' for sexual and reproductive healthcare i.e. GUM interventions (STI checks, HIV care) and SRH

⁶³⁵ Health Select Committee (2016) *Public Health Post-2013: Second Report of Session 2016-2017* Available at: <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/140/140.pdf>

⁶³⁶ See the PSHE Association's campaign page for full details of the huge support to make PSHE statutory: <https://www.pshe-association.org.uk/campaigns>

interventions (contraceptive care), SRH services should be placed on the [Integrated Sexual Health Tariff](#) (see response to question 2b) to avoid distortions in service provision.

5.9 At present, genitourinary medicine (GUM) services and sexual and reproductive health services (SRH) often work on different funding mechanisms; GUM is on tariff whilst SRH services are usually funded by block contracts. As tariff contracts allow service providers to be paid for activity to be delivered, whilst block contracts pay a fixed sum of money to provide a service set out in a specification, this can distort service provision and access to SRH in a way that is unrelated to need. This risks allowing distortions in provision between GUM and SRH services that are based on the desire to increase income, rather than providing a fully-integrated service driven by the needs of the patient.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

6.1 FSRH believes that the Government should truly prioritise prevention and help deliver the NHS pledge of a 'radical upgrade in prevention' by investing to save in public health interventions. As the recent Health Select Committee's report into public health post-2013 highlights, to do this the Government must address the mismatch between reduced spending on public health and the significance attached to prevention in the NHS *Five Year Forward View*.

6.2 The Government must also clearly outline where different responsibilities lie in respect of the main health system leaders i.e. the Department of Health, Public Health England and NHS England. This is particularly important if public health budgets are to be funded by 100 per cent business rate retention as Public Health England will no longer be the body accountable for public health funding and its distribution, therefore its mandate and responsibilities will need to be clarified.

6.3 More specifically, FSRH believes that in order to shift to a more preventative model of healthcare in terms of preventing sexual ill-health and unintended pregnancy, the Government must think across policy areas and enact statutory PSHE education/SRE. Statutory status and investment in training for education professionals in the delivery of high-quality PSHE education/SRE will ensure that young people are equipped with necessary skills to address their own sexual and reproductive healthcare needs and protect themselves against sexual ill-health/ unintended pregnancy and the NHS from the costs that sexual ill-health/ unintended pregnancy incur.

6a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

6.4 As FSRH outlines in its [Vision](#), an integral part of enhancing the population's health and wellbeing is high-quality sexual and reproductive healthcare that is accessible to all at every stage of the life course. Most women spend approximately 30 years of their lives avoiding

unintended pregnancy. High-quality, accessible reproductive healthcare empowers these women – and men - to avoid unintended pregnancy and sexual ill-health so that they are able to lead healthy, fulfilling lives. Therefore SRH needs prioritisation through investment.

Fully implementing the Department of Health’s *Framework for Sexual Health Improvement*

6.5 The Department of Health’s *A Framework for Sexual Health Improvement in England* (2013) already sets out best practice for the provision of high quality SRH services in terms of:

- Interventions and services that meet the needs of all age groups
- Collaborative commissioning of a range of services to ensure that they are offered at sites that are convenient for user
- Robust care pathways to ensure seamless onward referral
- Interventions and services being offered in a range of settings, with convenient opening times and appropriately trained staff (including timely access to long-acting reversible methods of contraception in primary care)
- Service provision targeted at groups with particular needs that might be vulnerable and at risk from poor sexual health, including young people, gay and bisexual men, some black and minority ethnic groups and people with learning disabilities⁶³⁷

6.6 However, current SRH service delivery is markedly different to that which the Department of Health sets out and in order to enhance the population’s sexual and reproductive health and wellbeing the Government must address these issues, taking steps to fully implement the Department of Health’s *Framework*.

Interventions and services that meet the needs of all age groups

6.7 FSRH recommends that the Select Committee strongly considers women’s life course as a key driver that can enhance public health outcomes. The *Framework* suggests that interventions and services should meet the needs of all age groups and specifically states the reduction of unintended pregnancies amongst *all* women of fertile age as one of its objectives. These objectives appear to recognise the World Health Organisation’s assertion that a woman’s reproductive age spans several age groups from 15-44 years of age.

6.8 Despite this point, there are now many examples of SRH services not being made available to all age groups. The Advisory Group on Contraception (AGC)’s⁶³⁸ audit of

⁶³⁷ Department of Health (2013) *A Framework for Sexual Health Improvement in England* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

commissioners in England, *Sex, Lives and Commissioning II*, uncovered many restrictions in access to contraceptive services based on a woman's age – directly contradicting national guidance set out in the *Framework*.

6.9 This evidence is indicative of the way in which local commissioners are not meeting the *Framework's* stated aims by commissioning SRH services that *do not* meet the needs of all age groups within localities. This is particularly worrying in light of recent abortion statistics, which show an increase in abortion rates amongst women over 25, indicating an evident unmet need for contraception.

Collaborative commissioning of a range of services to ensure that they are offered at sites that are convenient for user and follow robust care pathways

6.10 As discussed in our response to Question 5, there is a need for sexual and reproductive healthcare to be more broadly integrated into women's healthcare pathways in the NHS, to ensure more holistic care pathways that cater to patients' sexual and reproductive healthcare needs as opposed to medical and commissioning silos.

6.11 Both the Department of Health's *Framework* and Public Health England's *Making it Work* respectively advocate the 'collaborative commissioning of a range of services' and 'a whole system approach to commissioning'. However, cross-pathway SRH commissioning is yet to be realised in abortion and maternity services, where opportunities are often missed to address and provide women with contraception. This is creating barriers of access for vulnerable women who may not seek to address their contraceptive needs once they have left these care pathways.

Interventions and services being offered in a range of settings, with convenient opening times and appropriately trained staff

6.12 In addition, it is important to recognise that 80per cent of women choose to access their preferred contraceptive method through primary care. Yet despite the national guidance that stipulates women should be able to access contraception 'in a range of settings', there is complex and confused payment for contraception provision in primary care.

6.13 For example, the public health budget funds enhanced Long Acting Reversible Contraception (LARC) in primary care. However, the payments that practices receive were set several years ago and are outdated in terms of both patient demand and need. Consequently, this allocation of public health funding does not account for the current level of demand for enhanced LARC in primary care. This means that in many instances current levels of funding are not sufficient enough to cover the clinician time required and

⁶³⁸ The AGC is an expert advisory group of leading clinicians and advocacy groups who have come together to discuss and make policy recommendations concerning the contraceptive needs of women of all ages. The AGC was formed in November 2010 with a focus on ensuring that the contraceptive needs of all women in England, whatever their age, are met.

equipment costs, ultimately restricting access. GPs are increasingly reporting that they are not investing in training in LARC methods because they no longer receive funding to provide it or the funding is uncertain.⁶³⁹ FSRH believes that given the high proportion of women who access contraception through primary care, additional NHS funding should be identified for primary care to prioritise and manage the high demand for contraceptive care delivery in this setting.

Data collection and robust measures

6.14 An effective public health policy that is truly able to enhance whole population wellbeing must ensure that there is a comprehensive understanding of populations, informed by robust measures of local health and wellbeing needs. Whilst the SRH indicators in the Public Health Outcomes Framework and finger tips data provided by PHE's SRH profiles are useful indicators of unmet need, they are not a comprehensive or timely reflection of the unmet sexual and reproductive healthcare needs of women across the life course, with indicators skewed in favour over the under 25 age group, which are often several years out of date, thereby preventing a timely assessment SRH needs.

6.15 For a whole population approach to sexual and reproductive healthcare, indicators should be added to this framework that reflect the full spectrum of sexual and reproductive healthcare need across the life course. In addition, to fully assess the changing unmet need for contraception, a key element of public health policy would require a robust means of measuring sexual and reproductive healthcare outcomes and unintended pregnancies. As the CMO recommends in her report, this can be achieved through using the [London Measure of Unplanned Pregnancy \(LMUP\)](#). To put this measure into practice, the LMUP would have to be introduced into routine maternity data collection and included in the minimum maternity dataset.

6.16 Likewise, given that 80 per cent per cent of women access their desired method of contraception in primary care, it is paramount that health system leaders work to develop a well-functioning indicator to ensure better data collection, while better enabling assessment of access, outcomes and delivery of SRH in the primary care setting.

6.17 In terms of accountability and supporting the delivery and commissioning of services, we believe that Public Health England should have stronger enforcement powers to enable them to act on the findings and analyses of data. This would enable Public Health England to hold local authorities and commissioners to account for their performance (See 6b).

6b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

⁶³⁹ Primary Care Women's Health Forum (October 2014) *PCWHF Survey on Primary Care LARC Service* Available at: http://www.pcwhf.co.uk/images/LARC_Survey.pdf

6.18 An enhanced prevention and public health strategy must have clear lines of accountability. FSRH believes that to achieve the NHS Five Year Forward View's 'radical upgrade in prevention and public health' the State must be responsible for ensuring a centrally controlled public health budget. Public health funding should not be devolved to local level responsibility as part of 100 per cent business rate retention proposals as this risks drastically exaggerating existing, and creating new, health inequalities. Instead, FSRH believes that the public health budget, as a crucial healthcare spend, should be afforded the same level of protection and central control as the NHS budget.

6.19 In terms of local and regional responsibilities, there should be collaborative system leadership at a local level, which seeks to integrate public health into wider NHS and council services. As part of reinforcing local responsibility, it is paramount for Public Health England to develop more stringent accountability structures with local authorities. The APPG on Sexual and Reproductive Health's (2015) report [*Breaking down the barriers: The need for accountability and integration in sexual health, reproductive health and HIV services in England*](#) highlighted a worrying trend of councils not spending their public health grant on its intended purpose.

6.20 As such, FSRH supports the Health Select Committee's recommendation that local authority directors of public health should be required in their statutory annual reports to publish clear and comparable information for the public on the actions they are taking to improve public health and what outcomes they expect to achieve, and to provide regular updates on progress. Additionally, we support the introduction of benchmarking standards for all local authorities' public health functions, to improve accountability and provide reassurance that local authorities are actively working to improve the health and wellbeing of their populations.⁶⁴⁰

6c. Is there a mismatch between the funding and delivery of public health and prevention compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need?

6.21 FSRH believes there is a huge mismatch between the funding of public health compared with the amount of money spent on treatment. Primarily, the £200 million in-year cut to the public health budget in 2015, and the 3.9per cent year-on-year cut announced in the Spending Review, gravely undermine the Government's commitment to prioritise prevention as outlined in the NHS Five Year Forward View. Likewise, as illustrated in our response to question 2b, these cuts represent a false economy; investment in prevention is investing to save, in the long-term reducing the demand for, and need for money to be spent on, treatment.

6.22 As outlined above, FSRH believes that the responsibility for public health funding should not be devolved in the planned move to 100 per cent business rate retention. For public health budgets, the move to a 100 per cent business rate retention-based funding mechanism would mean that budgets are not determined in line with anticipated need, but,

⁶⁴⁰ Health Select Committee (2016) *Public health post-2013: Second report of the Session 2016-17* Available at: <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/140/140.pdf>

instead, in line with regional affluence. This presents a clear risk in terms of the exaggeration of health inequalities in socio-economically deprived areas.

6.23 Therefore, to bring public health funding in line with anticipated need, the Government must invest in prevention. Public health funding should be considered as a vital health care spend, equivalent to that of the NHS. As such, the Government must ensure the public health budget by extending the ringfence beyond 2019 and retaining central control of public health funding.

6e. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

6.24 FSRH believes that placing all integrated sexual and reproductive healthcare services (those delivering both GUM and contraceptive interventions) on tariff contracts would financially incentivise providers to invest in prevention. As discussed in question 5b., the way in which tariff contracts remunerate service providers for the amount of activity delivered would create a type of ‘Payment by results’ financial incentive for integrated SRH service providers to invest more funds in enhancing contraception and other prevention provision.

Conclusion

High-quality SRH that is accessible to all and integrated into existing NHS service models is a financially efficient healthcare spend that would greatly aid NHS sustainability by averting the immediate and associated treatment and societal costs of unintended pregnancy.

Ultimately, in order to minimise the impact of demographic change on the stability of the health and care system, the NHS must deliver its ‘radical upgrade in prevention and public health.’ With this in mind, the public health budget must continue to be centrally controlled and ensured, in the same manner as NHS budgets, beyond the 2018/19 ring fence.

23 September 2016

Dr Laurence Ferry⁶⁴¹ and Dr Florian Gebreiter⁶⁴² – Written evidence (NHS0046)

We welcome this opportunity to submit written evidence to the House of Lords Select Committee on the Long-term Sustainability of the NHS. This reply draws on recent published academic work and senior level personal experience of public service accounting practices.

The main focus of our response concerns the role of accounting and accountability practices in the long-term sustainability of the NHS. This is because the importance of NHS accountability and transparency arrangements being ‘fit for purpose’ recently came in for ‘specific’ attention given resource pressures (Ham et al., 2015) and structural fragmentation (National Audit Office (NAO), 2014, 2015a, 2016a, 2016b).

Since its creation in 1948 the NHS has had numerous crises and undergone various reforms to deal with its sustainability (Ferry and Scarparo, 2015). For example, concerns over cost and performance of the NHS were raised as early as the 1950s. Concerns about the efficiency of the service and the effectiveness of the tripartite administrative arrangements re-emerged in the 1960s and culminated in the first major reorganisation of the NHS in 1974. During the 1980’s and 1990’s there were attempts at neo-liberal reforms and introduction of New Public Management initiatives by the Thatcherite Conservative government to create a system of performance management that would improve NHS productivity and reduce waiting times. These reforms were controversial between the government and medical profession, but ultimately an internal market was introduced with market driven incentives and management budgeting. Nevertheless, again the NHS was dogged by funding issues. From 1997 to 2010 the New Labour government offered more investment for the NHS, but contrary to expectations also introduced further neo-liberal health service reforms. This greatly extended the era of governance by performance management inherited from the outgoing Conservative government beyond financial numbers to encompass all aspects of managerial and organisational performance through a framework of hierarchical accountability and centralised control. With reference to New Labour’s health policy record, the King’s Fund suggested that it included a mix of achievements and disappointments. It highlighted both the increased investment, but also the continuous upheaval and reforms.

Following on from New Labour, the Conservative led coalition government from 2010 to 2015 largely maintained accountability and transparency arrangements for financial conformance and operational performance in the NHS, but the structural and operational framework of hierarchical control was dramatically altered with significant consequences (Ferry and Murphy, 2015). This was due to significant changes from the Health and Social

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⁶⁴² Dr Florian Gebreiter is a Lecturer in Accounting at Aston University. He holds a PhD from the London School of Economics and Political Science (LSE), and his research involves accounting in healthcare contexts.

Care Act 2012, Local Audit and Accountability Act 2014 and other initiatives such as quality accounts implemented at a time of financial restraint. These changes resulted in fragmentation of services that seriously obscured overall accountability making it more complex and opaque, which undermined the ability to determine if value for money was being accomplished and thereby posed risks for financial sustainability (Ferry and Murphy, 2015). In particular, these changes meant that the healthcare system as a whole, and individual organisations and services within it, increasingly struggled to meet centrally set objectives and targets, most notably Acute Hospitals Trusts (NAO, 2014, 2015b). On the other side of the coin the NHS finances were under pressure for various reasons. The NHS budget was protected relatively to other public services, but it was arguable whether in real terms this was sufficient. Systemic risks from cuts in local government budgets especially that affected adult care inevitably meant costs were shunted to the NHS with more elderly people ending up in hospital that could have been looked after in the community. Attempts to link the NHS and local government budgets and services will take time to bed down to see if they are successful, but given the financial issues this time may be short lived. The position is also arguably further complicated by the inherited legacy of financial and service issues from New Labour such as servicing PFI debt interest, favourable changes to staff terms and conditions, and fallout from healthcare scandals that continue to have cost implications. In addition, unlike local government that has a statutory requirement to set a balanced budget (Ferry, Eckersley and Zakaria, 2015), there is no statutory imperative to set a balanced budget and so a systemic risk of financial failure is prevalent as services may be continued beyond the confines of the budget. Given these issues it is important to consider how accountability and transparency can be extended beyond the traditional hierarchical accountability structures of a NHS based on a public service delivery model so new hybridised and distributed forms of delivery involving various forms of arms-length bodies, commercialisation and privatisation can be properly and appropriately held to account (Ferry and Murphy, 2015).

Within the context of this history, while marketization of healthcare and governance through performance management have enjoyed some successes in maintaining services they cannot discipline and control health services and associated costs to solve the myriad of long-term problems facing healthcare sustainability in the 21st century (Ferry and Scarparo, 2015).

Having said that, it is arguable that concerns around the cost of health care are historically contingent rather than inescapable consequences of demographic and technological change. For example, Gebreiter and Ferry (2016) historically examined the emergence of concerns for health expenditure in wake of creation of British National Health Service in 1948, and their relationship with health service accounting practices. They suggested that nationalization of health services, together with compilation of health estimates and changing notions of health and disease, constituted the cost of health care as an insoluble problem in the mid-20th century. Health care became discussed as a cost rather than a potential investment in the economic and health of citizens that may provide relative benefits to GDP. They also showed health service accounting practices are both constitutive as well as reflective of such concerns, and that this did not merely begin with New Public Management reforms in the 1980's as widely believed. In addition, they cautioned that current reforms promoting the decentralization of health services in Britain and beyond

(e.g., Prime Minister's Office, 2011) could reduce rather than increase accounting's ability to facilitate the control of health service costs. Finally, they argued that both in the 1950s and the present day, concerns regarding ageing populations, expensive medical technologies and the cost of health care have focused much attention on accounting practices that seek to encourage hospitals to provide various health services at the lowest possible cost (i.e., maximize their technical efficiency). Conversely, questions whether hospitals use the most efficient mix of inputs to provide these services (i.e., maximize the allocative efficiency of health service inputs), and whether hospitals produce those services which provide the greatest health benefits relative to their costs (i.e., maximize the allocative efficiency of health service outputs), have attracted less attention. Indeed amidst emerging suggestions that health systems like the NHS cannot remain financially viable unless they focus scarce resources on those services that provide the greatest health benefits relative to their costs (e.g., Health Foundation, 2015), there needs to be more engagement with the issue of allocative efficiency in the health services.

In addition, consideration should be given to a broader monitoring regime that goes beyond merely adherence to budget conformance and/or service performance, and takes account of risks concerning governance arrangements and cultural specificities when considering sustainability (Ferry and Murphy, 2015). Interestingly, this was also highlighted recently as a concern in local government (Communities and Local Government Select Committee, 2016; Ferry, Coombs and Eckersley, 2017).

Furthermore, often the NHS is politically construed as a '*national treasure*' that is sacrosanct and somehow protected more relative to other public services. The protection afforded in recent budget rounds relative to say local government is evidence of this (Ferry, Eckersley and Zakaria, 2015). However while it may or may not be justifiable to prioritise the NHS it is important that it is not seen as an isolated and/or untouchable body. The NHS must be viewed as part of a broader health service that encapsulates other parts of the 'welfare state' including not merely adult care in local government but employment, housing and the welfare bill as examples. Also it seems important to reconsider these as investments and not merely costs.

The accountability and transparency arrangements of the NHS (Commons Select Committee, 2013), its financial sustainability (NAO, 2014) and the design of public services more generally (Lord Bichard, 2011) therefore requires exactly the type of focus provided by this select committee, but maybe a broader and more fundamental rethink about the foundations of the welfare state itself is in order to protect this most valuable ideal for both current and future generations.

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21 September 2016

Rt Hon Frank Field MP – Written evidence (NHS0182)

Introduction

1. The roots of the NHS are deeply embedded in our society. It has always contained an ethical ideal. We now live in an age in which our ethical language is dying out and yet, possibly, our ethical stimuli in respect of the NHS are as strong as ever. The founder of the NHS, Aneurin Bevan, defined its purpose as ‘society becomes more wholesome, more serene, and spiritually healthier if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but also their fellows have access when ill, to the best that medical skills can provide’.⁶⁴³ The funding crisis which is increasingly engulfing the NHS puts that ethical ideal, made a reality, at risk. But not all is lost.
2. The House of Lords Select Committee on the Long-Term Sustainability of the NHS is of the greatest importance if this ideal is to continue and to be developed in a way that safeguards the long-term future of our country’s health and social care services.
3. If the NHS was being devised today we would probably suggest many changes. One change that would meet with universal approval is that the NHS and social care cannot be considered as separate issues. The crisis in one reinforces it in the other.
4. This submission to the Select Committee looks at what I believe to be the most ethical and financially effective means open to society by which the future funding of the NHS and social care can be secured and onto which existing funding can be transferred. We live in an age in which taxpayers are rightly sceptical of handing over large parts of their income to politicians who decide how that money is spent. That is what occurred when the most recent major step change was made to NHS funding.
5. **The proposal here is for a hypothecated National Insurance contribution which would in the first instance pay for a necessary increase in funding that will have to occur during this Parliament, over and above the sums to which the Government is committed. The proposal is that, over time, the rest of the health and social care budget should be transferred onto this new, progressive National Insurance base, but that the Government would then commit itself to making equal, commensurate cuts in the standard rate of tax.**

Proposals

6. I welcomed the opportunity to give oral evidence to the Select Committee and here is the written evidence I promised to submit. The Select Committee’s work could not have been better timed. While there are many proposals for reform, there is no one set of proposals carrying Parliament’s authority around which public opinion could quickly unite. The Select Committee in choosing to undertake its work now, and publishing a report by March 2017, has clearly put itself in poll position to lead yet another of Britain’s quiet revolutions.
7. The funding of the NHS for the remainder of this Parliament is built upon extremely shaky foundations.⁶⁴⁴ It is therefore likely that at some stage in this Parliament, the

⁶⁴³ Bevan, A., *In Place of Fear* (London: Quartet Books, 1978, first published in 1952): p. 100

⁶⁴⁴ See Appendix

Government will be made by public opinion to increase the NHS budget. It would be a pity if this opportunity was not seized upon to begin to:

- recast how the NHS is financed;
 - incorporate both the NHS and social care services into a more comprehensive health package;
 - clearly earmark and deliver any increased expenditure to a combined health and social care budget; and
 - establish a new governance arrangement between the electorate, health and social care services, and the Government.
8. The submission I wish to make centres around the use of a reformed National Insurance base as a new form of contribution to health and social care services. The little evidence we have shows that the public sees a distinction between National Insurance contributions and general taxation. This evidence suggests the public sees a difference between:
- an increase in general taxation which it dislikes; and
 - an increase in National Insurance contributions which it understands and supports on the condition that it is hypothecated to an electorally determined end.⁶⁴⁵

The basis of this submission is that the Select Committee should build on this distinction. I hope the Select Committee will be radical in its proposals and see that any short-term necessary increases in National Insurance contributions should mark only the beginning of the process of moving towards a totally new way of the nation financing and owning health and social care services.

9. The longer term reform I wish to advocate consists of:
- A National Health and Social Care Service that would deliver health and social care;
 - A National Health and Social Care Mutual that would undertake key functions with the Service; and
 - A progressive, hypothecated National Insurance base that would fund the new Service.
10. The three main functions of the Mutual would be to:
- ensure that the funds allocated to the Service were fully received;
 - begin a dialogue with the Service on how best improvements in the delivery of care to patients can be achieved, so that the best possible value is obtained for each pound of National Insurance contributions. It would work with the existing services – the last thing health and social care services need is somebody to throw all the pieces up into the air again. In the longer term, the Mutual would lead a debate on the future shape of a Service that is not in a financial crisis; and
 - take on a similar role to the Office for Budget Responsibility in drawing upon current trends to forecast the likely patterns of demand for health and social care, and the necessary levels of expenditure to meet that level of demand. Its

⁶⁴⁵ Field, F., Diamond, P., and Todd, J., *Mutual endeavour: Winning support for a 21st century NHS* (London: Policy Network, 2015): p. 7

forecasts should be used to launch a dialogue with the public on the size of contributions that will be required to finance health and social care and to meet the nation's expectations of the Service. Equally important will be to conduct wherever possible a conversation with the Mutual membership – all UK-born members of the public who are included within the National Insurance system, people who were born outside the UK but who have built up a set period of National Insurance contributions, and the Service's own staff – on the size of the increase in contributions that will be required if the current rules of accessibility, the embracing of new drugs and technology, the maintenance and extension of cosmetic surgery are to continue to be part of the new services menu, and the best shape of health services to meet this objective.

11. In the first instance the governing Trustees of the Mutual should be appointed by the Government. Eventually, the Mutual should be governed by Trustees who are elected by its membership and would include a representative from the Service's staff. The Mutual would mark a major change in what is regarded as 'governance' in this country. Having a major part in setting the level of health and social care contributions denies power to the Treasury. But needs must. I see no other way of health and social care services gaining from taxpayers the monies they require, unless the Treasury surrenders its objections to hypothecation.
12. This reform would work with the grain of voters' wishes, rather than against them. It would be also advantageous for the future Mutual members, as owners of the Service, to feel that they are getting a flavour via the first instalment of the reform.
13. A first suggestion is that to meet the immediate and growing funding crisis in this Parliament:
 - the Government considers introducing a penny increase in employees' and employers' National Insurance contributions;
 - this penny increase applies to all contributors below and above the Upper Earnings Limit, but not to those below the Lower Earnings Limit; and
 - this new source of revenue heralds the establishment of the Mutual. It is crucial that this body is established quickly in conjunction with, or shortly after, the increase in National Insurance contributions. Last time, when a penny was put on National Insurance, much of the additional revenue was diverted to non-NHS projects.
14. The longer term aim would be to transfer the whole of the health and social care budget over to the Mutual. Before such a move was made, though, it would be desirable to reshape in its entirety the contributory base of the existing system along progressive lines.⁶⁴⁶
15. Likewise, as part of the public dialogue on this reshaping exercise, the Mutual would need to emphasise that, currently, only one fifth of National Insurance contributions currently go to the NHS – the overwhelming majority of the monies collected goes to pensions. The suggestion is that:
 - the Lower Earnings Limit for a progressive, hypothecated National Insurance base should be raised to the current Income Tax threshold, thereby giving a tax cut to the lower paid;

⁶⁴⁶ This should provide a blueprint for further such mutuals in time covering unemployment and sickness benefits, as well as the State Pension.

- a 10p band should be introduced between the Lower Earnings Limit and a 20p band – the standard rate for Income Tax;
 - the full contribution rate should apply from the 20p band, a higher rate should apply from the 40p band, and there should be no Upper Earnings Limit on the contribution;
 - the National Insurance exemption covering employees above the State Pension Age should be abolished, as part of the financing of social care.
16. The extension of the contributory base to cover employees above the State Pension Age is key to changing the way we pay for social care. It begins the process of moving the country away from a predominantly means-tested system of paying for social care, to a contributory one in which care is provided free at the point of use. A crucial advantage under this proposed system is that pensioners need not worry about having to sell their home, to pay for care. They will have paid for it, instead, through their record of National Insurance contributions. This aspect will need to pick up on the Note of Dissent submitted as part of the Royal Commission on Long Term Care.⁶⁴⁷
17. Part of the debate must be on whether extending the National Insurance contributory base to people over the State Pension Age would produce enough revenue. The rate at which contributions are levied for pensioners' incomes, and whether a fair contribution from pensioners is being made, can be considered once the principle is accepted.
18. This reform programme should not be used as cover for double taxation. It is therefore suggested that each tranche of £4.5 billion raised for the Service should be accompanied by a 1p reduction in the basic rate of tax.
19. The House of Commons Library analysis of the costings and the monies resulting from the proposals here is as follows:
- A penny increase in employees' and employers' National Insurance contributions would raise £51.2 billion in the five years to 2020-21.
 - Introducing a progressive, hypothecated National Insurance base along the lines set out in this submission would raise an annual budget of at least £140 billion.
 - Abolishing the National Insurance exemption covering employees above the State Pension Age would raise at least an additional £6.7 billion each year.
20. The NHS now has a unique place in the public's affection. Surveys show that the public not only wish to support the vision they have for the NHS with adequate financial contributions, but that they are up for a change in funding which will deliver them a better health and social care package when they need it. Having a greater sense of control over the money, and the vision of the Mutual members, I believe to be crucial to the next stage in the life of the one institution of the Attlee Government which still commands the affection of voters.
21. This common affection for the NHS carries a huge advantage, at a time of major fracture in our society. Here is the one organisation to which people feel its binding qualities. Taking in the funding of social care marks also a clear development in a service to which the public is committed.

⁶⁴⁷ 'Note of Dissent' in The Royal Commission on Long Term Care, *With Respect to Old Age: Long Term Care – Rights and Responsibilities* (London: The Stationery Office, 1999)

22. The reforms will not be the last word on an evolving National Health and Social Care Service. But I believe they offer the best prospect of funding open to such a Service, and one which will raise the spirits of the electorate at this time.

Appendix

The total funding gap in England, covering the period from 2016-17 to 2020-21, is £56.6 billion. The House of Commons Library estimates that across the United Kingdom, the equivalent gap reaches £67.7 billion. Efficiency savings are expected to reduce the gap in England by £22 billion. However, grave doubts have already been raised as to whether the NHS can deliver the size of the efficiency savings that are a key part of its current funding settlement. Likewise, the dispute continues over whether the current funding settlement has taken fully into account the differential impact of health inflation, as well as the ageing of the population.

22 November 2016

Dr Richard FitzGerald – Written evidence (NHS0016)

Question 2 on Resource Issues

Para 1 **The UK spends substantially less per head of population than other developed countries on healthcare.**

[https://en.m.wikipedia.org/wiki/List_of_countries_by_total_health_expenditure_per_capit
a](https://en.m.wikipedia.org/wiki/List_of_countries_by_total_health_expenditure_per_capita)

The current level of funding is having many adverse effects

1. Waiting times for diagnosis and treatment are increasing
2. Patient and public satisfaction is falling
3. NHS staff morale, and performance (eg voluntary unpaid overtime) is falling

Para 2 **Substantial extra revenue could be found for the NHS and Social Care by**

4. Vigorous enforcement of current tax rules to reduce tax evasion eg by employing more Tax Inspectors who are competent to deal with corporate tax evasion, inheritance tax etc

5. HMRC estimates that tax fraud costs the Exchequer £16 billion annually in lost revenue.

[http://www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/674/674
06.htm](http://www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/674/67406.htm)

6. large inheritances untaxed eg £9 billion Duke of Westminster estate
[https://www.theguardian.com/business/2016/aug/11/duke-westminster-hugh-
grosvenor-inheritance-tax-reform](https://www.theguardian.com/business/2016/aug/11/duke-westminster-hugh-grosvenor-inheritance-tax-reform)

7. New dedicated tax for NHS via National Insurance system
Increasing other taxes eg via Inheritance Tax increase aimed at more funding for
Social Care

Increasing Income Tax on income over say £150,000

Para 3 **Reducing extent of services covered by NHS**

The NHS has not provided free at the point of delivery healthcare for many years for most patients requiring

8. Dental care
9. Optician care
10. Many patients pay prescription charges

Hence the principle of NHS free at the point of delivery healthcare has been broken for decades.

Para 4 **There should be further charges for NHS care eg**

11. £20 per GP surgery visit

12. £ 30 per ambulant Casualty visit

These charges would not recover full NHS charges but would reduce inappropriate use, and improve access for those who required these services

Para 5 **The NHS should introduce an NHS entitlement card which would have details of**

13. Any benefits entitling patients to reductions/exclusions from NHS charges
14. Carer status with reductions/exclusions from NHS charges
15. Access to personal bank account details for paperless timely payment

Para 6 **All providers of NHS healthcare should be required to display posters of approximate costs relevant to activity to educate the public and patients and introduce a more realistic awareness of what the NHS can and can't afford to provide eq**

Para 7 Radiology Departments / Mobile MRI scanners would have a poster with

16. Cost of MRI scan including report
17. Cost of a Chest X-ray
18. Cost of an Ultrasound Scan
19. Cost of a CT scan
20. Cost of an MRI scan

Para 8 Casualty Departments would have posters with

21. Cost of Plaster of Paris
22. Cost of more expensive removable splints
23. Cost of care of a patient with a fractured hip

Para 9 Oncology Departments would have posters with

24. Cost of treatment for a patient with early Lung Cancer
25. Cost of treatment for a patient with advanced Breast Cancer
26. Cost of one episode of Breast Cancer Screening

Question 3 on Workforce

Para 1 ***The manpower crisis in Acute Medical Specialities, Emergency Medicine (A&E) , Paediatrics, Anaesthetics as well as Radiology is already having adverse consequences for patients, medical staff already in post , other NHS staff , as well public confidence in and support for the NHS***

Para 2 A doctor who has completed 2 years "Foundation" after graduation from Medical School, will require a minimum of 5 more years to train to be a specialist. Hence a wait until 2022 for more UK doctors to qualify as Specialists will be too late for so many patients. Doctors will burn out prematurely, opt for early retirement or part time working, or

emigrate Those who remain working will become progressively demoralised and their performance will inevitably deteriorate, and with reduction in unpaid voluntary work

Para 3 **The only credible source for the necessary urgent large number of doctors in these specialities is through resourced substantial recruitment of International Medical Graduates (IMG) doctors.**

Para 4 BrEXIT has reduced the likelihood of significant numbers of EU IMGs, and moreover they were always much smaller in potential number , English not first language etc etc.

Para 5 Americans , Australians etc are not likely to opt for UK when they look seriously at likely income , cost of housing and living, GMC processes etc

Para 6 Efforts by individual Medical Royal Colleges to encourage IMGs to work in the UK have been well intentioned but not resourced or co-ordinated .

Para 7 **Moreover it is NHS Trusts who recruit and employ doctors , not Medical Royal Colleges**

27. **NHS Employers should promote careers in the NHS to IMGs , especially in India.**

28. **NHS Employers should run courses and provide online resources to upskill local Human Resources Departments on facilitating IMG entry into NHS posts.**

Para 8 ***Recruitment is only the first part of of a process before NHS patients can optimally benefit from IMGs.....***

Para 9 **NHS Employers should fund Medical Royal Colleges to develop better website resources to help IMGs to adapt to the NHS.....and help local Consultants to mentor them effectively.**

<https://www.rcr.ac.uk/clinical-radiology/being-consultant/working-uk>

Para 10 The Academy of Medical Royal Colleges **Medical Training Initiative** for IMGs has not had the success it could despite participation by many Medical Royal Colleges eg RCR

<http://www.aomrc.org.uk/medical-training-initiative/>

<https://www.rcr.ac.uk/clinical-radiology/careers-recruitment/international-mentorship-scheme-iss>

http://www.rcoa.ac.uk/system/files/TRG-IP-OS-APP-GUIDANCE_4.pdf

<https://www.rcoa.ac.uk/sites/default/files/TRG-IP-MTI-FLOW.pdf>

Para 11 ***Currently such Medical Training Initiative IMGs have a Tier 5 visa which requires them to return to their country of origin after only 2 years.***

This makes such schemes profoundly unattractive

Para 12 ***However if the Home Office would change the visas for such schemes to a Tier 2 type, IMG doctors could apply for an extension for 2-3 years after their first 2 years (total 5 years)if their UK employer supported them.***

That would give them more time to work for the NHS, and the NHS would be likely to recruit more IMGs

These visa changes for doctors recruited through Medical Training Initiative schemes need priority action by the Home Office

5 September 2016

Dr Florian Gebreiter and Dr Laurence Ferry – Written evidence (NHS0046)

Dr Florian Gebreiter and Dr Laurence Ferry – Written evidence (NHS0046)

[Submission to be found under Dr Laurence Ferry](#)

General Medical Council – Written evidence (NHS0173)

Executive summary

- 1 The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.
 - We decide which doctors are qualified to work here and we oversee UK medical education and training.
 - We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.
 - We take action when we believe a doctor may be putting the safety of patients, or the public's confidence in doctors, at risk.
- 2 Professional regulators like the GMC need to ensure that they are supporting doctors and others in the health service to be good professionals and we should assist the profession and the wider healthcare system to adapt to the long term challenges facing the NHS.
- 3 We welcome the opportunity to provide evidence to the House of Lords Select Committee on the long-term sustainability of the NHS. Our submission addresses a range of issues that the Committee are considering around the supply, retention and skills mix of the workforce within the NHS. We also address some of the possible implications of leaving the EU on the medical workforce.
- 4 We have not sought to answer every question being considered by the Committee (such as funding and resources) which are outside of our statutory remit.
- 5 We hope that the Committee find our submission helpful. We would be happy to provide further evidence.

Ensuring the workforce of the future is sufficiently and appropriately trained

- 6 The healthcare system of the future will need doctors who are increasingly able to respond flexibly and adaptively to the complex health needs of patients in different settings. It will also need a medical workforce which is more agile in order to meet the needs of an aging population and an increasing number of patients with chronic and complex multiple co-morbidities.
- 7 These are issues that were considered by Professor David Greenaway's review of postgraduate medical training in 2013 and which are of relevance to the Committee's inquiry.

- 8 Professor Greenaway's review outlined that a balance between generalists and specialists was needed, with the NHS increasingly requiring doctors with a mix of generalist skills that enable them to deal with wider demands on the service.
- 9 The review also proposed greater flexibility of training to allow doctors to move more easily between specialties and into and out of training to ensure they are able to care for a range of patients in diverse circumstances and able to adapt to changing patient needs.
- 10 In addition, Professor Greenaway's review recommended the introduction of a framework for curricula for postgraduate training based on the GMC's core guidance for all doctors, *Good Medical Practice*. This framework should cover communication, leadership, quality improvement and safety.
- 11 As a result, with the Academy of Medical Royal Colleges, we have developed and consulted on a framework for generic professional capabilities (for launch in spring 2017) which has at its core the principles of *Good Medical Practice*. The nine-domain framework will identify the important core professional capabilities doctors should possess at specialist registration. Generic Professional Capabilities (GPCs) will act as an indicative curriculum framework and will for the first time explicitly state educational outcomes required of all postgraduate medical curricula. It will provide medical royal colleges/faculties with the opportunity to integrate and contextualise the GPCs framework across their 66 specialty and 32 sub-specialty curricula. It will also ensure that as requested by the service and Government that common capabilities are addressed consistently across the medical workforce in the future.
- 12 The framework will place appropriate importance in curricula that are underpinned by appropriate professional values, behaviours, knowledge, insights, skills, capabilities and experience. The framework places less emphasis on reductive box-ticking of individual tasks or competencies.

Introducing a medical licensing assessment

- 13 We are developing proposals for the introduction of a medical licensing assessment. This will create a single, objective demonstration that those who obtain registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.
- 14 The competencies tested by the MLA will be identified in light of patients' needs and aspirations as set out for example in Professor Greenaway's review. We are engaging closely with medical schools, the four UK governments and other agencies and experts to make sure that the content of the assessment is appropriate.
- 15 Currently, medical schools cannot show that a common standard is achieved when their students graduate and acquire GMC registration with a licence to practise. By contrast, most International Medical Graduates (doctors who qualified outside of the European Economic Area) need to take a national examination called Professional and Linguistic

Assessments Board (PLAB) which is run by the GMC. Fairness and assurance of a common standard requires an assessment that applies also to UK graduates.

- 16 We plan to consult on our proposals to introduce a medical licensing assessment by the end of 2016 and, provisionally, envisage full implementation of the MLA from 2022, following extensive piloting from 2018.

New and emerging healthcare professions

- 17 A future medical workforce will need to be flexible and be expected to work in multi-disciplinary teams supported by other healthcare professionals such as healthcare assistants and physician associates.
- 18 A report by the Primary Care Workforce Commission in July 2015 concluded that there are *'substantial potential benefits from a range of new approaches to staffing in general practices including the wider use of physician associates and healthcare assistants.'*
- 19 We have a particular interest in the development of the role of Physician Associates given they work within a medical model, are under the supervision of medically qualified practitioners have helped to reduce the burdens in general practice and other specialties.
- 20 Physician associates (named physician assistants in the case of anaesthesia PAAs) first appeared in the UK over 10 years ago with the development of the PAA programme, although they have been established in the USA since the 1960s where there are now around 100,000 practising: they represent the fastest growing group of health professionals. The physician associate model is also used in Canada, Australia, New Zealand and the Netherlands, among others.
- 21 Numbers in the UK remain small (around 200) at present. As of September 2015 there were 14 UK universities delivering physician associate training courses and a further 16 university training programmes under development. That growth has been stimulated by health service pressures as evidenced by the Secretary of State's announcement last year of the intention to create 1000 posts by 2020.
- 22 The expansion of training programmes and posts has led to growing calls for physician associates to be subject to regulation. On 21 April 2016 the Health Select Committee report on Primary Care called on the government to have drafted proposals within 12 months for the professional regulation of physician associates. The reports says that it is unacceptable to encourage new graduates to train as physician associates without giving the public or these new members of the primary care workforce the assurance that they will be regulated. We share the Committee's view that physician associates should be subject to regulation.
- 23 We are pleased with the government's intention to create more posts and would urge it to carefully consider how they are regulated. We have been clear that whether they are regulated and, if so, by whom, is a matter for the UK government to decide. The GMC

has stated publicly that if the four UK administrations were to ask us to take on the regulation of PAs we would give the matter serious consideration.

The role of regulation

- 24 Given the challenges facing the health service around financial, safety and workforce issues, we believe regulatory intervention can continue to play a crucial role in protecting patients. Professional regulation plays a key role in upholding patient safety and promoting best practice among health professionals. This will be enhanced through greater collaboration and information sharing between different regulators.

The effect of the UK leaving the European Union on the supply of healthcare workers from overseas

- 25 The Committee is considering the effect of the UK leaving the EU on the supply of healthcare workers from overseas.
- 26 There are currently more than 30,000 doctors from Europe on our medical register. It is not clear what impact the UK's withdrawal is likely to have on the future numbers. The decision to leave the EU does however raise a number of significant questions for the regulation and movement of doctors from Europe which we are considering.
- 27 The future registration of doctors who qualified in the European Economic Area (EEA) will depend on whether or not the UK remains part of the single market and continues to be bound by EU law on free movement of professionals.
- 28 In the event that the UK retains its access to the single market, EEA qualified doctors should continue to be able to have their qualifications recognised by the GMC under the current system.
- 29 In the event that we are no longer bound by the Directive on the recognition of professional qualifications, EEA qualified doctors are likely to be considered in the same manner as international medical graduates with an acceptable overseas primary medical qualification. Currently a doctor that falls into this category would normally need to sit and pass our two part PLAB examination and the International English Language Testing System (IELTS) test, the latter to the standard we require for other international medical graduates. These tests help to make sure that doctors practising in the UK have the language skills necessary to practise safely.
- 30 There are also significant questions for workforce arrangements in the devolved parts of the UK, especially Northern Ireland which is the only part of the UK that shares a land border with an EU country. We know that approximately 10% of doctors in Northern Ireland have a primary medical qualification from a university based in the Republic of Ireland.

4 October 2016

GenoMed Inc. – Written evidence (NHS0011)

Question 1. The future healthcare system: how can the NHS survive to 2030?

It is no secret what the future healthcare system will look like. We've been hearing about it for decades. It is a system in which chronic diseases are prevented or significantly delayed, outpatient clinics are favored over hospitals, and primary care physicians manage most diseases while specialists are used sparingly.

The irony is that it's 20 years' overdue. The biggest obstacle to the NHS's sustainability is the NHS itself. Every healthcare system is profoundly anti-innovative. Hospitals and dialysis units refuse to die. Subspecialists refuse to eliminate their diseases. The UK could become dialysis-free in the next five years (1). The relatively few remaining patients with kidney failure could all get transplanted. Acute renal failure (ARF) can be treated medically, and dialysis avoided in ARF as well (2).

About 70% of healthcare costs occur in the final 12 months of a patient's life. People will need to be cared for at home, if at all possible. Patients far prefer living at home than in a nursing home. In the US, patients often have to go to a nursing home because Medicare omits paying for something simple like a person strong enough to lift them in and out of bed. The NHS should pay for everything a patient needs to stay at home, including someone to prepare meals and clean up the house. It's far less expensive than a nursing home (GBP 50,000 annually). And rather than being hospitalized for their final illness, patients should be encouraged to die at home, which is what most people say they prefer. Their GP should transfer the patient home to die when it becomes apparent that further treatment is futile. Medically, this point is fairly clear even though it may be difficult for family members to deal with.

If 90 year-olds want heroic measures, they should be allowed to pursue it in the private sector. The NHS should not be required to provide them.

a) Disease priorities

The best outcomes are the least expensive. Preventing a disease altogether is clearly what patients want. It also costs the least. We currently prevent very few diseases, in large part because nobody in healthcare wants to. We need to prevent or at least delay the two biggest killers, cardiovascular disease and cancer, as well as the special scourges of aging: dementia, degenerative joint disease, and degenerative disc disease.

Preventing cardiovascular diseases is possible with existing medications. Our treatment goals need to be more ambitious: LDL below 80, blood pressure under 130/80, and heart rate below 70. ACE inhibitors, not diuretics, should be used as first-line treatment for hypertension. Since the intent is to inhibit the renin-angiotensin system (RAS), diuretics should be used as sparingly as possible since they stimulate the RAS. Ramipril should be used for pulmonary hypertension (primary or secondary, e.g. COPD [1]). Quinapril should be used for all other conditions, especially renal failure (1), left ventricular hypertrophy (3), and peripheral vascular disease (1,3).

By revealing the steps in a disease, genomics now makes it possible to prevent the disease. To prevent deaths from cancer, for example, germline SNPs associated with cancers should be used to predict who's at risk for each cancer (4). For solid cancers, the best hope for a cure is early diagnosis and complete surgical excision. Patients at risk for a particular cancer can be followed closely by existing techniques, such as colonoscopy, mammography, and PSA. For example, patients whose somatic DNA indicates that they're at risk of ovarian cancer could be followed every 12 months with a pelvic ultrasound, and more frequently if there's a question of a tiny ovarian nodule. Serial chest CT's could be reserved for those predicted from their genomic DNA to be at high risk for lung cancer.

Another urgent need is more effective and less toxic treatment of metastatic cancer. "Differentiation therapy" should become more effective when directed at cancer-associated genes (4).

Eliminating common adult cancers is the first step towards making a healthcare system sustainable. Childhood cancers, although horrifying, don't threaten to bankrupt the NHS. They are relatively rare. About as many children die of all types of cancer as adults with pancreatic cancer alone.

Dementias come in various types--Alzheimer's, Parkinson's disease, vascular dementia--but have in common neuronal apoptosis. Patients with all three classes of dementia could be tested with the same "fishing net" of SNPs, e.g. GenoMed's SNPnet[™] version 2.0, as we've done for the six leading cancers, to find genes that contribute to all three diseases (4). Inhibiting these gene products might delay the progression of all three kinds of dementia. Inhibiting a single gene can be enough to reverse the disease (1), especially when that gene occurs early in the disease pathway.

Degenerative joint disease (DJD) and degenerative disc disease (DDD) are extremely common in people over the age of 25. They both arise from the mechanical breakdown of cartilaginous tissues. Both are expensive to treat; neither is treated terribly well. Neither disease has received nearly the research attention its cost behooves. Like all polygenic diseases, DJD and DDD should lend themselves to genomic analysis using a set of SNPs like GenoMed's SNPnet(™) v. 2.0. Early detection of patients at risk, and delay in progression of disease, could then follow.

b) Reinvigorated clinical research

The NHS must begin to utilize its many practitioners to improve patient outcomes. Nobody knows clinical disease better than NHS doctors. The MRC, like the NIH in the US, as well as all of academic medicine, is much more interested in the mechanism of disease than in improving clinical outcomes. Model organisms are studied rather than patients, who are felt to be too complex. Ironically, genomics now makes human patients the study species of choice.

To improve patient outcomes, the NHS must first start recording them. How many of a GP's diabetic patients, for example, are still alive at the end of the year? How many are on dialysis? How many have had a heart attack? How many have suffered amputations? How

many of a GP's patients with congestive heart failure are still alive at the end of a year? Start with extremely simple epidemiologic measurements. The data are already available.

Then ask the physicians with the best outcomes to describe how they treat patients. Do they have their nurse ring up CHF patients once a week, or even more often, to find out their latest weight, and adjust the furosemide dose accordingly? Encourage the best performing GPs to post their protocols on a website for other NHS practitioners to see, to comment on, and to try to replicate. Most GPs will be proud to participate.

Most of the clinical innovation in the next decade will come from finding disease-causing genes using genomics, and then repurposing already existing drugs for new diseases. Examples include ramipril for pulmonary hypertension (1,6); trandolapril for sickle cell disease (5); quinapril for renal disease (1); losartan for multiple sclerosis (unpublished data) and West Nile virus (6); etc. This takes little time and even less money. Once a disease gene is identified, patients can be treated with a repurposed drug the same day, and the first dozen patients reported within a few months (6).

The nature of clinical trials must change "back to the future," so to speak. The randomized controlled trial currently serves as the only standard for clinical research. But RCTs are extremely expensive, and should be reserved for new drugs, since money is available in the private sector for launching new drugs. But research involving already existing drugs doesn't get any funding. In the 1920s and 30s, when, like now, there was no money for clinical research either, every physician was encouraged to feel like an investigator. Case reports were published by the major journals. Internists must again be allowed to publish consecutive case series, as in the surgical literature.

In short, the only way the NHS will survive is if healthcare is delivered the way patients want it to be: rarely in hospitals, and never in nursing homes. And if physicians become clinical investigators again, guided by genomics. Furthermore, medical genomics must be rescued from the clutches of crony science and put to clinical use. Expensive, futile projects like the Biobank and sequencing tumor genomes should be abandoned. GenoMed's much cheaper and quicker approach to finding disease genes and improving patient outcomes should be adopted instead.

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25 August 2016

Professor Sir Muir Gray – Written evidence (NHS0019)

SUBMISSION TO THE HOUSE OF LORDS ON NHS SUSTAINABILITY

The solution of the sustainability of the NHS is not on the demand side of the Health Service: it is on the supply side.

Our work in NHS Rightcare (<http://www.rightcare.nhs.uk>) illustrating unwarranted variation in the Atlases of Variation reveals the huge variation in activity that can neither be explained by variation in need nor by variation in demand, but by variation in supply. This is as a result of a culture that has evolved over decades during an era of growth. In this era, the personalities of many specialists and subspecialists have a bigger impact on, for example, whether the glaucoma or the cataract service develops faster, than the needs of the population and the evidence of effectiveness and value. Attached to this note is a summary table of some of the variations we have identified by using routinely available data. We have much to be proud of but as we move from the era of growth to an era in which there will not be growth in line with need and demand, there is a need for a different approach.

The NHS Rightcare Programme was set up by NHS England in 2010 and has now been adopted by NHS England as its principal means of managing resources. Its aim is to release £11.5 billion from the £115 billion available and shift it from lower value activity to higher value activity. Without this focus on value, and the development of a culture of stewardship among clinicians, the NHS is not sustainable unless a new paradigm, the value paradigm is adopted

THE NEED FOR A NEW PARADIGM

Tremendous progress has been made over the last forty years due to the second healthcare revolution, with the first healthcare revolution having been the public health revolution of the nineteenth century. However, there are still three outstanding problems which are found in every health service no matter how they are structured: One of these problems is huge and unwarranted variation in access, quality, outcome and value as revealed by the NHS Atlases of Variation which also reveals the other two problems:

- Overuse - which leads to
 - waste, that is anything that does not add value to the outcome for patients or uses resources that could give greater value if used for another group of patients
 - patient harm, even when the quality of care is high
- Underuse - which leads to
 - failure to prevent the diseases that healthcare can prevent e.g. stroke, and vascular dementia through the management of atrial fibrillation
 - inequity

What is needed is a complement the focus on the quality of institutional provision with a focus on value to shift at least £11.5bn from lower value care to high value care for populations and individuals.

THE TRIPLE VALUE METHOD

The term ‘value’ in the plural – ‘values’ – means principles, for example ‘this Trust values openness’. In the singular, the meaning is economic, and NHS Rightcare developed the concept of Triple Value

- Allocative - determined by how well the assets are distributed to different sub-groups in the population
- Technical - determined by how well resources are used for outcomes for all the people in need in the population. This is much more than efficiency, which is determined by the outcomes and costs for the patients seen, but ignores overuse and underuse
- Personal - determined by how well the outcome relates to the values of each individual

THE NEW PARADIGM

What is needed to increase value is to continue with good general management and leadership and with the specific processes that have increased effectiveness and value in previous decades, namely

1. Preventing disease to reduce need
2. Improving outcome by providing cost effective, evidence-based interventions
3. Improving outcome by increasing quality and safety of process
4. Increasing productivity by reducing cost

But more of the same, even better **quality** care is not the answer. The focus has to be on **better value** for individuals and populations. This requires a new paradigm, a Population and Personalised paradigm which is emerging in every country, for example as Realistic Medicine in Scotland and Prudent Healthcare in Wales.

Bureaucracy-based Paradigm	Population & Personalised Paradigm
The Aim is on effectiveness, quality and safety outcomes	The Aim is triple value & greater equity
Good service for known patients	Personalised service for all the people affected in the population
Improvement through competition	Improvement through collaborative systems and networks with patients & carers as equal partners
Transformation attempted by reorganisation & more money	Transformation by culture change & digital knowledge services

Clinicians act as the users of their institution's resources	Clinicians feel they are the stewards of the population's resources
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TRANSFORMING THE NHS FOR SUSTAINABILITY

Transformation needs

To the traditional four activities – prevention, evidence-based decision-making, quality improvement and cost reduction – add five new activities need to be added:

1. Ensuring that every individual receives high personal value by providing people with full information about the risks and benefits of the intervention being offered, and relating that to the problem that bothers them most, their values and preferences
2. Shifting resources from budgets where there is evidence from unwarranted variation of overuse, or lower value activity, to budgets for populations in which there is evidence of underuse and inequity
3. Ensuring that those people in the population who will derive most value from a service, get access to that service
4. Implementation of high value innovation funded by reduced spending on lower value interventions for the population
5. Increased rates of higher value intervention in every pathway funded by reduced spending on lower value interventions, e.g. switching resources from hospital nursing and polypharmacy to district nursing for end of life care

This work is now being led by Professor Matthew Cripps in the Finance Directorate of NHS England.

6 September 2016

Mrs Alison Griffin – Written evidence (NHS0037)

I have a unique perspective on the NHS.

I am a private individual who qualified in Medicine from the University of Leeds in 1983. I worked in the NHS for a few years until I left to become a housewife. I am married to a hospital consultant.

I wish to take part in this call for evidence because I have been commenting on the problems of Medicine for many years.

The long-term sustainability of the NHS is doomed on its present path.

The chief cause of the failings of the modern NHS is due to political interference with the profession of Medicine and with medical education over decades.

Examples of bad medicine are such as that reported in the newspapers today of several GP practices now offering their patients Skype consultations to save time and money. Similarly my own GP practice moved to a system of triage phone calls to remove the patient automatic right to an appointment because patients had too long a wait for appointments. The danger is that the GPs will be making a telephone diagnosis, which is unethical. There is a difference between making a diagnosis over the phone compared to simply deciding who should be seen that day. My practice failed to diagnose my fractured hand because they did not examine me in person but decided that my painful hand was just a sprain, over the telephone. Such a simple error will now be repeated many, many times and I believe must contribute to the excess demand on A&E where I eventually went to get my fracture diagnosed. I believe that a Skype consultation is also unethical for the same reason. I know full well how and why these processes have arisen and that technology now allows it. Clearly Medicine must move with the times and must update itself but these specific developments are also part of a rationing process in a politically controlled resource-limited system. It does not make them right. My clinical training involved basic principles all of which are largely discarded by the modern NHS. Those old hospital consultant teachers would be horrified by what happens now. My clinical training taught physical examination of the patient. The physical examination confirms or excludes any disease flagged up by the medical history. Remote diagnosis excludes this basic part of the diagnostic process. No amount of investigations compensate for this. The whole point of a medical examination, of any kind is to make a diagnosis. Without a proper diagnosis all further treatment is useless or harmful. It is for this reason that Skype and telephone diagnosis is unethical. There is another way that the modern NHS discards the old tenants of medicine. Many diagnoses are made because the history of the complaint is followed over time. For this to happen then the same doctor has to watch the progress of the illness. This was why the family doctor was so important because he or she knew you and followed you up. These days medical consultation events are rather like being served in a shop or part of a factory process. The doctor deals with specific problems in isolation and in doing so will miss the bigger picture. This contributes to both patient and doctor dissatisfaction and to some poor patient care. Large GP practices have a wealth of expertise and specialisms but the downside is that there is disjointed care over a time scale for each patient. For example a recurrent problem may

involve seeing different doctors over a short time period all about the same complaint. The patient has no say over this but has been dictated to by the staff because they are all working at different times and on different shifts. This problem will be most obvious in the elderly who often have numerous and multiple medical problems. The NHS is incapable of looking after an elderly frail person who does not have an active patient advocate to speak for them and even then data protection rules mean that the patient is actively harmed because relatives are not listened to. A time limited doctor will not stop to consider what a relative says if the patient is in any way capable of talking to them themselves. Such a patient may be confused or incapable of understanding the issues but if they can maintain any sort of conversation then they will be deemed to be an autonomous person in their own right often to their own detriment. I have experience of this because I have had to work tirelessly to get medical and hospital care for my elderly, frail mother. She cannot understand the modern NHS and as such cannot engage with it to her best advantage.

No one in his or her right mind would now study Medicine. The medical course has had large chunks of basic science removed that have been replaced with 'touchy feely' training. This has left it deeply repellent to young men. No one believes that either men or women make the best doctors but the medical course has developed in tune with liberal thought and the ascendancy of feminism and the result is a medical education that is not fit for either sex.

Run through training and the junior doctor shift system have further undermined standards in the practise of hospital medicine by removing the requirement to get a further placement during training (and subsequent weeding out of those who are unsuitable) and the removal of the consultant team led hospital care that maintained continuity of care for hospital patients. Run through training has the added disadvantage of making recruitment to district hospitals very hard because all the juniors are paired up and reluctant to move out of the city areas by then.

Without solution, medicine will become like dentistry, fine for those with their wits about them and who can afford good quality private care and second-rate provision for the rest on the NHS if they can find it and are able to access it.

In the present system the patient has no power except one of complaint and by then the damage is done. Medicine has been de-professionalized by the dumbing down of medical training and by the political control of how it is practised. An example of how political management makes things worse is when the target system was brought in for GP referrals. Those patients who were thought not to have cancer by the GP had a longer time for hospital diagnosis than those who were initially diagnosed by the GP as possible cancer cases because they had to wait while the targets for urgent diagnosis were met. Now any old doctor will tell you that it is the pathologist in the main who diagnoses cancer with help from the radiologists and that the GPs are very bad at it. This meant that the false negative GP referrals suffered while waiting for the false positives to be investigated urgently and ahead of them. Such is the way when a political gimmick is allowed to go ahead by those who do not understand the disease process and best medical practise but who nevertheless have the power to control the NHS.

The future health care system

Future health care systems should address the problems that I have outlined above. The patient should be able to refer themselves either to a chosen GP of their choice or directly to a hospital consultant of their choice. The NHS rations care by only allowing the GPs to refer. There is no medical reason to use the GPs as gatekeepers other than to deny access to resources. This is just denying care to people. A recently retired paediatrician told me how incensed she was by the changes brought in that stopped her from referring a patient to another hospital consultant within the same hospital but instead insisting that she go back to the GP to then do the referral. This is madness and entirely improper.

The power of choice, real choice needs to be with the patient. Clearly further provision may well be required and this could be facilitated by co-payments.

Resource issues

Everyone should contribute something. If access to the NHS is means tested then those who pay for everyone else but who have also to pay for their own will withdraw support. Co-payments should be proportional and very small for those on low incomes. Prescription charges are far too high and where the drug is cheaper than the charge it should be lowered to reflect the real price. There should also be a very small charge for everyone whatever their income or even for children to make the point that the system is not 'free' because someone has to pay for it. This charge could be measured in pennies for those on very low incomes. For many the charge would be on a point of principle and would still give some choice and therefore power to the poor. The country as a whole is not under-taxed and so no new taxes should be introduced to improve the NHS. There will never be enough tax money for the system as presently devised. Savings should be made elsewhere if necessary such as by getting rid of pensioner free bus passes or attendance allowance and putting the money towards the NHS instead. Sin taxes could be used in the setting of co-payments rather than as a blanket tax on say, sugar. The overweight could contribute to their more expensive care or obese induced medical treatment; say after being given 1-2 years to lose weight. This would also increase the provision of medical treatments for the obese. This is fairer than denying obese patients elective treatment as has been suggested. Increasing taxes is easy but ineffectual in the long term. The hard part is to make the connection for people between behaviour and health care spending which once started will lead to real solutions rather than false ones.

Workforce

Foreign workers have always propped up the NHS. My local hospital has to recruit internationally to fill some vacant posts even though it is in a nice part of the country. Recruitment will be very difficult in future and points to gross past mismanagement of the workforce provision. Opening new medical schools and vastly increasing medical student numbers can address this. An old GP tells me that the large female workforce do more part-time work which necessitates training more doctors. Junior doctors have enormous debts from their undergraduate training and their housing costs are sky high. Addressing these two problems would help to keep NHS wages down. New provision should be paid for partly by increasing the inducements for people to go private and also with co-payments for everyone. The NHS could part pay for private treatment if the patient chooses it. There are no private A&E and no private hospital medical training. This could be changed as a requisite

to the NHS paying co-payments for private medical treatment. Without some independence and autonomy for medical staff in decision-making then no progress will be made on improving the delivery of care. Improvements will remain largely due to technical advances, which will add to cost pressures unless say, a cure for cancer or Alzheimer's is found.

Integrated health services.

There will always be a requirement for state based care systems because modern families are split up and there are very few stay at home parents or homemaking adults. No further taxes will offer a realistic solution to what is a changed working environment for men and women. The majority of people will simply be unable to pay for their own care.

Prevention and public engagement.

Co-payments alone would incentivise people to improve their behaviour towards better health because there would be a financial incentive in the form of financial consequences. Unavoidable long-term conditions would need to be charged at an unbelievably low amount to avoid penalising those who are simply unfortunate to have bad health including those on high incomes because they would be contributing already through the tax system. People are largely disinterested in improving their health because medical care is 'free' and always there and because ill health is not something that people want to dwell on or worry about. Only the anxious and obsessive worry about their health and that leaves out the majority.

Now that smoking has been largely reduced from the high rate when I was young it would now be appropriate to remove the taxes on cigarettes. Such a move would give faith to people that 'sin' taxes were only temporary and because of the ill effect on behaviour and costs. It will be very hard to draw up a list of 'sin' co-payments unless co-payments are paid on all NHS care. There is a danger of mislabelling people as 'sinners' when the reality might be ignorance or that others cause their 'sin'. Modern supermarkets and food outlets mean that it is very hard not to be overweight. This also needs to be recognised. Banning cars from some roads and streets and building cycle highways might save more for the NHS long term because people would be safe from vehicular traffic and would simply move about and exercise more.

Technologies

Technologies must not be used as a substitute for real medicine because they will cause more problems down the line. Technologies could invade patient privacy and make people feel no better than a farm animal. The government should simply stop interfering with doctor and nurse delivered care and instead give the power to choose to the patients. Co-payments from all for every single bit of NHS spending will drive further improvements. Patients can ask to have a televisual consultation if they want it but they need to understand its limitation as well and that it is no substitute for the real thing. The principal of co-payments will be a very hard one for the population to accept. Nothing should be totally cost free even for the poor because if it is then it will change people's behaviour from a psychological point of view and will make the recipient powerless. In cases of extreme need and lack of means then co-payments could amount to even say 20p just to make the point that payment is expected. Collecting the payments could be cumbersome and costly itself but most of us cope with paying in supermarkets so it should not be difficult once systems are set up.

Mrs Alison Griffin – Written evidence (NHS0037)

I realise that my view is unorthodox but unless the NHS changes then it is on the road to ruin. Eventually it will become generally apparent that the NHS is not fit for purpose either for patients or for staff and then the population's anger at its breakdown will be most unpleasant.

20 September 2016

Professor Frances Griffiths – Written evidence (NHS0152)

Our research study findings are not yet published. We would appreciate this submission not being made public until we have published our findings in a peer reviewed journal.

Theme

Digitisation: How can new technology be used to ensure sustainability of the NHS?

Title of evidence:

The safe, ethical and cost limited use of digitally enhanced health care to improve the experience and impacts of specialist care for people living with long term health conditions.

Authors:

Professor Frances Griffiths, Warwick Medical School, University of Warwick

Professor Jackie Sturt, Florence Nightingale Faculty of Nursing and Midwifery, King's College London

Date: 26th September 2016

1. Introduction

- 1.1 Long term condition management accounts for the majority of NHS spending with conditions like diabetes alone accounting for 10% of the NHS spend (1). Adolescents and young adults living with long term health conditions (e.g diabetes, cystic fibrosis, mental health problems, liver disease) often disengage from health services and this often results in poor health outcomes for them (2-6) and high costs for the NHS.
- 1.2 Clinicians who specialise in working with these age groups (often called transitional care from paediatric to adult services) have started to use digital communication methods to try and improve engagement. In the UK, 90% of young people aged 16-24 years own a smart phone (7) and studies have reported requests from young people to be able to communicate via email, text and social media with their health care team (8, 9).
- 1.3 In the UK, policy and investment is driving the digitalisation of the NHS (10, 11). With the roll out of NHSmail 2 (12), NHS clinicians now have access to secure email and other digital channels for communicating with patients on clinical matters offering a level of data security that not previously been available. This service is available to clinicians providing specialist long term condition care to people across the age spectrum.
- 1.4 Previous systematic review evidence on the effectiveness of digital communication between clinicians and patients with long term conditions was equivocal, although no trials reported poorer health outcomes in the intervention arm (13). These reviews identified gaps in evidence as to how communication using digital channels might work, its cost, ethical and safety issues. The aim of the study on which this evidence is based aimed to address these evidence gaps.

2. Research design

- 2.1 The evidence draws on a mixed method case studies involving observation, interview and survey of 20 NHS specialist clinical teams from across England and Wales. The

clinics provided care for 13 different long term physical or mental health conditions. The digitally enhanced services had been in use in these clinics from between 1-13 years. Three studies clinics had not yet started to use them. The digitally enhanced services consists of mobile phone calls, text messages, email, Voice over Internet Protocol.

- 2.2 Participants were 165 young people aged 16-24 years living with a long term health condition; 173 clinical team members (e.g. Drs, nurses, dieticians, psychologists) and 16 Information Governance specialists from 17 NHS Trusts. Data were collected from these clinics to understand how digital communication works; what were patient safety and ethical impacts and what costs were incurred in providing these services.

Table 1. Study sites and participants (interviewees)

Condition	Number of case sites	Number of interviews			Number of staff shadowed
		Young people	Clinical team members	Information Governance specialists	
Cancer	2	23	18	2	11
Cystic Fibrosis	2	15	16	1	4
Dermatology	1	7	4	0	2
Diabetes	2	23	14	2	7
HIV	1	9	12	1	4
Inflammatory Bowel Disease	2	14	13	3	7
Liver	1	15	12	0	7
Mental health: Outreach/CAMHS*	2	9	22	1	7
Mental health: EIPT*	2	5	17	2	10
Renal	1	7	7	0	3
Rheumatology	1	16	8	1	1
Sexual Health	1	12	10	0	3
Sickle cell	1	10	13	2	9
Various (School Nurse)	1	0**	7	1	4
Total	20	165	173	16	79

- 2.3 Data were analysed by a team of researchers who are experts in the field of health services research, behavioural science, ethics, patient safety, health economics. Analytical techniques used were those appropriate to each of these academic specialties. Further details of the LYNC study methods and early outputs for clinicians to inform their digital service transformation plans can be found at <http://www2.warwick.ac.uk/fac/med/research/hscience/sssh/research/lyncs>. The full study report is currently under review with the funder (14).

3. Results

- 3.1 Communication between the young people with long term conditions and their clinical teams using digital channels was used in addition to traditional face-to-face appointments. It did not replace face to face contact but it did enhance the quality of

this contact, for example because tests results had already been shared or concerns raised through digital channels and routine tasks such as ordering supplies had been achieved digitally.

- 3.2 The use of digital channels of communication meant that the young people could easily get in touch with their clinical team when they needed to, for example when a new symptom developed, when they became unwell and wanted advice as to what steps to take, when they were anxious about their condition/treatment, when they were unsure of what to do with their treatment or when they were going to do something new such as travelling abroad and needed advice. This improved access prompted the young people to be more active in relation to their health condition and prompted better self-management. Clinicians initiated digital contact when the young people were using new treatment, were preparing for or just after a treatment such as a transplant, or were going through life changes such as going to university.
- 3.3 Digital communication between the young people and their clinical team improved trust and allowed for greater continuity of care. The young people felt they were receiving personalised care. Young people with long term conditions who had previously disengaged from their health care and were considered 'hard to reach' by the clinical team, had been re-engaged through using digital channels of communication.
- 3.4 We identified patient safety concerns related to the use of digital channels of communication about clinical issues. These included inadvertent disclosure of sensitive information, communication failures, failure to record the content of the communication in the clinical notes, and failure to consult the clinical notes prior to engaging in communication. Young people did not always recognise the potential risks of inadvertent disclosure of their health information, for example on their own smart phone, although others were aware and mitigated this risk. Clinical teams mostly mitigated the risks to patient safety, although often without engaging with their NHS Trust Information Governance manager for support.
- 3.5 Ethical issues we identified included:
 - a) Patient consent – whether implied consent through the patient initiating the digital contact was sufficient;
 - b) The potential for change in patient autonomy. This could be enhanced through empowerment of the young people, but there was potential for increased dependence on the clinical team as decision makers;
 - c) Reduction in the power imbalance between the young people with long term conditions and their clinical teams. The clinical teams were fitting in with the young person's world rather than the other way around. However, this meant clinicians did not have complete control over professional boundaries and the clinical information they shared with the patient;
 - d) Concern among clinical team members about their duty of care. For example, what to do if emails or texts arrived for the clinical team outside of their working hours. Solutions to this included clear messages on all digital communication about when the clinical team were available, and reinforcement of this information when in contact with the young people.

Information Governance specialists were familiar with the relevant policies and guidelines and wanted to provide support for their clinical teams in improving health care, although they also have a role in policing adherence to policy.

3.6 A trusting relationship between the young people and their clinical team was important for mitigating patient safety risk and ethical concerns.

3.7 The main cost of providing the enhanced access through digital channels was staff costs. These staff costs were not usually additional as the staff had been using other means for following up these young people.

3.8 We were able to identify mechanisms by which NHS cost saving were likely, for example reducing the number of appointments the young people had to attend, providing advice that avoided a visit by a young person to Accident and Emergency, reducing the incidence of complications of the long term condition through early treatment or improved adherence to treatment.

4. Conclusions

4.1 Digital channels can offer increased access for patients to their clinical teams, and visa-versa, when this access can make a difference to how the patient manages their condition. This digital service improves patient experience of care and patient engagement with care and prompts greater levels of self-management. The sustainability of the NHS will be greater if patients with long term conditions are fully engaged with their own health care.

4.2 Digital access for patients with long term conditions has potential to reduce health care inequalities.

4.3 Our findings can be applied to adult populations as they do not relate specifically to the age or clinical condition of the young people, particularly as smart phone ownership among older people is rapidly increasing (15).

4.4 Our study findings suggest how the introduction of enhanced access, using digital channels, could be safely achieved in a sustainable way:

- a) Initiate the enhanced service with patients where there is an existing relationship of trust between patient and clinical team. This is likely to be patients with long term conditions;
- b) Choose the population of patients with long term conditions that is offered the enhanced service according to an identified need, for example, patients in transition between services (such as the young people we studied), patients in transition between treatments (e.g. a diabetic starting insulin) or before/after treatment (e.g. liver transplant), patients in transition in their life (e.g. starting university);
- c) Prior to introducing the digital service clinical teams need to work out how they will manage safety and ethical issues, and use their Information Governance specialists as a resource. Improvements in the technological infrastructure have solved, or will solve some safety and ethical concerns, but others need to be addressed within the clinical team, often with simple measures such as messages within email signatures.

4.5 Further research is needed on the impact on health outcome and health service costs of the use of enhanced access to clinical teams through digital channels for people living with long term conditions.

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23 September 2016

Thomas Harrison – Written evidence (NHS0127)

1. DON'T spend £7 billion plus on the Houses of Parliament. The ministers are being moved to other office space within spitting distance of Parliament. Why cant they stay there?
2. Get rid of the House of Lords. Un-elected, jobs for the boys club.
3. Stop assisting in bombing innocent and unarmed people.

Etc, etc etc.

15 September 2016

HCL Workforce Solutions – Written evidence (NHS0118)

The following information is HCL Workforce Solutions' submission to the House of Lords Committee on the Long-term Sustainability of the NHS, approved by Chief Executive, Stephen Burke.

HCL is an approved provider of health and social care staffing, supporting NHS and social care partners through placing more than 2,000 frontline and administrative staff into the system. We have worked proactively with our NHS partners to enable them to put spend and staffing on a sustainable footing.

1. THE IMPORTANCE OF THE WORKFORCE

- 1.1 We welcome the Committee's inclusion of the workforce as a key aspect of this inquiry, as the NHS continues to navigate the numerous challenges associated with the issue; HCL possesses considerable expertise of the scale of the challenges and potential solutions.
- 1.2 60% of the costs of running an NHS Trust are attributed to staff; the workforce is the health service's greatest asset and can act as the vehicle for transformation and long-term sustainability across the system.
- 1.3 It is deeply concerning that the supply shortages of staff combined with ineffective management of those that work in the NHS has led to a negative impact on efficiency and patient care:
 - 23,180 last minute operations being cancelled for non-clinical reasons between January-March 2016
 - Current inefficiencies are resulting in expensive agency staff having to fill the gaps. This has contributed towards an increased agency spend of £3.7bn in 2015/16
 - Only half of NHS Staff Survey 2015 respondents were satisfied with flexible working opportunities
- 1.4 If the Government and NHS England are going to achieve their important objectives over the coming months and years, getting a firmer grip on workforce challenges is essential.

2. THE WORKFORCE SUPPLY AND DEMAND CHALLENGE

- 2.1 A range of factors have created a 'perfect storm'. Many of the current difficulties in how the NHS manages and uses the workforce are fundamentally the result of a supply and demand mismatch; this shows little sign of abating, at least in the short-term.
- 2.2 We support the ongoing efforts of Health Education England, NHS England and the Department of Health to increase training places to develop the UK's pipeline of

medical and clinical staff; however, this is a lengthy process due to time lags. The challenges are here and now and require immediate solutions.

- 2.3 Enabling the NHS to recruit the best and brightest from around the world is critical to the system's sustainability, and will help the system to navigate this precarious period. Recruiting internationally is a last resort for trusts, but offers an invaluable route to driving down costs for the system and protecting patient care.
- 2.4 There are key factors to consider with regards to EEA staff. Our own on the ground view suggests that the introduction of the international English language testing system (IELTS) is the primary reason behind a recent slowdown in the flow of EEA nurses into the UK. Consequently, we are forecasting a 20% drop in the number of HCL recruited EEA nurses commencing employment with NHS trusts in calendar Q3 compared to Q1 and we expect the IELTS requirement to continue to act as a drag factor on supply.
- 2.5 The result of the European Union Referendum has added a new dimension to the issue. Over the past couple of months, HCL has sought to reassure migrant health professionals about their important position in the country to ensure they do not consider leaving. I put on record HCL's support for an arrangement by the Government that safeguards the position of EU NHS workers already in the country, and prioritises health professionals under any new immigration rules
- 2.6 Regarding non-EU migrant workers, the Home Office's decision to include and retain nurses on the Tier 2 Shortage Occupation List (SOL) has provided some important respite for trusts. This arrangement must be kept in place for a minimum of three years while the domestic pipeline is boosted and the NHS improves the way the workforce is managed.
- 2.7 We are currently aware of very high levels of demand from trusts for non-EEA nurses, predominantly from the Philippines. HCL has current contracts with 17 NHS trusts to recruit 1,966 nurses from the Philippines with formal approaches from a further 18 trusts for an additional 2,015 qualified nurses. Identifying high quality Filipino nurses is simple; we currently have 1,300 nurses under verbal offer; and whilst we support IELTS in principle, it creates a significant constriction in the process with first time pass rates below 20%. We are enhancing our IELTS training processes and would expect other agencies to be doing the same to increase the rate of flow, however, the speed and volume of supply will remain weak due to the complexity.
- 2.8 Additionally the process from IELTS pass to the Nursing and Midwifery Council PIN allocation for non-EEA nurses is protracted and complicated to manage, again impacting the speed at which non-EEA nursing staff can start practicing. Certain consequences of the current shortage are fuelling a vicious cycle. The current workforce is fatigued and sickness rates are on the rise. This, in part, is leading to many leaving the profession altogether. Additionally, the shortage of staff is preventing senior workers from spending enough time supporting and mentoring new starters. This has an impact on career development and enjoyment of the role, which is instrumental in retaining staff particularly during the early years.
- 2.9 In addition, not only does an ageing population increase patient demand for services, but it has a significant impact on the NHS's staff pipeline. The demographic of the current workforce must be carefully considered. Health Education England has forecasted 23,200 FTE retirements for 2015-16 in adult nursing for example. This is a

significant number and will put further strain on the system. Moreover, individuals approaching retirement age cannot always work at the same intensity as when they were younger.

3. EMBRACING TECHNOLOGY TO OVERCOME WORKFORCE CHALLENGES

- 3.1 The above context is important and underlines the need for the Department of Health, NHS England, NHS Improvement and hospital trusts to find ways to improve recruitment and retention of workers. However, HCL understands the existing workforce can be managed more effectively.
- 3.2 Embracing technology is a fundamental part of effective workforce planning and presents an underutilised solution. A number of trusts have invested in workforce technology that is not fit for purpose.
- 3.3 Lord Carter's report on Operational Productivity and Performance in English NHS Acute Hospitals was very welcome and highlighted the need for better e-rostering as a recommendation. In our experience, an innovative approach consists of the following key elements:
- Staff rotas are demand-led – taking the same approach as successful large-scale industries
 - Real time visualisation tools present both graphical and numeric data in such a way that gaps, reoccurring shortfalls and cost overruns, along with a standard MI suite are made immediately visible
 - Shift swapping, which does not require any third person interaction by the roster team, only authorisation by the specific roster owner
- 3.4 . The benefits for staff, trusts and patients are significant:
- Staff are put back in control, enhancing their flexibility over work patterns. This will help to ensure a career in the NHS becomes more attractive
 - There is a reduced reliance on agency workers, thus, bringing the usage and cost of temporary staff down to an appropriate and sustainable level
 - Staff are only deployed where they are needed, and crucially, with the right skill sets to deliver the highest quality of patient care
 - There will be fewer last minute cancellations or operations and gaps in rotas, enhancing patients' experience of care and mitigating the risk of burnout and stress amongst staff
- 3.5 Putting in place solutions for managing the complex nature of the workforce does require investment, but the cost savings and benefits will significantly outweigh the investment in systems and technology long-term. We echo Professor Robert Wachter's National Advisory Group on Health IT's finding that the short-term return on investment is likely to be in the form of safety and quality improvements, while cost savings can take significantly longer to emerge.
- 3.6 We also support Professor Wachter's recommendations around strengthening the digital capability of staff within trusts, including at a senior level. There is no doubt trusts are operating in a hugely challenging environment, but there is considerably more that can be achieved by taking responsibility for workforce management; HCL is committed to assisting wherever possible.
- 3.7 Moreover, to further support this process, we believe a national 'workforce tsar' should be appointed to articulate what good looks like, and fit the numerous pieces

to this hugely complex jigsaw together. The system needs a highly visible, dedicated team to review the complexity around consultant job planning and facility-wide rota planning and management; setting targets to reduce attrition rates and mandating the development of vibrant in-house staff banks with realistic benchmarks as goals will all go a long way to improving the management and retention of the NHS's biggest and most valuable asset: its staff. This, in conjunction with sensible measures from the Government, such as keeping nurses on the SOL, will help to ensure the system can achieve long-term sustainable improvements.

23 September 2016

The Healthcare Financial Management Association – Written evidence (NHS0090)

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For more than 60 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has a particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are ‘fit for purpose’ and effective.

Introduction

This submission is based on the views of the HFMA and its members and draws on HFMA publications and research. We have focused on the areas where we have most knowledge and expertise. Consequently we have not answered all the questions set out in the call for evidence and instead have focused on the first three sections.

We welcome this inquiry and are hopeful that it will lead to changes that support the long-term sustainability of the NHS and a debate about the level of resources the government devotes to the NHS and whether it is sufficient to meet demand now and in the future.

Our responses to the questions asked by the House of Lords Select Committee on the long term sustainability of the NHS are set out below.

The future healthcare system

Taking into account medical innovation, demographic changes and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

1. To ensure the long-term sustainability of the NHS, greater emphasis needs to be placed on preventing ill-health and improving public health. Individuals need to be better educated about the impact of their lifestyle choices and take more responsibility for managing their own health, well-being and care. In our opinion this will have the single biggest impact on long-term sustainability of the NHS, or indeed any healthcare system. We believe that investment now in public health with a clear strategy supported and driven forward by all parties will pay dividends later. Part of this is about the NHS not being viewed in isolation from the other determinants of public health, including social care, education, employment, housing and transport.
2. There needs to be a continued focus on breaking down the barriers between different types of care, including primary, secondary and acute care, health and social care.

These should become more integrated with a focus on the patient and their care pathway and a move away from managing the NHS through organisational silos which prohibit this integration. The current organisational architecture of the English NHS may not enable care integration at the pace required. Work underway to develop sustainability and transformation plans (STPs) is a positive move and may lead to a more sustainable integrated health service. However these plans do not have a statutory basis and several individual statutory organisations are involved in each plan. To resolve the debate about whether there is sufficient NHS money there may be a need to re-organise the NHS, perhaps via a governance and organisational model centred on the STPs, as opposed to the current statutory organisations.

3. A culture of embracing and exploiting technological advances needs to be in place across the NHS. It will enable different ways of working, including care being provided in different settings and facilitating patients managing their own conditions. Health appears to be one of the few sectors where technology has not been fully exploited to reduce costs, improve quality and radically change the way in which services are provided.
4. Unwarranted clinical variation and how this can be narrowed needs to be a key part of any health policy going forward, both to improve clinical care and to ensure the efficient use of NHS resources. The work of the Right Care programme needs to be fully embedded within the NHS.
5. Payment mechanisms are complex and in many instances do not incentivise improvements in clinical behaviour. In our opinion doctors do not generally take into account the payment mechanism when making clinical decisions. Improvements to how services are delivered must be clinically-driven and focus on what is best for patients. Payment systems need to be redesigned to reward this and not act as a barrier to such improvements. They must also reflect the reality of what happens clinically rather than attempt to apply a theoretical approach to a real situation.
6. Patients make decisions based on ease and speed and so for example will go to accident and emergency departments, which are open in the evenings and weekends, as opposed to waiting longer to see a GP. It is essential that patients access healthcare at the right point of entry. This requires investment in an effective and accessible primary care sector, and a concerted campaign to ensure that patients make an informed and appropriate decision to access healthcare, for example, pharmacy, GP and 111, rather than ringing 999 and visiting their local accident and emergency department.
7. There is no 'one size fits all' and different places have geographic and demographic constraints that cannot be met through adopting the same approach across the country. STPs need to recognise and reflect the divergent needs of these populations and ensure that the payment mechanisms do more to recognise them.
8. Tackling many of the above factors form part of NHS England's Five year forward view, which is a sensible plan for the short to medium term. It effectively sets out the broad direction of travel for health services and was supported by our members. However finance directors do question how achievable the financial aspects of the *Forward view* are and the speed at which significant, transformational change can be delivered.

Resource issues, including funding, productivity, demand management and resource use

To what extent is the current funding envelope for the NHS realistic?

9. The current financial performance of NHS organisations show that the NHS is currently in the midst of a financial crisis. Many organisations, across all NHS sectors and in all parts of the country, do not have the funding they require to deliver their services. At the end of 2015/16 NHS trusts and foundation trusts reported a combined deficit for the year of £2,447million. The deficit would have been larger had it not been for some non-recurrent measures that were taken to reduce the overspend including a number within the commissioning sector. The 2015/16 deficit was three times larger than the deficit reported at the end of 2014/15 and marked a sharp decline in the state of NHS provider finances.
10. Three months into the 2016/17 financial year the overall deficit was £461m, £5m better than planned. This is an improvement from the quarter 1 position in 2015/16 of a £930 million deficit. However, this was only achieved with support from the sustainability and transformation fund (£1.8 billion for the full financial year), so in reality the underlying financial position facing providers is similar to that in 2015/16. NHS finance directors have made it clear in HFMA's regular *NHS financial temperature check*⁶⁴⁸ surveys that this cannot be allowed to continue. Providers are clearly living beyond their means in terms of the funding envelope being made available to them for the services they are required to provide.
11. Looking further ahead, NHS finance directors have strong reservations about whether the estimated efficiency requirement set out in the NHS five year forward view is realistic and whether the STPs currently being developed will deliver what is expected of them. Finance directors are positive about STPs being the right way to achieve the objectives of the Forward view, but are under no illusions about the scale of the challenge and are sceptical about whether the £22 billion of savings identified in the Forward view is achievable. While STPs are generally supported they are unlikely to solve all the issues, but providers and commissioners recognise working together to solve some of the issues on a wider basis than the traditional organisation focus is a positive step.
12. At the end of 2015 the HFMA asked finance directors to rank possible actions that would enable the NHS to return to financial stability while maintaining the current range of services and the required quality standards. The majority of finance directors in our sample (66%) ranked more government funding for health and social care, beyond that already promised as most important. The least palatable option for finance directors was the NHS ceasing to provide universal care regardless of ability to pay, for example by the introduction of increased forms of co-payments. If no extra government funding over that outlined in the Forward View is made available, finance directors were clear that the NHS would have to provide fewer, high quality services that are affordable within the resources available rather than continuing to live beyond its means, which it is currently doing.
13. The HFMA is of the opinion that now is the time for an open and honest public debate to identify whether there is an appetite for higher taxes to pay for the NHS and if not, what level and range of universal care should be provided. Currently the NHS is struggling to meet the demands being placed on it and local NHS organisations are

⁶⁴⁸ Healthcare Financial Management Association, *NHS financial temperature check: finance directors' views on the financial challenges facing the English NHS*, July 2016

struggling to balance their books. If demand for NHS services continues to increase, the pressure will continue to build. Already our members – and other healthcare managers – find themselves with the seemingly impossible task of cutting costs while activity increases. This position is not sustainable.

14. To inform a debate about the level to which the NHS should be funded and what level of access should be provided it would be helpful to consider the percentage of GDP spent on health in the UK compared to other developed nations. The Organisation for Economic Cooperation and Development (OECD) health data for 2015 shows that during 2013, the United Kingdom spent 8.5% of gross domestic product (GDP) on health⁶⁴⁹. This compared with an average across the 30 OECD countries of 8.9%. The share of the economy allocated to health spending is similar to Finland and Italy, but well below the levels of France and Germany (10.9% and 11.0% respectively). According to the OECD, per capita spending on health in the UK in 2013 was below the level in 2009, when adjusted for inflation. In our view it would be helpful for the government to commit to a fixed percentage of GDP to fund the NHS during a spending review period.
15. Finance directors are not saying that there is no scope for improving efficiency in the NHS. The Carter report identifies that there is room for improved efficiency in the way services are provided. We would also welcome its roll out to mental health providers as soon as possible, as the focus to date has been on acute hospitals. However, there need to be realistic expectations as to what extent improved efficiency will solve the funding needs of the NHS over the medium to long term. In our opinion, efficiency requirements, particularly on NHS providers have been set at too high and unrealistic levels over recent years.
16. Clarity around social care costs and who should be paying for what is required. A recent study by the King's Fund and the Nuffield Trust⁶⁵⁰ revealed that social care funding and reductions in the number of people being able to access social care have reduced by 25% and 26% respectively. Finance directors have reported to us that this reduction in both the amount of social care funding and the range of social care services being offered has had a direct knock on effect to the NHS due to increasing numbers of delayed discharges. This occurs where a patient is deemed to no longer require inpatient healthcare, but cannot leave the hospital until an appropriate care package is in place. This is particularly an issue for areas of the country with an elderly population. Cost pressures on NHS budgets have also arisen from increases in activity due to patients being admitted to hospitals when there are inadequate out of hospital services available.

Workforce

What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long-term needs of the NHS?

How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

⁶⁴⁹ OECD, *How does health spending in the United Kingdom compare?: OECD health statistics 2015*, July 2015

⁶⁵⁰ The King's Fund and Nuffield Trust, *Social care for older people: home truths*, September 2016

17. Analysis of the current NHS provider overspend shows that one of the major cost pressures they face is due to an undersupply of appropriately qualified staff which has led to high level of vacancies and an increase in the agency bill at premium and excess rates of pay.
18. Our members have stated that workforce costs could be lowered through a better recruitment model and through the operation of an oversupply of workforce model.
19. A review is needed on how doctors are educated and trained in the UK, how this is funded and what can be done to prevent newly qualified doctors moving to work abroad or in the private sector. Some of our members have suggested that consideration should be given to a wider loans based system paying for medical student training. These loans could then be eroded after a period of time spent working within the UK healthcare system. This would avoid the current problem of doctors being trained at significant expense to the UK taxpayer, only to see them go on to work outside of the NHS.
20. Service models, particularly out of hours services, need to be fundamentally reviewed to determine whether they are operationally sustainable from a workforce point of view. If not, options for changing the way these services are provided needs to be explored, such as the consolidation of services over a wider geographic footprint. This may mean that fewer services are provided locally, because it is not clinically and operationally sustainable to do so.
21. Finally, there needs to be an exploration of the make-up of the workforce in terms of specialists versus general lists who can operate across a number of different care settings. Getting this balance right will be essential in ensuring that the NHS develops a workforce with the necessary skills and ability to be adaptable to meet current and future needs.

23 September 2016

Health Education England – Written evidence (NHS0122)

Executive summary

1. The successful delivery of NHS services in an efficient manner depends on having sufficient staff available in the right place at the right time, with the right skills, knowledge, behaviours and values.
2. Health Education England (HEE) plans training commissions to ensure sufficient supply of professionals in the future workforce, and works with professional bodies and Higher Education Institutions (HEIs) to develop curricula which ensure which they have the right knowledge and skills.
3. The current workforce makes up the vast majority of the future workforce. HEE supports NHS providers in discharging their organisational responsibilities for the ongoing development of their staff – ensuring the skills and knowledge which will be needed for the delivery of the future NHS are imparted to the current workforce
4. As the system delivers the Five Year Forward View (FYFV) and moves towards a place based model for commissioning and delivering health and care services HEE will support local health systems in transforming the way they deliver care through Local Workforce Action Boards (LWABs) which will discuss all workforce matters, current and future, to seek common solutions locally and nationally.
5. Delivering these changes will not only require new models of delivering care, but will require staff of the NHS to not only develop new skills and competencies – but to change their behaviours and the way they work as individuals and teams.
6. The change to how the health and care is delivered identified in the Five Year Forward View will need to be built on after 2020 and viewed as setting a direction of travel rather than a time limited programme of work.

The future delivery of the National Health Service

7. The FYFV stated that the long term sustainability of the NHS will be dependent on a radical transformation in the way services are delivered, and the engagement of the general population in taking responsibility for their own wellbeing and prevention of ill-health.
8. Services, and therefore the workforce, must evolve to cross traditional barriers; working and learning in multidisciplinary teams, removing barriers between primary, community and acute care and between physical and mental health services. While the FYFV expressed this in terms of bridging the immediate challenge presented before 2020, these changes will need to continue through the coming decades if the NHS is to both remain financially sustainable and improve the experiences and outcomes of patients.

9. Successfully implementing and then continuing with the changes laid out in the FYFV over the long term is dependent on a variety of factors, including: the level of funding the health service as a whole receives from central government, the ability of the NHS to use new technology, the design and uptake of new roles – whether delivered through Continual Professional Development (CPD) or as wholly new professions/groups, or alternative entry routes into existing professions. All these can help the NHS realise the necessary productivity and efficiency gains to deliver the FYFV.
10. The challenges facing the system require a joined-up approach and increased partnership between national bodies. HEE continue to be committed to working closely with the NHS England, NHS Improvement, CQC, and other partners, at national, regional and local levels.
11. While national leadership of this programme of work will be of critical importance, the changes which are needed will always be delivered by the staff. HEE will work with NHS providers to supporting them their work in ensuring their development of new skills, behaviours, and competencies to meet these challenges.
12. As part of the implementation of the FYFV the NHS is moving toward a place based model for designing, commissioning, and delivering healthcare over the medium term. This will help the NHS remove inefficiencies and duplication in the delivery of healthcare and ensure the resources available are utilised efficiently in delivering health and care services for the population. The mechanisms for aligning NHS organisations behind this goal are the Sustainability and Transformation Plans (STPs) which will support the providers and commissioners of NHS services in specific geographies in moving from an organisational to a place based perspective.
13. HEE is supporting the STP process through creating LWABs which will help STP footprints in: current workforce design and transformation, planning their future workforce, as well as addressing wider workforce issues including localised pay and pensions questions. Included in this offer will be designing and implementing new workforce roles, new models of delivering training – including apprenticeships - to ensure the future supply of appropriately trained and skilled staff, in the right numbers, in the right place.

The role of Health Education England

14. HEE exists to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right skills, values and behaviours, and is available in the right numbers, at the right time and in the right place.
15. HEE does this by;
 - a. Directly commissioning the training numbers for some professions, including post-graduate medical training,

- b. Taking action where supply is at risk ensure sufficient supply of professions not commissioned directly by HEE,
- c. Supporting the delivery, and ensuring the quality, of clinical placements for health courses,
- d. Supporting employers in delivering their responsibility for learning and development of of the current workforce, either through local funding commitments, or national programmes such as e-learning for health,
- e. Developing and improving the data on workforce supply and demand to support the NHS system,
- f. Supporting local workforce planning and the delivery of change and improvement through the Local Workforce Action Boards, and local involvement in the Sustainability and Transformation Planning process.

Future Workforce Supply

Planning

16. Workforce planning is necessarily a long term activity given the lead times for training healthcare professionals. Most non-medical undergraduate courses leading to a registrable qualification are for a period of three years. For the medical consultant workforce, five years of undergraduate medical education followed by an additional seven to ten years of post-graduate specialist training are required to become a consultant, meaning planning takes place over a twelve year timeline.
17. As example of this lead time, since its establishment in 2013 HEE has increased the numbers of student nurses in training each year (a cumulative increase of 2732 or 14% between 2013 and 2016 commissions) – however the year the first of those increased training commissions enter the system as registered nurses to provide service will be 2017.
18. LWABs will allow local STP footprints to take a holistic, place based view, of their future workforce requirements and feed this into HEE's workforce planning process, ensuring that local workforce needs across a geography are reflected in the planning process rather than a provider-centric approach which may not have always reflect the need for a workforce to deliver health and care to the whole population and for specialists.
19. National aggregation of the STP workforce plans will continue to be supplemented by strategic planning for national priorities such as for clinical scientists and other specialist professions. Many of these may work outside the health system but are essential for the continued development of new medicines, treatments, technologies, and for the continued success of industries such as bio-technology and genomics.
20. Given the lead times extend beyond the initial focus of the STPs, HEE will continue to plan national numbers for post-graduate medical specialty training – ensuring a sufficient supply of Consultants in the specialties needed by the future NHS. Responding the Five Year Forward View, the numbers of placements in both General Practice, Clinical Psychology have reflected the long term ambitions to realise parity of esteem

between physical and mental health, as well as deliver more treatment into the community to benefit patients.

21. HEE's commissioning decisions will continue to provide the basis for secure future supply of clinical staff for the NHS. However, the majority of the workforce of the future is, in reality, the trainees and current workforce of today. The performance of the wider health and care system in making employment offers which are attractive to trainees and valuing and keeping its existing staff will continue to be of equal importance to the future supply levels.

New routes into education and training

22. For the majority of the non-medical workforce (Nurses, Midwives, and Allied Health Professionals (AHPs)) the reforms announced in the Comprehensive Spending Review (CSR) in 2015 will lead to significant changes in the way health education funding is provided, this will mean that from 1 August 2017;

- a. New students in England on nursing, midwifery and AHP pre-registration courses who currently have access to NHS bursaries will instead have access to the standard student support package of tuition fee loans and support for living costs.
- b. The cap on the number of students places will be abolished allowing universities and other Higher Education Institutions (HEIs) to increase the number of places on offer – increasing the total supply of these health professionals available to the NHS and social care sectors over the long term,
- c. HEE will continue leading on funding the minimum numbers of clinical placements identified through workforce planning, in the right geographies, and ensuring their quality through its quality framework

23. To supplement these reforms HEE is working with NHS providers and HEIs to design and develop new 'apprenticeship standards' which will allow individuals to earn, and provide service in the NHS, while gaining qualifications equivalent to academic qualifications up to degree level – including the development of an apprenticeship route into nursing. In the long term these will provide a cost effective way for NHS providers to produce workforce locally – as well as an alternative route into health and care professions for individuals for whom full time study at an academic institution is not the right option, as well as ensuring the future workforce is as diverse as possible by supporting the widening participation agenda.

New professions

24. One of the key ways HEE will support the NHS in sustainably delivering health and care services in the future will be developing and promoting new professions to support the existing workforce. This will free up their time to work at the higher end of their scope of practice, skill set, and training. These new roles will be key in efficiently delivering health and care services as NHS staff working at the lower end of their scope of practice unnecessarily represents an inefficient use of their time and skills.

25. An example of this is the Nursing/Nurse Associate (NA) which is currently being developed to provide a support role to the registered nurse and bridge the gap the role of a Registered Nurse and role of a Health Care Assistant (HCA). While the NA's scope of practice is currently being developed it is anticipated that they will be able to do many of the clinical tasks at the lower end of a nurse's scope of practice – for example possibly dispensing drugs, but not prescribing them, in addition to providing care to patients.
26. Physician's Associates (PAs) while not doctors work to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and /or general practice team under defined levels of supervision. Early take up shows them emerging as a key part of the future multi-disciplinary, multi-skilled, non-doctor workforce in the UK. In the future, increased use of PAs in clinical settings will free up the time of medics and advanced practitioners to work at the higher end of their scope of practice.

Future Skills

27. The development of new technology, diagnostics, medicines, and treatments will be key in ensuring the NHS is able to be sustainable in the future. HEE will continue to work with NHS providers, professional bodies and regulators, and HEIs, to ensure that training programmes of today help the future workforce develop the skills they will need tomorrow to utilise them. As well as ensuring the future workforce has these skills we will continue to support providers in ensuring the current workforce receives the CPD required to develop these same skills.
28. A good example of this is the work HEE has undertaken to improve the skills and knowledge of the NHS workforce in relation to genomics. Health Education England has developed a Genomics Education Programme for both specialist scientific staff and front line clinicians. This includes a full or part time dedicated Masters programme in Genomic Medicine, as well as modular training opportunities which will enable the wider workforce to develop new knowledge and skills as part of their continuing professional development. Ten HEIs have been appointed as preferred providers to deliver this training and the first programmes were available for NHS staff to take up from the spring of 2016.
29. HEE is also commissioning new training programmes at higher specialist scientific level in clinical bioinformatics, genetics, and molecular pathology which will prepare the scientific workforce for new technological developments and develop the scientific and research capability of the NHS.
30. HEE is leading the Building a Digital-Ready Workforce programme on behalf of the National Information Board to support the upskilling of all staff in health and social care with the digital skills delivery of healthcare will require in the future. The establishment of two umbrella professional bodies – the Faculty of Clinical Informatics and the Federation for Informatics professionals, to identify, empower and professionalise informaticians with digital skills in health and care organisations. This will be supported by a strand of work to support behavioural changes of the leadership at the top of health

and care organisations, and work to ensure the digital literacy of all current and future staff which will be delivered through health and care professional groups, e.g. nurses, doctors, AHPs, social workers and non-clinical professions.

The effect of 'brexit' on workforce supply

31. Quantifying the real impact of leaving the European Union (EU) on the supply of clinical staff to the NHS will remain difficult until a negotiated settlement has been reached between the UK and the member states of the EU.
32. The NHS has always needed to supplement domestic supply with people from across the globe. HEE are proud of this tradition and of HEE's role in supporting it. HEE supports the view that the delivery of high quality care is dependent on a workforce that feels valued and secure. It is understandable that some overseas staff, trainees and students might feel concerned at this time about the impact of the referendum outcome that Britain should leave the EU. As the negotiations continue it is important that overseas staff, trainees, and students' dedication and their contribution continue to be valued and appreciated by employers and – most importantly – the patients that use NHS services
33. The Prime minister has stated that the Government wants to protect the status of EEA nationals already living here, including those working in the NHS. She has also been made clear that the only circumstances in which that wouldn't be possible is if British citizens' rights to remain and work in European member states were not protected in return.
34. While not wanting to prejudge the outcome of the negotiations HEE would support the a negotiated settlement or development of any sensible migration system which continues to allow the NHS providers to recruit staff from the overseas where this is necessary to address short-term shortages for specific professions or specialties, as well as to address geographic mal-distribution of domestic supply.

Conclusion

35. HEE has, and will continue to, act to ensure that the system has access to the right numbers of staff, in the right place, with the right skills. This will involve working with HEIs to ensure curricula reflect the skills which will be required in the future (such as genomics), working the providers to ensure support is delivered to develop the current workforce, developing new professions, and new routes into existing professions.
36. HEE works to ensure a sufficient supply of the right staff, with the right skills, in the right place, for the delivery of healthcare in the future NHS, by directly commissioning some educational programmes, supporting HEIs in delivering others, and also supporting NHS institutions in their responsibility ensure their staff receive ongoing training and development throughout their careers.
37. The long-term sustainability of the NHS is dependent on a range of factors, many of which remain outside of the control of the individual institutions operating inside of it. However, even at the edges of horizon scanning, healthcare will essentially remain an

interaction between those people requiring care – and those people entrusted with providing it. NHS staff will remain the key to delivering the prevention, clinical interventions, and care - as well as the actions to make the service sustainable.

23 September 2016

The Health Foundation – Written evidence (NHS0172)

1.0 Executive summary

Overview

- 1.1 There is overwhelming and consistent support among the British public for the principles of the National Health Service.⁶⁵¹ But the NHS, in common with health systems internationally, faces serious challenges. Population needs are changing profoundly as more people live longer and with a rising number of long-term conditions, expectations and technological advances are expanding health care interventions and, in the wake of the great recession of 2008, funding growth has slowed substantially.
- 1.2 These challenges are significant. The NHS is seeking to address them over the coming few years through the vision set out in the NHS five year forward view (Forward View), published in October 2014.⁶⁵² The Forward View was widely welcomed and it was anticipated that full delivery of that plan would place the NHS in a much better position to face the future. Delivering the vision and funding set out in the Forward View is a necessary step towards a sustainable health care system but not a sufficient one. Beyond the Forward View, action will be needed to secure a high quality, sustainable health and care system for the 2020s.
- 1.3 A longer-term and more strategic approach is required across several areas to ensure sustainability. These areas include: public health and prevention (as well as action across the wider determinants of health), stable and sufficient funding for health and social care, transformation and improvement of health and social care, and the development of the NHS workforce.

Funding, resources and productivity

- 1.4 The current financial pressure on the NHS is unprecedented. Funding decisions made in the 2015 Comprehensive Spending Review (CSR) mean that the period from 2010/11 to 2020/21 will be the most austere decade in the NHS's history.⁶⁵³ Funding for the UK NHS as a share of national income will fall from an historic peak of 7.6% of GDP in 2009/10, to 7.4% in 2015/16, and an estimated 6.9% by 2019/20.⁶⁵⁴
- 1.5 After accounting for inflation and population growth, spend per head for the English NHS will be similar in 2020/21 to what it was in 2010/11, rising by an average of 0.2%

⁶⁵¹ Gershlick B, Charlesworth A, Taylor E. [Public attitudes to the NHS: An analysis of responses to questions in the British Social Attitudes Survey](#). Health Foundation, 2015.

⁶⁵² NHS England. [NHS five year forward view](#). NHS England, 2014.

⁶⁵³ Health Foundation, The King's Fund and the Nuffield Trust. [Impact of the 2015 Spending Review on health and social care](#). Health Foundation, The King's Fund and the Nuffield Trust, 2016.

⁶⁵⁴ Licchetta M, Stelmach M. [Fiscal sustainability analytical paper: fiscal sustainability and public spending on health](#). Office of Budget Responsibility, 2016.

a year in real terms.⁶⁵⁵ Pressures on NHS services other than population growth, such as ageing demographic and rising costs, must be met through improved efficiency. So the English NHS is aiming to achieve efficiency growth of 2-3% a year to unlock £22bn savings by 2020/21. One-third of these savings are expected to come from pay restraint.⁶⁵⁶

- 1.6 For the last two decades, the rise in health care spending in every country covered by the Organisation for Economic Co-operation and Development (OECD) has exceeded GDP growth, including the UK. Meeting financial pressures in the long-term will require sustained growth in efficiency, and additional funding at least in line with GDP growth. Neither of these are unrealistic assumptions based on historic trends. However, in the short term, funding for the NHS is likely to fall as a share of GDP up to 2019/20.
- 1.7 Recent projections by the Office for Budget Responsibility (OBR) estimate that UK NHS funding would need to rise to between 8.3% and 8.9% of GDP by 2030/31 to meet future costs, depending on the rate of growth in productivity as non-demographic pressures rise. Based on current prices this is worth an extra £86bn – £102bn respectively.⁶⁵⁷ This is equivalent to an annual increase of 4.4% to 5.1% a year (or 3.8% to 4.5% per head) in real terms after 2020/21 – significantly above current planned spending increases.
- 1.8 Projections of funding growth are largely affected by assumptions about the scale of wider cost pressures and the rate of productivity growth. If health service productivity grows in line with the trend rate of 2.2% productivity growth across the economy as a whole, and wider cost pressures are avoided, the OBR projects that funding could be as low as 7.4% of GDP in 2030/31.
- 1.9 The OBR's method, which is consistent with most national long-term projection models, assumes that as the UK national income (GDP) rises, society will prioritise improvements in health care in line with that growing wealth, even if this exceeds changing population needs. However this is not the case for the current decade, in which funding will fall as a share of GDP from 7.6% in 2009/10 to 6.9% in 2020/21.
- 1.10 An alternative approach, used by the Health Foundation, is to project direct demand pressures for different services separately⁶⁵⁸, at the person level where possible, taking into account: demographic change, increasing care for people with long-term conditions and rising costs (predominantly increases in pay). This provides an estimate of the minimum level of spending required to maintain the range and quality of current services, without allowing for increasing expectations as the country gets richer, or major new advancements in technology.

⁶⁵⁵ Health Foundation. [NHS finances outside the EU](#). Health Foundation, 2016.

⁶⁵⁶ NHS England [NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios](#). NHS England, 2016.

⁶⁵⁷ Licchetta M, Stelmach M. [Fiscal sustainability analytical paper: fiscal sustainability and public spending on health](#). Office of Budget Responsibility, 2016.

⁶⁵⁸ Services include inpatient, outpatient, A&E, GP attendances, mental health care, community care and prescribing.

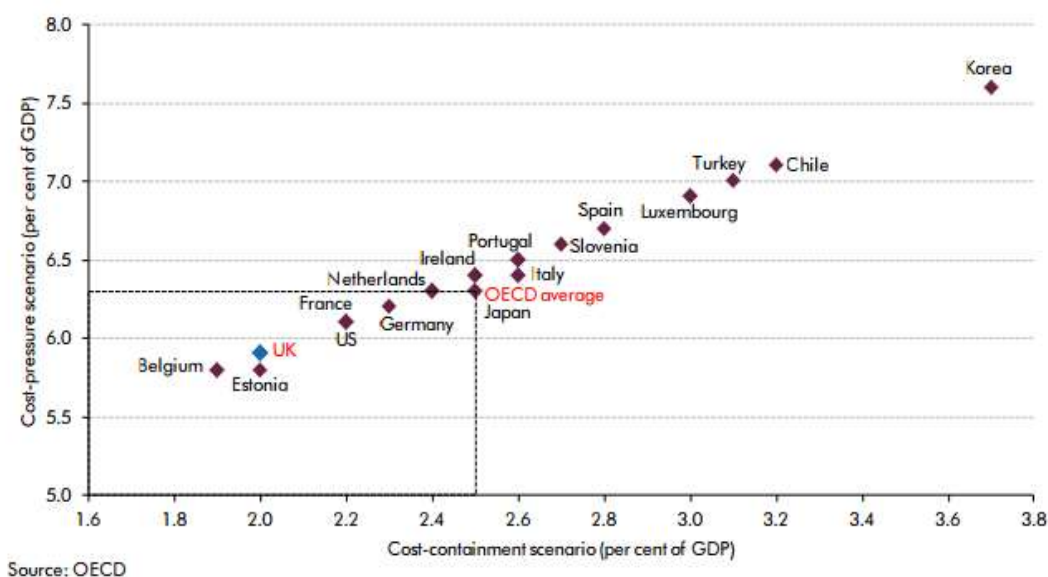
- 1.11 Our projections are also sensitive to the assumed productivity growth achieved by the NHS. With no growth in productivity, we estimate that UK NHS spending would need to rise to at least 8.1% of GDP in 2030/31⁶⁵⁹ to maintain the current range and quality of services. This would be an extra £80bn above 2015/16 spend (2016/17 prices). If productivity rises by 1% a year, close to the long-run trend for the NHS⁶⁶⁰ then UK spending would reach 7.4% of GDP by 2030/31, an extra £61bn. Maintaining the higher rate of productivity growth achieved more recently (1.5% a year)⁶⁶¹ would see spending rise to 7.1% of GDP, an extra £53bn on current spend.
- 1.12 The OBR and our model both show that spending will need to rise as a share of GDP after 2020/21, from 6.9% to between 7.1% and 8.9% by 2030/31. The range depends on assumptions for productivity growth, rising expectations and additional non-demographic pressures, predominantly from increasing relative health care costs and advances in technological innovation.
- 1.13 The OECD's research shows that all developed nations face similar pressures and, in fact, the UK is in a better position than many other countries. Figure 1 compares likely health spending increases for countries across the OECD on two scenarios. The cost-pressure scenario projects the percentage increases in GDP that would be required for health if no action is taken to address rising cost pressures in these countries, whereas the cost-containment scenario assumes some policy action to reduce these pressures. According to the OECD, public health spending in the UK and the US is projected to rise at a relatively similar rate, with the cost-pressure (high growth in spending) and cost-containment (low growth) scenarios coming in at below the OECD average for both countries. However, there remain differences between the UK and the US in the current level of spending as well as the funding mix. For example, total health spending in the US was nearly twice as large as a share of GDP in 2015 compared to the UK, whereas private spending was four times larger. This means that of the two systems, the UK is in a better position to increase the percentage of GDP it spends on health as it is starting from a lower base, with less spent on public health services and significantly less spent on private health care.

⁶⁵⁹ This assumes that pay rises in line with current [assumptions](#) – an average of 0.4% a year in real terms to 2020/21, and in line with the trend rate of 2% a year between 2020/21 and 2030/31

⁶⁶⁰ [Public Service Productivity Estimates: Healthcare 2013](#) (10 December 2015). Office of National Statistics (ONS)

⁶⁶¹ Bojke C, Castelli A, Grašić K, Howdon D, Street A. [Productivity of the English NHS: 2013/14 Update](#). Centre for Health Economics, University of York, 2016.

Figure 1: Change in age-related spending in the OECD (2010-2060)



1.14 The UK is neither a very low or very high spender on health according to OECD definitions. Using the internationally consistent measure of health spending for the UK as a whole (public and private), the UK devotes 9.9% of GDP to health. This is slightly above the OECD average of 9.0% and in line with the EU14 average of 9.8%. There is no evidence that changing the funding model for the NHS would reduce the cost pressures from health care which we need to address as a society.

1.15 In previous decades health funding has grown rapidly as governments have shifted public spending from areas considered to be lower priority (including defence and housing). As a result health spending is now £1 in every £5 of public spending and it is difficult to see how further increases above GDP growth could be absorbed by cuts to other services. It is therefore important that there is an inclusive and honest debate with the public about the cost of health care and the choice we face as a society. Namely, within the broad funding model of how we pay for our health and care as our population grows and ages, and the changes that need to be made to services to increase productivity and reduce avoidable demand. However health care is funded, and at whatever level, part of the problem which the NHS has faced for many years is uneven growth in funding – where there have been short-term funding cycles of boom and bust. This makes planning to meet changing needs very difficult and almost certainly undermines the drive to sustain improved efficiency. Delivering a more consistent rate of increase and providing clarity over the path of funding for longer time periods should be priorities.

Social care

1.16 The Committee is focused on the sustainability of the NHS. As the Forward View made clear, a high quality service is one in which patients' needs are addressed holistically. A sustainable health system needs a sustainable social care system. It is clear that the social care system is facing pressures which may require radical reform of its funding model. Reductions in spending since 2010 have led to fewer people

receiving the care they need, with the gap increasing by more for the more deprived areas of society.⁶⁶²

- 1.17 In the CSR, the government announced additional funding for social care through the Better Care Fund, reforms to local government finance and a new social care precept for council tax. Together these measures are likely to mean real-terms increases during this parliament. However, this funding is unlikely to keep up with demand and cost pressures, especially the impact of the new living wage. The Care Act 2014 sought to address one of the key weaknesses in the current system – the failure to protect people from catastrophic costs, but implementation has been delayed to at least 2020 because additional funding required to implement this policy has been difficult to find. As levels of unmet need rise and social care providers withdraw beds and services from the market, the NHS is likely to find it increasingly hard to refer, treat and discharge patients to the standard they've been used to. There is an urgent need to look again at social care funding – the current system no longer fulfils the principles of access, quality and solidarity in funding which the UK signed up to in health care, and which are also relevant to social care.

Workforce

- 1.18 Problems with the NHS workforce have been repeatedly highlighted in recent years. The UK NHS has staffing shortages and high vacancy rates in key professions. In addition, mounting agency costs are a large contributor to unprecedented budget deficits in the NHS provider sector. NHS workforce policy is fragmented⁶⁶³ and driven by short-termism. Mismatches between funding, staffing levels and policy aspirations – including repeated reorganisations – have led to inadequate planning and a 'boom and bust' approach to NHS front-line staffing.⁶⁶⁴ A long-term vision for the NHS workforce is needed, backed up by realistic and coherent planning of staff numbers. The vision should include not only numbers of staff needed (training and recruitment) but also retention and development issues such as working conditions, workplace culture, and pay as well as role development and training. Continued pay restraint, ongoing workforce shortages and the marked overreliance on temporary staff and international recruitment is not sustainable and is largely avoidable. Given the time it takes to train NHS professional staff, the health system needs to have a far more effective approach: an overarching workforce strategy which aligns all the key elements of workforce policy (flow of new staff, pay, retention, skill mix) with the needs of the service. The Health Service Journal recently reported that the Department of Health has begun work on such a strategy.⁶⁶⁵

Models of service delivery and integration

⁶⁶² Burchardt, T., Obolenskaya, P. and Vizard, P. (2015) [The Coalition's Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015](#).

⁶⁶³ Health Foundation [Fit for purpose: workforce policy in the English NHS](#). Health Foundation, 2016

⁶⁶⁴ Buchan J, Seccombe I, Charlesworth A. [Staffing matters; funding counts](#). Health Foundation, 2016.

⁶⁶⁵ Restell J. Exactly what we need in a workforce strategy. *Health Service Journal*, 14 September 2016. www.hsj.co.uk/topics/workforce/exactly-what-we-need-in-a-workforce-strategy/7010589.article

- 1.19 A sustainable NHS is one that continually learns, improves and adapts to ensure the delivery of high-quality health care for the population as a whole. Many changes needed to improve quality and productivity can only be seen at the front line, and must be discovered and addressed at this level. Policymakers and system leaders can help achieve this sustainability by not only securing the necessary resources, but supporting providers to develop the capacity, capability and culture needed to improve quality themselves, as well as giving them the time and headspace to do it. Again an effective workforce strategy would help develop staff to ‘discover’ improvement and innovations faster and design and implement changes better.

Digitisation of services, Big Data and informatics

- 1.20 Big data and digital technologies have the potential to significantly improve health and health care, but they are not a silver bullet to achieve an increasingly productive and higher quality NHS. Staff and patient engagement is fundamental to the success of new technologies and innovations, irrespective of how well these have worked in their original context. This takes time but is important if these innovations are to be successful.

Prevention

- 1.21 Health should be treated as a long-term social and economic asset that drives prosperity. The government should protect traditional public health spending and explore further ways to raise revenue for prevention, as well as safeguard the nation’s health through legislation. More widely, the government should acknowledge that health is determined by much more than health care. It should take a long-term approach, ensuring a focus on health in all policy areas to protect and improve the population’s health.

2.0 About the Health Foundation

- 2.1 The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

3.0 Defining sustainability

- 3.1 Health care is very complex, and the most challenging area in the public sector to contain expenditure. Over the last 20 years, health spending in countries across the OECD, has grown at a faster rate than GDP and most health care spending is publicly funded.⁶⁶⁶ The OECD average spending on health has grown from 7.0% to 9.0% of GDP over that period, and has doubled from 4.6% of GDP in 1970.
- 3.2 Over the next 15 years, the rising demand for, and cost of, health care is likely to see it take an increasing proportion of GDP and government spending in many countries worldwide. Therefore, to be sustainable, health systems need to continue to achieve the best value and adapt to meet the future needs of their populations – without compromising wider public spending.

⁶⁶⁶ OECD. [Fiscal sustainability of health systems: bridging health and finance perspectives](#). OECD 2015.

- 3.3 In 2006 the Council of the European Union issued a statement on common values and principles for health systems in the European Union (EU). These were: universal coverage, solidarity in financing, equity of access and the provision of high-quality care.⁶⁶⁷ Following the great recession in 2008, the challenge facing all health systems in the EU is to ensure financial stability without undermining these core values.
- 3.4 The challenge for governments and system leaders is to ensure that health and care systems deliver the best value for money, and that any increases in health spending do not undermine the long-term sustainability of public spending. The OECD recommends that countries adopt and strengthen governance frameworks and policies that enable them to define their fiscal sustainability challenges, identify the risks to fiscal sustainability of their health and care system and innovate to ensure greater sustainability.⁶⁶⁸ The redistribution of resources is a fundamental aspect of all publicly funded health and care systems – for example from higher to lower rate taxpayers, from the healthiest to those with particular health needs, from those in employment to those not. Where health spending is concerned, the key question for any society is what level of redistribution the public considers to be appropriate.⁶⁶⁹
- 3.5 The International Monetary Fund has concluded that stabilising public spending in relation to GDP is an important aspect of any plans to reduce high levels of public debt; this includes containing growth in health spending. However, the decision to meet rising demand for health and care by reducing other areas of public spending is a political choice, although reforms to improve efficiency can help.⁶⁷⁰

4.0 Resource issues, including funding, productivity, demand management and resource use

What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care?

- 4.1 There is overwhelming support among the British public for a national health system that is tax-funded, free at the point of use and provides comprehensive care to all citizens.⁶⁷¹ While other models for funding services exist, there is no clear evidence to suggest that changing the model for the NHS would lead to better value. For example, it has been suggested that adopting social health insurance models may lead to higher spending and lower employment without significant improvements in quality.⁶⁷² OECD analysis found that,

⁶⁶⁷ Council of the European Union. [Council Conclusions on Common values and principles in European Union Health Systems](#). Official Journal of the European Union, 2006.

⁶⁶⁸ OECD. [Fiscal sustainability of health systems: bridging health and finance perspectives](#). OECD 2015.

⁶⁶⁹ OECD. [Fiscal sustainability of health systems: bridging health and finance perspectives](#). OECD 2015.

⁶⁷⁰ International Monetary Fund. [Macro-fiscal implications of health care reform in advanced and emerging economies](#). International Monetary Fund, 2010.

⁶⁷¹ Gershlick B, Charlesworth A, Taylor E. [Public attitudes to the NHS: An analysis of responses to questions in the British Social Attitudes Survey](#). Health Foundation, 2015.

⁶⁷² Wagstaff A. [Social health insurance vs tax-financed health systems: evidence from the OECD](#). World Bank, 2009.

‘there is room in all countries surveyed to improve the effectiveness of health care spending; there is no health care system that performs systematically better in delivering cost-effective health care. Big bang reforms are therefore not warranted; increasing the coherence of policy settings, by adopting best policy practices within a similar system and borrowing the most appropriate elements from other systems will likely be more practical and effective to raise health care spending efficiency.’⁶⁷³

- 4.2 With pressures on health spending rising each year from a growing and ageing population, increasing costs and rising prevalence of certain long-term conditions, the NHS will need more money to meet future demand without reducing quality.⁶⁷⁴ But how much money will depend on the efficiency of the system and the value generated in terms of health outcomes – the effectiveness of the system. Ensuring that health policy and practice is well aligned to the goals of improving system efficiency and effectiveness is key to sustainability.
- 4.3 The OBR is responsible for producing regular projections of the UK’s overall fiscal sustainability, including projections of health spending pressures. In the standard projection of their recent update⁶⁷⁵ the OBR suggests that NHS spending for the UK would need to grow as a share of GDP from 6.9% of GDP in 2019/20, based on current spending plans, to a minimum of 7.6% of GDP by 2030/31 to keep pace with demand and cost. This would be an extra £67bn for the UK NHS compared to 2015/16 (2016/17 prices). However, the OBR acknowledges that it is optimistic to expect the NHS’s productivity growth to match the 2.2% of growth forecast for the economy as a whole, given recent trends.
- 4.4 If, instead of assuming NHS productivity rises in line with whole economy productivity, they assume it rises in line with health sector productivity of 1.2% a year, then health spending would need to rise to 8.3% of GDP by 2030/31. This is an extra £86bn compared to 2015/16.
- 4.5 In another scenario, the OBR models additional non-demographic cost pressures, predominantly from increasing relative health care costs and advances in technological innovation. NHS England estimates that non-demographic pressures rise by around 2.7% a year for primary care and 1.2% for secondary care (cash terms).⁶⁷⁶ Adopting these scenarios, the OBR estimates that health spending would need to rise to 8.9% of GDP in 2030/31, £102bn more than 2015/16. However, if there is a form of cost containment over this period⁶⁷⁷ the OBR estimates that health

⁶⁷³ Journard I, Andre C, Nicq C. [Health care systems: efficiency and institutions](#). OECD 2010

⁶⁷⁴ Roberts A, Thompson S, Charlesworth A, Gershlick B, Stirling A. [Filling the gap: Tax and fiscal options for a sustainable UK health and social care system](#). Health Foundation, 2015.

⁶⁷⁵ Office for Budget Responsibility. [Fiscal sustainability analytical paper. September update](#). Office for Budget Responsibility, 2016

⁶⁷⁶ NHS England. NHS [Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios](#). NHS England, 2016

⁶⁷⁷ To do this the OBR assume that the additional non-demographic cost pressures converge to 1% a year by 2060/61. This is in line with the approach taken by the US Congressional Budget Office (CBO).

spending would rise to 8.8% of GDP in 2030/31, £99bn more than in 2015/16 (Table 1).

- 4.6 The OBR method, consistent with most national long-term projection models, assumes an income elasticity of 1 for health care. This means that as a country’s wealth rises, it will continue to prioritise health care proportionately. Therefore, the assumption is that as national income (GDP) rises, society will prioritise improvements in health care in line with that growing wealth, even if this exceeds changing population needs. However this is not the case for this decade, where funding will fall as a share of GDP from 7.6% in 2009/10 to 6.9% in 2020/21, discussed later.

Table 1: Range of projections in UK NHS spending from Health Foundation and OBR.

Source	Assumption	% GDP in 2030/31	Average annual increase, 2020/21 to 2030/31	Average annual increase per head, 2020/21 to 2030/31	Estimated increase funding from 2015/16 (2016/17 prices)
Health Foundation ⁶⁷⁸	No productivity	8.1%	4.2%	3.6%	£80bn
	Productivity of 1.0% a year	7.4%	3.3%	2.7%	£61bn
	Productivity of 1.5% a year	7.1%	2.8%	2.2%	£53bn
OBR ⁶⁷⁹	OBR Central	7.6%	3.5%	2.9%	£67bn
	OBR Low productivity	8.3%	4.4%	3.8%	£86bn
	OBR Constant other pressures	8.9%	5.1%	4.5%	£102bn
	OBR Declining other pressures	8.8%	5.0%	4.4%	£99bn

- 4.7 Another option is directly to project demand pressures facing the NHS, using a ‘bottom-up’ approach. The Health Foundation model separately projects demand pressures for different services,⁶⁸⁰ at the person level where possible, due to demography, increasing care for people with long-term conditions and rising costs (predominantly increases in pay). The model provides an estimate of the minimum level of spending required to maintain the range and quality of current services, without allowing for increasing expectations as the country grows richer, or major new advancements in technology.

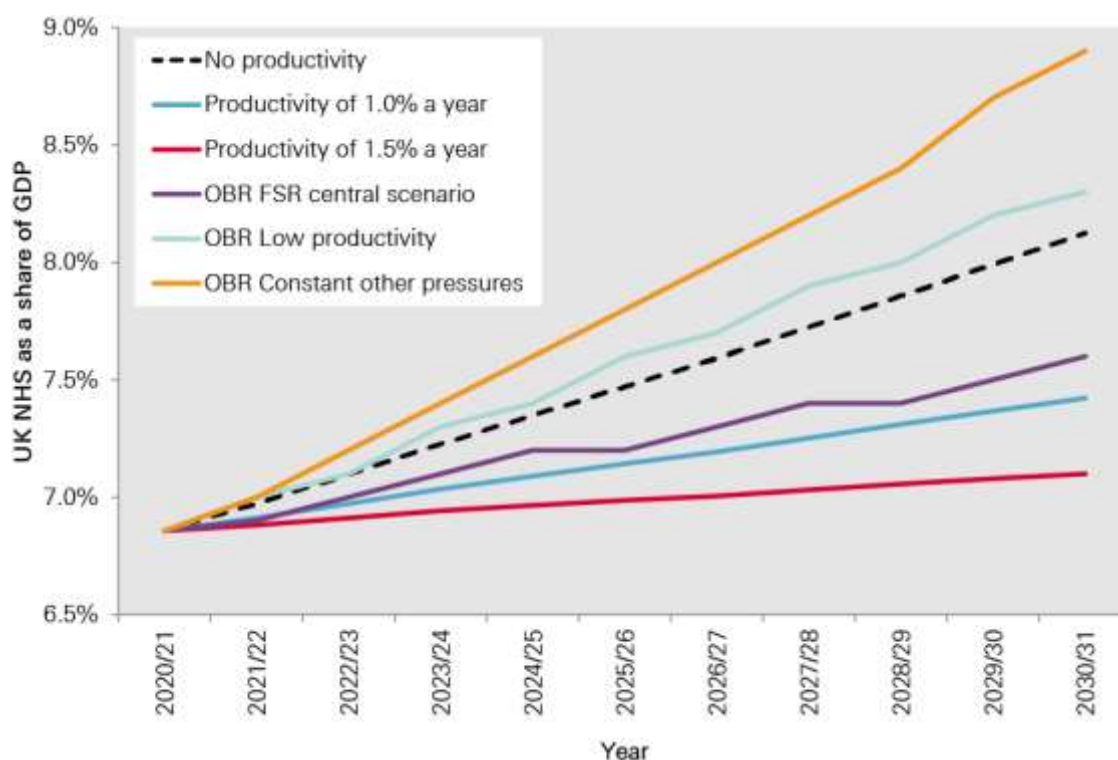
⁶⁷⁸ Health Foundation. [NHS finances outside the EU](#). Health Foundation, 2016.

⁶⁷⁹ Licchetta M, Stelmach M. [Fiscal sustainability analytical paper: fiscal sustainability and public spending on health](#). Office of Budget Responsibility, 2016.

⁶⁸⁰ Services include inpatient, outpatient, A&E, GP attendances, mental health care, community care and prescribing.

4.8 With no growth in productivity, we estimate that UK NHS spending would need to rise from 6.9% of GDP in 2015/16, to at least 8.1% in 2030/31⁶⁸¹ to maintain the current range and quality of services. This would be an extra £80bn above 2015/16 spend (2016/17 prices). If productivity rises by 1.0% a year, close to the long-run trend for the NHS,⁶⁸² then UK spending would reach 7.4% of GDP by 2030/31, an extra £61bn. Maintaining the higher rate of productivity growth achieved more recently (1.5% a year)⁶⁸³ would see spending rise to 7.1% of GDP, an extra £53bn on current spend.

Figure 2: Health spending scenarios for 2020/21 to 2030/31



Note: OBR FSR refers to the standard scenario of 2.2% productivity growth.

4.9 Both models show that spending will need to rise as a share of GDP after 2020/21, from 6.9% to between 7.1% and 8.9% by 2030/31. The range depends on assumptions for productivity growth, rising expectations and additional non-demographic pressures, predominantly from increasing relative health care costs and advances in technological innovation. If funding for the UK NHS rises to 8.9% of GDP by 2030/31 – as described in the OBR’s rising non-demographic cost scenario – this would mean an extra £100bn above 2015/16 spend. Around £60bn would be required to maintain the current range and quality of services (using HF model), the remaining £40bn would be to meet the costs of rising expectations and technological improvements (accounting for income elasticity and non-demographic costs).

⁶⁸¹ This assumes that pay rises in line with current assumptions an average of 0.4% a year in real terms to 2020/21, and in line with trend rate of 2% a year between 2020/21 and 2030/31

⁶⁸² [Public Service Productivity Estimates: Healthcare 2013](#) (10 December 2015). Office of National Statistics (ONS)

⁶⁸³ Bojke C, Castelli A, Grašić K, Howdon D, Street A. [Productivity of the English NHS: 2013/14 Update](#). Centre for Health Economics, University of York, 2016.

- 4.10 The NHS is not expensive when compared to other countries in Europe, but nor is it obviously a low spender. The UK has recently started contributing data on spending, which reflects the definition of health spending used by the new OECD System of Health Accounts 2011. This is a more comprehensive measure of health spending which is consistent with definitions in other countries. It is a UK- wide measure of public and private spending and includes long-term care services, focused on meeting health needs. Using this more comprehensive measure, the UK spent around 9.9% of GDP on total health care in 2014, lower than eight other countries in the EU-15 but slightly higher than average for the EU-14 (the EU-15 minus the UK). Even though the NHS accounts for the majority of the country's total health spend (with 80% of UK spending being government spending), the UK still spends less on public and compulsory⁶⁸⁴ health care as a percentage of GDP than six of the EU-15.
- 4.11 The new definition includes some (but not all) of social care spending. This, along with the addition of long-term care, explains most of why the 9.9% of GDP figure is higher than it has been in previous years. Under the old definition the figure would be 8.7% of GDP.

To what extent is the current funding envelope for the NHS realistic?

- 4.12 OBR and Health Foundation modelling both show that long-term fiscal sustainability of the NHS is likely to require additional funding above expected growth in GDP, as well as improvements in efficiency.⁶⁸⁵ However, as part of the government's priority to close the national fiscal deficit, funding for the UK NHS is currently growing at a slower rate than GDP (Figure 3). The share of GDP spend on the NHS has fallen from the historic peak of 7.6% in 2009/10 to 7.4% in 2015/16, and is expected to fall to 6.9% by 2019/20.⁶⁸⁶

⁶⁸⁴ Defined as government and compulsory health insurance schemes.

⁶⁸⁵ Health Foundation. [NHS finances outside the EU](#). Health Foundation, 2016.

⁶⁸⁶ Licchetta M, Stelmach M. [Fiscal sustainability analytical paper: fiscal sustainability and public spending on health](#). Office of Budget Responsibility, 2016.

Figure 3: Estimated public spending on health in the UK as a percentage of GDP, 2009/10 to 2020/21



Note: Planned spending for NHS England with resulting Barnett consequentials for Scotland, Wales and Northern Ireland. Source: OBR.

4.13 The 2015 Comprehensive Spending Review confirmed that 2010/11 to 2020/21 will be the most austere decade for the NHS in its history. After accounting for inflation and population growth, spend per head for the English NHS will be similar in 2020/21 to what it was in 2010/11 (Figure 4), rising by an average of 0.2% a year in real-terms. Pressures on NHS services other than population growth, such as ageing population and rising costs, must be met through improved efficiency. So the English NHS is aiming to achieve efficiency growth of 2–3% a year to deliver £22bn savings by 2020/21. One-third of these savings are expected to come from national pay restraint.⁶⁸⁷

⁶⁸⁷ NHS England [NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios](#). NHS England, 2016.

Figure 4: Annual change NHS spend per head in England, 2009/10 to 2020/21

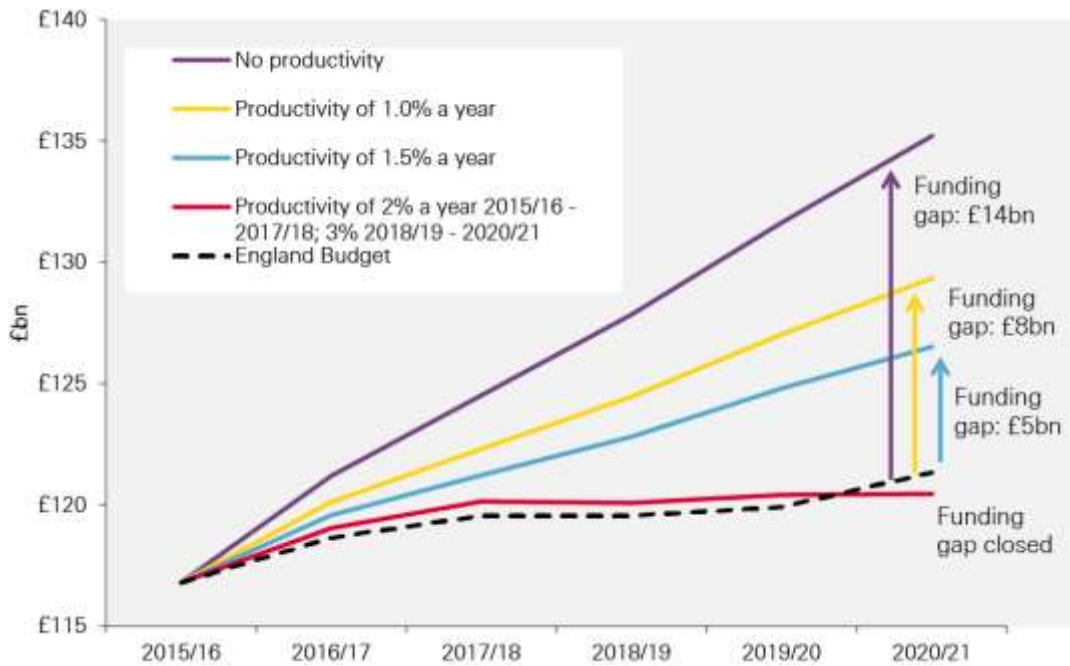


- 4.14 The lower funding has led to a focus on improving efficiency growth to protect the quality of services. However there are concerning signs that the NHS is struggling to meet these challenges. The financial position of NHS providers has rapidly declined from a surplus of £0.5bn in 2012/13 to a record net deficit of £2.5bn by the end of 2015/16. All parts of the NHS are struggling with system-wide pressures, resulting in 65% of NHS trusts and foundation trusts reporting a deficit by the end of 2015/16.
- 4.15 The pressures of an ageing population, rising chronic conditions and increasing costs mean there is an increasing gap between demand for NHS services and the funding available. The funding gap for the NHS in England by 2020/21 will depend on the level of efficiency growth that can be achieved. Based on the current planned budget and the Health Foundation’s projection model, with no improvement in NHS efficiency there would be a funding gap in 2020/21 of £14bn (Figure 5).⁶⁸⁸ However, if the NHS achieves the ambitious target of 2–3% efficiency growth set out in the Forward View, this funding gap would be almost closed by 2019/20 within the current budget. However, this would be well above the long-term trend for efficiency growth in the NHS – 1.2% since 1979/80. It would also mean reversing the trend of the past three years when productivity has declined.⁶⁸⁹

⁶⁸⁸ This assumes that the [current national pay policy](#) of average pay awards of 1% in cash terms between 2016/17 and 2020/21, with allowance for incremental drift and skill mix effects, with uplifts of 1.75% in 2016/17 to account for pension reform, and 0.4% in 2017/18 for the apprenticeship levy. See www.gov.uk/government/publications/economic-assumptions-201617-to-202021/economic-assumptions-201617-to-202021

⁶⁸⁹ Health Foundation. [NHS finances outside the EU](#). Health Foundation, 2016.

Figure 5: Funding gap scenarios, 2015/16 to 2020/21



4.16 Estimates of improvements in productivity across the NHS as a whole vary from an average of 0.9-1.4% per year (Table 2). However, our analysis shows that productivity of acute hospitals has risen at just 0.1% per year from 2009/10 to 2014/15. Some of the differences between our estimates of productivity growth and those found by Monitor and Deloitte, are due to the use of different inflation factors.⁶⁹⁰

⁶⁹⁰ Lafond S, Charlesworth A, Roberts A. [A perfect storm: an impossible climate for NHS providers' finances](#). Health Foundation, 2016.

Table 2: Estimates of annual average change in NHS productivity

	Scope	Annual average change
University of York, 2016 ⁶⁹¹	England, NHS wide Total Factor Productivity (TFP) with quality adjusted output, 2004/05 -2013/14	1.4%
ONS, 2015 ⁶⁹²	UK NHS Wide TFP with quality adjusted output, 1997-2013	0.9%
OBR, 2016 ⁶⁹³	Combined projection of Oliver 2005 and ONS, 1979-2013	1.2%
Deloitte, 2014 ⁶⁹⁴	English NHS acute hospitals efficiency frontier shift, 2008/09 -2012/13 1.2%	1.2%
The Health Foundation, 2016 ⁶⁹⁵	Acute Care in English NHS hospitals, 2009/10-2013/14	0.1%
Monitor, 2016 ⁶⁹⁶	English NHS acute hospitals 2008/09-2013/14	1.4%

4.17 There is significant scope for the NHS to improve productivity, as there are significant variations in performance across the provider and commissioning sector in both the care provided and the cost of delivery.⁶⁹⁷ The NHS Right Care programme has identified major variations in the care provided which is not based on need. Equally, the review of operational productivity led by Lord Carter of Coles has identified major variations in the cost of care. NHS Improvement’s analysis of hospital efficiency also found significant variations in performance. Narrowing the gap between efficiency of the best and the average would make a substantial contribution to the efficiency challenge in the Forward view. However, people working in the NHS need the capacity, capability and head space to identify and achieve recurrent or year-on-year efficiencies.

4.18 The UK’s decision to leave the EU means future funding is uncertain. The vast majority of economic forecasts expect economic growth to be lower following the UK’s departure from the EU. Other things being equal, this would mean less money for public spending, and potentially the NHS. Based on optimistic and pessimistic scenarios of economic growth following EU departure, we project that the funding gap by 2030/31 could increase to between £19bn and £28bn.

⁶⁹¹ Bojke C, Castelli A, Grašić K, Howdon D, Street A. [Productivity of the English NHS: 2013/14 Update](#). Centre for Health Economics, University of York, 2016.

⁶⁹² [Public Service Productivity Estimates: Healthcare 2013](#) (10 December 2015). Office of National Statistics (ONS)

⁶⁹³ Licchetta M, Stelmach M. [Fiscal sustainability analytical paper: fiscal sustainability and public spending on health](#). Office of Budget Responsibility, 2016.

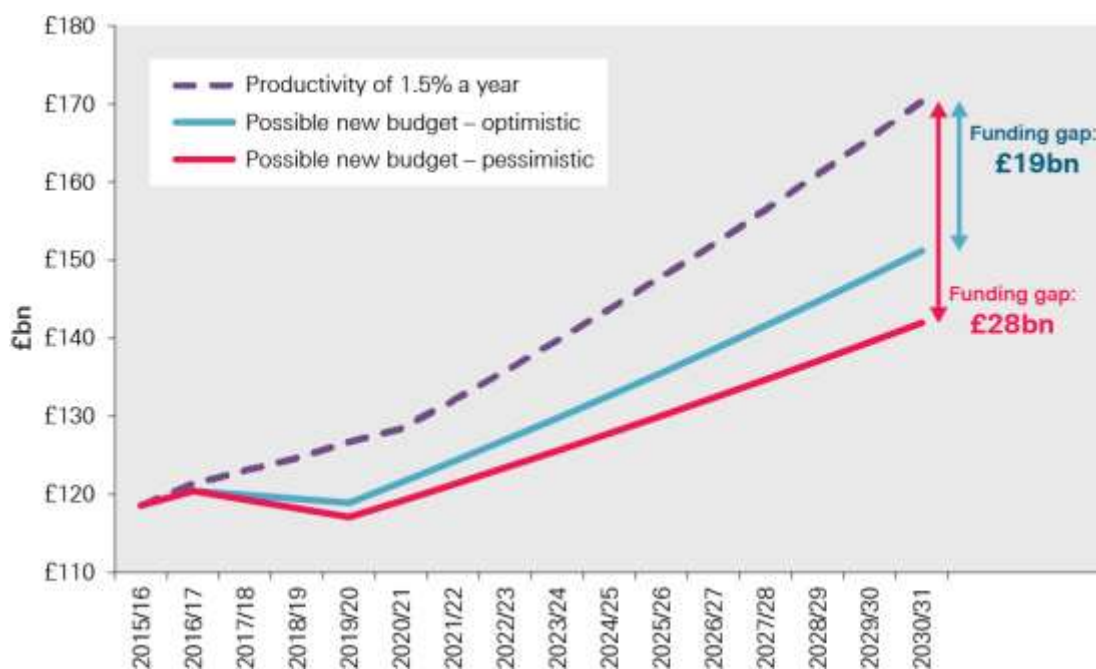
⁶⁹⁴ Deloitte. [Evidence for the 2015/16 national tariff efficiency factor. Final Report](#). Deloitte, 8 July 2014.

⁶⁹⁵ Lafond S, Charlesworth A, Roberts A. [A perfect storm: an impossible climate for NHS providers’ finances](#). Health Foundation, 2016.

⁶⁹⁶ Monitor. [2016/17 National Tariff Payment system: A consultation notice. Annex B5: Evidence on efficiency for the 2016/17 national tariff](#). Monitor, 2016.

⁶⁹⁷ Lafond S, Charlesworth A, Roberts A. [A perfect storm: an impossible climate for NHS providers’ finances](#). Health Foundation, 2016.

Figure 6: Funding gap scenarios for 2015/16 to 2030/31



4.19 To protect current funding plans for the health service, the government would need to extend the period of fiscal deficit, increase taxation and/or add further reductions to other areas of public spending. The need to bring public spending back into balance is understandable, but the impact of this choice on the NHS and wider health and social care system, and therefore the public who depend on these services, should not be underestimated.

What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

4.20 One option for filling the funding gap over the longer term is to pursue additional forms of revenue. Analysis from economists at the Health Foundation and IPPR examined the potential revenue raised from a one percentage point increase in a number of different tax rates.⁶⁹⁸ The estimated revenue raised by 2030/31 range considerably. For example, a one percentage point increase in the employers’ main rate of National Insurance would raise around £8bn by 2030/31 (current prices). Annex 1 examines the important issues to bear in mind with different tax options as a source of revenue to fund health care.

⁶⁹⁸ Roberts A, Thompson S, Charlesworth A, Gershlick B, Stirling A. [Filling the gap: Tax and fiscal options for a sustainable UK health and social care system](#). Health Foundation, 2015.

Table 3: Estimates of revenue raised from a one percentage point increase in key tax rates

	1 percentage point increase	£bn (16/17 prices)
Income Tax rates	Change basic rate	4.3
	Change higher rate	1.0
National insurance contributions rates	Change Class 1 employee main rate	3.8
	Change Class 1 employer rate	4.8
Sin taxes	Alcohol duties	0.1

Source: HMRC. Direct effects of illustrative changes (in 2018/19)

- 4.21 There are a number of different models for funding health care. Most developed countries opt for a system which is predominantly funded through taxation or social insurance.⁶⁹⁹ Each system has benefits and drawbacks. With tax-funded systems such as the NHS, long-term planning can be difficult as resources and priorities can change with successive governments and political preferences. Additionally the funding available can depend on the total fiscal budget which in turn depends on tax revenue raised, and so can be volatile in times of large scale economic shocks. While hypothecated taxes may increase funds when they are first introduced, they can limit the flexibility to protect health budgets in the future. An alternative approach might be to set a minimum level to the share of GDP spent on the NHS, similar to the levels set for national defence and foreign aid.
- 4.22 Ultimately, the funding available to health care depends how government adjusts its budget as a consequence of the context.⁷⁰⁰ Social insurance is a model of funding commonly used across Europe to fund health and social care. However, the challenge of this model is that payments are linked to employment. Demographic changes which lead to an ageing population place pressures on this model. Changes in the structure of labour markets with more self-employment and casual employment also make it harder to raise revenues from employment. More generally the concern with charges on employment is that they create a barrier to high employment. It is worth noting that many of the issues identified with social insurance would also apply to a hypothecated national insurance system.
- 4.23 There is no clear evidence that fundamentally changing the revenue raising model for the NHS would lead to better value. One study for the OECD showed that adopting social health insurance models may lead to higher spending and lower employment without significant improvements in quality.⁷⁰¹ How resources are effectively deployed appears to be a much more pertinent issue for long-term sustainability than how the resources are raised.

⁶⁹⁹ OECD. Financing of health care. In: [Health at a glance 2011: OECD Indicators](#). OECD, 2011.

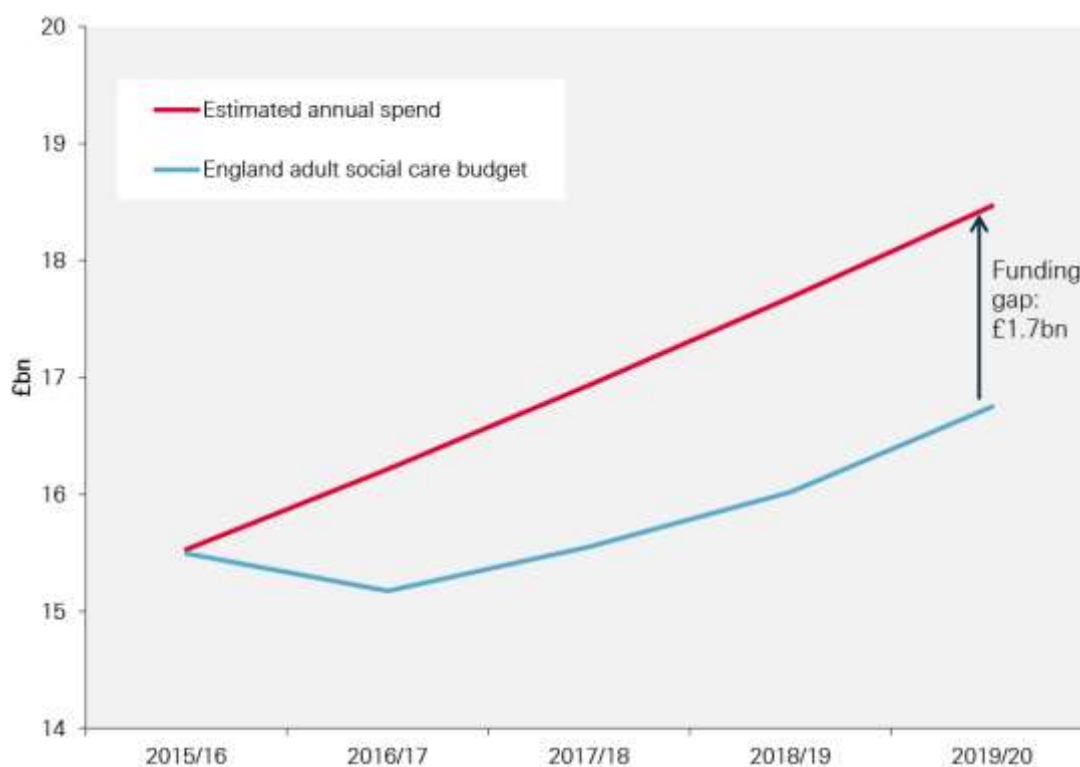
⁷⁰⁰ Doetinchem O. [Hypothecation of tax revenue for health](#). World Health Organization, 2010.

⁷⁰¹ Wagstaff A. [Social health insurance vs tax-financed health systems: evidence from the OECD](#). World Bank, 2009.

Social care spending pressures

4.24 Achieving fiscal sustainability for social care looks more challenging. Demand pressures are expected to rise by around 4% a year from an ageing population and the rising prevalence of long-term conditions. The new council tax precept is expected to raise up to £2bn by 2019/20, and new investment through the Better Care Fund has been announced, reaching an extra £1.5bn by 2019/20. But even with this there is likely to be a social care funding gap in 2019/20 of around £1.7bn. On top of this, many social care workers will be eligible for the new living wage, which is expected to increase total spending pressure by an extra £800m. This is before allowing for the economic impact of the UK’s decision to leave the EU.

Figure 7: Social care funding gap scenarios for 2015/16 to 2019/20



4.25 While NHS funding has remained relatively flat over the last parliament, overall spending on social care is estimated to have fallen by 2.2% a year between 2009/10 and 2014/15.⁷⁰² For example, by 2013/14, 17.4% less was being spent on services for people aged over 65. This is despite the number of people aged 65 and over increasing by 10.1% over the same period, and an 8.6% increase in the population aged 85 or over. Reductions in publicly-funded social care over the last five years have resulted in fewer people being able to access care and support, with older

⁷⁰² Health Foundation, The King’s Fund and the Nuffield Trust. [Impact of the 2015 Spending Review on health and social care](#). Health Foundation, The King’s Fund and the Nuffield Trust, 2016.

people on lower incomes experiencing the greatest levels of unmet need.⁷⁰³ There is a gap in the number of people needing help in Activities of Daily Living (ADLs) (eg eating, bathing, dressing) and the number of people receiving help with these activities. While the gap between needing and receiving help has halved for men with the highest incomes (from a 10 percentage point difference to just a 5 point difference), it has grown for both men and women with the lowest incomes (Figure 8). For women in the lowest third, the percentage of people needing help (36%) is three times that of people receiving help (12%).

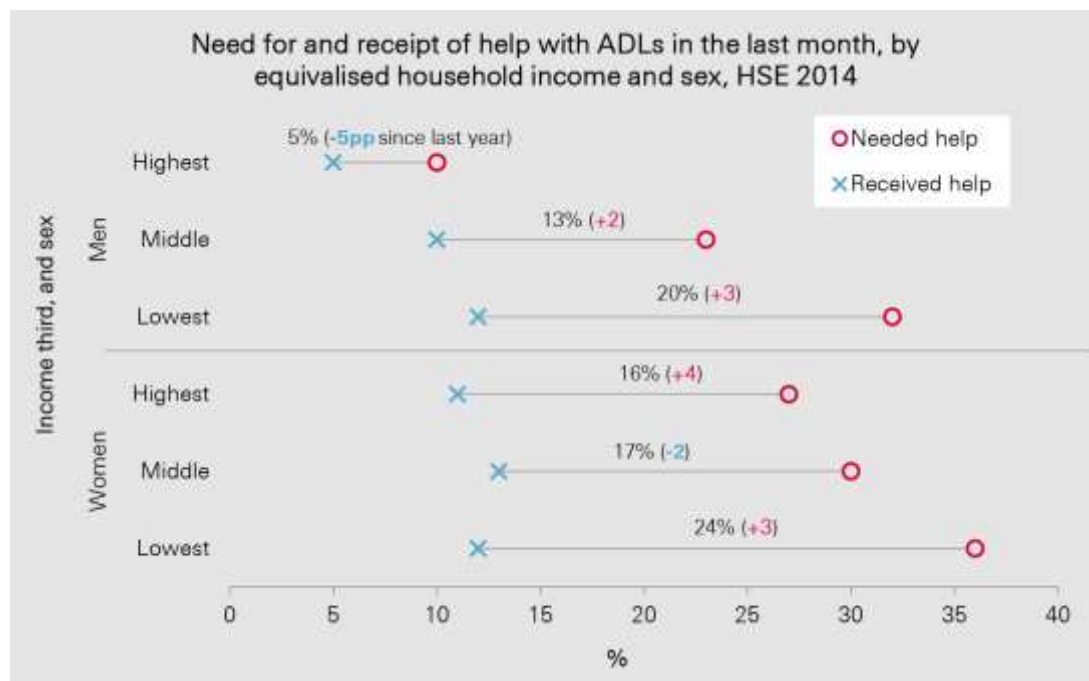
- 4.26 Plans to change funding arrangements for social care were announced in 2013, following recommendations by the Commission on Funding of Care and Support (the Dilnot Commission). Initially planned to be implemented in 2016, they were delayed until 2020 following concerns including its cost (expected to be £6bn over five years, and just over £1bn in 2019/20).^{704,705} Without these, or similar reforms to the social care system in England, it is hard to see how social care could be fiscally sustainable in the future.

⁷⁰³ Burchardt, T., Obolenskaya, P. and Vizard, P. (2015) [The Coalition's Record on Adult Social Care: Policy, Spending and Outcomes 2010-2015](#).

⁷⁰⁴ Jarrett T. [Social care: Announcement delaying introduction of funding reform \(including the cap\) and other changes until April 2020 \(England\)](#). Briefing paper, no 7265. House of Commons Library, 2015.

⁷⁰⁵ Department of Health. [Social care funding reform impact assessment](#). Department of Health, 2015.

Figure 8: Need for and receipt of health with Activities of Daily Living in the last month by equalised household income and sex



Source: Health Survey England 2014

Public health spending pressures

- 4.27 Despite the importance of public health and prevention in the Forward View, public health spending is set to fall by at least £600m in real terms by 2020/21, on top of £200m already cut from this year’s budget.⁷⁰⁶ This will affect a wide range of services including health visiting, sexual health and vaccinations. Funding for public health services is vital, but the impact of wider austerity measures on the population’s health is as yet unknown.
- 4.28 During the March 2016 budget, the government announced the introduction of a sugar tax. This is expected to raise £520m in its first year (2018/19), which will be ring-fenced for doubling school sports funding and providing breakfast clubs.⁷⁰⁷
- 4.29 More broadly, there needs to be much greater recognition of the impact of policy outside of health and social care on the health of the population, and a focus on a more holistic strategy to improve health for the long term. This should include action across the wider determinants of health including education, the environment, employment, housing and communities.

5.0 Models of service delivery and integration

⁷⁰⁶ Health Foundation, The King’s Fund and the Nuffield Trust. [Impact of the 2015 Spending Review on health and social care](#). Health Foundation, The King’s Fund and the Nuffield Trust, 2016.

⁷⁰⁷ HM Treasury. [Budget 2016](#). HM Treasury, 2016.

What are the practical changes required to provide the population with an integrated National Health and Care Service?

- 5.1 We support a vision of the future in which care is organised around the needs of people not services, giving patients more control of their own health and care, alongside a greater focus on preventing illness and maintaining good health so that people can contribute to social and economic prosperity. This has the potential both to improve patient experience and to increase the value for the taxpayer.
- 5.2 This vision is partly dependent on better integration of health and social care services – a view that is widely recognised. The government’s mandate to NHS England for 2016-17 sets out that there should be ‘better integration of health and social care in every area of the country’ by 2020. Similar aspirations are reflected in the multi-organisation care models envisaged in the Forward View and in the requirement for NHS commissioners and providers to develop longer-term system-wide plans across newly established ‘sustainability and transformation plan’ (STP) footprints.
- 5.3 Transformational change of the scale and complexity required to achieve this vision takes time and careful detailed management. It can only be achieved with the sustained support of, and commitment from, the NHS workforce, the public and political leaders.
- 5.4 The health and care system is intended to serve the population for the long term, but so much of what shapes it is short term – as highlighted by our recent work on quality in the English NHS.⁷⁰⁸ Transformational changes in the NHS – including the realisation of an integrated health and social care system – should move away from policy and operational planning that typically looks five years ahead at the very most – principally in line with the parliamentary cycle.
- 5.5 A more sustainable approach would be to develop a clear strategy for the next 10-15 years, which can accommodate inevitable and justifiable political priorities as well as aligning plans, actions and resources with longer-term goals. If leaders could be held to it, this could help break the cycle of constant change and the ensuing levels of change fatigue.

What role should national policy play in supporting the improvement and transformation of service delivery?

- 5.6 The focus of national policy should be to enable change towards sustainability, rather than unwittingly erecting barriers to it. Historically, there has been a greater emphasis on policy levers focused on ‘short-term payback’ rather than ‘longer term sustainability and progress’ – in particular developing the capacity, skills and resilience of NHS providers to improve and transform service delivery themselves over the medium-to-long term.⁷⁰⁹ For example, according to a recent evaluation,

⁷⁰⁸ Molloy A, Martin S, Gardner T, Leatherman S, [A clear road ahead: creating a coherent quality strategy for the English NHS](#). Health Foundation, 2016

⁷⁰⁹ Allcock C, Dormon F, Taunt R, Dixon J. [Constructive comfort: accelerating change in the NHS](#). Health Foundation, 2015.

participants in the Integrated Care Pioneers programme described a focus on short-term financially driven goals as all-consuming and a barrier to engaging in wider transformation efforts.⁷¹⁰ More detail is set out in Section 8 on learning health systems.

How can local organisations be incentivised to work together?

5.7 A more integrated system will require people across health and social care to work closely together, and any reforms should be considered a means to this end. Incentives can take a number of forms: regulatory; financial; performance management; and accountability for performance to the public and to professional peers through the publication of information on performance levers. It is important these are closely aligned with nationally-driven programmes aimed at promoting greater integration.

How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

5.8 If separate budgets act as a barrier to people working more closely together, then a single integrated budget – that aligns policies and levers to support closer ways of working – should be explored.

5.9 In order to prevent budget protectionism, an integrated budget for health and social care may need to be managed by a single integrated commissioner. Recent reforms, for example the Better Care Fund in England⁷¹¹ and in the NHS in Scotland,⁷¹² may shed light on whether an integrated budget can be administered jointly by NHS and local authority commissioners.

5.10 Three key questions arise when looking at how the integration of health and social care budgets should proceed:

- Should the extent of redistribution of resources between health and care vary from area to area or should there be a national framework for this? Current practice in England is unclear, not least in areas which have secured some kind of ‘devolution’ deal with NHS England⁷¹³.
- What form of democracy and accountability is required to ensure a fair and transparent redistribution of resources? Should this be determined locally or nationally?

⁷¹⁰ Erens, B, Wistow, G, Mounier-Jack, S, Douglas, N Jones, L, Manacorda, T and Mays, [Early evaluation of the Integrated Care and Support Pioneers Programme, Policy Innovation and Research Unit](#), Policy Innovation Research Unit, 2016

⁷¹¹ NHS England. [Better Care Fund Plan](#).

⁷¹² Scottish Government. [Health and Social Care Integration Narrative](#). June 2015

⁷¹³ Dormon F, Butcher H, Taunt R. [Catalyst or distraction? The evolution of devolution in the English NHS](#). Health Foundation, 2016.

- Can the fundamental difference between how people access health and care services (universality versus means-tested) be reconciled within an integrated budget?

5.11 For an integrated budget to work well, these kinds of questions would need to be worked through at a national level, in collaboration with local leaders and communities – for example, local authority representatives and those leading STPs and other major transformation programmes.

6.0 Workforce

6.1 Health care is a people business. The sustainability of the NHS is dependent on training, retaining and motivating sufficient numbers of appropriately skilled staff to deliver the service. Questions over levels of NHS funding, productivity and quality are inextricably linked to workforce policy – how the health service plans, trains, regulates, pays and supports its people. Yet workforce issues are typically an afterthought in policymaking when they should be front of mind.⁷¹⁴

6.2 The approach to workforce policy in the NHS is fragmented and in need of a coherent on-going national strategy, in which funding, workforce planning and policy are aligned. Achieving this will require government and national leaders across health and social care to develop a long-term vision for the NHS and social care workforce.

6.3 A long-term vision for the NHS workforce needs to be broader than just numbers of staff, training and recruitment. It should also address the development of staff, working conditions and workplace culture, as well as pay. A coherent and effective set of policies are essential to reward staff and incentivise the improvements in quality and productivity the NHS desperately needs.

What are the requirements of the future workforce going to be, and how can the supply of key groups of health care workers such as doctors, nurses, and other health care professionals and staff, be optimised for the long-term needs of the NHS?

6.4 Staff shortages present a major risk to the sustainability of the NHS. The Health and Social Care Information Centre's (now NHS Digital) latest workforce census reveals significant ongoing problems in the supply of NHS nurses – the largest professional group in the NHS workforce. There is an estimated shortfall of 7% in nursing numbers overall across England, with an increase of less than 1% in nursing staff over the last year. However, data on applications to university show that demand for student nurse places exceeds the supply of funded places. Recent reforms to student funding – the scrapping of bursaries covering the cost of training - have the potential to help reduce workforce shortages in key areas, particularly nursing. It will be important to ensure there is a sufficient supply of high-quality clinical placements and then to

⁷¹⁴ Health Foundation. [Fit for purpose? Workforce policy in the English NHS](#). Health Foundation, 2016.

monitor the impact closely to ensure that the decision to pass the financial burden onto prospective trainees does not reduce demand for training.⁷¹⁵

- 6.5 General practice is vital for the continuing care of the ageing population and people with long-term conditions, the fastest-growing areas of need. In contrast, primary care is facing major issues of GP recruitment and retention, as well as an ageing workforce, with one in five GPs aged 55 or older.⁷¹⁶
- 6.6 Staff costs are the biggest area of spending for NHS providers, accounting for 63% of total expenditure in 2014/15. Any change to staff costs will therefore have a substantive impact on the financial viability of NHS providers. The impact of staff shortages on the NHS's finances is illustrated by the increase in real terms spending on agency staff, which increased by 27% in 2014/15 alone – rising to £3.4bn from £2.7bn in 2013/14. Our analysis showed that a trust is more likely to have a worse financial position if a higher proportion of its staff spending is accounted for by agency staff.⁷¹⁷ Problems in staff shortages are not purely financial; in addition, the lack of a stable team may undermine efforts to improve the quality and productivity of care.
- 6.7 The use of temporary staff and international recruitment are vital components of a comprehensive approach to workforce supply, as they give local providers flexibility to respond to local variations in capacity and demand. However, they are not a sustainable or effective approach for addressing systemic workforce shortages of key staff groups.
- 6.8 About one in eight nurses working in the UK was trained in another country. The rate of internationally trained nurses has risen since 2009, with migration from EU countries accounting for most of the increase. The recent decision to leave the EU has implications for how the service will attract and retain European staff in the future.
- 6.9 At present, recruiting staff from overseas has been used as a quick, relatively cheap, fix for employers faced with the immediate pressure to fill vacancies. However, in the long term, there is a role for government in monitoring and moderating international recruitment, so it becomes a more integral part of a sustainable, long-term approach to the effective supply of health professionals for the NHS. Sustainable plans for the recruitment of foreign staff to fill shortages will require more effective coordination of different central government departments, including the Department of Health, the Home Office and the Treasury, as well as professional regulatory bodies.
- 6.10 Continued pay restraint with no action to address work pressures is not sustainable and unlikely to deliver the improvements in productivity that the NHS needs in the future. NHS England's plan to deliver the Forward View rests in part on implementing

⁷¹⁵ Health Foundation. [Staffing matters; funding counts – pressure point: Student nurses](#). Health Foundation, 2016.

⁷¹⁶ Buchan J, Seccombe I, Charlesworth A. [Staffing matters; funding counts](#). Health Foundation, 2016.

⁷¹⁷ Lafond S, Charlesworth A, Roberts A. [A perfect storm: an impossible climate for NHS providers' finances](#). Health Foundation, 2016.

the government's 1% cap on public sector pay up until 2019/20. If this continues then pay would have been centrally restrained for 10 years.

- 6.11 In addition, while flat pay between 2010 and 2015 was low compared to a long-run average of 2% a year, it was comparatively better than private sector pay, which fell during this period in the fallout from the 2008 global economic crisis. Public sector pay is now expected to fall relative to private sector pay, which may result in difficulties training, recruiting and retaining staff in the NHS as the relative benefits of working elsewhere increase⁷¹⁸.
- 6.12 There is a high risk that continuing pay restraint will undermine the ability to use pay as a way to recognise, reward and motivate members of NHS staff and encourage them to work productively.

How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

- 6.13 The NHS of 2030/31 and beyond is likely to require a different mix of skills and professions from today. As set out in the 'Shape of Training' review,⁷¹⁹ the future challenges of care provision are more likely to be met through broad-based specialty training that enables transferable skills to be built up, rather than creating ever more specialist roles. This type of training needs to encompass the use of new technology, quality improvement and skills that support self-care and self-management of long-term conditions.
- 6.14 A priority for a long-term workforce strategy is a review of medical education to ensure that we are training doctors with the skills and attitudes needed for the future NHS. Training doctors for broad areas of care, following patient pathways, rather than by location of services (hospital/community) could be important to creating career opportunities that are more attractive than certain specialities are currently perceived by many doctors in training, such as general practice.
- 6.15 The NHS has a mixed record in the effective development and sustainable implementation of new roles to support high value care. Roles such as 'physician associate' are being trialled but at suggested rates of trainee intake (650 physician associates per year) this will be slow to show any impact on staffing and skill mix. It may be more practical to rapidly increase the scale of investment and opportunities for nurse practitioners to close skill gaps and improve productivity.

How can workforce policy support the retention and motivation of people working in the NHS?

- 6.16 In our report, *Constructive comfort: accelerating change in the NHS*, we argued that people-focused approaches to drive improvement are relatively under-used.⁷²⁰ This is

⁷¹⁸ Crib, J, Emmerson, C. and Sibieta, L. (2014) [Public sector pay in the UK](#). Institute for Fiscal Studies.

⁷¹⁹ Greenaway D. [Securing the future of excellent patient care](#). Shape of training review, 2013.

⁷²⁰ Allcock C, Dormon F, Taunt R, Dixon J. [Constructive comfort: accelerating change in the NHS](#). Health Foundation, 2015.

despite evidence that staff engagement is closely linked to safety, effectiveness and patient experience. The inherent psychological burdens of care combined with a poor organisational culture and stressful working conditions can create compassion fatigue and emotional burnout. A focus on rediscovering health care professionals' 'joy in work' is gaining traction as an important factor in ensuring that care is safe, compassionate and effective. Furthermore, experiments such as the Buurtzorg approach to community nursing in the Netherlands – where staff are given greater control over patient care – have shown that people-focused approaches have the potential to not only improve care, but also reduce costs and boost morale.

- 6.17 NHS workforce policy has tended to focus on contractual and financial incentives to encourage NHS staff to improve performance or productivity. While these are important, there is a glaring lack of attention on equally important factors – staff engagement, work-life balance, stress, morale and supportive management. This is not only important to make progress on productivity, but also to achieve safer care: a key factor found by the CQC to be associated with lower quality care in a hospital provider is a poor result on the NHS staff survey. The NHS has yet fully to realise the potential benefit people-focused approaches to policymaking can bring.⁷²¹

7.0 What does a learning health system look like and how do we get there?

- 7.1 Supporting health care services to improve and innovate, and then rapidly to spread what works best, should be at the heart of a sustainable NHS. Much greater emphasis is needed on supporting providers to develop the capacity and capability they need to improve quality, rather than on external levers such as regulation and inspection. There is a wealth of evidence – from health care and other industries – which shows top performance often comes not from regulation but from creating a culture of continuous improvement within organisations, one where there is a commitment to learning and that staff are fully engaged in.⁷²²
- 7.2 A shift is needed in the approach to improving quality, towards supporting and empowering providers and communities to drive up quality themselves. Achieving this will require helping them to develop into learning health systems.
- 7.3 In health care, improvement usually follows an evolutionary path of development – with 'transformation' being a process resulting from numerous complementary changes achieved through iterative testing, learning and course-correction from within teams over time (as opposed to an event to be commanded from the outside). This requires the tools for adaptive thinking and learning⁷²³ – and 'learning health systems' are ones that have this adaptive capability and focus.

⁷²¹ Health Foundation. [Fit for purpose? Workforce policy in the English NHS](#). Health Foundation, 2016.

⁷²² Allcock C, Dormon F, Taunt R, Dixon J. [Constructive comfort: accelerating change in the NHS](#). Health Foundation, 2015.

⁷²³ Gharajedaghi, J (2011) [Systems Thinking: Managing Chaos and Complexity: A Platform for Designing Business Architecture](#). Third Edition, Elsevier.

7.4 There are several ingredients to a learning health system:

- Improvement skills – technical skills (eg Lean methodology and PDSA techniques), relational skills (eg communication and negotiation) and learning skills (eg reflection and questioning).
- Improvement leadership.
- A culture of learning and challenging assumptions.
- Appropriate freedom for staff to experiment and innovate.
- Senior management who create conditions where front-line teams are supported to undertake improvement work, and who can resolve issues and demands beyond the role of these teams.
- Data collection, analysis and feedback to identify priorities for improvement, monitor the impact of ongoing improvement work and feedback appropriate metrics to guide action.⁷²⁴

7.5 These capabilities and approaches are evidenced in some of the best health care systems in the world, such as Intermountain Healthcare in the US or Jönköping in Sweden. Similarly, UK providers that have built improvement capability at scale are increasingly being recognised as leaders on quality, such as East London NHS Foundation Trust, recently rated outstanding by the CQC, and Salford Royal NHS Foundation Trust, one of just four trusts recently judged to be in a position to lead hospital chains.

7.6 While conventional wisdom is to attribute differences in operational performance to differences in tools, technologies and techniques, studies suggest that the sources of competitive advantage are in fact behavioural, not technological: great performance is achieved by repeatedly accumulating insights, improvements and innovations, and putting them to good use.⁷²⁵ This insight is not only relevant for making progress within a provider, but also across providers, for example in the development of integrated care and new models of care as referred to earlier.

7.7 Policymakers and system leaders can play a major role in creating an environment conducive to provider-led improvement:

- **Ensure the NHS has the right skills and capability for improvement.** This includes ensuring sufficient leadership and management capability for improvement, ensuring that staff are equipped with the quality improvement skills and knowledge they need and ensuring capability in data analytics for a

⁷²⁴ Deeny S, Steventon A. [Making sense of the shadows: priorities for creating a learning healthcare system based on routinely collected data](#). *BMJ quality and safety*, 2015.

⁷²⁵ Spear, S. (2012) [Reinventing healthcare delivery](#). Thought paper. The Health Foundation, May 2012.

learning health care system, including a sufficient supply of skilled data analysts through adequate training, networking and professional development.

- **Ensure providers have the resources, time and headspace to pursue change.** What the Health Foundation sees time and again from our work with front-line teams is just how much planning is needed to implement change successfully – getting the right people on board and ensuring you have the right skills and infrastructure in place. Yet we also see system leaders commonly underestimating the time and space required for change; whether driven by financial troubles, the political timetable or the need to be seen to act in response to local performance problems, many of the expectations placed on the system don't reflect the realities of managing service change. What is needed is a supportive environment where national leaders give organisations and communities the space they need to plan and pursue change.
- **Recognise the limitations of regulation and inspection for driving improvement and foster a culture of openness and support.** System leaders must recognise that the best people to drive up provider quality are usually providers themselves. Recent years have seen an over-emphasis on regulation and inspection in the hope that policing the system to identify poor performance will somehow drive improvement. But this approach doesn't simply miss the opportunity to support provider-driven improvement; if it creates a culture of fear and blame it can actually harm the prospects for doing so by destroying the trust and space required. So there needs to be a major shift in the approach to improving quality in the NHS. This should recognise the limitations of trying to drive improvement through regulation and inspection and instead see the impetus for improvement as coming from within providers themselves – and giving them the tools and resources to do so.

8.0 Digitisation of services, Big Data and informatics

What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

- 8.1 Big data and digital technologies have the potential significantly to improve people's health and health care. However, for these to be implemented successfully, staff and patient engagement is essential.
- 8.2 The use of new and multiple apps within the NHS provides the opportunity for patients to collect data on their own health, share this with their doctor and the wider health service and allow the use of these data to improve services, making them more efficient and sustainable.

- 8.3 Over the last five years the Health Foundation has supported the development of a number of apps that are designed to help people to manage their health better and improve the way in which they communicate with care providers (see Annex 2). Where these new technologies have been successful, patients and front-line staff were closely and actively involved in their inception, design and delivery.
- 8.4 Getting the innovations off the ground requires good project management, and people with the right clinical, technical and operational management skills in place at the start, along with executive level support for the changes. Relationship building and stakeholder management are as important in technology focused projects as they are in any process-related improvement or transformation project.
- 8.5 The same issues apply when it comes to spreading technology-related innovations into new organisations. For example the expansion of telehealth within the NHS has not always resulted in the desired reduction in hospital admissions or efficient use of services.⁷²⁶ However effective it has been in its original context, teams seeking to adopt an innovation need to work with staff and patients to assess its potential value in their setting, and the cultural and infrastructural challenges that would need to be addressed should they choose to go ahead. It is crucial therefore not to underestimate the time and resource required in scaling up successful technology related innovations.
- 8.6 The NHS currently has challenges in making the best use of existing datasets to improve patient care. As patients with complex health care needs are increasingly cared for by a network of providers outside the traditional acute hospital setting. Therefore, we need to ensure that information about patient health and outcomes can be accessed and analysed across the system, while ensuring data security, to assist patient care, monitor the quality of care and evaluate changes to NHS services and interventions.
- 8.7 As has been acknowledged elsewhere in our submission, the health of patients and the sustainability of the health service depends upon social care services, and wider determinants of health. Links between the health, social care and other government service datasets would allow the NHS to better understand and respond to patient needs and plan for the future.
- 8.8 Patients are increasingly using apps developed and owned by the companies outside the NHS. The question of who owns, has access to and use of data generated by these apps and how they are best incorporated into the health record of patients, shared with clinicians providing care (and others) is a significant issue over the long-term. Experience from other countries has shown the benefits of such data collection and integration to both patients and the wider health care system – for example, the Swedish rheumatology quality registry uses patient reported data as a decision

⁷²⁶ Steventon, S. Bardsley, M. Billings, J. Dixon, J. Doll, H. Hirani, S. Cartwright, M. Rixon, L. Knapp, M. Henderson, C. Rogers, A. Fitzpatrick, R. Hendy, J and Newman S. (2012) [Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial](#) *British Medical Journal*: 344. (Published 21 June 2012)

support tool to optimise treatment during routine clinic visits and for comparative effectiveness studies. These data have also been used to examine the impact of multiple genetic, lifestyle and other factors on the health of patient.

- 8.9 Building capability in informatics requires a supply of skilled data analysts. A good starting point would be to improve the training, networking and professional development opportunities available for the analytical capability that already exists within the NHS. The Health Foundation is supporting this in part through the improvement analytics unit.⁷²⁷ It also requires building better links between the experts and the front line of improvement in the service. There is also a need to provide a supportive environment for analytics; raising awareness in senior decision makers, and setting a standard for good quality analysis to support innovation and improvement.

9.0 Prevention and public engagement

- 9.1 Health is primarily an emergent property of our life chances and environment, rather than an output of the NHS. While securing the sustainability of the NHS is essential, it is not sufficient if the aim is providing everyone with the chance of a healthy life. This requires a focus on the wider determinants of health including improvements in access to education, good work and decent homes, a healthy food system and strong communities. It requires the government to take a long-term view in protecting and promoting health, as the major causes of ill-health are largely preventable.
- 9.2 The current and future health crises in avoidable chronic diseases – such as diabetes, respiratory diseases, cardio vascular disease and cancers – present complex challenges which the present public health system wasn't designed for.

Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment?

- 9.3 The economic and social cost of poor health is clear. While life expectancy has increased in recent decades, healthy life expectancy has reduced, meaning that more people are living longer, but with chronic conditions that lead to long-term sickness, early retirement and greater formal and informal care needs.
- 9.4 The government should recognise that health and wellbeing is an essential social and economic asset to be protected and promoted, not simply something we can 'afford' when the economy is thriving. The current mismatch between funding for prevention and the amount spent on treatment is a false economy.
- 9.5 It is estimated that 40% of the burden on health services in England may be preventable through action on the determinants of such conditions. However, the total costs of preventable ill health are far greater than the costs to health and care services alone, including the cost to the economy of days lost from work, lost years of working life and informal care. For example, according to the National Obesity

⁷²⁷ www.health.org.uk/programmes/projects/improvement-analytics-unit

Observatory the direct costs to the NHS in England of treating obesity, and related morbidity, is estimated to have increased from £479.3m in 1998 to £4.2bn in 2007, while the indirect costs of obesity on the economy is estimated to be between £2.6bn and £15.8bn⁷²⁸.

9.6 *How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?*

- 9.7 Traditional public health expenditure must be protected. This includes traditional public health spending on services and interventions known to be both efficacious and cost-effective – such as stop smoking services and brief interventions for people with alcohol problems.
- 9.8 Furthermore, with the planned removal of the ring-fence for local authority public health budgets, there will need to be alternative protections and support to ensure that public health is not squeezed by the intense pressures on local government budgets and, in particular, that local authorities maintain core public health expertise and priority services. This will be important to protect services for people with the poorest health, who tend to be in the most deprived areas.
- 9.9 The government should be very actively exploring alternative means of raising money for public health, such as the levy on the soft drinks companies and the proposed levy on the tobacco industry, under the principle that ‘the polluter pays’.

Should the UK government legislate for greater industry responsibility to safeguard national health, for example the sugar tax?

- 9.10 The planned sugary drinks levy not only presents a means to encourage changes in the market to reduce sugar consumption, it also aims to raise badly needed revenues for public health purposes to be delivered outside of the health and care sector – in this case largely within education. Other evidence-based examples where government legislation is needed to protect and promote health are: minimum unit pricing for alcohol, strengthened licensing powers for local authorities and controls on marketing and promotions for unhealthy food and alcohol.
- 9.11 The predominant discourse about the major health threats and their determinants still places the emphasis on personal responsibility for so-called ‘lifestyle choices’. This, together with a deregulatory agenda, has generally kept the focus of action away from legislative measures or regulation towards public education and voluntary commitments from business. However, there is little evidence that these have had meaningful impact. The ability of individuals to access the conditions for a healthy life is constrained by social, economic and environmental factors outside their control. The dramatic rise in overweight and obesity in recent decades points to a profound change in the food environment, not a mass collapse of self-control.

⁷²⁸ Morgan, L. and Dent, M. (2010) [The economic burden of obesity](#). National Obesity Observatory, October 2010.

- 9.12 Local authorities and community organisations struggling with growing burdens of ill-health and reduced resources for public health interventions cannot meet these challenges without the support of government-led action to help create the conditions which support healthy communities. Recent examples include legislation to create smoke-free public places which has provided environments which not only protect non-smokers but reinforce local interventions to support smokers trying to quit. What is lacking is an equivalent response to the emergent crisis in dietary health such as controls on marketing to protect vulnerable consumers, including children. Blackpool Council is an example of a local authority that is calling on the government for national policy action including restrictions on food marketing to children and the proposed sugary drinks levy to underpin and support their efforts to tackle childhood obesity.⁷²⁹
- 9.13 The government’s childhood obesity plan failed to regulate marketing of unhealthy food. This was in spite of evidence from Public Health England that showed all forms of marketing consistently influence food preference, choice and purchasing in adults and children, that higher sugar foods are promoted more than other foods, and that foods on promotion account for 40% of all expenditure on food and drinks consumed at home.⁷³⁰ Surveys of parents have shown strong support for tougher restrictions to protect children from junk food marketing. For example, 74% of adults supported a ban on junk food advertising before the 9pm watershed in a poll conducted in January 2016 by YouGov and funded by Cancer Research UK.⁷³¹
- 9.14 Evaluation of the public health Responsibility Deal alcohol pledges indicated that the actions taken by companies (on labelling, education and responsible drinking messages) did not include the most effective evidence-based actions such as reducing marketing or availability.⁷³² Action by food companies through the Responsibility Deal were found to be not much more than ‘business as usual’, with little or no action on the most effective strategies such as reducing marketing or reducing sugar in products.⁷³³
- 9.15 A related study of voluntary approaches around the world indicated that the most effective voluntary agreements include substantial disincentives for non-participation and sanctions for non-compliance. If the government is not yet willing to regulate in these areas, at a minimum, any future voluntary agreements with alcohol and food companies should move towards these more formal approaches.⁷³⁴

⁷²⁹ [Blackpool Council signs up to healthy charter](#). Blackpool Council, March 2016.

⁷³⁰ Public Health England. [Sugar reduction: the evidence for action](#). Public Health England, 2015.

⁷³¹ Obesity Health Alliance. [Briefing on marketing to children – policy briefing](#). Obesity Health Alliance, 2016.

⁷³² Knai C, Petticrew M, Durand MA, Eastmure E, Mays N. Are the Public Health Responsibility Deal alcohol pledges likely to improve public health? An evidence synthesis. *Addiction*, 2015. 110, 1232–1246.

⁷³³ Knai, C et al. Has a public-private partnership resulted in action on healthier diets in England? An analysis of the Public Health Responsibility Deal food pledges. *Food Policy*. 2015. 54, 1–10.

⁷³⁴ Bryden A, et al. Voluntary agreements between government and business—A scoping review of the literature with specific reference to the Public Health Responsibility Deal. *Health Policy*, 2013. Volume 110, Issue 2, 186–197.

What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

9.16 Over the next 10-15 years the changing burden of disease will require new responses from a reinvented public health system, which brings together a much broader range of agencies, government departments and organisations to address the socioeconomic and environmental determinants of health. These actions are vital if the NHS is to be sustainable and for a healthy population contributing to economic growth and wider prosperity.

What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

9.17 Making this a reality will require changes in the approach to government accounting of expenditure on health promoting measures. This includes:

- a cross-government commitment, which recognises the responsibilities of all departments to protect and promote health and which places meaningful obligations on policymaking to deliver health in all policies
- a long-term commitment to both action and investment over the life course which must not be hampered by short-term mechanisms of evaluation or quick political wins
- the full use of legislative and regulatory powers to support a 'whole of society' approach to better health– to deliver the 'fully-engaged' response described by the Wanless Review in 2004.⁷³⁵

9.18 These guiding objectives could be the basis for a new Public Health Act; one that is framed to address the wider determinants of health; to health-proof government policies; to enable national and local government action on complex issues; to prioritise public health and remove barriers to policymaking; and to require action to reduce health inequalities across the wider policy agenda.

10.0 ANNEX 1: Tax options

10.1 Several considerations need to be taken into account when discussing tax options for financing public spending. These include the following points:

- **Distributional implications**
The burden of a tax or an increase in tax will fall disproportionately across the population, either in cash terms or as a proportion of individual or household income. It is important to consider the shape of the burden of tax changes in this way. This is because the UK tax and benefit system has, by design, a goal of redistributing income from

⁷³⁵ Wanless, D. [Securing good health for the whole population](#). HMSO, 2004.

those higher up the distribution to those towards the bottom, achieved through rising tax rates and means-tested benefits. Changes to tax rates alter the distributional character of the tax–benefit system, and this change should be analysed. When considering using tax rises to fund a particular area of government spending, it is also useful to question who is paying more in tax and who is benefiting from increased spending. In the case of health and social care, a key distinction is how much extra tax is paid by those of working age versus those above the state pension age (although this matters less when considering a lifecycle perspective).

- **Economic efficiency**

Aside from questions of distribution, it is important to consider the economic impact of tax changes. In the context of taxes on earnings, there are particular distortionary risks to take into account. A tax increase can affect an individual's incentives to work more, or to work at all. This is particularly the case for those on lower incomes, who face high effective tax rates on income due to the withdrawal of in-work benefits, and have been shown to be particularly responsive to incentives to move into work. Another important consideration is that a tax increase on one type of income, such as wage earnings, can increase incentives for individuals to be remunerated through other forms of income that are taxed less or not taxed at all. This is particularly the case for some types of workers, such as the self-employed (who can more readily shift income from earnings to other, lower-tax forms of income) and high earners, who have greater access to financial planning services to reduce their taxable income.

10.2 Among the taxes we've analysed, the following have particularly important distributional and efficiency implications.

- **Basic rate of income tax/main rate of employees' National Insurance**

The vast majority (87%) of taxpayers only pay tax at the basic rate, and as all taxpayers pay the basic rate, the revenue that can be raised from increasing that rate is far higher than from an increase in either the higher or additional rate. A similar pattern holds for the main rate of employees' National Insurance. That said, those taxpayers on lower incomes often face very high effective marginal tax rates, as a result of both the basic rate of income tax (20%) and the main rate of employees' National Insurance (12%) and how these interact with the withdrawal of in-work benefits. The Mirrlees Review found, for example, that 15% of workers face effective tax rates above 75%. It has been argued that raising National Insurance does the most damage to work incentives, since it is only levied on earnings (unlike income tax, which includes income from assets already owned). A rise in either the main rate of income tax or employees' National Insurance would weaken work incentives.

- **Higher rate of income tax/employees' National Insurance above the upper earnings limit**
As noted above, those on higher incomes are, in some ways, better able to reduce their taxable income in response to increases in tax rates. This is particularly true for National Insurance but is partially true for income tax as well, for which individuals can make use of conventional tax-favoured forms of savings and income such as Individual Savings Accounts (ISAs), pensions and owner-occupied housing. For those on the highest incomes, tax planning, avoidance and evasion is also a response that needs to be considered when evaluating the impact of raising tax rates.
- **Extending National Insurance to pensioners**
The employment of those aged over 65 has increased substantially in recent years. Where pensioners remain in work, they are currently exempt from paying employees' National Insurance. This favourable treatment comes at a cost in terms of lost revenue. However, removing this exemption will decrease the incentive to remain in work post-retirement, and it has been shown that older workers are more responsive to work incentives.
- **Employers' National Insurance**
An increase in the rate of employers' National Insurance is likely to affect employers' behaviour in relation to setting rates of pay for employees. Employers may choose to pass on the entirety of the extra burden of a rise in National Insurance over time through slower pay growth for employees. Not only would this result in reduced employee earnings and household incomes, with important distributional consequences, it would also reduce the extra revenue raised, as slower earnings growth implies lower tax and National Insurance receipts and reduced in-work benefit withdrawal. Even if not passed on in this way, a rise in employers' National Insurance may reduce employers' profits and therefore corporate tax revenues.
- **The main rate of VAT**
While VAT is not a tax on earnings, it can have an impact on work incentives. A rise in the main rate of VAT decreases spending power and therefore weakens the value of income at the margin, and may reduce incentives to work more or increase earnings in general.
- **'Sin taxes'**
Taxes on goods perceived to have harmful effects on individuals have been a feature of the UK tax system for many decades, with alcohol and tobacco the main focus (although others, such as betting and gaming duties, also exist). These range from 31% of the price of a pint of beer to an average of 78% of the price of a pack of 20 cigarettes. More recently, taxes on other products shown to be unhealthy, such as sugary goods, have been introduced in several

countries and cities. These are distinct from most other indirect taxes in that they are deliberately designed to change people's behaviour. As such, the high rate of tax reflects both the harm users of these products do to themselves, but also wider societal costs such as increased demand on health services as a result of using these products.

11.0 ANNEX 2: Health Foundation projects, programmes and research

11.1 For many years the Health Foundation has supported providers and communities to improve quality and develop improvement capability. Current initiatives include the following:

- Q, which is helping to develop improvement capability at scale through connecting people skilled in improvement and supporting peer-to-peer learning;
- The Improvement Analytics Unit, which is an innovative new partnership between NHS England and the Health Foundation that will provide rapid feedback on the progress being made by local health care projects in England to improve care and efficiency. The Improvement Analytics Unit aims to help to spread the use of data analytics in the NHS for the purposes of quality improvement and strengthen the robustness of evidence to inform policy development. Specifically, it will provide the NHS with the capability to rapidly test interventions in the health and care system, in as close to real time as possible, so that changes can be implemented to the system as rapidly as possible to improve patient care. The unit will work with up to 10 local initiatives by the end of 2017. By 2019, approximately 20 local initiatives will be involved in the project.⁷³⁶
- GenerationQ fellowships, which support the development of improvement leadership capability.
- The Improving Flow Programme, led by the Sheffield Microsystem Coaching Academy, which is looking at how to apply team coaching skills and improvement science at care pathway level in order to improve flow through a health care system.
- Projects we are supporting through professional bodies to improve the development of quality improvement skills, including with the Royal College of General Practitioners and the Academy of Medical Royal Colleges.

⁷³⁶ www.health.org.uk/programmes/projects/improvement-analytics-unit

- Our recent report, *A clear road ahead*, which identified some practical steps that would help to bring about greater strategic coherence to national activity on quality, including a shared definition of quality, a single set of quality goals and a core set of metrics.⁷³⁷
- We will soon be publishing a report on how to improve the flow of people, information and resources across whole health and social care systems.

11.2 Over the last five years the Health Foundation has also supported the development of a number of apps that are designed to help people to manage their health better and improve the way in which they communicate with care providers.⁷³⁸ Some of these innovations have led to improved patient outcomes and reduced costs and have been disseminated widely. These include the following examples:

- ‘[Flo](#)’, a text messaging system that sends people reminders and health tips tailored to their needs. The system was originally developed by a team at NHS Stoke for use with people with hypertension and diabetes. A clinical trial supported by the Health Foundation found that it was effective in managing peoples’ blood pressure. Enabling people to measure their own blood pressure at home, rather than in their surgery, also proved less costly. Flo has now been adopted by over 70 health and social care organisations across the UK and is used by people with a wide range of long-term conditions.⁷³⁹
- ‘[MyBirthplace](#)’, an online app designed to help women decide where to give birth, with support from their partners and midwives. Developed by a team at Portsmouth Hospitals NHS Trust, its use led to a significant increase in the proportion of women who had made a decision about where to give birth by 36 weeks. The app has now been disseminated across Wessex and Scotland.⁷⁴⁰
- ‘[Activate Your Heart](#)’, an online cardiac rehabilitation programme. Developed by a team at University Hospitals of Leicester NHS Trust it provides people with a tailored programme of exercise with access to health care specialists through discussion forums, chat rooms and e-mails. The programme has succeeded in widening the uptake of rehabilitation services: feedback from users suggested that 90% of them would not have used conventional rehabilitation services. A version of the programme has now been adopted in Scotland.⁷⁴¹

⁷³⁷ Molloy A, Martin S, Gardner T, Leatherman S, [A clear road ahead: creating a coherent quality strategy for the English NHS](#). Health Foundation, 2016

⁷³⁸ Health Foundation, Shine: [Improving the Value of Local Healthcare Services](#), 2014

⁷³⁹ www.getflorence.co.uk

⁷⁴⁰ <http://mybirthplace.org/portsmouth>

⁷⁴¹ www.activateyourheart.org.uk

30 September 2016

The Health Foundation (NHS0196)

The Health Foundation (NHS0196)

			£000s																				
			1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
			1994-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13	13-14	14-15
K1	Adult social care	England	5	5	6	6	6	7	7	8	9	10	12	12	13	13	15	16	16	16	15	16	15.51
	NHS	UK	39,400	41,400	42,800	44,500	46,900	49,400	54,200	59,800	66,200	74,900	82,900	89,800	94,700	101,100	108,700	116,917	119,826	121,254	124,302	129,389	134,053
	Adult social care		5	5	6	6	6	7	7	8	9	10	12	12	13	13	15	16	16	16	15	16	16
	NHS	UK	39	41	43	45	47	49	54	60	66	75	83	90	95	101	109	117	120	121	124	129	134
		England	31.914	33.534	34.668	36.045	38.23	40.12	44.14	48.87	53.7	60.75	67.79	73.2	76.83	83.23	89.92	96.12	98.35	99.8	102.46	107.31	111.73
			65.873725	67.874525	70.469375	71.5845	72.5588	72.94675	74.443275	75.3968	77.102525	78.832925	80.924975	83.084725	86	87.6765	90.0589	91.2982	93	94	96	825475	25
	Adult social care		7	8	8	9	9	10	11	12	13	14	15	15	15	17	17	18	17	16	16	16	
	NHS	UK	61	62	62	63	66	69	74	80	87	96	104	110	112	117	122	130	131	130	131	134	137
		England	49	50	50	51	53	56	60	66	71	78	85	89	91	96	101	107	107	107	108	111	114
	Adult social care			9.4%	5.6%	4.7%	4.2%	7.4%	5.2%	4.2%	11.7%	13.0%	7.5%	4.2%	0.9%	0.0%	12.0%	2.8%	0.3%	-4.6%	-3.3%	-0.6%	-1.4%
	NHS	UK		2.0%	-0.4%	2.4%	4.0%	4.8%	7.5%	8.9%	8.3%	10.7%	7.8%	5.5%	2.4%	4.2%	4.7%	6.1%	0.6%	-0.2%	0.4%	2.4%	2.1%
		England		2.0%	-0.4%	2.4%	4.6%	4.4%	7.8%	9.3%	7.5%	10.0%	8.7%	5.2%	1.9%	5.8%	5.2%	5.4%	0.5%	0.1%	0.6%	3.0%	2.6%
				7.4%	6.1%	2.3%	-0.4%	3.0%	-2.6%	-5.2%	4.2%	3.0%	-1.2%	-1.0%	-1.0%	-6%	6.8%	-2.6%	-0.1%	-4.7%	-3.9%	-3.6%	-4.1%
	Adult social care		100	109	116	121	126	135	143	148	166	187	202	210	212	212	237	244	245	233	226	224	
	NHS	UK	100	102	102	104	108	113	122	133	144	159	171	181	185	193	202	214	215	215	216	221	
		England	100	102	102	104	109	114	122	134	144	159	173	182	185	196	206	217	218	219	220	226	
			81%	81%	81%	81%	82%	81%	81%	82%	81%	81%	82%	82%	81%	82%	83%	82%	82%	82%	82%	83%	83%

1 1994-95 to 2006-07 figures include estimated Service Strategy and Asylum Seekers Assessment and Care Management apportioned to Adult Services and Children and Families Services. 2007-08 data is based on the 2007-08 data.

2 In 2009-10 Fairer charging - Community services was introduced, this is the sum gross of current expenditure on Home care and Day care / Day services

3 In 2011-12 the Valuing People Now transition was completed, so responsibility and funding for providing certain services to young adults (aged 18-64) with learning disabilities in residential care moved from the Health Foundation to the NHS. Rs. Funding for these services was provided by the NHS.

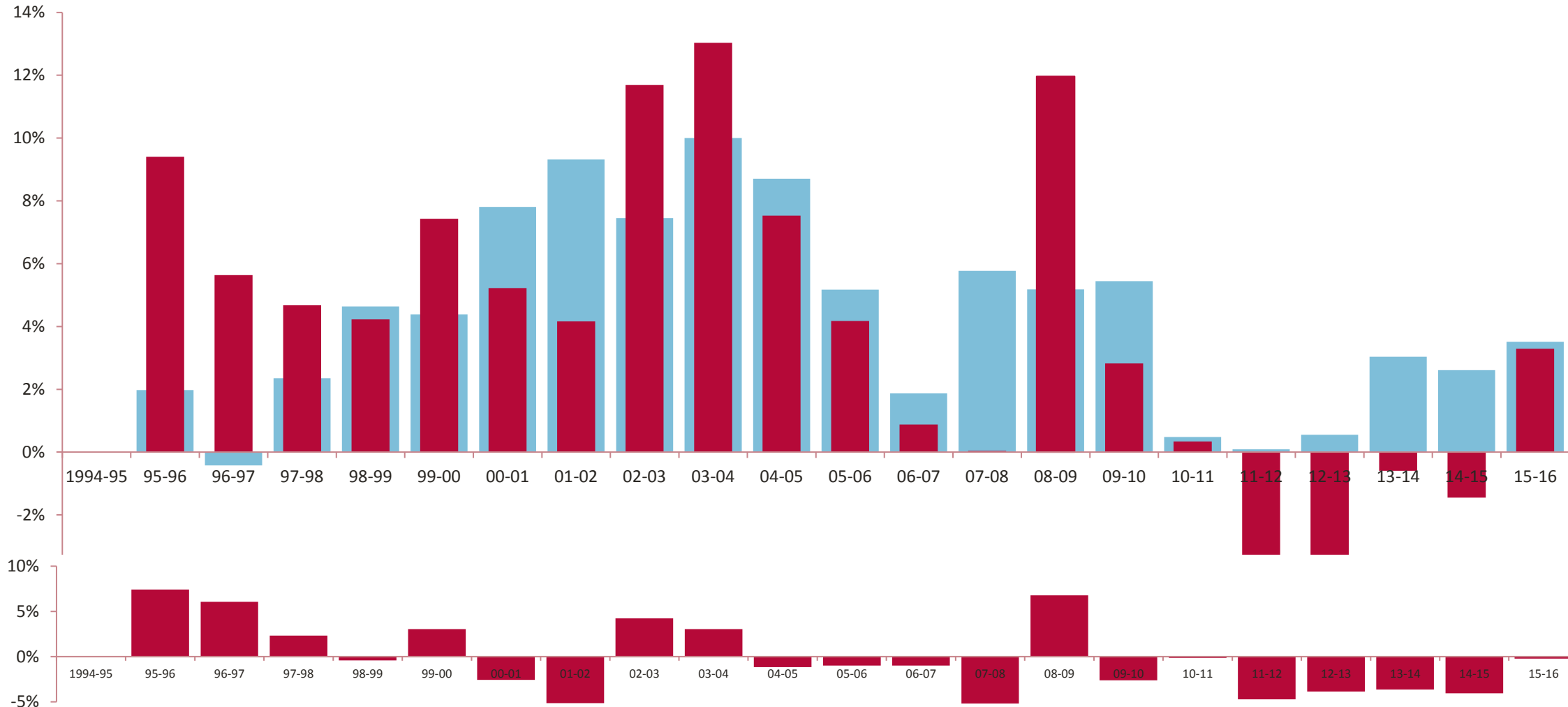
Between 2008-09 and 2010-11, CASSRs had provided these services but were reimbursed by the NHS and so the monies were netted-off prior to being reported on the PSS-EX1 return.

.. means data not available

March 2017

The Health Foundation (NHS0197)

Yearly change in spending on the NHS and social services



The Health Foundation (NHS0197)

March 2017

Health Research Authority – Written evidence (NHS0143)

1. The Health Research Authority (HRA) is a non-Departmental public body sponsored by the Department of Health (DH). Our statutory objective, as set out in the Care Act 2014, is to protect and promote the interests of patients, service users and the public in health and social care research. Our statutory functions include: co-ordinating and standardising the regulation of health and social care research with a view to promoting proportionate regulation; operating the Research Ethics Committees (RECs) whose review of health and social care research proposals is required; approving the processing without consent of confidential patient information for medical research, on the advice of the independent Confidentiality Advisory Group (CAG), which we also appoint; and functions as a member of the UK Ethics Committee Authority as set out in the Medicines for Human Use (Clinical Trials) Regulations 2004 (S.I. 2004/1031).
2. Research is a core function of health and social care and is crucial for the sustainability of the NHS. It is essential for our health and well-being and for the care we receive. Research should improve the evidence base, reduce uncertainties and lead to improvements in future care, while the quality of current care may be higher in organisations that take part in research and adopt research findings. Improved care can give people a better quality of life and the country benefits from more money and jobs if the UK environment for research attracts international research funders to invest in this country and carry out their research here. Research develops the skills of staff in our universities, businesses and health and social care providers. It also involves patients, service users and the public in the pursuit of knowledge that may benefit them and others, not only by their participation in research but also by their involvement in its design and conduct, in public engagement about research, as members of research approval bodies such as research ethics committees or in funding research through taxes and charitable donations.
3. As set out in paragraph 2.191 of the Plan for Growth (www.gov.uk/government/uploads/system/uploads/attachment_data/file/221514/2011_budget_growth.pdf), the HRA plays a key role in reducing the regulatory burden on the life sciences industry, improving the timeliness of decisions about research proposals and hence the cost-effectiveness of their delivery in the UK. This, in turn, should lead to quicker and more cost-effective improvements in treatment and care. Our activities to achieve this are set out in our business plans (www.hra.nhs.uk/about-the-hra/our-publications/business-plan/). For example, we have improved the approval processes for research by rolling out HRA Approval, a single approval process for all study types taking place in the NHS in England. We are also reducing waste in research by promoting research transparency, with a view to more research projects being publicly registered and research findings being published, so that research is not unnecessarily duplicated and research evidence is not lost.
4. Regarding question 1: We aim to enhance the attractiveness of the UK for research and innovation, and our work to achieve this should lead to the availability of a range of new diagnostics, interventions and therapies. This will add to the quality of healthcare on a number of measures, such as quality of life and extension of life. However, the net cost

either of the innovation itself (as a replacement for current practice or as a completely new practice which is therefore additive) or to the wider health economy (replacing other costs, such as reducing bed days) is uncertain. Whether the health system will be able to evaluate and adopt innovation may require, for example, a more holistic approach to the appraisal of innovation, which is covered in part by the role of the National Institute for Health and Care Excellence (NICE) as well as the HRA. Having had a role in supporting innovation, we would stress the importance of clear and effective mechanisms for its adoption. We have been told by some in the life sciences industry that clinical trials of new medicines may sometimes not get run in the UK because the NHS's uptake of those medicines once the research is completed is not reliable. We are working with NICE and the pharmaceutical industry to promote designing research in order to generate findings which will result not only in a marketing licence by satisfying the Medicines and Healthcare products Regulatory Agency (MHRA), but also in an actual place on the market by satisfying NICE.

5. Regarding question 3: We are concerned about the impact on research of continued pressure on NHS staff resources, to the detriment of activities other than the immediate delivery of care. This will affect the availability of NHS staff not only to design, conduct and manage research, but also to ensure its quality, ethics and legality by acting as peer reviewers and as voluntary members of the committees we operate (RECs and CAG). For example, we have heard from industry that research teams are turning down more studies because (among other factors) of the calls on the time of clinicians who are already stretched; and we have seen a one-third reduction in the turnover of REC members who are doctors, with 28 leaving over the last year and only 19 joining.
6. Regarding question 4: We believe the expectation is outmoded that healthcare professionals will learn about research by doing a project from beginning to end as part of their course. This is not a good learning opportunity given that this is a simplistic view of research. It also encourages only certain types of research (particularly staff questionnaires) and does not give appropriate exposure to the breadth of research. Moreover, it creates a burden on the NHS in terms of the staff responding to these questionnaires and in terms of the staff providing significant support to poorly prepared researchers. There are more innovative ways of ensuring that healthcare professionals understand about research from their time as students through ongoing Continuing Professional Development, so that healthcare delivery is evidence-based, appropriate innovation is properly managed and patients benefit from the outcomes of research.
7. Regarding question 5: We are aware of the growth of integrated commissioning jointly across both health and social care and that we will need to consider further how we handle research applications covering both health and social care as we expect these to increase. Integration will also challenge NHS organisations to think financially across a healthcare economy instead of focusing on their individual budgets – the increasing impact of financial constraints on some research has seen some NHS trusts which previously took a pragmatic approach to absorbing the Excess Treatment Costs (ETCs) of research suspend any funding towards ETCs, resulting, for example, in a deterrent burden of complexity in agreeing to pass the money around the system for clinical trials where there will be savings in primary care but costs to secondary care. Related, we have heard from hospital chief executives, when sharing their experiences about what

would make their roles and responsibilities easier, commonly mention reducing both the burden of regulation and the number of regulators and regulatory systems. The HRA and other regulators have a mutual duty to co-operate with each other to co-ordinate and standardise their regulatory practice relating to health and social care research. For example, we have introduced an Integrated Research Application System so that researchers only need to provide information about their research proposals once, rather than repeat it to each individual approval body. We are also reducing the burden of collecting research performance information by collaborating with various bodies under the National Institute for Health Research (NIHR) to share performance data. Like regulators, the NHS bodies which are responsible for policy decisions and gaining assurance around compliance could work more closely together with the aim of removing duplication in terms of asking the same questions of the same people but in a different regulatory or oversight capacity. Although the regulatory capacity may vary, the overall purpose is generally shared: ultimately, to protect people and their data. The compliance assessment model used by the HRA as part of HRA Approval could be adopted more widely by other regulators to reduce the burden of compliance and inspection. There may be learning from our work with regulatory agencies to design duplication out of systems that could be helpful to NHS organisations.

8. Regarding question 8: A long-term challenge for the NHS will be how 'Big Data' and informatics impact on public confidence and what needs to be in place to maintain public confidence in how their data are used in the research and development of new services and treatment. To successfully protect public interest in 'Big Data', there will need to be government support for co-ordinated action between key stakeholders, including the HRA, and a commitment to address any regulatory shortfall revealed, e.g. initiatives such as accelerated access to medicine and 'real world' studies could see a blurring from the traditional demarcation between research and 'routine' clinical practice, which may need a new regulatory approach. We are concerned that current governance models are fully equipped to address, and to respond to future developments in, the societal implications of big data and associated developments such as machine learning. For example, the currency of debate remains focused on individual identification and has not moved on to consider issues associated with group privacy or differential treatment due to algorithms built using non-personal data. There is a risk to public confidence in effective governance if people do not feel their own, or family, interests are being taken into adequate account when regulatory decisions are taken and perceive, or read media reports of, negative effects down the line. The challenges of addressing such risks are considerable. Public confidence needs to be maintained in an environment where industry involvement is perceived as problematic and there continues to be a prevailing ownership paradigm within which people query who 'owns' the data.

23 September 2016

Hospital Consultants and Specialists Association – Written evidence (NHS0075)

Introduction

The Hospital Consultants & Specialists Association is the only professional association and trade union solely representing post-foundation year hospital doctors. Most of our membership work at consultant grade.

The future healthcare system

- Reorganisation and restructuring are essential to the process of NHS modernisation and renewal, but their implementation is often stressful and exhausting to those providing the service and alienates the public.
- All too often, healthcare planning is rigidly constrained by budgetary pressures, leading to piecemeal cuts and restructuring that result in the loss of local services, and without full involvement in local communities. Service provision and public confidence have been affected, and costs have not been contained.
- Healthcare delivery is critically affected by continuing cuts in social care budgets. Hospital discharges of dependent patients are delayed (“bed-blocking”), and rising pressures on hospitals are linked to an ageing population, homelessness and housing, and social deprivation. Clearly, there is a need for better integration of health and social care provision.
- HCSA supports a strategic approach to financial allocation, matching national standards to local needs, and supported by accurate outcome data. The creation of health and social care budgets in all areas (not just in urban areas under Regional Mayors) should be considered in order to allow a more planned approach to financial allocation. There should be a far greater clinical input into allocations for acute care. Providers’ role in strategic planning could be enhanced by reviewing the provider-commissioner split.
- We believe that this reconfiguration needs to take place via a considered bottom-up approach, actively involving clinical voices and measuring the needs of local communities and providing services to match.

Resource issues, including funding, productivity, demand management and resource use

- Funding earmarked for the forthcoming period, and by extension to 2030, has already been declared grossly insufficient for the services already commissioned, as evidenced by recent reports by the Health Select Committee report and the Public Accounts Committee, and most recently by NHS Providers.
- This is in the context of NHS England’s estimate of a £30bn deficit by 2020. If transformation is to be given a chance and is not to fall victim to the pressure on budgets, then sufficient funding must be found firstly for the current service and subsequently for the future gap.

- HCSA does not support rationing of healthcare services, a “postcode lottery” or means testing. Access should be based only on need. However, consideration could be given through education or other mechanisms to imbuing in patients the financial value of the NHS services that they are provided, in an effort to encourage greater individual responsibility.
- HCSA favours the view that the NHS should remain free at the point of use and access should remain funded through general taxation and not via a hypothecated tax, which has a number of flaws:
 - There is no firm evidence that this will improve overall funding levels in the long term.
 - The yield from any salary-related levy could go down as well as up, impeding a strategic approach to future investment
 - A move towards a personal payment, hypothecated approach would take us a step closer to an insurance-funded NHS. Evidence from other countries shows that ultimately this would be a more costly approach, with additional money spent on administration and bureaucracy rather than clinical services. Singapore is, however, one example where costs are lower within a mixed personal/public funding model, currently at beneath 5 per cent of GDP. We note though that Singapore is not directly comparable to UK and Western health systems due to differing age demographics, its small population and compact topography.
- The alternative to higher taxation – a nationwide policy of charging, rationing and/or means testing – has clear downsides both in terms of the NHS’s role as a universal public service and the costs of potentially more complex cases further down the line, although in effect rationing is already taking place at a local level.
- The UK spends a smaller proportion of its GDP on health care than Germany, France and the Netherlands. It spends a larger proportion than Spain, Finland and Ireland (OECD Data). The UK should seek to match spending as a percentage of GDP to countries with a similar economy and population, such as Germany or France.
- Making the case for additional funding through taxation will require a national public debate about the expectations and future shape of the NHS. There is a large volume of data available – both demographic and from within the health economy – through which to model future costs and anticipate future budgetary requirements.
- Inefficient expenditure through long-term PFI contracts and the growing burden of litigation on NHS budgets should be reviewed with the goal of reducing costs.

Workforce

- HCSA represents senior hospital doctors and is concerned that workforce planning for medical education has been poorly executed over the past decade. Although NHS Improvement’s Workforce Analysis (February 2016) states that the number of

consultants has increased faster than activity, despite expansion in the consultant workforce demand is outstripping supply in some specialties.

- This is at least in part contributed to by limitations in learning and working hours as a consequence of the European Working Time Directive, so that all clinical skills and training opportunities have to be gained within the trainees' 48-hour working week. Much of the trainees' time is spent in service delivery to meet targets rather than their education, reducing their readiness for specialist practice.
- The size, training levels and composition of the consultant workforce is likely to have a substantial impact on the way health care is delivered over the next 20 years.
- Recent HCSA research has produced evidence of a widespread trend by Trusts to reduce Supporting Professional Activities time due to financial pressures. This trend is resulting in reduced levels of clinical governance, auditing, teaching and research, all of which have a lasting negative impact. We believe that a 2.5-7.5 ratio, as defined in the 2003 Consultant Contract, is required in order to ensure that valuable work other than clinical duties can be conducted.
- We are also concerned about the overall decline in morale and pressure of working in an under-resourced NHS. HCSA undertook an extensive survey of members in 2015 and this pointed to real worries about work-related stress and ill health caused by the working environment.
- If Consultants and Specialists are seen as pivotal in the delivery of high-quality healthcare in England then these concerns must be addressed.
- The increase in the numbers of Senior Trainee doctors who are on "less than full time" contracts, increasing proportion of women trainees, and a noted increase in the number of trainees with disabilities, will inevitably mean significant demand for part-time consultant contracts in the future.
- Flexible working terms, family friendly, and supportive contracts should be promoted to encourage retention and improved morale.
- To counter low morale among health professionals it is also important for employers to engage meaningfully with employees rather than, as now, at arm's length.
- There are currently too many examples of hospital management teams buying in the services of expensive short-term external consultant companies and individuals to identify strategic plans or manage efficiency programmes which do not result in any directly attributable savings or improvements.
- In-house management teams should be qualified to address these areas and should be held accountable for inefficiencies. Health services and Trusts should select,

appoint and employ on a permanent basis appropriately trained management employees to fully manage and undertake their required roles.

- Trusts and health services should be encouraged to involve medical expertise to identify potential successful service transformations and efficiencies as they are more likely than short-term external contractors to understand local complexities, as well as understanding difficulties already encountered and addressed.
- If a trust or Healthcare service/provider is in financial difficulty and unable to regain control of their finances the DOH should retain a last resort power to take control and place a Department of Health determined executive rescue team that should be DoH funded, compiled and placed with clear performance indicators for a three-year term, accountable to the DoH.

Models of service delivery and integration

- Integration of services requires far greater communication with and involvement of those working within them on the ground, not at the theoretical, overview level as is currently seen. Most employer annual surveys show that staff feel they have been disengaged from, are not valued, and are simply seen as an obstruction to good business principles.
- The management style currently practised is overly weighted towards “measurable” data, meaning that aspects of health provision that are hard to measure – in particular care and quality – are not given adequate emphasis. Clinical leadership based on patient-level clinical indicators of need and benefit should guide service provision rather than financial targets, which is the only guide currently.
- The easiest way to promote local co-operation is to combine these organisations while rebalancing decision-making away from non-clinical staff, so that those who identify the need and bring about the benefit in daily practice play a significant role in decision-making.

Prevention and public engagement

- HCSA is concerned about the direct impact on the work of our members of the transfer of public health functions to local authorities in England. We have noted particular concerns over the provision of sexual health services and bariatric services.
- Local authority commissioning has been inhibited by deep cuts to council budgets. We believe that this budgetary crisis must be addressed in order to avert additional long-term pressure on hospitals as a result of more complex and acute cases.
- HCSA recognises the need to have a more “joined-up” approach in the co-ordination of public health strategy. The linking of health and social care budgets and protection of budgets from serious reductions in funding are essential.

- Additionally we believe that patient education must begin at an early age to imbue an understanding that the privileges of state health care come with responsibilities.
- “Sin” taxes on high sugar foods, tobacco and related products, which alongside public health education underline the public’s personal responsibility for their own health, are attractive. However, in order to ensure the best public health outcomes, some form of taxation should also be considered for the manufacturers, retailers and wholesalers promoting “sin.”

Digitisation of services, Big Data and informatics

- An integrated nationwide computer system recording all hospital and GP appointments, no matter which hospital or practice was attended, would eventually cut costs and improve efficiency by providing immediate information, optimising and sharing essential patient information, and avoiding the need for paperwork. However, previous NHS information technology failures should serve as a warning that inadequate resourcing, planning, and lack of clinician / user involvement from the start, will again prevent successful implementation.
- The current system of individual Trusts utilising individually procured systems is inefficient, costly and results in delays and lack of ability to access data where systems between Trusts are incompatible.
- Responsibility for NHS IT should be centralised and standardised throughout all NHS service providers so that no issues of compatibility affect rapid access to patient data, imaging and reports.
- Many HCSA members have welcomed and have been at the cutting edge of research and development of new technologies in the delivery of healthcare.
- We welcome the development of tele-medicine in that this can enable Consultants and Specialists to advise and direct care to remote locations, and via primary care centres.
- HCSA also supports greater investment in wearable technology and smartphone apps, which mean that information can be passed quickly and securely to healthcare providers. They can use the information gleaned from this to provide bespoke care without the need to see patients, freeing up slots to see patients who do need to be seen. This will work particularly well with some conditions, such as diabetes and hypertension.
- Future planning needs to protect and ensure continuing and increasing investment in research and development in new clinical and surgical techniques, including the development of robotics and non-invasive surgical methods.

23 September 2016

ID Medical Group Ltd – Written evidence (NHS0076)

Workforce: Supply, Retention, and Skills

1. As the Committee is already aware, the NHS is struggling. National diktats are being issued from the DH and NHS Improvement, among others. Locally, providers are required to serve their communities, hugely varied across the country, without going against these nationally-set expectations. There is very little room for flexibility. The Committee has identified that flexibility is the future of the NHS, particularly as it concerns workforce. Instead, we see no allowances made for the needs of individual trusts. This concern was raised during the consultation on the agency pay caps – and subsequently ignored. Now, the service is facing the most severe staffing crisis in its history.
2. Looking to the future, the damage done to workforce resiliency now is likely to be persistent. Certainly, clinicians who have chosen to leave the country to practice elsewhere will be difficult to re-recruit. Many of those working through healthcare recruitment agencies such as the UK's leading agency have become accustomed to the flexibility this type of working offers. It is unlikely that these individuals will return to full-time NHS working without the same flexibility.
3. Healthcare recruiters have a unique perspective on the industry. We not only understand why people choose to leave full-time substantive work (to either be part-time or entirely agency), but also the pulse of the industry across multiple trusts. While the NHS has been encouraging cross-trust working, this has proved quite difficult under current budget constraints.
4. This sort of regional understanding, coupled with the wider national and international knowledge the leading UK agency has, is an untapped resource. Healthcare's demand for temporary workers will never go away, regardless of how hard the Department of Health and its arms'-length bodies try to restrict the industry. Given that agencies will continue to exist, it seems wise to begin including these sources of information in the workforce planning process.
5. Our in-house analytics team is already applying data on vacancies and availability to knowledge of the marketplace, leading to intelligent decisions about future shortfall areas. In this way, we are able to predict staffing trends as far as five years in the future. We understand that this Committee is looking much further in the future than that, but this is a capability that has only been developed in the last year. Moving forward, we would expect to be able to forecast even further. And while we are not attempting to create a numerical value for these trends like Health Education England must, this is still a significant improvement on how the majority of our clients interact with forecasting.
6. Through our work, we are already beginning to see the start of long-term changes to the system as a result of everything happening now. This Committee's role is to look

far into the future to determine the sustainability of the NHS, but the future is created by the success and missteps of today. The short term response to these issues will create the challenges faced in 20 years.

7. It is impossible to address major workforce challenges for the long term with multiple poorly prepared and rapidly implemented regulations being pressed upon the NHS repeatedly. Issues like the agency pay caps and junior doctors' contract have dramatically disrupted the very careful planning of numerous NHS organisations, including Health Education England. In order to secure the long-term sustainability of the NHS workforce, multiyear regulatory stability and methodical implementation must begin now.
8. The leading UK healthcare recruiter is particularly well placed to address three particular issues of interest to the Committee: international and workforce retention and flexibility.

International Recruitment

9. Our agency has a long-established international supply chain. The Committee has asked specifically for evidence on long-term issues around international recruitment and immigration. We can attest to the fact that international recruitment has a positive impact on both workforce levels and agency spend. Permanent international recruitment has been a feature of the NHS workforce for years. Recently, there has been significant growth in this area as a result of the growing pressure across the healthcare system.
10. While Brexit itself may not be a long-term issue for the purposes of the Committee, the impacts of leaving the European Union will almost certainly have that kind of longevity. Many of our existing channels of international recruitment have begun to show the strain of the Brexit decision. Where previously candidates were highly enthusiastic about working in the NHS, the general attitude has taken a downward turn. Some of this is directly attributable to the unease surrounding Brexit. Unfortunately, some of it is tied more deeply to the NHS itself. Perceptions of the NHS globally are not as strong as they once were. The junior doctors' dispute, the ongoing staff shortages and rapidly rising demand, and the general tone of the conversation around the NHS all contribute. This sort of perception shift is difficult to change over time and the current trajectory indicates it is unlikely to reverse soon. This will see the flow of highly qualified international clinicians decrease. Given how substantially the NHS relies on international clinicians, this will undoubtedly have a detrimental impact on workforce.
11. The instability of the pound has also contributed to the reluctance of some to choose the UK. For some clinicians, particularly doctors, coming to the UK for several years is a viable option because of earning potential. It is difficult to predict what impact the volatility of the pound will have over the long-term; it is certainly outside of our remit. We do, however, feel it is important to highlight that financial motivations are absolutely a part of why clinicians choose to immigrate to the UK. When coupled

with the other fallout from Brexit, the currency volatility can only further worsen the situation. Experienced staff are weighing their options and finding staying in their home country to be the better choice.

12. Entry systems are critical to maintaining supply of international clinicians. According to recent reports, a points-based system has been roundly rejected by the Government. Other countries rely on points-based systems to ensure smooth flow of highly qualified immigrants, including clinicians. Already NHS clients have to wait as long as 18 months for successful non-EU applicants to actually arrive in the UK to begin work. EU applicants can come into work much more quickly, saving trusts a substantial amount of money. All clinicians seeking to immigrate to the UK to practice should be given a faster, easier route.

Workforce Retention and Flexibility

13. The Committee is already well aware of the existing recruitment and retention crisis facing the NHS. Retention is something that must be addressed in the short term, but will need to be built into the system in the long term. A key feature of the NHS of the future is going to be enhanced multidisciplinary working and increased individual flexibility. The move towards flexible working is happening across all sectors; healthcare is no exception. Many of the clinicians who work via the UK's largest agency have chosen agency working in order to gain flexibility. Managing caring roles and maintaining personal relationships both are often made more difficult in full-time, substantive NHS roles.
14. An area that has not been fully utilised is the further development of alternative training routes. The existing system does allow doctors to become consultants along non-traditional career paths, but this is poorly publicised and not well supported. Our agency spends a not-insignificant amount of time offering career support to clinicians of all types, providing them with access to courses and work opportunities that actually expand and enhance their skillsets. While this is certainly not the only non-traditional educational opportunity currently on offer to clinicians, the NHS must begin to explore the opportunities offered outside of the formal training structure. Alternative training allows those who opt out of the formal training structure to develop into consultants and senior staff grades who do fit into the training structure, providing the senior staff bank needed to support a service under increasing pressure.
15. The introduction of new staff groups has gained traction lately as an alternative to traditional staff structures. While these new staff groups may yet support the changing needs of the NHS, our experience demonstrates that existing staff have a lot to offer outside of their current work. We regularly place physicians in departments other than their primary specialty, bringing their knowledge to a new area and expanding their own skillset at the same time. This avoids the need to develop entirely new training structures and registration mandates. This will also not be a magic bullet, but it dovetails neatly with the demand for increased flexibility

and is something that organisations like the largest UK healthcare recruiter are already providing.

16. A flexible workforce is also reliant on staff having multiple skillsets. Currently, agency staff are able to acquire these through working in various departments. In the early stages of a doctor's career, they spend time in various specialties as part of their rotations – working as a locum offers doctors the opportunity to continue “rotating” without the requirement for a formal structure. The NHS training infrastructure is currently targeted at increasing specialisation, rather than the increasing generalisation demanded by a flexible health service. That's not to say there isn't a place for specialists – there will always be demand for those with highly-refined specialist skills. But a flexible workforce requires clinicians who can comfortably work across a range of specialties.
17. Building a flexible workforce does come with a cost. The rates currently demanded by the agency workforce highlight the expectations of those who cover at short notice and move from location to location quickly to fill gaps. This sort of flexibility is central to making the NHS demand-responsive, but it will not be accomplished by simply forcing the existing workforce to cover for no additional pay. Flexibility is, in some ways, its own reward, but those who respond to demand will continue to expect to be rewarded commensurately.

23 September 2016

Candace Imison – Written evidence (NHS0193)

The pressures on the NHS workforce are as great, if not a greater, threat to the future sustainability of services as the pressures on finances.

- There are serious and growing gaps in the NHS workforce, in both numbers and skills. These threaten the quality of care and the NHS's capacity to deliver improvements in productivity.
- A striking feature of the gaps in the clinical workforce is their concentration in the areas where the needs are greatest, and where new models of care are seeking workforce expansion. Thus they undermine the capacity to deliver these new models of care.
- Despite planned expansions in training numbers, a wide range of factors could magnify the current gaps in the clinical workforce, in particular, the pressures on the workforce created by the current productivity challenge. The falling morale in many staff groups and subsequent loss of skilled and experienced staff will not be easy to repair.
- While the NHS has invested billions of pounds in training doctors, nurses and other clinical staff, it has invested little in the skills and capacity to plan, develop and manage this highly skilled workforce. Despite a huge productivity challenge, this position has not changed, in fact it has deteriorated, with raids both on training and continuing professional development budgets.

There are opportunities to address these challenges, making better use of the NHS's most valuable resource, its human capital, but none are quick fixes, and each is hampered by the current constraints on NHS funding. These include:

- Improving retention, both in training and at work, through improved staff management.
- Providing more flexible training pathways and investing in continuing professional development.
- Changing skill mix to tap the full potential of staff and deliver more patient-focused care. This requires careful planning and implementation. There is an urgent need for more evidence in this area.
- Improving our approach to workforce planning. The focus should be on developing a flexible approach that does not seek long-term predictive precision but can identify potential medium-term issues, and, most importantly, enable the current workforce to evolve and adapt to the inherently unpredictable health care environment. A core foundation for this should be a deep understanding of the skills gap in the current workforce. This is currently lacking.

- Making better use of information technology to support more flexible working and improve productivity. This will require service improvement and organisational development as well as technological capacity, and may take many years to achieve, but the benefits could be considerable.

Introduction

Around 1.3 million staff work in the NHS, with a further 1.6 million in social care. The health and social care workforce together account for 13/100 jobs in the United Kingdom. In common with other countries, the health and social care workforce is a growing proportion of the overall workforce.

The NHS has 824,000 clinical staff, including 141,000 doctors and 329,000 FTE nurses (NAO, 2016). The NHS is therefore heavily dependent on staff with high-level skills that take long periods (3-15 years) to acquire. In addition, staff need continuing professional development to keep abreast of medical and other technological advances, as well as respond to changing patient needs.

Gaps in the health and social care workforce, in terms of both numbers and skills, now threaten the quality and efficiency of care.

Responding to these challenges requires sophisticated workforce planning, development and management skills as well as significant investment in new technologies, service improvement and organisational development.

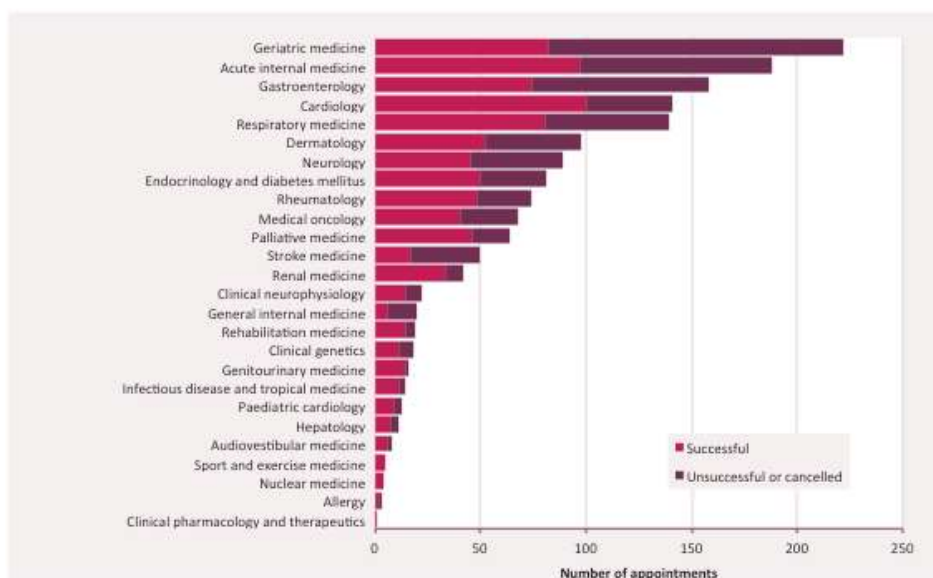
Challenges facing the NHS workforce

Large and growing gaps in the clinical workforce

There are workforce pressures across the globe but the workforce pressures faced by the NHS are growing and acute. The National Audit Office (2016) estimated there were 50,000 vacant clinical posts in 2014. The NHS spent £3.7 billion on agency staff in 2015/16, compared to £2.2 billion in 2009/10. 61% of the requests for agency staff were to cover staffing vacancies (NAO, 2016).

The gaps in nursing, particularly in some geographies and services, are acute. In London, the RCN puts the vacancy rate at 17% and one London mental health trust recorded an overall nurse vacancy rate of 30% (RCN, 2016). In community settings there are vacancy levels of over 21% for district nurses and 46% for children's nurses (MAC, 2016), at a time when policy is driving a shift to community-based care. There are also pressing gaps in the nursing workforce within social care, gaps often neglected by NHS workforce planners (NAO, 2016). New trainees are failing to compensate. More nurses are leaving the profession than joining it. In 2014, there were 13,400 graduates from nursing school while 7,500 nurses retired, but more worryingly 17,800 nurses left before retirement (NAO, 2016).

In medicine there are similar problems. The graph below shows data from the Royal College of Physicians on the rate of success of current job adverts. The gaps in geriatric and acute medicine are stark.



Source: Dr Andrew Goddard, Royal College of Physicians

General practice also faces significant pressures. A recent BMA survey found a third of practices reported at least one vacancy for a GP partner, with similar vacancy rates for salaried GPs and practice nurses. A small number of these practices had been trying to recruit for more than three months (BMA, 2016).

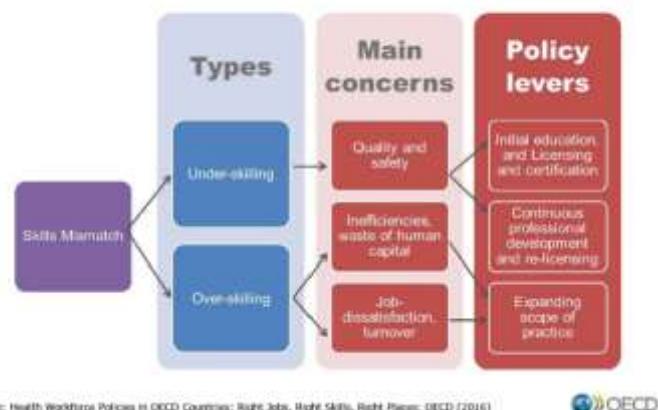
A striking feature of the majority of the gaps in the clinical workforce is their concentration in the areas where the needs are greatest, and where new models of care are seeking workforce expansion. Thus they undermine the capacity to deliver these new models of care.

Skills gaps

A recent and large OECD study, across 22 countries, showed that 51% of doctors and 43% of nurses felt they were under-skilled for what they are currently doing, whilst 76% of doctors and 79% of nurses felt that elements of their role were over-skilled. Being under-skilled raises issues of quality and safety, while over-skilling suggests inefficiency and can lead to job dissatisfaction and turnover (OECD, 2016). The findings underline a key message in our research (Imison et al, 2016); that the skills of the current health workforce do not match the work that needs to be undertaken. Better aligning skills to work can create more rewarding careers for staff and improve patient experience. Current roles are poorly designed – resulting in a mismatch between staff skills and requirements. A recent survey in

England of the health care support workforce, found that nearly 20% are being asked to do things beyond their scope of competence (Unison, 2016).

Two types of skills mismatch in health sector: under-skilling and over-skilling



Continuing austerity and rising workload pressures

Many professional bodies have raised concerns about increasing work pressures and burnout in the staff they represent. *“The morale of the medical workforce in the UK is at a low ebb and has continued to fall for much of the past decade”* (RCP, 2016). Half of GP practices say workload is “unmanageable a lot of the time” or all of the time (12.45%) (BMA, 2016). Ambulance services are experiencing unprecedented annual increases in demand on their services, placing increasing pressure on their staff. This is leading many staff (including paramedics) to leave their jobs and ambulance services are finding it increasingly difficult to recruit to posts due to the lack of trained paramedics. This then puts pressure on those remaining staff, exacerbating the retention problems (Unison, 2015). The number of NHS staff that left to achieve a “better work/life balance” has more than doubled in the last five years. Over 17,000 staff left for this reason in the year to June 2016 (NHS Digital, 2016).

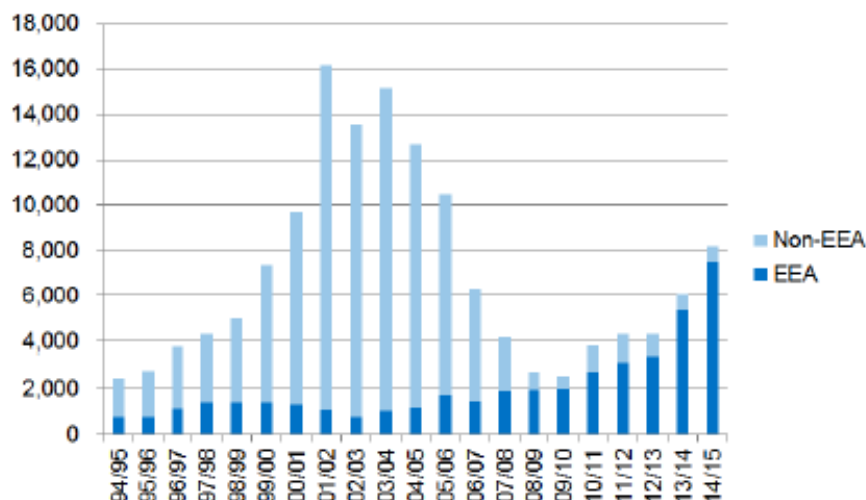
Austerity has also driven constraints on pay. The current median pay for nurses is £31,500, which is £7,500 below the median in other graduate occupations (MAC, 2016). RCM estimates that if midwives’ pay had increased with RPI since 2010, they would earn £6,000 more.

The impact of Brexit

The UK has a significant reliance on overseas recruits. The proportion of staff who trained overseas varies between staff groups. In 2014, they accounted for around 35% (14,600) of hospital consultants, 22% (8,000) of GPs and an estimated 14% (47,000) of nurses (NAO, 2016). With growing curbs on international migration there has also been a significant shift towards dependence on staff from the European Economic Area (EEA) – see Figure 3. Brexit

could both trigger a withdrawal of staff as well as making overseas recruitment more challenging.

Figure 3: New registrations on the Nursing and Midwifery Council register according to EEA and non-EEA origin



Source: RCN (2015) *International recruitment 2015*

Removal of NHS bursaries for non-medical staff

The shift away from centrally-funded bursaries for nurse training in England means that future training numbers will be driven by the perceived attractiveness of nursing as a profession. This was not a problem in the past, but the current pressures on pay and services could act as a major deterrent. There are also constraints on training placements with limited training budgets and placement availability. Given the scale of the problem facing nursing, the Government cut to nurse training budgets carries significant risks.

Potential solutions to the challenges

Improving staff retention – in training and work

While nursing courses have generally been heavily oversubscribed, they have also had relatively high drop out rates – 20% on average and up to 50% on some courses (Willis, 2015). There is growing evidence of the same happening in medicine (RCP, 2016a). Much more attention needs to be paid to reducing the rates of drop out in training.

As highlighted earlier, one of the biggest drivers of the current workforce shortages is also poor retention, with more clinical staff leaving the NHS than joining it. There is good evidence that empowering and developing your workforce can significantly improve retention rates. This can be achieved by creating opportunities for staff to develop professionally; offering increased autonomy and participation in decision-making; flexible employment; and access to continuing professional development. The recent cuts to continuing professional development budgets were short sighted, and are likely to have cost the NHS much more than their face value savings.

Pay should not be forgotten as a factor in this equation. When there was a severe nurse shortage in the late 1990s and early 2000s, the Pay Review Body responded with substantial real pay increases. According to the Migration Advisory Committee review of the nursing workforce, “available pay flexibility is insufficiently used”.

More flexible training pathways and continuing professional development

There are considerable opportunities from creating more flexible training pathways within and between professional groups. For example, training and developing the support workforce, enabling them to enter training for skilled nursing and other clinical roles. Not only does this expand the potential training pipeline, it widens participation and creates a clinical workforce that better mirrors its local community.

There are also opportunities to create pathways that help bridge the gaps between different parts of medicine, particularly between primary and secondary care. There should also be more routes into medicine for experienced clinical staff.

Skill mix change

Our recent report “Reshaping the workforce to deliver the care patients need” (Imison et al, 2016) laid out some of the key opportunities from skill mix change.

Support workforce

There are considerable opportunities to grow and develop the staff who are not professionally qualified, training them to take on more caring responsibilities and reduce the workload of more highly qualified staff. This part of the workforce is highly flexible, and short training times mean that numbers can be grown relatively rapidly. The additional training can also provide the first step towards more formal professional training, opening up new pathways to health care roles.

Assistant practitioners are a good example of the potential of support roles. In Taunton and Somerset NHS Foundation Trust, assistant practitioners – higher-level support workers who complement the work of registered professionals – have been recruited to support its radiology team amid a shortage of radiologists. The practitioners have helped to streamline the service, eliminate hold-ups for ultrasounds and biopsies and enable the unit to offer more one-stop clinics, decreasing the number of visits to clinic per patient.

Extending skills of registered health care professionals

Extending the roles of the non-medical workforce provides opportunities to manage the growing burden of chronic disease more efficiently and effectively. It also provides the opportunity to enrich the work of professional staff. There is some evidence that these new ways of working can release some savings and help bridge workforce gaps, particularly in primary care.

They also create opportunities to deliver a more complete package of care for patients. For instance, the Nottingham CityCare Partnership utilises ‘holistic workers’ to support their nursing and health care services across the city. The ‘holistic worker’ is a new breed of health care professional that is able to assess a patient’s complete care needs by receiving training beyond their registered profession. Each worker is registered in one area: nursing, physiotherapy, occupational therapy or social work, but goes on to expand their knowledge and skills across all four areas. As a result, each professional is able to provide cohesive support to their colleagues and a rounded experience for patients.

Use of these roles has allowed for a more efficient use of resources, with professionals able to do more for patients within a single visit.

Advanced roles

Advanced roles – which we’ve defined as those that require a Master’s degree in advanced practice – offer opportunities to improve clinical continuity; provide mentoring and training for less experienced staff; offer a rewarding, clinically facing career option for experienced staff; and help to bridge some of the gaps in the medical workforce. The roles can be developed relatively rapidly in about three years.

For example, Sheffield Teaching Hospitals NHS Foundation Trust has developed the advanced clinical practitioner (ACP) role. It has 70-80 ACPs working across a range of services and has established a faculty to standardise training and supervision requirements, among other things. Although a comprehensive evaluation of ACPs in the trust has not been carried out, anecdotal feedback from junior doctors working with ACPs and other staff has been positive, suggesting reductions in delays for patients in some areas.

A large number of countries are expanding the scope-of-practice of nurses in primary care. This includes nurses working in advanced roles as ‘generalists’ to take on some of the GP work and fill gaps in the GP workforce; nurses working in advanced roles as single-disease specialists particularly for chronic disease management; and nurses undertaking health promotion and prevention activity. For example, the USA is anticipating a significant expansion in the numbers of advanced nurses and physician associates.

Change is vital, but will not be easy

Changing the way people work is not easy. It takes skill, resources and persistence. Careful attention needs to be paid to role design, governance and effective change management. The financial context makes this agenda particularly challenging.

Improved workforce planning

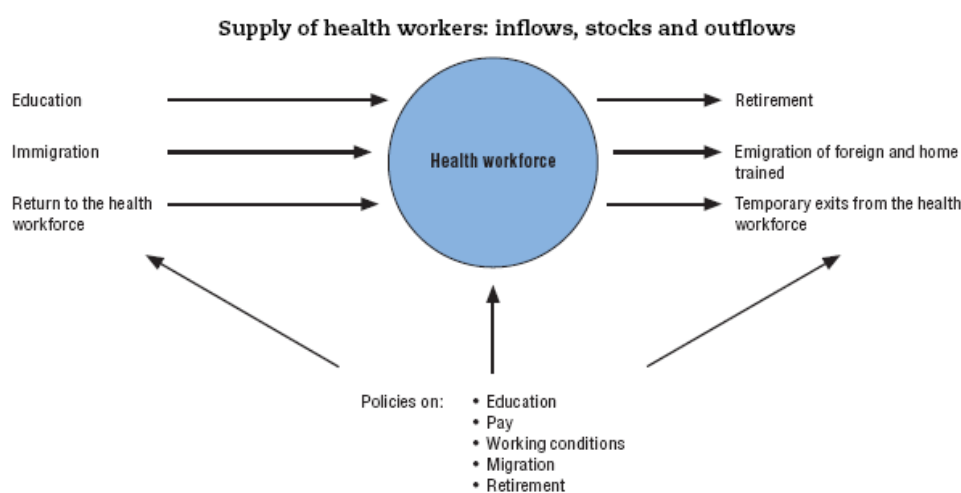
Assessing the future supply and demand for doctors, nurses and other health professionals 10 -15 years ahead is a complex task fraught with uncertainties around both demand and

supply (OECD, 2016; NAO, 2016). It would be hard to point to any country as a model of success. The boom and bust of NHS workforce supply is a common experience internationally (OECD, 2016).

Despite the difficulties, most countries use what is known as “numerus clausus” for medical training, whereby limits are set on the number of doctors in training. This method avoids supply-induced demand, helps manage the cost of training and helps align training placements in health care providers with university output. It is less common for countries to try and control numbers and plan for other professional groups.

Figure 4 below is a schematic of the many factors that need to be taken into account when modelling the supply of workforce, while Figure 5 shows the factors that need to be taken into account when modelling demand. In their recent report (NAO, 2016), the NAO criticised Health Education England for poor quality assumptions around many of these factors.

Figure 4: Overview of supply factors



Source: OECD

Figure 5: Overview of demand factors



Source: Nuffield Trust Analysis

England has recently placed significant reliance on provider plans for its workforce planning assumptions. The problem with this is that financial pressures will moderate trusts' workforce plans. Providers also struggle to look to the long term and lack workforce planning capacity and capability.

The changing demand for health care and the limitations in forecasting mean there is a high degree of uncertainty in the estimates of future workforce pressures. For example, Health Education England's previous analysis suggested that the difference between supply and demand for adult nurses in 2015 could range from a shortfall of 63,700 to an oversupply of 7,900 depending on different scenarios. The NAO pointed out that Health Education England has not undertaken a comprehensive investigation into the level of uncertainty, including the relative risks and implications of over- or undersupply. It is therefore unclear how the uncertainty is feeding into risk management across the health system (NAO, 2016).

Many of the recommendations of the report "Workforce Planning: Limitations and Possibilities" (Imison, Buchan & Xavier, 2009) still stand.

- *The focus should be on developing a flexible approach that does not seek long-term predictive precision but can identify potential medium-term issues, and, most importantly, enable the current workforce to evolve and adapt to the inherently unpredictable health care environment.*
- *Workforce planning at local and national level should be a core part of the productivity and quality improvement agenda. Workforce planners should undertake scenario modelling, workforce costing and supply-side projections, and future projections should include changes in the number, pay and mix of staff, in order to give employers and policymakers the information they need to help improve productivity.*
- *The annual assessment of priorities should look at the workforce in the round, not just the different professional groups and their sub-specialist elements.*
- *The assessment of risks should provide relevant information on:*
 - *education*
 - *employment law*
 - *pay*
 - *working conditions*
 - *national and international flows.*
- *There is a particular need to link pay policy to broader workforce goals.*
- *The planning and funding of broader workforce development, including leadership skills, should be given a higher priority.*
- *As part of the annual risk assessment, management and leadership capacity should be given specific attention. Consideration should also be given to whether the balance of investment is*

correct between the clinical and non-clinical workforce, as well as between the current and future workforce.

- *The multi-professional approach to workforce planning should be strengthened.*
- *Planning capacity at regional/local level should be audited and improved.*
- *There should be greater transparency about the degree of inherent uncertainty. The risks and assumptions in the workforce planning cycle should be made more transparent. Any annual assessment of workforce priorities needs to highlight and quantify the inherent uncertainties and risks in supply and demand.*
- *Workforce planning information needs to be secured from all health care providers. Workforce information is also needed from organisations that do not submit data via the ESR – that is, non-NHS providers and independent contractors within primary care. It will be important to find robust ways of capturing their workforce data.*

The role of technology

A key uncertainty in this uncertain future is the role of technology. In our recent report (Imison, Castle-Clarke & Watson, 2016) we described what that future might be and some of the implications for the workforce.

We mapped out two potential futures.

“Technology Heaven”

Health care will transform from the messy, inefficient world it is today, with much that is clinically uncertain and variable, to a glorious nirvana of streamlined efficiency, clinical certainty and consistency and patients who are so effective at managing their own health and care that they barely need to trouble the doctor.

“Technology Hell”

A bleak world where clinicians are tied to computers, trying to interpret a sea of data, while patients are overburdened with self-management tasks and anxiety about health, generated by obsessional monitoring and difficult-to-interpret probabilistic predictions about their genetic risk factors.

Information technology and the digitisation of health information are disrupting the health care landscape and the outcome of that disruption is inherently uncertain. Given that health warning, our best assessment of what the future may hold, is as follows.

First, information technology will be omnipresent but much less visible. No more carts with personal computers on the ward. Medical technology will become more and more intelligent. Data will be held remotely in the cloud, allowing professionals to use hand-held

devices that give them access to everything they need. Some have described the smartphone as the new stethoscope – the difference being that the patient has one too.

Second, technology is driving a fundamentally different relationship between patient and professional. This requires new skills for both. Professionals will require new coaching skills in order to ‘activate’ and engage people in their care. They will also need skills that can adapt to the wide range of patient capabilities and new consulting styles. In some areas, technology and the ability of patients to self-manage will require a very different approach from how professionals work now.

Third, technology is also driving a very different relationship between professionals. It supports medicine as a team rather than individual pursuit. This too will require new ways of working. As the traditional barriers between primary, secondary, community, social and mental health care are broken down, so will some of the traditional roles and services. For example, the current hospital outpatient model looks increasingly anachronistic in a world where consultants can offer advice to professionals and patients remotely. Multiskilled staff with a range of core therapeutic skills are likely to become an increasingly fundamental part of the workforce.

Fourth, the management of the potential sea of data presents health care and its workforce with their greatest opportunity and challenge. All staff will need to develop and extend their analytical skills. Meanwhile, new professional roles in the area of clinical and medical informatics are likely to emerge and become a core part of any clinical team. Many have talked about how the new access to clinical decision support tools will enable all staff to work to the top of their licence. This may well be true, but it may also present opportunities to work beyond the scope set by current professional boundaries. We need to move from the sea of data and wealth of information, to a personalised, informed and intelligent environment.

Fifth, managerial staff will also require new analytical skills in order to maximise the benefits from the newfound intelligence about their organisation and how it is operating. They will also need sophisticated organisational development competences in order to take staff on the transformation journey that technology can facilitate.

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5 January 2017

Independent Age – Written evidence (NHS0053)

About Independent Age

Whatever happens as we get older, we all want to remain independent and live life on our own terms. That's why, as well as offering regular friendly contact and a strong campaigning voice, Independent Age can provide you and your family with clear, free and impartial advice on the issues that matter: care and support, money and benefits, health and mobility. A charity founded over 150 years ago, we're independent so you can be.

Introduction

Independent Age welcomes this House of Lords Select Committee on the long term sustainability of the NHS. With the Five Year Forward View providing strong consensus for the direction of travel until 2020, the time is right for a detailed consideration of how to ensure a sustainable NHS beyond that date. This submission reflects Independent Age's interest in ensuring a health and care system that works to protect the dignity and independence of older people in this country. We know that this is a major concern for older people themselves; polling we conducted in 2014 revealed that the provision of healthcare and the NHS was the biggest issue of concern for those aged 65 and over⁷⁴².

1. The need to consider social care alongside the NHS

We were pleased to see that the Committee's stated areas of interest include reference to 'how we can move towards an integrated National Health and Care Service'. We strongly echo Richard Murray's comment in the second oral evidence session to the Committee that the NHS can no longer be thought of as 'an island that stands alone from what is going on around social care'.⁷⁴³

In recent months, the impact of a poorly funded social care system on the NHS has become all too clear with record levels of delayed transfers of care from hospitals. As we know from the work on our Helpline, behind these statistics lie numerous individual stories of older people spending longer in hospital than they need to and suffering significant negative health and wellbeing outcomes as a result.

There is now a growing consensus that the pressures on the NHS simply cannot be tackled in isolation. Over the summer Simon Stevens made the case that 'were extra funding to be available, frankly we should be arguing that it should be going to social care'.⁷⁴⁴ Any serious examination of the long term sustainability of the NHS must include reference to the sustainability of social care. We encourage the Committee to hear evidence from a wide range of voices within social care and to keep the sustainability of both health and social care at the heart of its deliberations.

⁷⁴² 73% of over 65s included provision of healthcare/NHS as amongst their top three biggest challenges for the country over the next 20 years. A quantitative survey of 2,421 UK adults was undertaken between 10th and 25th September 2014. 2,221 interviews were conducted online. A further 200 interviews were carried out by telephone to ensure a representative range of older people (65+) were included.

⁷⁴³ Evidence session no. 2, July 19 2016, page 2.

⁷⁴⁴ <http://www.theguardian.com/politics/2016/jun/17/nhs-boss-says-promise-of-8bn-in-extra-funding-may-be-far-from-enough>

However, we would also caution against the idea that integration of health and care is in itself an answer to the future sustainability of the NHS's finances. In a meta-review of the economic impacts of integration programmes, Nolte and Pitchforth (2014) conclude that the evidence for cost savings following integration is still weak and uncertain.⁷⁴⁵ Increasing numbers of people with complex care needs requires a system that brings together a range of professionals and skills from both the health and social care sectors. Integration is therefore the right thing to do to improve the quality of care people receive. But it does not completely answer hard questions about how we choose to prioritise and fund health and care for the future.

2. Future workforce issues – EEA workers

A sustainable future health and social care system must be equipped to care for the increasing numbers of older people who are frail and/or living with multiple comorbidities. A key component of this is a sufficiently large and well trained workforce. Since the EU referendum result of 23rd June there has been increased focus on European Economic Area (EEA) migrants who work as nurses and doctors in the NHS and their future as the government decides what, if any, guarantees to provide to migrants already resident in the UK.

However, not enough attention has yet been given to what Brexit potentially means for the country's social care workforce, increasing numbers of whom come from Europe to provide personal care and support to an ageing population. Around one in 20 (6%) of England's social care workforce are EEA migrants (around 84,000 people). And more than 90% of these EEA migrants do not currently have British citizenship, meaning they could be at risk of changes to their immigration status following Brexit.

This is particularly concerning given the long term picture. Over the past decade, there has been significant increase in the proportion of migrants from the EEA in the social care workforce. The rate at which EEA migrants have been filling vital care worker vacancies is accelerating as immigration rules affecting non EEA workers continue to place limits on unskilled labour. In the first part of 2016 alone, over 80% of all migrant care workers who moved to England to take on a social care role were from the EEA.

Independent Age has worked with the International Longevity Centre on a new analysis which reviews future workforce shortages in adult social care.⁷⁴⁶ To model the impact of post-Brexit immigration changes on the social care workforce, we looked at a number of possible scenarios for 2037:

- In a zero net migration scenario⁷⁴⁷, the social care workforce gap could reach just above 1.1 million workers by 2037. This means that there would be 13.5 older people for every care worker - compared to a ratio of seven for every care worker today.

⁷⁴⁵Ellen Nolte, Emma Pitchforth, What is the evidence on the economic impacts of integrated care? World Health Organization, 2014. Available online at http://www.euro.who.int/_data/assets/pdf_file/0019/251434/What-is-the-evidence-on-the-economic-impacts-of-integrated-care.pdf

⁷⁴⁶ The full report can be viewed here: <https://www.independentage.org/policy-research/research-reports/brexit-and-future-of-migrants-social-care-workforce>

⁷⁴⁷ A zero net migration scenario means total levels of emigration and immigration are equal, with no fewer or no more immigrants to the UK, than there are emigrants from the UK.

- In a (more likely) low-migration scenario, where the sector remains as attractive as it is today, but the government delivers on its commitment to reduce levels of net migration, there will be a social care workforce gap of more than 750,000 people by 2037.
- Even in a scenario where there are high levels of migration and the care sector becomes more attractive, the social care gap will be as big as 350,000 people by 2037.

The implications of a social care workforce gap of between 350,000 and 1.1 million workers for older and disabled people are clear – far fewer will be able to access the care they need to live meaningful, independent lives.

To avoid this outcome, in the short term we are calling on the government to ensure that all EEA migrants currently working in social care in the UK have the right to remain post-Brexit. The government also needs to ensure that any future migrant social care workers are appropriately recognised in any new approach to migration. This could be achieved in the number of ways, from guaranteeing freedom of movement within the EEA, to allotting care workers priority access rights in a work permit system.

To tackle a social care workforce gap over the longer term, we recommend that that government increases the attractiveness of the care sector to new recruits by offering additional training (including ‘careprenticeships’) and aiming to attract more men to the sector. As Baroness Kingsmill’s 2014 review of working conditions made clear, there are also systemic issues around job progression and job security that must be tackled to improve recruitment and retention in the sector.

However, we recognise that the sector is unlikely to become dramatically more attractive to anyone without a clear plan to ensure sustainable funding for the provision of social care.

3. Funding settlement – the need for an honest debate

The demographic challenges that our health and care systems will need to meet as a result of our ageing population are well established. The long term response to demographic change in many countries within the OECD has been to raise the share of GDP that is spent on health and social care.⁷⁴⁸ Decisions about the proportion of GDP that the country should spend on health and social care are explicitly political choices. As such they require a proper debate about the value that we as a society place on health and care and how much we are willing to pay for them.

That is why Independent Age has been calling for an independent commission on the future of health and social care.

4. An independent, cross party commission on the future of the NHS and social care

In spite of attempts made by successive governments, the issues facing both the NHS and the social care sector have never been more serious and have been touched on above.

A combined solution for health and social care is both in line with Government policy (via funding mechanisms such as the Better Care Fund) and strongly supported by health and care professionals. Research by the NHS Confederation found that 87% of NHS leaders wanted to see

⁷⁴⁸ <http://www.nuffieldtrust.org.uk/data-and-charts/uk-health-spending-share-gdp>

a five-year financial commitment covering both the NHS and social care⁷⁴⁹. However, significant questions remain about how, and when, integration will effectively take place.

A commission into the future of health and social care in England will be well placed to look beyond the funding challenges facing the country, and set out a roadmap for how and when health and care should be integrated, while placing older people, patients and service users at its heart. It will also have the opportunity to examine international models of finance, to establish how best our growing demand for health and care services can be met.

There is broad support for the campaign from the public - three quarters (74%) of whom support the idea of an independent commission to review how we run and fund social care, and nine in ten (91%) want all political parties to work together to ensure we can rely on health and care services as we get older, according to polling commissioned by Independent Age in February 2016⁷⁵⁰.

Since the beginning of the year, the campaign for a commission has won the support of former Health Ministers, including the Rt Hon Stephen Dorrell and Rt Hon Alan Milburn, current MPs and Peers including Norman Lamb MP, Frank Field MP, Liz Kendall MP and Lord Taverne, sector bodies including the Royal College of GPs and the Royal College of Nurses, several local authorities including Essex and Somerset, a number of NHS Trusts including Taunton and Somerset, Poole, and Northampton General Hospital NHS Trust, and strong support from organisations and individuals in the health and care sector. In total, 75 individuals and organisations are publicly signed up to the campaign, calling on the Government to act.

In view of such wide and diverse support, we call on this Committee to recommend that the Government establish a commission to address the long term sustainability of the NHS and social care. This commission should examine the possible ways in which the problems with the health and care system can be addressed including funding, workforce, and addressing the demographic challenges, and these recommendations should be agreed on a cross party basis, so that they outlive the course of a single Parliament. It should also use this Committee's findings on NHS sustainability as the basis for future analysis.

So far, the evidence sessions that the Committee has held have highlighted that the NHS Five Year Forward View has not addressed all of the challenges facing the NHS, and that it has become apparent that without a new settlement for social care, the expected £22 billion worth of NHS efficiency savings will not be achieved.

With the demographic challenge set only to increase as our population ages, there is no room for complacency. We need to ensure that we have an NHS and social care system which is fit for purpose for generations to come.

This Committee is an important step in addressing some of the challenges faced by our health and care system. We urge the Committee to recommend that the Government establish a

⁷⁴⁹ <http://www.theguardian.com/social-care-network/2015/nov/19/nhs-spending-review-social-care>

⁷⁵⁰ Findings are based on a ComRes poll of 2,014 adults in Great Britain, conducted online between 24th and 25th February 2016. Results were weighted to be representative of all adults in Great Britain aged 18+.

Independent Age – Written evidence (NHS0053)

commission to act on its findings, in order to find a way of making our health and care system sustainable for generations to come.

22 September 2016

Institute and Faculty of Actuaries – Written evidence (NHS0038)

Summary

1. It is important that the Committee considers social care in its assessment of the sustainability of the NHS. Social care needs are rising, yet State spending is falling. The affects of this are already being seen with the proportion of delayed transfers of care attributable to a lack of social care provision increasing. In order to create a sustainable framework in England, both health and social care funding need to be considered.
2. The funding models for the NHS and social care are different. If the future of health and care funding is to be sustainable, there needs to be a balance between these two approaches, and therefore, between Government and individual funding. International experience and pensions policy here in the UK demonstrate that governments can take a lead role in increasing the number of people saving towards future costs. Success has been achieved through awareness raising campaigns and implementation of national social insurance and saving programmes.
3. Our recommendations to the Committee are:
 - a. Widespread public engagement is needed on the cost of social care
 - b. Saving for care must be incentivised not penalised
 - c. Telehealth and wearables can encourage healthier living and create efficiencies in the health care system

Response

4. The Institute and Faculty of Actuaries (IFoA) is the UK membership body for actuaries. Health and care is a growing area for actuarial work as actuaries collaborate with other health professionals in financial planning for the NHS, researching ways to restructure funding models to meet the demands of an ageing population and to offer health and care insurance solutions.
5. To achieve long-term sustainability, and intergenerational fairness, it seems reasonable to find some way of ensuring that those benefitting from longer lives and access to health and care services contribute to this increasing cost. This is particularly important as the 'old age dependency ratio' (the number of people over the State pension age for every 1,000 people of working age) is increasing. This is resulting in a growing proportion of State expenditure being focused on those over State pension age, including health, social care and other age-related benefits.⁷⁵¹ We wish to bring to the Committee's attention a recent report by the Government Actuary's Department (GAD) 'A Cohort Approach to Social Care Funding'.⁷⁵² In this paper, GAD suggests tailoring the approach to social care funding by generation to develop solutions for the longer term. A further policy option that is being explored

⁷⁵¹ Cracknell, R. (2010) *The ageing population*. Key issues for the New Parliament 2010 House of Commons Library Research

⁷⁵² Government Actuary's Department (2016) *A Cohort Approach to Social Care Funding* (September 2016)

elsewhere in Government, and where the actuarial profession has completed further analysis, is increasing State pension age, to increase the number of people making National Insurance contributions.⁷⁵³

6. The IFoA welcomes the Committee's commitment to long-term sustainability. Moving towards a health and care system that is clear on what social care the State can afford to provide could be politically risky in the short-term, but it will enable people to plan and prepare for any additional needs not met within the free at the point of need funding arrangement. In particular, we note that Government could do significantly more to raise awareness amongst the public that they will need to fund their social care, unless their needs are substantial or they fall below the means-testing thresholds. Without this, people will continue to have to make decisions about their care at the point of need, which could result in additional stress at what will already be a difficult time.
7. We ask the Committee not to overlook the importance of social care funding in its assessment of the long-term sustainability of the NHS for the following reasons:
 - a. The number of people with social care needs in later life is rising. The Department of Health estimates that by 2018 there will be over 1 million more people with three or more long-term conditions in England than there were in 2008.⁷⁵⁴ Despite this forecast of an increase in demand, between 2009 and 2014, local authority spending on social care for older people fell in real terms by 17% and the number of people receiving publicly funded social care fell by 25% from 1.7 million people to 1.3 million meaning only those with substantial or critical needs are receiving public funding.⁷⁵⁵
 - b. An under-funded social care system and an increase in demand is already having a detrimental impact on the NHS, with the proportion of delayed transfers of care attributable to social care increasing between 2014 and 2015 from 26.7% to 31.1%.⁷⁵⁶ The National Audit Office has estimated the cost of treating older patients in hospital, who no longer need to be there, in the region of £820 million per annum. It notes this is a conservative estimate.⁷⁵⁷
 - c. The 2015 Spending Review reaffirms the Government's commitment to integrating health and care. In addition to considering what this means for delivery, there is also a disparity between the funding of these two systems. Funding of the NHS is through general taxation, yet funding for social care is largely through the individual's savings and housing wealth, unless they are eligible for means-tested benefits. Both the health and social care systems already face a deficit based on what the Government has committed to spending over the rest of this Parliamentary term. The integration of the two

⁷⁵³ IFoA (2016) *IFoA submission to the State pension age review* [Available online: <https://www.actuaries.org.uk/documents/state-pension-age-review-foa-submission-sir-john-cridlands-review>]

⁷⁵⁴ Department of Health (2012) *Long Term Conditions Compendium of Information: Third Edition*

⁷⁵⁵ The Kings Fund (2015) *How serious are the pressures in social care* [Available online: <http://www.kingsfund.org.uk/projects/verdict/how-serious-are-pressures-social-care/>]

⁷⁵⁶ ADASS (2016) *Submission to the Health Committee's inquiry 'Spending Review impact on health and social care'*

⁷⁵⁷ National Audit Office (2016) *Discharging older patients from hospital HC 18 Session 2016-17*

systems creates an opportunity for debate about the balance between State provision and self-funding across the health and care system.

8. For these reasons, we have focused our response on how the Government might strike a balance between Government and individual funding to meet health and care needs within a sustainable framework. Financial services can play a role in helping self-funders to meet their care costs and the IFoA has completed a series of research papers, which we have detailed in this response, on how this market might develop in a way that is complementary to Government funding. We would welcome the opportunity to share this with the Committee and discuss it in further detail.

Resourcing issues

Q. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care?

Q. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

9. Our analysis of international funding systems could be of use to the Committee in addressing both of the questions highlighted above.
 - a. In France, local governments fund around 70 percent of the care budget, with the remaining 30 percent being funded by central government. Central government funding is through employers' social security contributions, as well as general taxation, with additional funding coming from France's Solidarity Day. On Solidarity Day, employees donate their earnings from that day to fund care. This Government-led public awareness campaign has also led to a growth in private insurance. Less than 1% of care spending in 2007 was from private insurance provision, but by 2010, 15% of the population, aged over 40, had a care policy. This growth has been mostly attributed to the public becoming more aware of the risks and costs involved, as well as the gaps in public provision.
 - b. In Germany, there is a mixture of social and private insurance schemes. Compulsory social insurance was introduced in 1995. However, those with higher incomes, civil servants and the self-employed may opt for private insurance instead of the social insurance. Contributions to social insurance are split between the individual and the employer. This structure enables both public and private systems to sit alongside one another.
 - c. In 2000, Japan created a care social insurance programme. This programme covers domiciliary and residential care and the benefits are set nationally. It is compulsory for those over 40 years of age to contribute and it offers access to social care for those aged over 65. The level of contribution is dependent on income, but the benefit is dependent on need, as opposed to being means-tested.

- d. The Netherlands set up a publicly funded scheme to ensure no one had high expenses for meeting care needs. However, this has undergone review as costs have risen by 66 percent from €14bn to €23bn between 2000 and 2010. This has meant the system has been in constant flux.
 - e. Medicaid in the US is funded through general taxation and is a means-tested welfare programme for the poorest. The private insurance market is relatively well developed with products covering both domiciliary and residential care. The 2010 Affordable Care Act regulates and subsidises health insurance to make it more affordable and as of 2016, large employers have to provide health-coverage to full-time workers.⁷⁵⁸
10. Our conclusions from this research are that whilst Japan and the Netherlands have taken an approach that has a greater emphasis on publicly funded provision for care, an approach that aligns with the NHS funding model, the costs associated with this, particularly in the Netherlands, have led to a costly and potentially unsustainable system. Therefore treating social care the same as health care, and being funded through taxation could result in greater proportion of the Government's budget being spent on health and care than is already the case. The Government should consider whether this would be sustainable in the long-term when integrating health and care.
 11. On the other hand, the US has taken steps to increase private provision by creating a health insurance market that is affordable for consumers. By contrast, the market for long-term care financial products has been slow to develop in England where these products are seen as unaffordable for the majority of people. Germany has achieved a system where public and private funding sit side-by-side and where employers also contribute. The German system mirrors the UK's approach to auto-enrolment, where there has been success in driving up the number of people saving for their retirement. Perhaps a similar approach could be adopted for care. Both of these examples highlight that there is a key role for the Government in increasing levels of saving for care and in stimulating a market that is affordable.
 12. Finally, France managed to significantly increase the amount of private provision for care through a Government-led public awareness campaign. In the Care Act 2014, for the first time the UK Government legislated for changes to the current system with the aim of encouraging innovation in this market. The lack of market response was cited as one of the reasons for the deferral of these reforms to 2020. If the Government genuinely wants people to be aware that they may have to fund care needs themselves and to make provisions then we believe the following needs to happen:
 - a. Widespread public engagement is needed to create the scale of demand required for any financial product solutions to develop that are commercially viable.
 - b. Savers must be incentivised, not penalised.

⁷⁵⁸ IFoA (2012) *Long term care: A review of global funding models* [Available online: <https://www.actuaries.org.uk/documents/long-term-care-review-global-funding-models-0>]

Q. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

13. If the Government is looking to individuals to meet more of their care costs then it is important that the system incentivises, and does not penalise, savers. In our most recent report we highlight that the current means testing system for social care could act as a disincentive to saving, in particular for those with assets between £20k and £40k. For every £1 they save, 80p of means test benefits will be lost. The new thresholds set out in the Care Act provide a greater level of reward for savers with this dropping to 50p for every additional £1 saved.⁷⁵⁹
14. We therefore suggest that should the Committee recommend a means-tested approach that it considers the impact on savers. One solution could be the introduction of a new category of financial products that allow savings to be exempt from the means test up to a specified threshold. This cost could be met by removing existing loopholes to the financial assessment that allow a person to qualify for means testing benefits whilst having significant assets saved. The kind of products in scope (to the extent they are used or earmarked for health and social care costs) would potentially be pension savings, ISAs, equity release from property and any new products which may come from market innovation e.g. disability-linked annuities. Tax incentives for personal saving for health and social care needs could also be considered, for example, allowing withdrawals from pension saving to be tax free if used for such health or social care needs.
15. We also suggest that before the Committee recommends a Dilnot-style cap continues to be pursued, that it also recommends that an assessment be completed on the level at which the cap is set, to determine what proportion of the population is likely to benefit, as well as the potential overall cost to the Exchequer. It should also be made clear what costs the cap covers to avoid any misunderstanding amongst the public. Our research on the Care Cap legislated for in the Care Act 2014, found that for individuals entering care at age 85 (typical age) around 8 percent of men and 15 percent of women would benefit from the cap, and that on average they would have spent £140,000 before reaching the '£72,000 cap'.⁷⁶⁰
16. Should the Committee wish to either explore the means-tested or care cap approach in further detail we would welcome the opportunity to discuss our work. We plan to complete further analysis on the impact of different thresholds and this may be of interest to the Committee as part of this inquiry.

Digitisation, big data and informatics

⁷⁵⁹ IFoA (2015) *How financial products can work alongside the Care Act 2014 to help people pay for care* [Available online: <https://www.actuaries.org.uk/documents/how-financial-products-can-work-alongside-care-act-2014-help-people-pay-care-december-2015>]

⁷⁶⁰ IFoA (2015) *How pensions can help meet consumer needs under the new social care regime* [Available online: <https://www.actuaries.org.uk/documents/how-pensions-can-meet-consumer-needs-under-new-social-care-regime-full-report-updated>]

Q. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

17. As many actuaries price and reserve for insurance products, we have drawn from our experience in the insurance sector. Experience from overseas shows that technologies such as telehealth and wearables can encourage healthier living. In the US, the insurance sector is already using wearables to promote healthier living. One example is Blue Shield: Wellvolution, a non-profit insurer based in California. This scheme assigns challenges to employees that they earn points for completing and as a result, amongst its 5,000 employees, it has seen a 50 percent reduction in smoking, hypertension has reduced by 66 percent and it has saved the employees \$3million per annum in insurance premiums.⁷⁶¹ Another example is Discovery Limited in South Africa. Its Vitality programme incentivises members to live healthier lifestyles by providing them with rewards for achieving specified health goals. Rewards include discounts on travel, healthy foods and leisure activities. This programme allows members to connect their wearables to their profile to collect data that assesses their progress towards earning points. This also enables a more granular assessment of risk and provides greater insight into a policyholder's morbidity and mortality risk. These benefits would be the same for health services.⁷⁶²
18. In addition, the use of wearables is creating efficiencies that could be equally useful in the health sector. Wearables are helping insurers to improve upon resource intensive and costly underwriting practices. Access to the continuous picture of a policyholder's health can reduce inconvenience to policyholders and provide the potential for insurers to digitally streamline their underwriting process, reducing cost.⁷⁶³
19. Again, as with funding, linking with employers could be beneficial. Here in the UK, Havenrock Group's income protection scheme for its employees incorporates wearables to improve employee health. Insured employees get a free activity tracker and a free annual health check-up at their workplace. Data from these are combined on an online health portal that offers employees advice, annual reports and notification of any health issues they might wish to seek medical advice for. The employer also benefits from an anonymised overall annual health status report on its employees. It has seen improvements in productivity and reduced stress, fatigue and absenteeism.⁷⁶⁴
20. The greater use of wearables will not be without its challenges. A significant amount of analytical work is required to turn the data from healthcare wearables into meaningful rating factors to incorporate into estimates of morbidity or mortality. This will be made more complex by the interaction of multiple factors in determining someone's risk profile. However, the benefits of better estimates of morbidity and

⁷⁶¹ <https://www.blueshieldca.com/bsca/about-blue-sheild/careers/wellvolution/incentives.sp>

⁷⁶² IFoA (2016) *Wearable technology: A health and care actuary's perspective* [Available online: <https://www.actuaries.org.uk/documents/wearable-technology-health-and-care-actuaries-perspective>]

⁷⁶³ *ibid*

⁷⁶⁴ *ibid*

mortality could have significant cost saving for health and care services by enabling better targeting to high-risk groups / areas. Social care demand is increasing: better targeting of services could help increases in healthy life expectancy to catch up with increases in overall life expectancy, thereby reducing the demand and ultimately the cost of providing care.

21 September 2016

Institute of Physics and Engineering in Medicine – Written evidence (NHS0092)

The Select Committee on the Long-term Sustainability of the NHS of the House of Lords, chaired by Lord Patel, is conducting an inquiry into the sustainability issues facing the NHS and the impact they will have over the next 15–20 years. The Committee invites interested individuals and organisations to submit evidence.

Background

The Institute of Physics and Engineering in Medicine (IPEM) is the Learned Society and professional organisation for physicists, clinical and biomedical engineers and technologists working in medicine and biology. We are a charity with around 4,300 members from healthcare, academia and industry and our aim is to advance physics and engineering applied to medicine and biology for the public good.

Our members help to ensure that patients are correctly diagnosed and safely treated for illnesses such as cancer and stroke. They also maintain and manage medical equipment such as MRI and ultrasound scanners, X-ray machines, drug delivery systems and patient monitors. Their research and innovation leads to new technologies and methods that improve on existing medical treatments. They provide new solutions that enable older people and patients with injuries or long-term conditions to complete everyday tasks.

IPEM's response to this consultation focuses on the questions surrounding the workforce issues.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

c. What investment model would most speedily enhance and stabilise the workforce?

1. Addressing matters concerning the UK leaving the European Union:
2. European Union professionals, including healthcare scientists, employed in the NHS need special protection. They are already important contributors to our health service, often in shortage disciplines. Arrangements also need to be put in place to continue to attract healthcare workers from the EU to UK shortage professions. The simplest mechanism would be that EU workers who were already ordinarily resident [as confirmed by council tax or voting register, or had a National Insurance number] on 24 June 2016 can convert to indefinite leave to remain. Those who enter the UK after this date, do so knowing the Brexit situation and therefore cannot assume automatic leave to remain. A scheme similar to that of the [EU Blue Card](#) or five tier points-based system (currently used for non-European members) should be introduced for EU citizens. This system would need to respond in a timely manner.
3. The UK NHS workforce is ageing. If the UK is to become less dependent on employing staff from Europe, then the NHS needs an urgent national strategy to invest in funding the training of more Clinical Technologists and Clinical Scientists. To date, this long term vision and funding has been lacking from the national agenda.
4. In order to protect patients, Clinical Scientists are state-registered in the UK and the title 'Clinical Scientist' is protected by law. There are reciprocal arrangements with other EU countries so that Clinical Scientists registered in the EU can register and work in the UK. The UK should continue to recognise European equivalence, irrespective of EU membership.
5. UK and EU legislation requires the appointment of Medical Physics Experts (MPEs) to work in the fields of Diagnostic and Interventional Radiology, Nuclear Medicine and Radiation Oncology/Radiotherapy. The UK Government should seek to encourage harmonised systems of training, education and competence of MPEs throughout Europe. This need not be limited by the EU if all countries are following the same system.

6. Moving away from issues surrounding the UK leaving the EU to address those concerning training:
7. The Modernising Scientific Careers framework covers the career pathway from Assistants and Associates, Practitioners, Scientists and Higher Specialist Scientists. The training models and delivery differ along the framework, but a significant element of the training is delivered in the workplace, and strong links are needed between the employers and the HEIs. The current programmes are the Practitioner Training Programme (PTP), Scientist Training Programme (STP) and Higher Specialist Scientist Training (HSST)
8. There is a need to increase the workforce in Medical Physics and Engineering. The UK Shortage Occupations List includes Radiotherapy and Nuclear Medicine Scientists and Practitioners. Health Education England's 16/17 Workforce Plan for England states there has been a 4.3% increase in the number of healthcare scientist STP commissions for 16/17. However this overall figure for healthcare scientists disguises the changes in commissions in the individual specialties. The Clinical Scientists (Medical Physics) commissions for 16/17 have decreased by 8% compared to the previous year. The reason for the reduction in the number of commissions is not clear - there is evidence that some training centres have reduced their commissions due to the high training workload that the STP generates, while on the other hand at least two large centres have not had their requests for trainees to start in 2016 fulfilled.
9. To produce a high quality healthcare workforce both the HEI education and the workplace education and training are essential and cannot be decoupled. The PTP requires 50 weeks of clinical placement over 3 years. A Clinical Scientist (Medical Physics) 3 year STP trainee may typically spend up to six months directly at the HEI with the remaining 30 months of the programme within the workplace.
10. To increase the workplace training capacity workplace funding and investment would be required, to provide the training infrastructure and training support. There may be particular difficulties in providing placements for smaller specialised groups of health workers, where the small number of students, and the associated workplace funding may not be sufficient to support the workplace training infrastructure required, and there may be difficulties in providing the breadth of training required.
11. The NHS will be a major contributor to the apprenticeship levy. Supporting the use of the levy through encouraging apprenticeship schemes within the Modernising Scientific Careers framework would benefit the scientific workforce.
12. The experience with the Practitioner Training Programme (Medical Physics) has shown that it is not attractive at undergraduate level without funded places; only the places **funded** by the Welsh Assembly have ever been filled in physics. The **self-funded**, undergraduate PTP has yet to produce **any** trained staff in Radiotherapy

Physics, Nuclear Medicine Physics or Radiation Physics, and only very few (less than 25 over 3 years) in Engineering.

13. The failure of the PTP programme to attract suitable trainees and deliver the practitioner workforce required in Medical Physics and Engineering has demonstrated that without adequate funding for clinical placements including the provision of suitably qualified supervisors/mentors, self-funded undergraduate schemes that require substantial clinical placements find it extremely difficult to produce the required numbers of qualified staff.
 14. The Scientist Training Programme (STP) , which is currently a salaried programme, is in competition for candidates with other highly-paid graduate programmes from industry. If Clinical Scientist training ceases to be an attractive option to high quality physics and engineering graduates, this will be detrimental to the patient care.
 15. Without access to a salaried programme the STP training becomes unworkable. IPEM's view is that a salaried programme is essential to underpin postgraduate clinical scientist training.
 16. IPEM's view is that funding to the workplace training providers is essential to ensure an increase in the numbers of trainees and to maintain the quality of the training.
- 23 September 2016*

Integrated Care 24 – Written evidence (NHS0136)

1. ABOUT INTEGRATED CARE 24

- 1.1 IC24 delivers a range of integrated urgent and unscheduled care services, including GP-led out-of-hours and NHS 111. With 25 years of experience, we are leaders in the sector, providing out-of-hours coverage for 2/3 of the week and NHS 111 coverage 24/7, to over 6 million patients.
- 1.2 Working in partnership with 29 Clinical Commissioning Groups, we operate in Kent, Brighton and Hove, East and West Sussex, East Surrey, Essex, Great Yarmouth and Waveney, Northamptonshire, and Norfolk and Wisbech, where our workforce of around 1,500 dedicated people provide care for our patients.
- 1.3 We understand the needs and challenges of each area we work in, and deliver locally-focused services to support our commissioners and patients. Very often this includes working with A&E departments and other local services to deliver a joined-up and effective service for patients.
- 1.4 As a not-for-profit social enterprise, we are passionate about making a difference to our patients, people and partners. We are a member of Urgent Health UK, a federation of unscheduled and urgent care social enterprises, and always seek to share learning and best practice across the sector.
- 1.5 Further information about IC24: <http://www.ic24.org.uk>

2. RESOURCE ISSUES

- 2.1 With the right support, unscheduled and urgent care has huge potential to help overcome many of the challenges that the NHS is facing, putting the system onto a more sustainable footing long-term. IC24 and other similar providers can be flexible and responsive to changing patient demands, but must not be treated as a short-term fix when pressures in A&E become too high.
- 2.2 We recognise that across the entire NHS, funding is a challenge; however, we firmly believe that integrated unscheduled urgent care represents a major opportunity to ease current pressures particularly given the consensus that activity must be shifted out of hospitals. We have in recent years experienced a substantial rise in activity for our services. Between 2014-15 and 2015-16, there was an 8% increase in cases through our out-of-hours services. For NHS 111, there was a 21% increase in calls during the same period. Despite this, regrettably, funding for services in this sector remains on a downward trend. For a number of out-of-hours services, IC24 receives as low as less

than £6 per head of population covered in a block contract that does not increase income as activity increases. This is not sustainable for a sector that is experiencing such a significant increase in demand. Moreover, the knock-on effect is higher costs in A&E and other parts of the NHS; it is a false economy – funding reductions in integrated unscheduled and urgent care must be reversed.

2.3 Funding, particularly invested in underperforming A&E departments, should be redirected to integrated unscheduled urgent care, so our sector can fulfil its potential in coping with fluctuating patient demands long-term and taking pressure off the acute sector. It must be recognised the performance of A&E departments is dependent on other providers in the health economy; we are committed to playing our part, but must be supported to fulfil this potential.

2.4 NHS England's Urgent and Emergency Care Review has been useful in making progress to develop new and innovative ways of working in our sector, and IC24 has been working to take forward the requirements and recommendations. We were also pleased to see integrated unscheduled urgent care feature in the General Practice Forward View and Planning Guidance for the Sustainability and Transformation Plan Process. A focus on this sector is crucial to enable A&E departments to meet access standards which is recognised as a 'must-do' in the STP Planning Guidance. For this to be achieved by hospitals, integrated unscheduled urgent care will have a major role to play in taking on even more activity.

2.5 By prioritising changes and improvements in integrated unscheduled urgent care, patients will receive the right care, in the right place, at the right time enhancing their experience, whilst the NHS will be put onto a more sustainable footing long-term. It is widely recognised that patients attending A&E unnecessarily damages their experience of care. Moreover, for certain patient groups, such as those suffering with mental health conditions, A&E is an inappropriate setting.

RECOMMENDATION 1: Funding reductions in integrated unscheduled urgent care must be reversed and the sector should be embraced as a central solution to easing pressures on the NHS.

RECOMMENDATION 2: NHS England should produce a further update on progress of the Urgent and Emergency Care Review and next steps to ensuring long-term change.

3. WORKFORCE

3.1 Investment is just one of the challenges restricting the sector from making an even greater contribution. Workforce shortages remain a serious issue and must be addressed urgently. The commitment from the Government, NHS England and Health Education England to recruit more GPs is welcome, but obstacles to achieving this must be broken down to ensure that the NHS has a workforce fit for the future and the NHS becomes more effective at retaining staff.

3.2 The high cost of clinical indemnity is one example of a deterrent to out-of-hours work, and we hope NHS England will put in place a long-term arrangement to address this – our initial reaction to the interim decision on 28th July is that it will not fully address the challenges. Until there is a sufficient pipeline of staff, enough of whom are willing to work in GP-led out-of-hours to fill current rotas and expand our work, IC24 cannot make the most effective contribution.

3.3 IC24 previously surveyed our staff to assess the impact and their views on a resolution – the headline figure is that 86% said indemnity is limiting the number of out-of-hours shifts undertaken. Moreover, while 88% of respondents were aware of the initial Winter Indemnity Scheme in 2015, worryingly, 68% of this group did not try to gain additional cover. We can present the full data to the Committee.

3.4 An increased “multi-disciplinary” approach with a bigger mix of clinical staff is required to provide services. This will help to fill shifts, but will also ensure patients are receiving joined-up care for their potential multiple needs. A flexible workforce that can work across the system is critical for the NHS to deal with patient demand. Furthermore, by enabling primary care to deliver more services in the community, secondary care will be able to deal with more complex patients. To make this a reality, the workforce needs to be upskilled.

RECOMMENDATION 3: Further steps must be taken by Health Education England, NHS England and the Department of Health to increase the recruitment and retention of GPs, in order to support integrated unscheduled urgent care, fill rotas and extend our capacity to take activity out of secondary care.

RECOMMENDATION 4: The Government must work with NHS England to address the issue of rising indemnity costs and put in place a long-term sustainable solution that doesn't penalise those who work in the integrated unscheduled urgent care sector.

RECOMMENDATION 5: Further steps must be taken to upskill staff to enable a flexible workforce that can flex with demand and create a more sustainable NHS.

4. MODELS OF SERVICE DELIVERY AND INTEGRATION

4.1 We are already making a major contribution to our NHS partners, but the integrated unscheduled urgent care sector can be even further enhanced, driving new and innovative ways of working. Partnership working is central to IC24's approach to delivering the highest quality of care and this is enabling us to ease the burden on A&E departments, whilst we test, design and pilot new models. We understand that solutions must be locally sensitive to truly meet the needs of all parties, including, crucially, patients.

4.2 In Norfolk and Wisbech, IC24 is taking the lead to adopt one of the first clinical hubs in the country, making NHS England's vision for the urgent and emergency care sector a

reality. Working in partnership with our commissioners and local GPs, we are focused on increasing capacity in the out-of-hours service to provide face to face assessment if required, and enabling referrals from A&E to the clinical hub 24/7. We are very confident that this approach will prove to be successful, characterised by innovative use of the workforce, clear pathways across service boundaries and a reduction in demand caused by failures in other parts of the health system. We have been encouraged by initial findings from a short term pilot which shows positive outcomes for patients, alongside important financial implications – 115 outcomes for patients were changed, with savings for A&E and 999 estimated at £26,200. Enhancing and rolling out this model more widely as a means to integrate urgent, emergency and primary care provides a significant opportunity to help put the NHS onto a more sustainable footing whilst improving patient care. We have a detailed report on the outcomes which we would be delighted to share with the Committee.

4.3 In addition, in West Suffolk, we piloted an NHS 111 reception point in the A&E department over a weekend. This allowed a clinically safe and effective triage at book in and management of patient flow through the department. Of the 35 patients referred to an Urgent Care Clinic, 31 were seen by the GP and discharged without further treatment, 2 were referred onto the Emergency Department for further assessment and treatment, and 2 were medically expected. These outcomes signal the success of the pilot in reducing pressure on the A&E department and delivering a key message to patients that if it is not an emergency, there are better alternatives. We would be delighted to share the outcomes in more detail with the Committee.

4.4 Furthermore, IC24 were commissioned as the lead provider to deliver the West Kent Urgent Care Service (WKUCS) – the service includes GP-led out-of-hours, a home treatment service, and primary care stream in A&E. As part of the solution, IC24 sub-contracts Kent Community Health Foundation Trust (KCHFT) and developed collaborative working with Maidstone & Tunbridge Wells Trust (MTW). The three elements have enabled us to develop joint working across organisational boundaries. We believe the service should evolve into a clinical hub.

4.5 In order for new ways of working in urgent and emergency care to be successful and adopted across the country, it is essential to break down existing barriers to integration and partnerships across organisational boundaries. Notably, co-location or cross working between integrated unscheduled urgent care and A&E departments is hindered by misaligned financial incentives. A new uniform payment mechanism for all sectors would incentivise collaborative working and integration, which will enable the NHS to flex with demand.

RECOMMENDATION 6: NHS England and the Department of Health should produce guidance citing examples of best practice in integrated urgent and emergency care, in

order to share learning and promote the sector as a key solution to overcoming challenges facing the NHS.

RECOMMENDATION 7: NHS England, the Department of Health and NHS Improvement must work to break down disincentives to models that foster closer collaboration between A&E departments and integrated unscheduled urgent care providers.

RECOMMENDATION 8: A new uniform payment mechanism for all sectors should be introduced in order to incentivise collaborative working and integration.

5. PREVENTION AND PUBLIC ENGAGEMENT

5.1 An integrated NHS 111 and out-of-hours care are vital to the sustainability of the system, however there is a lack of awareness amongst the public of these services. Public Health England should be involved in campaigns nationally to promote NHS 111 and out-of-hours and the range of services available to patients; this will help patients to attend the most appropriate setting for their care and is vital to reducing pressure on the acute sector. With an ageing population and demand for all services increasing as a result, we cannot afford to underutilise integrated unscheduled urgent care due to a lack of awareness. With appropriate funding, IC24 would be in a strong position to help deliver these messages in schools and GP practices.

RECOMMENDATION 9: Public Health England must do a campaign on NHS 111 and out-of-hours to increase public awareness of the range of services available to them.

6. DIGITISATION OF SERVICES, BIG DATA AND INFORMATICS

6.1 IC24 pride ourselves on innovation in healthcare, specifically by adopting new IT solutions to enhance our offer. This enables staff to carry out their duties to a higher standard, which is clearly positive for patient outcomes. Our electronic clinical patient management system (CLEO – Clinical Excellence Online) is nationally accredited by NHS Digital for NHS Spine integration and currently one of only three systems licenced by NHS Pathways which also puts us in a good position to provide the supporting infrastructure required for integration.

6.2 The increasing focus of NHS England and commissioners on integrated IT systems is right and is aligned with IC24's intentions to enhance our services. It is crucial our clinicians can access the

Patients GP Record directly in our urgent care clinical system to make the best judgments for patients. However, barriers exist in the market to truly joining up systems. These barriers increase the likelihood of a patient visiting another part of the system which is not sustainable.

6.3 Making progress on this point is much simpler than commonly perceived. Our CLEO system already links up with the Medical Interoperability Gateway and proposal has been submitted to NHS England & NHS Digital to support CLEO being considered as one

of the First of Type solutions through the NHS Digital GPsoc GP Connect Programme. This will provide access to these key Patient records if access is granted at a GP practice level and would provide staff at IC24's services with crucial information on patients in an easy-to-digest format. Designing and implementing complex and costly sharing systems is unnecessary when simple steps can be taken in the short-term.

6.4 It is promising that the Secretary of State, Jeremy Hunt MP, recently announced the expansion of NHS 111 to include a new online triage service for less serious health problems, enabling patients to enter their symptoms online and get tailored advice or a call-back from a healthcare professional according to their needs. IC24 firmly believe NHS 111 has the potential to bring care closer to home whilst taking the pressure of the acute sector.

RECOMMENDATION 10: Barriers to integrating IT systems must be overcome to ensure patient records can be shared and clinicians can make more informed decisions.

23 September 2016

The Intergenerational Foundation – Written evidence (NHS0148)

The Intergenerational Foundation (www.if.org.uk) is an independent think tank researching fairness between generations with regard to such issues as housing, employment, taxation, education, the environment and health. IF's guiding principle is that policy should be fair to all – the old, the young and those to come.

Introduction:

The Intergenerational Foundation (IF) welcomes the opportunity to comment on the long-term sustainability of the NHS, and we would like to make the following points in response to this public inquiry:

1) Ageing and health costs share a complex relationship

The current debate surrounding the long-term sustainability of the NHS appears to be predicated on the questionable assumption that population ageing will automatically lead to higher healthcare costs. Although demographic factors have a strong influence on healthcare costs, this assumption overlooks the body of evidence which suggests that other factors may be of greater significance in determining the future sustainability of healthcare services. The assumption that healthcare costs inevitably rise in lockstep with rising longevity may also divert attention away from examining the precise set of causal relationships between these two phenomena, which appear to be more complex than is often assumed.

IF has recently undertaken a review of the research literature on healthcare costs, which revealed two points that are of relevance to the committee's inquiry. Firstly, most of the analysts who have examined the issue of rising healthcare costs have concluded that demographic change is only one contributory factor: Barker (2014) found that one of the most important explanations was that countries choose to spend proportionally more resources on healthcare as they become wealthier; Newhouse (1992) and Cutler (1995) showed that over 50% of the cost increases observed in America's healthcare system in the latter half of the 20th century were due to technological progress, and Spijker and MacInnes (2013) have modelled projections that show medical progress and the growing numbers of people of all ages living with comorbid medical conditions are likely to be biggest sources of pressure on the NHS in the future, rather than simply the increasing number of older people.

The second important point revealed by this literature review was that medical costs are highly concentrated among a small section of the population, even among the elderly. This was demonstrated by data from Kelly et al. (2015), displayed in Fig.1:

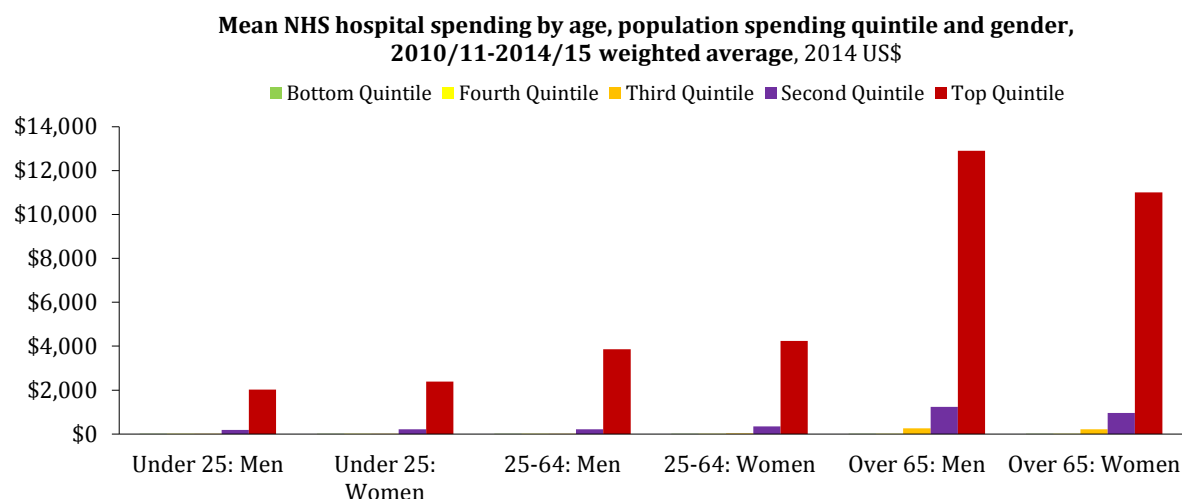


Fig.1 The distribution of patient expenditure in NHS hospitals, using data from Kelly et al. (2015)

Kelly et al. used data from NHS administrative records to show that, if you divide the English population into quintiles on the basis of how much they cost the NHS within a given year, then only the top fifth – the 20% of patients who had the highest expenditure – require any significant expenditure at all, and this holds true across all age groups. Remarkably, she found that in each of the years she analysed, 32% of all healthcare spending was being consumed by just 1% of the population. However, spending on the top quintile of patients was highest overall among the elderly; this is supported by other studies which have shown that healthcare spending on the typical individual rises rapidly during the final few months of their life.

The largest study of this kind, Cutler et al. (2007)’s longitudinal analysis of 10,000 American Medicare recipients (America’s system of public health insurance for the elderly) between 1991 and 2009, concluded that “compression of morbidity” had taken place over this period: disability-free life expectancy had grown over twice as quickly as overall life expectancy, with the result that the typical person was living “longer but fitter” instead of “longer but sicker.” These findings were echoed by Aragon et al. (2015), whose analysis of 15 years’ worth of detailed patient-level spending records within the NHS was that spending on medical interventions in the year of death has risen more rapidly than overall medical spending; in other words, it is the number of people who are dying – rather than ageing per se – which could potentially endanger the long-term sustainability of the NHS.

What makes this research especially pertinent to the committee’s inquiry is that Aragon et al. also observed that death at younger ages is actually more expensive, on average, than death at older ages, possibly because there are more potential treatment options which doctors and patients are willing to try to prevent someone from dying at a younger age. This suggests that further increases in longevity could actually *reduce* demands on the NHS over the longer term as long as a) disability-free life expectancy continues increasing more quickly than overall life expectancy, and b) variations in healthy life expectancy are addressed. On the latter point, investing in public health interventions which should increase healthy life expectancy (such as anti-obesity and anti-smoking campaigns) is likely to prove cost-effective over the long-term.

2) Healthcare spending is really about *politics*, not demographics

Despite the evidence given above that healthcare costs and ageing have a complex relationship, it is inevitable that demand for healthcare services will continue rising in the UK because a) an older population will have higher mortality, b) more people of all ages will be surviving for longer with multiple comorbidities, and c) medical progress will continue advancing, broadening the range of treatments which doctors can offer their patients.

However, it often seems to be assumed in the debate about NHS sustainability that rising *demand* will automatically lead to rising *costs*. A number of expert bodies, most notably the Office for Budget Responsibility (OBR), have produced projections of what NHS spending is likely to be in future years on the basis of changes in the demand curve for healthcare (which are themselves usually based on demographic projections of what Britain’s population will look like in future). However, the narrow focus of such exercises on demographics means they run the risk of overlooking the reality that the most significant factor governing how much we spend on the NHS is politics. Throughout the history of the NHS, different governments have invested wildly different amounts in funding the NHS, depending on whether or not it was one of their major policy priorities (Fig.2):

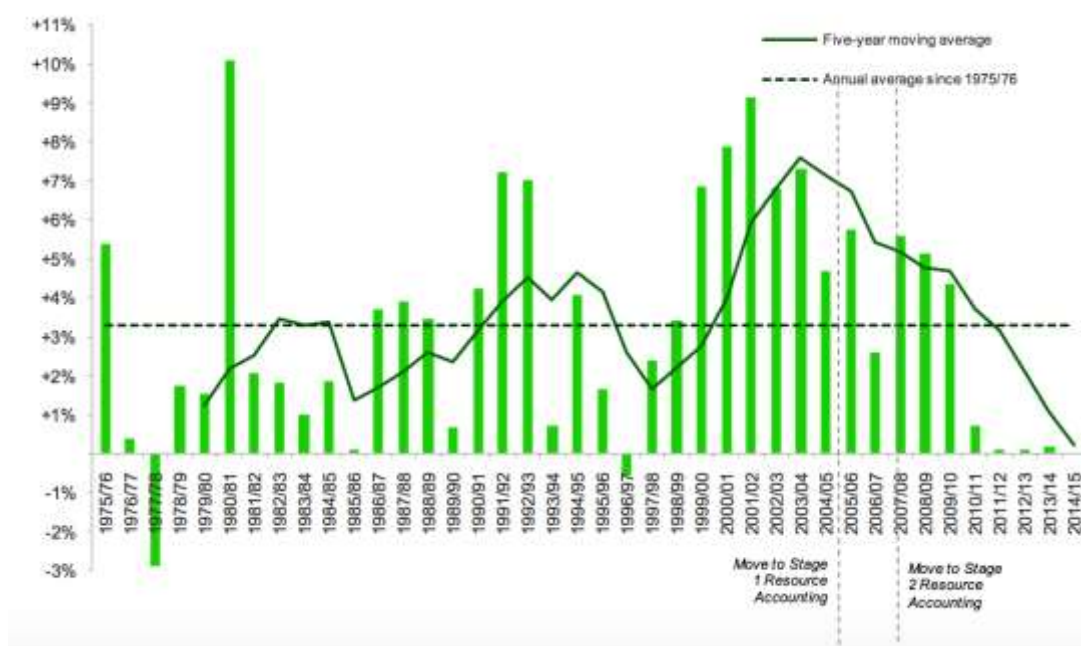


Fig.2 Annual percentage change in real terms NHS expenditure and planned expenditure in England, 1974/75 to 2014/15 (reproduced from Harker, 2012)

The inconsistent nature of these changes in NHS funding suggests that they have had only a cursory relationship with the actual demand for healthcare. Instead, they broadly reflect the political salience which different governments have placed on the NHS: there was clearly a very big shift in emphasis between the 1997–2010 New Labour administrations and the 2010–15 Coalition government, for example. International comparisons show that the UK is currently spending slightly less than the OECD average on healthcare (9.8% of GDP against 10.3%); there are other countries which have a similar level of development to the UK that spend significantly more or less (just among other European countries, Switzerland spends

as much as 11.5%, while Iceland spends as little as 8.8%) (OECD, 2016).

IF is not in any sense ideologically committed to either shrinking or enlarging the state; these comparisons are included merely to suggest that there is no “right” level of GDP to spend on healthcare purely on the basis of our demographic profile. Many experts would argue that even if demand for healthcare was flat, more should still be spent on the NHS to improve the quality of service it offers. IF would argue that the NHS’s current short-term financial problems have more to do with a lack of political will to provide an adequate level of funding to finance the levels of service which the public currently expects to receive than it does with healthcare being “unaffordable.” We strongly believe that there needs to be a much more honest public debate about what degree of service citizens expect the NHS to provide, and how much they are willing to spend on funding it, than is currently taking place. Overall, the key question governing the NHS’s long-term sustainability is not “can supply keep up with demand?”, but “can the political and public will to pay for the NHS be sustained?”

3) If the public wants higher spending on the NHS then higher taxes shouldn’t fall on the young

A clue as to what the public’s priorities are regarding the NHS has been provided by the Health module from the British Social Attitudes Survey (Appleby et al. 2016). This asked a representative sample of UK adults the question “If the NHS needed more money, which of the following do you think you would be prepared to accept?” and asked them to pick from a range of possible answers. Altogether, around 35% of respondents selected an answer which would involve raising more tax to pay for the NHS, although they were split between raising existing taxes and creating a new “NHS tax” with some degree of hypothecation.

Other opinion polls have consistently shown that the NHS is one of the leading priorities for additional government spending. Obviously, this suggests that the public wants a more a generously-funded NHS. If that is the most popular answer to the NHS’s sustainability challenge, then IF believes very strongly that the targeting of any future tax increases should be as progressive as possible, which will include making wealthier older people pay their fair share of the burden rather than simply increasing taxes that fall mainly on those of working-age, such as Income Tax and National Insurance. This is broadly the same argument that was made by the Barker Commission (2014b) in their proposals for a more sustainably funded health and social care service:

“Given that we are seeking to spread the burden of care more fairly, and given that on average the present generation of pensioners is relatively well off (both compared to past pensioners, and to the likely prospects for the present generation under 40), it seems right that many of the tax and other changes we propose should, at least initially, affect this group.”

The Barker Commission suggested a range of measures which they estimated could raise an additional £3 billion per year, including making pensioners pay prescription charges, means-testing universal benefits and levying National Insurance contributions on people who work beyond State Pension Age. Some kind of new tax on wealth, especially the private property

wealth that disproportionately belongs to the Baby Boomer cohort and is currently very lightly taxed, was also suggested as a longer-term source of additional funding (perhaps by lowering inheritance tax reliefs). More ambitiously, the Institute for Fiscal Studies has called for a review of the £19.5 billion of tax relief which is currently given each year to private pension savers, most of which regressively benefits the well-off. IF would support all of these recommendations, if the public is really in favour of spending more money to maintain current levels of service.

23 September 2016

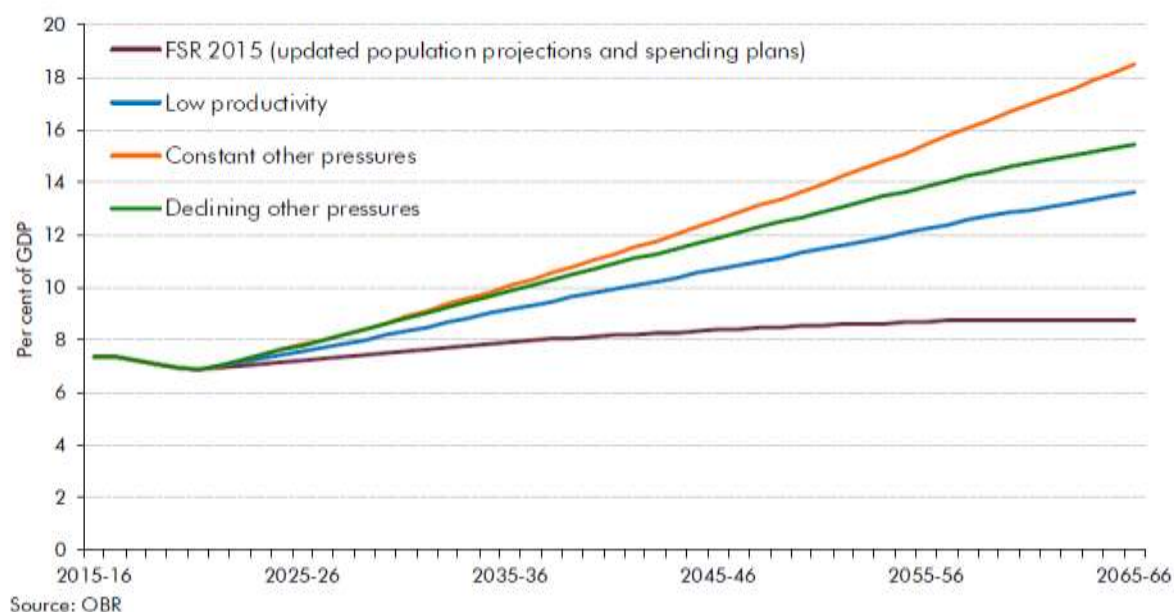
Paul Johnson – Written evidence (NHS0195)

1. To what extent do you agree with the OBR's latest analysis of long term projections on health spending?

The main point is that long term projections are extremely sensitive to assumptions. The main projections from previous years suggest only relatively modest increases in health spending over the medium to longer term because they only factor in the impact of an ageing population. They assume that productivity in healthcare grows along with that in the rest of the economy, and don't account for increases in other cost pressures. So at best one can think of these projections as lower bound, but probably they are below a reasonable lower bound.

You will be familiar with chart 3.7 from the OBR's latest working paper on the topic, reproduced below which shows just how sensitive the future projections are to different assumptions. The line tracing out a lower productivity scenario, based on historic experience of productivity in health, is certainly in my view a more realistic scenario than the main FSR 2015 scenario. Additional cost pressures could make a big additional impact.

Chart 3.7: Long-term projections and other cost pressures



The differences between these scenarios have a very big impact on long term fiscal sustainability. Just the difference between the FSR 2015 scenario and the low productivity scenario comes to 2% of GDP within two decades. (For comparison the triple lock adds no more than 1% of GDP to pension costs by the same date). Given these projections and historical and international experience it would surprise me if we could contain health spending growth to much less than 3% of GDP over the next 20-25 years. That inevitably implies more spending cuts elsewhere, or tax rises.

2. How can the Government accommodate a growth in health spending?

As a nation we could decide to increase taxes by 2 or 3% of GDP over the next couple of decades. That would not be easy but it would not take tax to unusually high levels by UK historic or European standards. Further cuts of that magnitude to other areas of public spending, on top of those implemented or planned over this decade, would likely be really quite difficult. That said big changes in the shape of the state have happened before. We have dramatically reduced our spending on defence, housing and industrial support over recent decades, by more than enough effectively to fund increased spending on health and welfare. Which areas of current activity could be cut in the same way going forward it is hard to see from our current vantage point.

It has been suggested that funding would be made easier by hypothecating some source of tax revenue to the NHS. That could mean simply saying that a tax rise is being used to provide extra money, as happened with the increase in NICs introduced in 2001, explicitly for that purpose. That is an option, essentially a way of selling a tax rise to make it politically more palatable. A more serious kind of hypothecation would tie NHS funding to revenues from a particular source. For it to be real hypothecation that would require funding to rise and fall with the revenues, which would be patently absurd. That leaves two alternatives. One is just to pretend that revenues are hypothecated, and not cut services when revenues fall. I am deeply uncomfortable with that since it seems to be designed deliberately to fool people. An alternative would be to set up a fund into which extra revenues from the tax are placed during good times and from which the NHS could borrow during bad times, with the rate of the tax varying to ensure balance over time. The Treasury would, rightly, want to count any borrowing in the fund against public borrowing. The temptation to spend additional revenues when they are buoyant would seem just as big as at present. Politics apart it is hard to see any argument for such a convoluted arrangement. But politics matter and it may be that there is a case for some such arrangement if taxes cannot otherwise be increased to pay for a service people want. But it should be clear the case only exists as a second best option in face of political failure.

3. It has been suggested that the cycle of 'boom and bust' in funding for the NHS is one of the weaknesses of the system. Do you think it is possible to deliver more sustainable levels of funding?

The pattern of spending on health over the last 25 years – famine, feast, famine – is clearly sub-optimal. It is almost certain that had we started with spending where it was in 1992 and increased on a smooth and planned path to its current level, the money could have been used more efficiently, possibly significantly so. There is an inherent set of challenges here. The changes are in large part related to overall fiscal and economic conditions. The swift increases in the 2000s were in part predicated on a presumption that the economy would continue to grow. It is hard to think of a set of public institutions which would have slowed growth in spending in the 2000s and then kept spending rising after 2010 given other economic and fiscal knowledge and policy at the time.

4. The OBR's expert independent analysis of spending in health spending clearly provides a vital insight into the sustainability of the health system. Given the extent of the pressures on both the health and social care systems, do you think further independent analysis of the funding and workforce needs for the health and care system based on a rounded assessment of medical advance, demography and productivity would be beneficial?

I am not an expert on what does exist, but my sense is this does not exist at present in an independent, usable and fully credible form. If it does not the case for doing it strikes me as being very strong.

January 12 2017

Keep Our NHS Public – Written evidence (NHS0109)

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

1.1 Legal framework and allocation of funds

- The first thing that needs to change is the wasteful competition made compulsory by the Health and Social Care Act 2012. The National Health Service Bill, due for its second reading on 4th November would reverse the 2012 Act and restore the legal responsibility of the Secretary of State for Health to provide a comprehensive health service in England. The 2012 Act was the culmination of managerial changes to the NHS which began with the introduction of general management in 1984, then the introduction of the internal market and the purchaser provider split in 1990. Following this the use of the Private Finance Initiative to build hospitals in the late 1990s and the introduction of Independent Treatment Centres from the early years of this century, has meant that money has been wasted on non-clinical matters and repeated re-organisations which not only lose money but lose experienced staff and deplete the organizational memory. An important book about these changes is 'The Plot against the NHS' (1).

The experimental 'World Class Commissioning programme' was examined by the Health Select Committee in 2009-10 (ref 2). They noted the increased transactional costs and '*were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures of staffing levels and cost dedicated to commissioning and billing in PCTs and provider trusts*'. They concluded '*If reliable figures for the costs of commissioning prove that it is uneconomic and if does not begin to improve soon, after 20 years of costly failure, the purchaser provider split may need to be abolished*'. The next Health Committee under a different government did not follow this damning criticism up and all energies were directed to the white paper '*Equity and Excellence ; Liberating the NHS*' which laid the foundations of the Health and Social Care Act 2012. With what information available it seems that administrative costs in the NHS rose from 5% in 1984 to 14% in 2003 when a lower proportion of the GDP was spent on health than currently (ref 3). The latest (conservative) estimate by the Centre for Health and the Public Interest is £4.5 billion, about 4% of the budget (ref 4) falling from a high of £8 billion in 2010.

- The second thing that needs to change is the allocation of money to the NHS which is considerably less than similar counties. This year the OECD changed the way that they calculate health spending to include some previously classed as social care expenditure but although this increases the proportion of GDP allocated to health that still leaves the UK 9th of the 12 counties with similar accounting systems. Estimates for 2015 are that Switzerland, Germany, Sweden and France will all spend over 11% of GDP whereas UK will reach 9.9% (ref 3) With GDP about £2000 billion a year each 1% of GDP is worth 20 billion which

means that if we spent the same proportion of our GDP as France does we would have over £20 billion more to spend on the NHS. In addition this funding should be guaranteed over at least a five year period to allow longer term planning to be enabled. The NHS needs at least 11% of GDP or £5,500 per person instead of the current approximately £4000.

1.2 Provision of services

- Although policy makers have been urging de-centralisation of services and ‘care closer to home’ there is remarkably little evidence to support their plans and the contention that this will be cheaper seems based on hope rather than hard evidence. What evidence there is suggests that implementing change is difficult and may well not save money (ref 5). Any major change to the structures on which our health system is based should only be made after rigorous analysis of properly designed pilot studies which should include patient evaluation of the services.
- A network of District General Hospitals (DGHs) needs to be maintained so that patients do not have to travel long distances to receive diagnosis and treatment. This is inconvenient for patients and their families and often costly and difficult if they have to rely on public transport which becomes more likely as they age. Longer journeys also contribute to air pollution and climate change.
- Each DGH should have a full range of surgical and medical specialties to ensure that patients with multiple conditions can be adequately cared for. Inter consultant referrals in hospital should be facilitated and the wasteful and time consuming business of sending patients back to their GP should be stopped. Consideration should be given to the provision of clinics for elderly people where consultants from different specialties work together so facilitating multidisciplinary working and preventing patient having to make multiples journeys to hospital. Specialist units centralised for well-evidenced clinical reasons should be continued but balanced carefully against the increase in average travelling time that follows.
- Each DGH should have access to smaller residential units where patients can be referred for rehabilitation and ongoing physiotherapy, nutritional advice, podiatry and monitoring of diabetic control. These units would be staffed by Health Care Assistants overseen by a qualified nurse on each shift, with access to a multi-disciplinary team including OT and physiotherapy, but patients would be encouraged to self care and cook for themselves and there could be facilities for gardening and outdoor exercise.
- A smaller number of tertiary hospitals for services such as stroke, major trauma, coronary care and vascular emergencies or other conditions which clinical research has shown to have better outcomes if admitted to specialist units, should continue in each sub-region. Care must be taken to ensure that the time of transfer to such a unit does not cancel out the benefit of the specialist care and research is needed to establish whether there are other conditions which would benefit from centralisation.
- The importance of good primary care facilities cannot be emphasised enough. It is the bedrock of our NHS and more money needs to be spent on supporting General Practice. Patients value the continuing care by a known doctor. We do

not think that the polyclinic model or placing expensive X-Ray facilities in group practices is the way forward. Where GPs wish to arrange laboratory tests or X-ray investigations the protocols for doing these should be agreed with the DGH consultants and access should be speedy, where the DGH is accessible to the patients and venepuncture should be local.

1.3 Demographic changes

- Increases in population from a higher birthrate and immigration should be recognized in the funding formula and the lesser use of the NHS by these younger people will counterbalance the increased use due to longevity of the elderly. We need to concentrate on the determinants of health, providing good education for all, decent housing, a adequate income via employment or good pensions, facilities for exercise and a nutritious and non-diabetogenic diet. Air pollution needs to be tackled vigorously as does obesity both areas where health expenditure could be reduced if dealt with effectively. This requires action in all government departments to assess the impact of planned expenditure and a willingness to tackle food and drink companies using taxation or legal changes if necessary as has been done successfully with the tobacco industry.
- The continued negative emphasis on the cost of elderly care is misguided and we should celebrate the fact that people are living longer and many of them are healthier for longer than in previous generations, but we need to organize the specialist aspects of their care more efficiently and to be more patient friendly.

2. Resource issues, including funding, productivity, demand management and resource use. To what extent is the current funding envelope for the NHS realistic?

2.1 The NHS is underfunded and has always been although the attempt by the last Labour government to reach the European average expenditure briefly remedied this. The effect of austerity since 2010 has led to increasing calls for increased expenditure, the latest by the Royal College of Physicians (ref 6) and the effect of years of underfunding has meant poor infrastructure. The disastrous PFI programme means that too much money is diverted to (companies for the new hospitals which were built this century, (£2bn annually – a significant proportion of which relates to the high interest repayments.) We have now has fallen behind our European neighbours as described above (1.2). The NHS needs at least 11% of GDP. The government should accept that provision of a health service, recognized as being the most cost-efficient in the world (ref 7) is the hallmark of a civilized country and stop trying to shrink the state which damages the poorest most. Investment in health makes sense and the economy benefits fourfold through the fiscal multiplier effect (ref 8). An increasing proportion of the NHS budget is going to private companies £2.9bn in 2013-4, £15.8bn in 2014-5 according to the NHS Support Federation(ref 9) which rely on the NHS to train medical and nursing staff, for back-up when things go wrong and do not provide expensive A&E or intensive care departments. In addition the burden of regulation and the cost of the ineffective CQC and requirements for hospitals to provide masses of data to NHS Improvement means less is spent on direct patient care. The escalating cost of NHS England where six figure salaries for posts which did not exist 10 years ago proliferate and are of questionable value and the high salaries paid to Chief Executives of Trusts mean another estimated 2bn diverted from frontline care.

Productivity of the GP workforce is unparalleled but the strain of rising demand and falling resources are beginning to take their toll. Productivity is a vast subject well reviewed by the Kings Fund (ref 10) so the only comment we have is that diverting money from the NHS to private companies who have not been shown to be more efficient, means less money for NHS services to improve systems and manage the patient load. It wastes valuable managerial time preparing tenders and being involved in the unnecessary market mechanisms. The best way to manage demand for health care is to reduce the need for health care and the best way to do that is by funding public health adequately and dealing with unhealthy environmental factors as mentioned above taking into account the wider determinants of health. But for those in need of healthcare, the NHS publicly administered, funded and provided is the well-evidenced best option internationally.

2.2a Does the wider societal value of the healthcare system exceed its monetary cost?

Yes. People are proud of the NHS and value the freedom from the fear of illness bankrupting them, They respect the democratic route of funding it from general taxation. They also accept the principle of caring for those less fortunate than themselves and the solidarity which adds to the sense of community. The NHS is seen by many as an essential part of our national identity. Educating schoolchildren on the history and best use of the NHS is the best way ensuring that society continues to understand, respect and use appropriately the health service.

2.3b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? Funding from general taxation with a guaranteed amount over a five year cycle to allow planning

What financial system would help determine where money might be best spent? The work done by NICE in evaluating the value for money of drugs and now systems of care is a reasonable way of doing this. Ways of involving patients in the discussion should be found. If the system were adequately funded a lot of the controversy would be avoided.

2.4 c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

What we need is an adequate amount of money set aside for the NHS which as a civilised country with the fifth largest economy we should be able to afford.

A hypothecated tax merely labels tax receipts in a particular way and the expense of separating out money in this way does not seem justified. Adding new taxes again adds to complexity and is unnecessary. Co-payments are a barrier for those who can least afford care and are counterproductive (ref 11)

2.5 d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

No. All these suggestions will incur transaction costs make those least able to pay reluctant to see the doctor and interfere with the doctor patient relationship.

Dilnot's recommendations were for social care not health care and whilst the idea of merging health and social care has merit until there is adequate funding for both this seems unwise.

3. Workforce

The Department of Health has been poor at planning and it is disgraceful that a rich country such as ours relies so heavily on doctors and nurses trained in the developing world. The introduction of health care assistants was ill-judged and they need to be professionally overseen like other health care professionals as recommended by Francis. Programmes for physician assistants are beginning but their work needs to be piloted before their use becomes widespread as although paid less than doctors they may refer more patients and end up costing the NHS more money. We think the balance of doctors, nurses and the professions allied to medicine seems about right. The UK has only 2.8 doctors per 1000 population less than the OECD national average of 3.2 of whom 28% were trained abroad. We should plan to produce enough doctors and nurses for our own needs. We have more nurses than most other countries and increasing their autonomy and responsibility in enhanced roles is a good way forward. Whilst the Government announces increased employment of doctors, it does not report this in relation to increased population and in terms of doctors/nurses/hospital beds per 1000 population. On workforce, this is an essential way to compare where we are in England over time and comparatively with European neighbours

UK citizens are keen to train in all parts of the NHS and although medical school applications have fallen recently there are still enough to fill the training places but these should be increased so that we do not need to import doctors or nurses from abroad. Training standards are good and professionals can be trusted to adapt to changing circumstances. Retention requires proper remuneration for the work done, good working conditions including control over hours of work, opportunities for advancement including further training, and improvement in morale which has been declining under austerity. Professional staff need to be in control of training and standards and respected for their skills not bullied or subjected to repeated re-organisations and dictats from on high or from managers without adequate knowledge or training. The current impasse with the junior doctors cannot be solved by imposition of a contract rejected by a majority of those working in the NHS and is not the way to go forward. Work life balance is important for all workers and the emotional demands of working in the NHS mean preserving a good work life balance is essential in any contracts for staff to prevent burnout. It should be possible for in-service training to help staff move across roles but 'agility' and skill mix are words often raising suspicion that roles are to be downgraded so staff have to be involved in any major restructuring of the workforce.

The effect of the UK leaving the EU could be disastrous and the government should take steps to reassure EU staff that they can remain working in the NHS whatever happens to free movement.

5. Models of service delivery and integration

What are the practical changes required to provide the population with an integrated National Health and Care Service?

5.a Firstly there is the question of funding. The proposal by Andy Burnham in his plan to integrate Health and Social Care to have a capitation fee which covered the cost of whole person's care for a year was a radical first step which sadly has gone no further. If health and social care were properly and publicly funded and if citizens, CCGs, Local Authorities

and providers of care in the NHS could work together collaboratively, this would be the way forward. but the Sustainable Transformation Plans (STP) have been introduced in secret in a climate of massive cuts in social care and health and are of questionable legality. These 44 ‘footprints’ created by NHS England are virtual organisations where the purchaser provider split is abandoned as dysfunctional. The NHS is carrying the costs (including opportunity costs) of a shadow planning system and a market system which cost at least £3bn to implement and £4.5 billion to operate. The risk is inescapable in this present climate, that the STP plans will lead to loss of well established services and plundering of the NHS estate. The difficulties in amalgamating two large services with different cultures and funding are huge; NHS free, social care means tested. A first step would be to make social care free. For those who are well off an increase in tax paid as income increases would fund their care and would be cheaper to collect and easier to administer than imposing a cap. Whilst both the NHS and Local Authorities are underfunded it is hard to see how any group will want to relinquish part of their budget.

5.b Pilot studies which show how different services can work together should be funded and evaluated and best practice shared. Staff are keen to improve services and the care of patients and reduce bureaucracy so clear proposals are the only incentive needed to get people to participate.

5.c There has to be adequate provision of services before staff feel able to work towards integration. Innovative examples such as putting mental health teams in GP surgeries in Barnet and Islington improve the care of patients and save money so if shared can be spread throughout the NHS.

6. Prevention and public engagement

What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

We are sure the public health doctors will answer the questions in this section but it is counterproductive for the government to cut spending on public health which Marmot suggested should be at least 0.5% of the budget. As far as (d) is concerned the government should legislate to compel the food and drink industries to show greater responsibility. The example of harm reduction from tobacco consumption by combining taxation and legislation shows what can and should be done. Obesity has reached epidemic levels. In relation to (f) reduction in poverty and planning for healthier cities and legislation to improve workplace safety and imposition of punitive fines where employers fail to do this would enable people to choose healthier options.

7. Digitisation of services, Big Data and informatics

How can new technologies be used to ensure the sustainability of the NHS?

We defer to those with more knowledge of this technical field but believe that the usefulness of digitization requires careful evaluation in pilot studies. The record of using computers in the NHS has been lamentable and costly although GPs pioneered effective systems, which need to be linked to hospital systems. This should be arranged locally by clinicians working together rather than having IT firms who impose their ideas seemingly without consultation with those who are forced to use them. An example is choose and book which replaced a perfectly good system of GPs writing to or emailing hospital consultants selected by the GP to suit the patient with a faceless bureaucratic mess where neither the GP nor the patient know who they are referred to and patients often get lost in

the system. Pilot studies using new technology should be evaluated before rolling out new digital systems. The idea of putting summary information on to a memory stick which people could keep in their wallet or handbag and have updated when seeing their GP, should be explored. This would maintain patient confidentiality and have information where it is needed at minimal cost.

The importance of personal contact and the clinician patient relationship in healing is immense and cannot be provided by a smart app or internet chat. It also discriminates against those without such IT skills or access, and without adequate English language skills for communication.

In a densely populated country such as ours the use of tele-health is probably not cost effective as the equipment is expensive although less sophisticated systems such as Skype consultations and telephone home monitoring can be cheaply provided and convenient for patients.

Confidentiality of records is crucial and the risk of hacking and loss of devices has made many people reluctant to share data.

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Keep Our NHS Public – Written evidence (NHS0109)

Keep Our NHS Public was founded in 2005 by the NHS Consultants Association, NHS Support Federation and Health Emergency and has now grown as a grass roots organisation pledged to defending the NHS with 36 KONP groups and another 46 fully affiliated groups and 49 supporting affiliated groups spread throughout England.

Our broad aim is to Keep our NHS public, which means publicly provided and publicly accountable as well as publicly funded. We are a membership organisation and our members are drawn from all walks of life. They include many NHS workers , patients and carers with experience of the NHS.

Visit our website www.keepournhspublic.com for further details

23 September 2016

Kevin Kelleher – Written evidence (NHS0164)

I enclose a submission in reference to your call for information on the Long Term Sustainability of the NHS and refer to issues, which affect the NHS, Patients, HM Government, Carers etc.

Thought the points maybe already be known and some issues outside the committees remit on Resources, Workforce, Service Delivery, Prevention and Engagement and Digital Services, it is to try and summarise and support topics of discussion with established findings, data and statics.

1. Choice, Control, Independence and the Law: Through Parliament legalisation, the Law Commission reported on Adult Social Care <http://www.lawcom.gov.uk/project/adult-social-care/> , which we have the Care Act 2014, this collated previous Acts of Parliament, e.g. National Assistance Act, the Chronically Sick and Disabled Act, Community (direct payment) Act, some 42 different primary legislations plus any additional regulations. Choice, control, independence comes from both partnership with all, understanding the individual needs, law sets a basic level and aspirations of the individual might differ and is complex for all.

2. Through Parliament and its people scrutiny, investigations, enquiries continue to look at matter effecting it people through the actions, funds, involvement <http://www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/news-parliament-2015/improving-access-mental-health-services-report-published-16-17/> to report on the complexity and social return on investment. 21st century living is more complex with higher expectations of what the Laws allow people to access, support needs etc.

3. With division of services through social services, NHS, local commission groups, charities, NGO, forums, PALS etc. I suggest people find it frustrating to challenge the status quo with everyone fighting for the rights and prevaliages life comes with. Right or Wrong their is a limit which breaks the mind and soul of an individual to take the action.

4. I refer also to previous information, freedom of information requests to support the enclosed information for all to make an informed discussion and discuss the matters, which affects us all living with life and the realities, which united are personal and in depth, monies are spent to support the economy, life choices, options, needs of illness, thats what life is about. Powerful as people are through what we achieve in life, we work to better outcomes, understand what is expected of us and that which Parliament offers in return.

5. Health Inequalities: <http://www.kingsfund.org.uk/projects/verdict/has-government-put-mental-health-equal-footing-physical-health> and <https://www.nice.org.uk/advice/lgb4/chapter/introduction> and http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/HealthInequalitiesOverview.aspx

6. Employment and Structure: NHS provides employment, structure, opportunities for those who work, with just under £12bn spent in 2012/13 on Mental Health Services, refer

<http://www.nuffieldtrust.org.uk/data-and-charts/nhs-spending-top-three-disease-categories-england> , 2016 suggest £9.2bn is spent on Mental Health ,refer
<http://www.wired.co.uk/article/nhs-mental-health-taskforce>

7. Funding and Resources: Refer Employment, Local Authorities, Charities, NHS Networks and Partnerships, Employment and Structure and Alternative Community Support Verses Hospitalization. A Department of Health budget of around £120bn. Social Services budget, Charitable spend and giving, EU funding equates to a much higher resources spent in services, GDP, Taxes, needs.

8. Alternative Community Support verses Hospitalization: Suggested cost figures, refer <https://www.rethink.org/about-us/commissioning-us/alternatives-to-admission> and attached. This suggests a cost of £3,832 pounds cost of admission and yet a weekly benefit payment, in arrears can be £182pw, costs for residential care and other places can be cost effective than hospitalization?

9. NHS network and Partnerships: Each of the listed partnerships <https://www.england.nhs.uk/ourwork/part-rel/> provide employment, contribute to the UK GDP, taxes etc. Though indirectly not on the front line of services day to day, they contribute in various means?

10. Charities: I have enclosed reference to what UK Mental Health charities spend in the UK, this also provides employment, structure, GDP, Taxes etc. to the economy. (Refer UKCRCHRA2014.pdf)

11. Population: The UK has over 65million people to support through its needs from birth to death, I refer <http://www.agediscrimination.info/statistics/Pages/CurrentUKpopulation.aspx>

12. Local Authorities: Local authorities have use to the Local Government Finance Settlement which is advised in advance by the DCLG. Example <http://www.southampton.gov.uk/moderngov/mglIssueHistoryHome.aspx?IId=17931> and <http://www.publicfinance.co.uk/news/2015/12/local-government-settlement-offers-councils-four-year-funding-deals>

13. NHS staff sickness, I refer to for costs of £2.4bn the NHS pays <http://www.qualitywatch.org.uk/indicator/nhs-staff-sickness-absence#>

14. Lord Carters report into procurement savings, refer <https://www.supplychain.nhs.uk/news/company/lord-carters-report/> and <https://www.gov.uk/government/news/review-shows-how-nhs-hospitals-can-save-money-and-improve-care>

15. NHS Litigation Authority which paid out £1.1bn in 2014/15, refer attached accounts and <https://www.evidence.nhs.uk/search?q=litigation+and+financial+cost+to+the+nhs> and <https://www.themdu.com/press-centre/press-releases/nhs-claims-liabilities-of-22bn-shows-need-for-reform-of-compensation-system>

16. Agency and other news related staffing costs, I refer <https://www.gov.uk/government/news/clampdown-on-nhs-staffing-agency-costs> and

<http://www.ntda.nhs.uk/blog/2015/09/01/new-rules-launched-to-reduce-agency-spend-in-the-nhs/> and
<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx>

17. The DoH and NHS budget 20/21, refer <http://www.health.org.uk/chart-breakdown-planned-dh-and-nhs-england-budgets-202021> and <https://www.nao.org.uk/report/reports-on-department-of-health-nhs-england-and-nhs-foundation-trusts-consolidated-accounts-2015-16/>

18. Personnel Budgets and NHS Continuing Care fund, spent, criteria, refer attached information (file. Pdf and p_h_b...pdf)

19. NHS and Social Care integration, I refer http://www.huffingtonpost.co.uk/dr-louise-irvine/nhs-funding_b_6688632.html

20. Authorities, Trusts and CCG, refer <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx>, should mental health trusts and others be brought under one umbrella enlarging for responsibility, transparency, care instead of affiliated care and responsibilities?

21. NHS and Hospice Care, End of Life options, refer http://www.endoflifecare-intelligence.org.uk/data_sources/place_of_death

22. Junior Doctors strike, rights responsibilities of all

23. Ghost Patients costs <https://www.generalandmedical.com/cms/news-media/posts/2016/july/nhs-england-to-remove-ghost-patients-from-gp-registers/>

24. NHS Fraud cost's, refer <https://www.rt.com/uk/316411-nhs-england-fraud-corruption/> and <https://www.nursingtimes.net/roles/nurse-managers/fraud-costs-nhs-7bn-enough-to-pay-for-250000-nurses/5069258.article>

25. Discharging, supporting, inpatient care, resources spent refer <http://www.bbc.co.uk/news/health-35481849>, whilst other means of support limited, suggest management rethink to address the needs of the patients first. Readdress lack of community support by the NHS and Local Authorities, readdress inequalities etc.

26. Drug pricing increases, CMA, SFO and other authorities investigations, refer <http://www.cips.org/supply-management/news/2016/august/nhs-failed-to-challenge-125m-drug-price-hike/> and

<http://www.bristowscipboard.com/?tag=/PricingRPM>
and http://www.pharmatimes.com/news/nhs_drugs_bill_fattened_by_corporate_profiteering_investigation_claims_1034841

26 September 2016

The King's Fund – Written evidence (NHS0171)

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

In line with the terms of reference for the inquiry, our response focuses largely on the NHS. However, it is not possible to consider the future health system without considering social care, so we have also highlighted issues relating to social care where these are relevant.

Executive summary

- The health and social care system is facing unprecedented financial pressures and will require fundamental change if it is to successfully respond to the challenges it faces over the next 20 years, including the needs of an ageing population, the changing burden of disease and rising public expectations.
- As the Barker Commission recommended, a new settlement is needed that ends the historic divide between the health and social care systems by moving to a single, ring-fenced budget and a single local commissioner of services.
- While there is scope to improve productivity, if increased funding is not forthcoming, the growing crisis in health and social care will become much worse, with patients waiting longer for treatment, quality of care compromised and access to publicly funded social care further restricted.
- The UK spends less on health than countries such as Germany, France and the Netherlands, while public spending on social care will fall back to less than 1 per cent of GDP by the end of the parliament.
- As the Barker Commission recommended, the long-term aim should be to increase spending on health and social care to the same level as in other comparable nations.
- Increasing spending on health and social care is affordable and sustainable if hard choices are made about how to find the resources needed. The first step is for politicians to be honest with the public and to hold an open debate about how this should be paid for.
- Demand for the future health and social care workforce is likely to exceed supply. An effective workforce strategy will be needed to address these challenges, while staff will also need to work differently, increasingly working across current professional boundaries.
- New models of care, sustainability and transformation plans and the move to place-based systems of care offer significant opportunities to integrate care. However, genuine integration will be hard to achieve while the fundamental differences in funding and entitlements between the NHS and social care remain.

- Unhealthy lifestyles have a negative impact on health and wellbeing and cost the NHS and the economy billions of pounds a year. The weakness of the childhood obesity plan highlights the need for a much bolder approach to improving public health that recognises the role that regulation and taxation have to play.
- More needs to be done to strengthen the role of patients and service users as partners in their own care. The evidence shows that when people are involved in this way, decisions are better, health and health outcomes improve, and resources are allocated more efficiently.

1. The future health and care system

A number of trends and drivers will affect health and social care services over the next 20 years (Imison 2012). The most significant include:

- financial context: the NHS and social care are currently experiencing unprecedented financial pressures, and future projections suggest that these pressures are likely to continue
- demography and future patterns of disease: an ageing population will mean more people living longer and healthier lives but also increasing numbers of people living with disabilities and multiple long-term conditions
- medical advances: the pace of medical and diagnostic advances is rapid, offering great promise but with potentially significant implications for future spending
- information technologies: digital technology has the potential to transform the way patients and service users engage with services, improve the efficiency and co-ordination of care, and support people to manage their health and wellbeing but it is not certain that these opportunities will be grasped
- workforce: there are significant challenges in matching the skills of the workforce in health and social care with the changing needs of patients and service users, and growing shortages in some key areas, driven by both training and budgetary constraints
- public attitudes and expectations: patients and service users increasingly expect modern, convenient and personalised services.

2. Resourcing

This Committee's inquiry is taking place at a pivotal time for health and social care. In the context of deficit reduction and significant cuts to many departmental budgets, the NHS received a comparatively favourable settlement in the 2015 Spending Review, and the pressures on social care were also acknowledged. However, the NHS is currently halfway through the most austere decade in its history, and NHS providers recorded their biggest ever annual deficit last year. Funding pressures can affect patients in a range of different ways, some of which are hidden (Robertson 2016); one of the most visible ways in which they are affected is by having to wait longer for treatment. Key performance targets for

acute hospitals are now being missed all year round, general practice is in crisis and community and mental health services are under huge pressure (Murray *et al* 2016).

Six years of cuts to local authority budgets in the face of increasing demographic pressures have led to 26 per cent fewer people getting publicly funded care and support, increasing the burden on older and disabled people, their families and carers. The social care market is under unprecedented pressure, with increasing numbers of providers choosing to leave the market and going out of business. With a funding gap of at least £2.8 billion set to open up by the end of the parliament, it is clear that the social care system in its current form is unsustainable (Humphries *et al* 2016).

There is significant scope to improve productivity in the NHS, ensuring the greatest value for patients from every pound spent on care. Estimates show, however, that productivity in the NHS as a whole improved at a rate of around 1 per cent a year over the past 35 years, some way short of the 2–3 per cent gains needed to meet the target of delivering £22 billion in productivity improvements by the end of the parliament. Many of the central policy levers used in recent years – in particular national controls over pay and prices – have reached their limits.

This means that further improvements will have to be delivered differently. Our review of the evidence suggests that there are significant opportunities to improve outcomes and deliver better value by tackling variation in the delivery of care through changes in clinical practice. Examples of overuse (when unnecessary care is delivered), underuse (when effective care is not delivered) and misuse (when care is poorly delivered leading to preventable complications and harm) of care are still common across the NHS (Alderwick *et al* 2015a). Realising these opportunities will require a sustained commitment to supporting clinical teams, investing in the right kind of leadership and providing staff with skills in quality and service improvement (Ham 2014; Ham *et al* 2016).

The long-term trend has been for health spending to increase in real terms by 3.8 per cent a year (Office for Budget Responsibility 2016). In contrast, spending over the current parliament will increase by less than 1 per cent a year in real terms, as it did over the course of the last parliament. Given rising demand for services, this rate of increase is clearly unsustainable, even if the NHS can significantly improve productivity.

The pressures on the NHS have been recognised by the Office for Budget Responsibility (OBR); their recent report on fiscal sustainability and public spending on health concluded that, to maintain current policies in the face of the latest population projections, spending on health care will increase as a proportion of GDP (Office for Budget Responsibility 2016).

Longer term funding options should be informed as far as possible by regular detailed forecast and projections based on the latest data and modelling approaches – this more in-depth analysis could be carried out by the OBR. A priority for the Committee could be to produce some future spending scenarios to assess the range of possible spending paths.

In the short to medium term, if increased funding is not forthcoming, patient care will suffer, with longer waits for treatment and quality of care compromised. It is also inevitable that more NHS organisations will be forced to restrict access to certain services or dilute the

quality of care they provide. This would raise significant issues of public acceptability. In the latest British Social Attitudes survey very few (3 per cent) respondents were willing to accept longer waiting times or raised thresholds for treatment (9 per cent) (Appleby *et al* 2016). A failure to increase spending and reform social care would result in a growing funding gap and an increasingly residual service that is only available to the poorest and neediest.

Although the latest data from the Office for National Statistics (ONS) suggests that UK health spending as a proportion of GDP has previously been underestimated in comparison with other countries, it remains lower than countries such as Germany, France, Netherlands and Sweden. Public spending on social care as a proportion of GDP will fall back to less than 1 per cent by the end of the parliament.

Increasing spending on health and social care is affordable and sustainable if hard choices are made about how to find the resources needed. As the government's decision to abandon the plan to deliver a budget surplus by the end of the parliament shows, there are political choices to be made about priorities, public spending and taxation. The first step is for politicians to be honest with the public about the need to increase spending on health and social care and to hold an open debate about how this should be paid for.

To answer the long-term question about how to ensure adequate resources to meet future needs, The King's Fund established an independent Commission on the Future of Health and Social Care in England (2014). Chaired by the economist Kate Barker, the Commission was asked to consider whether the post-war settlement – which established the NHS as a universal service, funded through general taxation and free at the point of use, and social care as a separately funded, means-tested service – is fit for purpose.

The Commission's final report, published in September 2014 suggested that the long-term aim should be to increase spending on health and social care as a proportion of GDP to the same levels as other comparable nations. The report concluded that:

- England needs a new settlement for health and social care that breaks down the historic divide between the two systems and better meets the needs of patients and service users
- this should be achieved by moving to a single, ring-fenced budget for health and social care with a single local commissioner of services
- the current maze of entitlements should be simplified by bringing Attendance Allowance within the new single budget
- entitlements to social care should be fairer, more consistent and generous, while entitlements to NHS services should be unchanged
- the settlement should be introduced in a phased approach:
 - first, care should be free at the point of use for those whose needs are currently defined as 'critical', ending the current distinction between NHS continuing care and means-tested social care for those with the highest needs

- second, as the economy improves, free social care should be extended to those with 'substantial' needs
- third, some limited support should be extended to people with moderate needs, with the expectation that they would contribute to those costs subject to a means test.

The Commission considered a number of different options for funding their proposals, including social insurance and increased user charges, concluding that the drawbacks outweighed the advantages in both cases. Instead they recommended that the bulk of the additional funding needed should come from the public purse. On the grounds of inter-generational fairness and equity, they recommended that the older generation and people nearing retirement age – who would be among the biggest beneficiaries of a new settlement – should make a significant contribution.

The Commission recommended a radical package of measures to pay for their proposals including:

- releasing resources by targeting some existing benefits more effectively (free TV licences for the over-75s and winter fuel payments)
- reforms to prescription charges to raise more revenue without increasing charges
- ending the existing exemption from employee's National Insurance once people reach state pension age (with a contribution of 6 per cent rather than the standard 12 per cent), increasing contributions for those aged over 40 by 1 per cent and for those above the upper earnings limit to 3 per cent
- a comprehensive review of wealth and property taxation with a view to spending all or part of the proceeds on health and social care.

Results from the latest British Attitudes Survey show that the public remain committed to an NHS free at the point of use (Appleby *et al* 2016). Other work we have done on public attitudes to paying for health and social care found that people strongly supported the principle that access to health care should continue to be based on need rather than ability to pay, and means testing was unpopular both in principle and for practical reasons (Galea *et al* 2013a). Some polling data also suggests strong public support for raising taxes to increase funding for the NHS (Ipsos Mori 2015).

3. Workforce

Current pressures

Problems with recruitment and retention are currently being experienced in both the health and social care sectors. The current approach to workforce planning and the general oversight of the health and care workforce have not worked well to date. Although recent data suggests there have been increases among key staff groups including consultants and nurses (Murray *et al* 2016), there was a shortfall in 2014 of 5.9 per cent (equating to around 50,000 full-time equivalents) between the number of staff that providers of health care services said they needed and the number in post, with particular gaps in nursing, midwifery and health visitors (National Audit Office 2016). Major imbalances between the supply and

demand for nurses means that NHS trusts continue to rely on employing more costly temporary staff to fill the gaps (Dunn *et al* 2016).

Our research shows particular issues in general practice, community health services and social care.

- There are huge pressures on general practice, where rising demand and increasing workload has not been matched by growth in either funding or workforce (Baird *et al* 2016). Practices are finding it increasingly difficult to recruit and retain GPs, and there are challenges in relation to other members of the primary care team. It will be challenging to deliver the government's policy objective to recruit and retain 5,000 more GPs by 2020.
- The number of nurses working in community health services has declined, with the number working in senior 'district nurse' posts falling dramatically over a sustained period and dropping by almost half between 2000 and 2014 (Maybin *et al* 2016). These pressures are having a deeply negative impact on staff wellbeing, with unmanageable caseloads common and risks that quality of care may be compromised. This is despite the longstanding policy ambition to provide more care in the community.
- Social care providers across the country have been struggling to recruit and retain good-quality staff (Humphries *et al* 2016). The care sector as a whole has a vacancy rate of 4.8 per cent (compared with a vacancy rate of 2.6 per cent across the economy). This rises significantly for qualified nurses, where the vacancy rate is 9 per cent; slightly more than a third of nurses were estimated to have left their role within the past 12 months (Skills for Care 2016b).

Brexit

Current problems could be compounded by the UK's vote to leave the EU (McKenna 2016). Both the health and social care sectors have benefited from the EU's policy of freedom of movement and mutual recognition of professional qualifications, with many members of the current workforce having come from other EU countries. This includes 55,000 of the NHS's 1.3 million workforce and 80,000 of the 1.3 million workers in the adult social care sector (Health and Social Care Information Centre 2015; Skills for Care 2016a).

Until the UK extracts itself from its obligations under EU treaties, the policy on freedom of movement remains unchanged. However, given the current shortfalls being experienced in both the health and social care sectors, we urge the government to clarify its intentions on the ability of EU nationals to work in health and social care roles in the UK, not least to avoid EU staff currently working in these roles deciding to leave to work in other countries.

In the longer term, we have argued that providers of NHS and social care services should retain the ability to recruit staff from the EU when there are not enough resident workers to fill vacancies. This could potentially replicate the recent approach taken by the Home Office, by adding specific occupations to the Migration Advisory Committee's shortage occupation

list, which currently enables employers to recruit nurses and midwives outside the European Economic Area.

Future needs

Across the globe, the demand for health and social care workers is growing. However, the World Health Organization (2013) predicts that it will become increasingly difficult to recruit health workers, anticipating a global shortage of 12.9 million health care workers by 2035. Due to factors including an ageing nursing workforce, the international movement of health care workers and fewer people training to be nurses, the Royal College of Nursing has predicted that the number of nurses could fall by 28 per cent (100,000) by 2022 (Buchan and Seccombe 2011).

In social care, modelling suggests that if the workforce grows in line with demographic trends, 275,000 additional jobs will be needed by 2025 – an increase of 18 per cent (Skills for Care 2016c). Between 2010 and 2030 the number of people requiring informal care (unpaid care provided by friends and relatives) is expected to grow to 3 million, (Wittenberg *et al* 2011), while the number of people living alone and isolated from family support is growing.

Integration of care means that staff may be increasingly required to work across traditional organisational boundaries, and there will be a need to both facilitate and co-ordinate that care. Many of the clinical and professional skills required to support integration of care already exist within the workforce; however, as our research points out, they are often insufficiently available or inefficiently distributed (Gilburt 2016). There is therefore a need to consider the current skills and responsibilities of the workforce and how they can be deployed most effectively.

In recent years, organisations have sought to integrate care through the development of discrete multidisciplinary teams and, in some cases, of new roles such as care co-ordinators, case managers and personal assistants. While these have facilitated integration in individual areas of care, evidence to support their use more widely is limited and they have often proved unsustainable. Our research finds that successful integration needs to move beyond creating organisational forms and roles to deliver integration to supporting staff across the workforce to work in new ways. This will need a programme of training and ongoing development, supporting staff to build their skills and capabilities to deliver care across boundaries that is focused on meeting the holistic needs of patients.

Workforce planning

It should be obvious that the NHS and social care cannot function well without access to appropriately qualified staff. The complexity of the health care workforce, the long lead times in training new staff and the need to provide care now to those that need it mean that workforce planning is a critical and complex function (Addicott *et al* 2015). Addressing current and future workforce challenges requires a workforce strategy that builds up from: the need for health care; the forecast availability of workforce now, in the medium term and the long term; and mitigation strategies where there is a gap.

Staff costs account for just under half of total NHS spending. Many assumptions made about future savings imply a smaller workforce (and therefore a lower paybill). This poses two risks:

- overly optimistic assumptions about efficiency and demand management can lead to workforce shortages
- training additional staff – for example, in mental health and community settings – will lead to more staff only if NHS commissioners commit sufficient money to providers to employ them.

Both risks can be reduced through a workforce strategy that links demand, affordability and the supply of staff. This should be done alongside a similar assessment for social care.

The Department of Health and its NHS partners also need to establish a balance between national, regional and local responsibilities for the workforce. For example:

- when developing new roles, there is a case for doing this beyond organisational boundaries as more standardised roles common across employers can increase the opportunities for career development and dedicated training
- there is also a case for regional or national co-ordination of overseas recruitment rather than expecting each individual employer to run recruitment campaigns in other countries
- each employing organisation should have the skills and capabilities to improve staff retention, with regional and national bodies limited to the provision of support and training.

Supporting the role of volunteers

In thinking about how to resource the workforce of the future, the potential for volunteers to play an important role should not be underestimated. Our analysis of the British Social Attitudes survey shows that around 1.7 million active adult volunteers in Britain already formally volunteer in the health and care sectors (Buck 2016a). In addition, half who do not currently volunteer in health and care services said they would consider it if asked – representing an untapped reserve for the sector.

In relation to the NHS specifically, volunteers perform an incredible diversity of roles (Galea *et al* 2013b), are highly regarded by patients, and have a positive impact on patients' wellbeing (Babudu *et al* 2016). Our 2013 survey found that only half of acute trusts in England had a volunteering strategy, and there was little correlation between size of trust and number of volunteers (Galea *et al* 2013b). The NHS should do more to support volunteering and to make it easier for the 6 million people who say they cannot volunteer due to illness or disability.

4. Models of service delivery and integration

The need to improve the co-ordination of care around the individual requires services to be much more integrated. This might mean hospital specialists working much more closely with

primary, community and social care colleagues in out-of-hospital settings (Robertson *et al* 2014), general practices collaborating in federations and networks to deliver extended services (Addicott and Ham 2014) and genuinely integrating physical and mental health services (Naylor *et al* 2016). However, providing more integrated services within the complex and fragmented organisational arrangements of health and social care services is not a simple task.

Since 2010, the government has introduced a number of measures to promote integrated care, including the Better Care Fund, integration pioneers, and a requirement for all areas to have achieved integration between social care and the NHS by 2020. Yet progress has remained patchy.

In 2015, 50 'vanguard' sites were selected by NHS England to test and implement the new models of care outlined in the *NHS five year forward view* (Forward View). Good progress is being made. However, while these initiatives offer significant opportunities to improve care, they are unlikely to deliver substantial financial payback in the short term. If they are to succeed, it is important that they receive the funding and support needed to build on progress to date, and to share and spread learning to other areas. Most importantly, they will need to be given the time to demonstrate results.

The King's Fund has set out practical proposals on what should be done to remove barriers to the development of these new care models, entailing the fundamental redesign of policies on commissioning, regulation and payment systems, as well as the support provided to NHS organisations (Ham and Murray 2015). Specific recommendations include support from national bodies for commissioners to implement new forms of commissioning and contracting, and support from commissioners for interested and capable general practices to operate at scale in the form of federations, networks and super partnerships. To ensure that the behaviour of the regulators facilitates the development of new care models, other recommendations emphasised the importance of developing a whole-system approach to regulation and intervention.

The variety and complexity of current payment systems reinforces the fragmented nature of NHS provision. These systems also contain conflicting incentives. With NHS funding now tightly constrained, and the focus having shifted to how care can be better integrated around the needs of people with long-term conditions, much more emphasis needs to be given to payment systems that support this objective. To address this, NHS England and NHS Improvement should accelerate the development of new payment systems such as capitated budgets, pooled budgets and integrated personal commissioning.

Funding to support transformation is also essential. In previous work with the Health Foundation we made the case for a dedicated transformation fund for the NHS to accelerate change at scale and pace (Charlesworth *et al* 2015). We envisaged the fund operating as an active investor by providing proactive support to local areas, enabling them to invest in staff time, programme infrastructure, physical infrastructure and double-running costs. This year's Sustainability and Transformation Fund combines deficit support funding with money for transformation – as opposed to ring-fencing the latter – and the vast majority of the money will be spent on deficit reduction. If current and future transformation initiatives and

programmes are to succeed, dedicated funds will be needed to support local areas to transform the way in which care is delivered.

Moving care out of hospitals and into the community

Policy-makers and service leaders aspire to a health care system that more effectively supports people to remain well and independent and cares for people as close to home as possible. To achieve this vision, strong general practice, mental health and community services are essential. However, these sectors are characterised by prolonged under-investment and weaknesses including a lack of data and oversight on the workforce, service capacity and quality of care (Baird *et al* 2016; Maybin *et al* 2016; Gilbert 2015).

National targets and monitoring systems remain broadly focused on the acute sector, with A&E and referral-to-treatment commitments at the heart of the NHS Constitution. Similarly, the bulk of the additional funding provided through the Sustainability and Transformation Fund in 2016/17 is being used to tackle deficits in the acute sector rather than to support ambitions to move more care into the community and achieve parity of esteem between physical and mental health. Similarly, NHS Improvement's new oversight framework for NHS providers is heavily weighted towards oversight of acute providers.

These issues must be addressed if non-acute services are to play an increased role in future. We welcome recent attempts by the national bodies to address this imbalance through the Forward View in relation to mental health services and general practice, although there has not yet been a similar initiative in relation to community services. However, new care models and sustainability and transformation plans (STPs) offer an opportunity to redesign systems of care with a greater focus on these services.

Integrating physical and mental health services

The disconnect between care for mental and physical health has significant implications for both health outcomes and the sustainability of the health system (Naylor *et al* 2016). People with long-term physical health conditions are two to three times more likely to experience mental health problems. Similarly, people with mental illnesses commonly suffer from poor physical health for a variety of reasons, including the side effects of medication and high rates of smoking. Our research indicates that between 12 and 18 per cent of current NHS expenditure on long-term conditions is linked to poor mental health and wellbeing (Naylor *et al* 2012).

To be sustainable into the future, health services will need to be built on an integrated approach in which every contact with patients is used to support both their physical and mental health. This will involve developing new approaches to mental health in general practice; embedding mental health support in physical health care pathways; and making changes to education and training to ensure that all health professionals have the skills, confidence and support required to consider patients' needs in a holistic way (Naylor *et al* 2016).

Integration of health and social care services

Although integrated care has been a longstanding policy aspiration of successive governments, progress has been limited and patchy. This reflects fundamental differences between the NHS and the social care system in terms of funding, governance and accountability.

Building on the recommendations in the Barker Commission's report, we have set out recommendations to integrate commissioning in all parts of the country by 2020 (Humphries and Wenzel 2015). A key message from this work was that there is no one-size-fits-all solution and that CCGs and local authorities should agree locally how best to integrate commissioning, responsibilities and budgets.

Working in 'place-based systems of care'

The King's Fund has argued that further progress will depend on establishing 'place-based systems of care' in which organisations work together across geographical areas to improve health and care for the populations they serve. To support these systems to emerge, commissioners should become more integrated and strategic, defining outcomes to be delivered and measuring the performance of the system as a whole (Ham and Alderwick 2015).

We therefore welcome the work to develop five-year sustainability and transformation plans (STPs). These represent a significant change in the way the NHS plans its services – emphasising collaboration over competition between NHS organisations – and are an important opportunity to bring together health and social care services to improve co-ordination and deliver better care for patients. However, for this collaboration to be successful it must be based on a realistic assessment of the services needed to meet changing population needs, the time it takes to transform these services to make them fit for the future, and the savings that can be achieved by reducing reliance on hospitals and strengthening services in the community.

Place-based systems of care should not just involve closer integration between the NHS and social care. Improving population health requires co-ordinated action across sectors and communities to address the wider determinants of health. Moving to a focus on population health will require NHS organisations to work more closely with a wide range of local partners. It will also require alignment at all levels, starting in central government (see Alderwick *et al* 2015b).

Overall, although considerable efforts are being made to integrate care across health and social care, genuine integration will be hard to achieve while the fundamental differences in funding and entitlements between the NHS and social care identified by the Barker Commission remain.

5. Prevention and public engagement

The scale of the challenge

Unhealthy lifestyles have an impact on the health and wellbeing of the population, as well as costing the NHS and the economy billions of pounds every year. For example, obesity costs the NHS £5.1 billion a year, with an estimated cost to the economy of £27 billion (Public Health England 2015) due to its effect on productivity, earnings and welfare payments. Despite this, the health system is still largely set up to provide episodic care in hospitals, treating people when they fall ill rather than preventing illness and supporting individuals to maintain active and healthy lifestyles.

NHS leaders recognise the impact of unhealthy behaviours on expenditure; the various funding scenarios set out in the Forward View were predicated on a 'radical upgrade in prevention and public health'. The 2012 reforms, however, meant that a significant proportion of public health funds and responsibilities were transferred from the NHS to local authorities, marking a clear distinction between the two. Although we welcome the transfer of public health to local government, this has weakened the onus on the NHS to take responsibility for public health.

The rationale for investing in public health and prevention

Although estimates vary, it is widely recognised that our health is influenced most strongly by the social, economic and physical circumstances in which we are born, live and age. Our lifestyles are next, followed by the role of health and care services (The King's Fund 2013). Public health and prevention services can contribute to all three – the wider determinants of health (for example, through helping provide decent and safe housing), lifestyles (supporting behaviour change) or services (through preventive drug treatment).

The criteria for assessment of public health interventions

Public health efforts can delay demand for health and care services and in some cases may lead to long-term reductions in spending. However, it is important to recognise that public health interventions cannot eliminate costs entirely. The appropriate criteria against which investments in public health and prevention interventions are judged should be the same as those for NHS and social care interventions – that they are cost-effective actions that improve health while contributing to reducing health inequalities. Any further return on investment – for example, reducing demand for NHS services – should be seen as a bonus, not the purpose of public health and prevention.

Smoking cessation, for example, may delay costs in the short term, but ex-smokers will live much longer than current smokers and so will incur extra health costs over time. A similar picture exists for obesity (van Baal *et al* 2008).

The Department of Health, NHS England, Public Health England and local government should clarify these criteria for investment in public health measures. Without this, there is a risk that the 'invest to save' mentality focuses only on cost-reducing measures and ignores

the cost-effective contribution to health and wellbeing that public health measures can make.

Funding public health and prevention

Around £4.8 billion was spent on prevention and public health through the Department of Health budget in 2015/16; around 40 per cent on NHS England functions (for example, health screening), the remainder on the current local authority grant and other functions provided or commissioned by Public Health England. This means public health accounts for 4.1 per cent of all health spending, although this does not take account of some activities in the NHS or the activities of other government departments that contribute to prevention (we know, for example, that better education improves health outcomes).

Despite the government's stated commitment to prevention, the 2015 Spending Review announced reductions to local authority public health budgets amounting to a real-terms reduction of at least £600 million in public health spending by 2020/21, on top of a £200 million in-year cut to the 2015/16 budget. This is a false economy – not only will these cuts affect a wide range of services including health visiting, sexual health and vaccinations, but they will also have a knock-on effect on the NHS.

While we believe that more should be invested in prevention and public health, it is difficult to estimate the optimal level of spending in these areas. The public health reforms 'lifted and shifted' existing funding levels from primary care trusts (PCTs) to local government, but there was no estimate of the overall level of funding required. The responsibility for undertaking this analysis needs to lie with the government, and we support the recent Commons Health Committee's calls for a Cabinet Office minister with responsibility for driving forward strengthened cross-departmental working on public health (House of Commons Health Committee 2016).

The NHS's role in prevention

The NHS needs to maximise its own role in secondary prevention. While there have been welcome initiatives, the NHS remains underpowered in its response, particularly in tackling health inequalities. There is a host of evidence-based cost-effective action that, if delivered systematically and at scale, would narrow inequalities in health. Many of these lie in secondary prevention, such as cholesterol and blood pressure and smoking control. In the past these have been modelled by the Department of Health (2008) and assessed by the National Audit Office (2010) as being the most cost-effective actions the NHS can take. Often they are not new or novel initiatives, but they are essential and implementation remains patchy. NHS England needs to take the lead in rolling these out, co-ordinating with local government partners.

NHS England also needs to make better use of its existing spend. The NHS should be considered an important wider determinant of health, given its economic and employment footprint in all communities. Through better recognising its impact on social value, the NHS can help to tackle poverty (which is a significant driver of NHS costs (Asaria *et al* 2016, Bramley *et al* 2016)), as well as treating and paying for the consequences (Buck and Jabbal 2014).

The government's role in supporting people to live healthier lives

While individuals are responsible for their own and their children's health, the government also has an important role to play. The Wanless report (2004) made the case for government to try 'shifting social norms' using regulation, taxes and subsidies as well as health services and information. Regulation and taxation are powerful tools and have an important role to play in promoting healthier lives.

The government's childhood obesity plan is an example of where it should have gone further (Buck 2016b). It is widely known and accepted that obesity is not an issue that can be tackled through the selective use of one or two approaches, instead requiring a cross-society, cross-government response with multiple levers deployed. Although the plan re-affirms the government's commitment to a sugar levy, its proposal to achieve product reformulation on a voluntary basis does not go far enough and has been criticised by leading voices in the food retail industry, who have called for mandatory targets and for the government to play a stronger, co-ordinating role.

Key elements of a public health policy

Public health policy requires balanced action across all of the factors that impact on our health – the wider determinants, healthy behaviours, health and care services and genetics – with a strong awareness of how they inter-relate. Given their central role in influencing the wider determinants of health, government policy on housing, education and across other ministries can do more to maximise their contribution to population health and wellbeing. This should include the potential role of regulation and taxation. This also applies to local government policy (see Buck and Gregory 2013). The NHS needs to accept and strengthen its role in prevention and public health as well as treatment, joining up the dots between integrated care and public health (Alderwick *et al* 2015b), but also acknowledge that it contributes to the wider determinants of health through its employing and economic power in local communities. Communities (including businesses) and individuals can also do more, but it is clear that individual actions on health behaviour are strongly conditioned by economic and social circumstances, so providing information and education to the population is not enough on its own to improve population health and reduce inequalities.

The role of patients and service users as partners in their own care

The idea that people should have a stronger voice in decisions about their health and care, and that services should better reflect their needs and preferences, has been a goal of politicians and senior policy-makers in health for at least 20 years. Despite this, and some small pockets of improvement, there has generally been a lack of progress towards fully involving people in their own health and care. The evidence shows that when patients are involved in their care, decisions are better, health and health outcomes improve, and resources are allocated more efficiently (Foot *et al* 2014, Hibbard and Gilbert 2014).

Options for increasing participation include making shared decision-making a reality, giving people the support and information they need for effective self-management, involving families and carers, giving people personal budgets where appropriate, and engaging people in keeping healthy.

6. Digitisation, big data and informatics

Digital technology has the potential to transform the way patients engage with services, improve the efficiency and co-ordination of care, and support people to manage their health and wellbeing.

Previous efforts to digitise health care have resulted in considerable progress being made in primary care – partly driven by the fact that, since 2007, most primary care IT systems in England have been centrally funded – while secondary care lags significantly behind.

Given the potential benefits, the government has rightly emphasised the importance of this agenda, setting out a high-level vision as well as goals for digitising the NHS. However, there is a risk that expectations have been set too high (Honeyman *et al* 2016). As with other innovations and medical advances in the NHS, new technologies should be introduced on the basis of robust evidence and evaluation.

Barriers to progress include:

- lack of clarity about funding available to support implementation
- the risk that progress on transforming care is crowded out by other priorities, not least stabilising performance in the short term
- there are few incentives for NHS leaders to attempt large-scale transformation involving digital technology.

Most importantly, progress in this area will require much more focus on engaging and upskilling the people (at all levels in the NHS) who are expected to deliver it, as highlighted by the recent review chaired by Dr Robert Wachter (2016). The importance of engaging clinicians in particular, and conveying the benefits associated with digitisation should not be underestimated.

Finally, data-sharing is essential for conducting research and improving patient care. Recent reviews present an opportunity to address legitimate public concerns about data-sharing in the NHS and ensure that information governance is not a barrier to progress.

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28 September 2016

Lord Layard – Written evidence (NHS0178)

Some issues on hypothecated taxes for the NHS

1. The case

The case is well-known. At present there is no easy way in which the public's wishes about NHS funding can be translated into practice. If there were a hypothecated tax, debated at each election, this could improve the translation of wish into action. It would link people's reflections about tax to their reflections about spending – at least in the health area.

2. National Health Insurance, set every 5 years

The most obvious approach would be to turn NI into National Health Insurance (NHI).

The rate of NHI would be set after each election. The process would be as follows.

1. Decide the share of GNP to be spent on health on average over the Parliament and thus compute its forecast value in £.
2. Phase the expenditure over the Parliament.
3. Fix the NHI tax rate for the Parliament to raise the (expected) total over the Parliament.
4. If in a year Tax exceeds Expenditure, put it in a stabilisation fund; if Expenditure exceeds Tax, finance it from this fund (if possible), otherwise by borrowing. At the end of the Parliament, close the fund and transfer the debt to the consolidated National Debt.

3. The transition

NHI would need to collect more than the present NI. A key issue is whether it would include public expenditure on all social care. If it included social care, NHI would need to raise some £158b plus the existing shortfall in NHS expenditure – say £180b in total. NI raises £115b. So there would need to be a rise in the coverage and/or rate of NI to raise the extra £65b. At the same time other taxes could be cut by £43b.

11 November 2016

Lifeways Group – Written evidence (NHS0096)

I am writing in my capacity as Chief Executive of the Lifeways Group to provide evidence to the Select Committee on the Long-Term Sustainability of the NHS, which is set out below. We welcome this important work and would relish the opportunity to provide evidence during future sessions.

Paul Marriner

Chief Executive, Lifeways

1. ABOUT LIFEWAYS

- 1.1 For background, Lifeways is a major provider of supported living services to people with learning disabilities, supporting over 5,250 people across the UK.
- 1.2 We deliver high-quality, local services, personalised to meet individual needs and aspirations. Our services offer support for people with a range of needs, providing solutions which empower and enable them to become more independent and live fulfilling lives. Integral to our philosophy is ensuring the people we support are treated with respect, dignity and in line with their wishes.
- 1.3 Our aim always is to provide people with just the right amount of care and support, and to ensure that this is done as flexibly as possible. This offers choice to our service users, and good value to commissioners and to the taxpayer.

2. RESOURCE ISSUES

- 2.1 Lifeways welcomes the Government's decision to ring-fence the NHS budget as well as the commitment to £8bn per year by 2020 to fill the current funding gap outlined in the NHS Five Year Forward View. However, without urgent measures to ensure that social care is properly funded these pledges will be undermined, as the NHS is interdependent with the social care sector.
- 2.2 Furthermore, it was right that these pressures on social care were recognised at the Spending Review in November 2015, but regrettably, the subsequent solutions announced by the Government only partially address the current challenges; the ongoing challenges are unsustainable and require further action.
- 2.3 Lifeways fully echo Simon Stevens' call at the NHS Confederation's annual conference for additional funding in future to be directed to social care. Failure to address the funding pressures is a false economy that is damaging both the social care sector and NHS; a strong social care sector props up the NHS. It is more cost effective to invest in social care as a means to improve patient flow in hospitals and increase their capacity to deal with patients who are in most need of acute care.

2.4 Lifeways – along with other care providers – has been doing more for less over the last five years, and has felt the full force of the severe cuts in Local Government spending. Lifeways has received virtually no inflationary increases since 2011. We have also worked closely with local commissioners to find ways of delivering better services for less money. Therefore, in real terms we have faced major decreases in our budgets, during a period in which we have improved workforce terms and conditions in order to recruit and retain high quality staff and increased our investment in training and leadership support to ensure we meet the expectations of the people we support, and our funders and regulators.

2.5 The challenges of local authorities and providers has only increased as the National Living Wage (NLW) has been introduced. Lifeways fully supported the introduction of the NLW and we recognise that it is critical that staff are properly rewarded; however it must be funded in a sustainable way. For Lifeways, taking into account the overall inflationary impact of the NLW, including the costs of maintaining differentials and additional staffing on-costs, the total figure stands at c£15m. This consists of c12.5m for supported living services and c£2.5m for registered care. In 2016-17, the total cost of the NLW to Lifeways will be £4.795m and will increase per annum until 2020. We have comprehensive data on this point that we can provide to the Committee.

2.6 A number of councils have recognised the difficulties providers face in continuing to provide high quality services under such pressure, by agreeing to fee uplifts to account for the NLW. However, this has not been the case across the country. Furthermore, we are already fast approaching the time that will require us to kick-start discussions for the following year. Close collaboration and partnership working will continue to be crucial over the coming months and years to ensure the system supports the vulnerable people that need to be cared for. To aid these discussions and efforts, we need urgent clarification from the Government on whether measures will be introduced to support care providers and commissioners to fund the NLW.

2.7 The 2% council tax precept, announced as a means to address the funding shortfall, has introduced significant variation across the country and although most councils have opted to use this power and many councils have been willing to provide an uplift to alleviate challenges such as the NLW, others have still been resistant. It is crucial that extra revenue through the social care precept is passed onto providers, and that the impact of such extra funding is measured. The uplift process for the next year will start shortly, so urgent support is critical.

RECOMMENDATION 1: The Government must play its role in ensuring social care is sufficiently resourced, to close the large and growing funding gap and prevent a knock-on effect on the NHS.

RECOMMENDATION 2: The Government must provide urgent clarification on whether measures will be introduced to support care providers and commissioners to fund the NLW.

RECOMMENDATION 3: Local authorities must have the freedom to raise the social care precept above 2% to enable them to make a greater contribution towards funding for social care.

3. WORKFORCE

3.1 Lifeways welcome the work underway as part of the new models of care vanguards, particularly around raising skill levels in social care which is crucial for the recruitment and retention of staff. Moreover, the system needs to break down barriers between professions to ensure whole person care. Our dedicated staff ensure that we can continue to provide services and keep people out of A&E or stuck in hospital for longer than they need to be.

3.2 Lifeways know that supporting, incentivising and training staff directly benefits the vulnerable people we work with. Our offering in the marketplace is “an hour of time”; that hour needs to have value for the person being supported. Lifeways does, and continues to prioritise, investing in staff but cannot do so in an atomised system. Recognition needs to be given that funding margins impact the attractiveness of the sector to staff and therefore impact of care delivery. This is not sustainable for the long-term.

3.3 On recruitment, it is important to get the composition of the workforce right – some individuals may be initially less qualified, but if their values and motivations are right they can be great assets to the families and individuals we support – subject to a robust training programme. Developing values based recruitment is a priority for us and should be a priority for NHS England and Health Education England going forward. Lifeways recognise that competitive pay and conditions for staff help to keep morale high, attract high quality staff and improve retention. As a result, we are fully supportive of the NLW to ensure staff are properly rewarded for their hard work, however as outlined above the initiative must be funded in a sustainable way to ensure the sector can be sustainable in the long-term.

3.4 The impact of Brexit is already being felt, with evidence that EU nationals working in social care are uncertain of their future.

RECOMMENDATION 4: NHS England and Health Education England must ensure that staff within the health and social care sector continue to expand their skill mix and the barriers between professions are broken down.

RECOMMENDATION 5: NHS England and Health Education England should incentivise value based recruitment to ensure the composition of the workforce is right.

RECOMMENDATION 6: The Government must recognise that funding pressures impact on the ability of providers to incentivise staff to work within the sector, and therefore act to alleviate some of the financial pressures facing providers, such as the NLW.

RECOMMENDATION 7: The Government must work with the social care sector to ensure that, post Brexit, we have in place a system which ensures that sufficient staff are available to meet the social care needs of the British people.

4. MODELS OF SERVICE DELIVERY AND INTEGRATION

- 4.1 Lifeways are fully supportive of developing integrated ways of working that enable individuals with learning disabilities to live as independently as possible. Lifeways has developed an innovative Flat Scheme model – working in collaboration with housing associations, we develop purpose new built accommodation and tailored care packages for service users, enabling people to move out of inappropriate settings at pace and at scale in line with their needs. It is important to note that although we work with Clinical Commissioning Groups and local authorities from an early stage, no funding commitment is needed from commissioners for the capital development. Lifeways don't just build, we work with commissioners to understand and make sure there is genuine need. This is the type of collaboration required to ensure effective long-term models. Additionally, we view this type of locally-focused model as a method to accelerate integrated care services. Please see a brief with further information below this submission.
- 4.2 Supported living has clear benefits for service users, transitioning away from inappropriate institutionalised care and being part of the community again. Primarily, everyone has their own front door with their own key, meaning there are no restrictions on them (unless criminal justice related). The flats are tailored to individual needs, thus helping them to live as independent a life as possible. There is also no compulsion on anyone to live in the flat scheme, and whilst Lifeways' agreement with the local authority is to deliver the core care services, it is up to the individual who delivers the wider care services – they can use another provider or make use of personal budgets to enable them proper choice. It is essential that the centre provides the necessary support to roll-out these types of model at pace. Failure to do so will harm vulnerable individuals and put pressure on the care and NHS systems.
- 4.3 A potential risk to the long-term sustainability of supported living and subsequently, Lifeways' Flat Scheme Model, was announced at the Spending Review in November 2015. The Government's intention to cap the amount of rent that housing benefit will cover in the social sector to the relevant Local Housing Allowance caused vast uncertainty within the sector. The recent announcement by Damian Green MP, Secretary of State for Work and Pensions, to further defer the application of the cap until 2019/20 and introduce a new funding model is welcome, however the ongoing uncertainty within the sector regarding the final design of the system will continue to cut off much-needed institutional investment for supported accommodation. This is likely to impact on the housing options available to people moving out of inpatient facilities and thus undermine post-Winterbourne View efforts to transition individuals with learning disabilities into the community. In turn, this will impact on hospitals and will only increase delayed transfers of care; a strong social care sector is needed to prop up the NHS.
- 4.4 Whilst devolving ring-fenced funding to local authorities to provide additional 'top up' to providers where necessary, such as supported living, Lifeways eagerly anticipate the publication of the consultation and the details of such an arrangement. It is right that

the Government have recognised the higher average costs associated with supported accommodation and are taking action to alleviate against this. Moreover, it is right that the 'top up' funding devolved to local authorities will be ring-fenced, however the Government need to ensure that people with learning disabilities are sufficiently protected. Lifeways understand the need to prevent inflated rates, however the new funding model will need to ensure that the money devolved is sufficient, gets passed onto the right people, and will provide flexibility in the long-term to ensure that the sector can remain sustainable.

4.5 Lifeways sits on NHS England's Social Care Provider Reference Group which is exploring new integrated care models – we are committed to sharing best practice and helping to progress the aims of the Five Year Forward View. The enhanced health in care homes vanguard is already showing positive results; this model can be rolled out more widely. Whilst we recognise there needs to be a focus on the elderly population, there is a growing population of people with learning disabilities and the need, and opportunity, to reduce delayed discharges for both populations is significant. Lifeways is also fully supportive of the devolution agenda as an opportunity for local areas to make local decisions and do things differently. We hope the Government will continue to give attention to these important new approaches to care provision, as it presents an invaluable opportunity to do things differently in a sustainable way.

4.6 Finally and closely linked with the above point, Lifeways strongly supports the use of personal budgets as an innovative approach to the design and delivery of adult social care. One of the most important contributions personal budgets have made is that all providers of social care services now have to consider much more carefully what we offer and how we communicate with the people we support and their families. The enhanced choice for service users through personal budgets has made social care a public service that is genuinely accountable to and controllable by the people being supported; this is essential to a high quality and responsive social care system. We firmly believe personal budgets have helped to instil a strong culture across the social care system that puts the needs and wishes of service users front of mind for commissioners and providers. The work being done on personalised services was initially pioneered in social care some years ago and we hope to see the agenda accelerated in the coming months and years. Flexible, personalised services are Lifeways' main offering and we can help to develop such services in the NHS.

RECOMMENDATION 8: The Government must ensure that they listen to the sector when designing the new funding model.

RECOMMENDATION 9: The Government must ensure that the new funding model will provide flexibility in the long term, to prevent vulnerable people ending up in the acute sector unnecessarily.

RECOMMENDATION 10: The Government must provide local authorities with a sufficient amount of funding and ensure that the money reaches people with learning disabilities.

RECOMMENDATION 11: The Government must continue to recognise the potential of the devolution agenda and new integrated care models, and drive these initiatives forward with a focus on learning disabilities.

RECOMMENDATION 12: The Government should encourage the roll-out of personal budgets and see them as a central component of how new models of care are delivered.

5. PREVENTION AND PUBLIC ENGAGEMENT

5.1 The current models of delivery in the NHS are going to have to change in order to suit the modern makeup of the country. In 1948 there were 10 people aged under 65 for every one over 65. Now it is 3.5, and within the next 20 years it will be less than 3. Prevention is critical and adult social care has a significant role to play in this. Lifeways Flat Scheme Model and the Positive Behavioural Support (PBS) that is central to our care deliver are key to preventing conditions escalating and people ending up in hospitals unnecessarily. Lifeways invest in PBS as the recommended and valued framework for working with people with learning disabilities at risk of behaviour that challenges and this investment delivers excellent outcomes for our service users. As demand increases and pressures mount on the acute sector, Lifeways call for the consideration of the accreditation of training in PBS.

5.2 For patients to receive whole person care, there must be a greater awareness of the interaction between health and social care and a welcome understanding that the NHS of the future will look very different. The public, as well as politicians, need to be engaged and invested in the process of change in order to deliver high quality sustainable services for patients.

RECOMMENDATION 14: The Government must instil an awareness and appetite for change within both Parliament and the public to ensure that the system can deal with an aging population; social care has a critical role to play in this.

RECOMMENDATION 15: There should be widespread recognition of the benefits of PBS and as such, there should be a PBS Standard and tiered accreditation system for individuals and organisations delivering and receiving PBS.

23 September 2016

Local Government Association – Written evidence (NHS0125)

1. About the Local Government Association (LGA)

- 1.1. The Local Government Association (LGA) is the national voice of local government. We work with councils to support, promote and improve local government.
- 1.2. We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

2. Summary

- 2.1. The current social care and health system is unsustainable and will buckle under the weight of demand unless we put adult social care funding on a sustainable footing. We need to re-engineer our planning and service provision to promote healthy choices, prevent sickness and intervene early to minimise the need for costly hospital treatment.
- 2.2. Trying to fix this by focusing on treatment alone is not the answer. We need preventative strategies that mitigate or defer the need for costly interventions and at the same time deliver better outcomes for individuals.
- 2.3. An adequately funded social care and support system is essential to this and therefore essential to supporting the sustainability of the NHS by reducing the demand it faces. Adult social care is critical to the health and wellbeing of people with a complex range of often intense needs, their carers and families, and our communities more generally. Yet funding remains in a perilous state. It is concerning that the Government does not believe the service is underfunded.
- 2.4. The consequences of growing and unresolved pressures on funding are exacerbating existing tensions and creating new ones. There are concerns about the duration and quality of commissioned care, carers' ability to continue their caring role, and there is a genuine threat to the viability of some providers within the market.
- 2.5. Putting adult social care on a more sustainable financial footing will enable councils to: better support those with the greatest needs (and those at risk of not having their needs met); further embed personalisation; invest more heavily in prevention; properly support informal carers; and help stabilise and properly fund the provider market.
- 2.6. Social care is also a major contributor to our national economy. Most care providers are small businesses that form a sizeable proportion of the local economy in many places. It contributes as much as £43 billion to the national economy and supports 1.5 million full time equivalent jobs.

3. Resourcing issues: including funding, productivity and demand management. Is the

current funding model for the NHS realistic in the long-term? Should new models be considered? Is it time to review exactly what is provided free-at-the-point of use?

- 3.1. An adequately funded social care and support system is essential to the sustainability of the NHS. Without considerable investment in adult social care and prevention, the NHS will not be able to withstand the increasing demand on its services. Now, more than ever, we need to look towards health and social care integration. Not just looking at the services we deliver, but how we are delivering them.
- 3.2. The integration agenda is moving at pace. The challenges in this are significant. Planning and delivering integration is taking place at a time of persistent health inequalities; when public services are expected to make significant economies as part of a national government austerity programme; when adult social care continues to face severe resource challenges; and when the NHS must tackle provider deficits while delivering major transformation.
- 3.3. However, there are also opportunities. Many acknowledge that funding constraints have brought organisations together to identify joined-up, innovative solutions. The move towards devolution is also encouraging organisations to cooperate across larger footprints, and can be particularly useful for large-scale health and wellbeing initiatives.

Local government funding overall

- 3.4. Overall, councils with adult services responsibilities will see a reduction in their 'core spending power' by 0.2 per cent over the period to April 2020.
- 3.5. This effectively means that councils face an outlook in which total available funding for core services will be broadly similar in cash terms in 2019/20 to what it was last year. Consequently, any pressures on spending will have to be offset by savings. These pressures include:
 - a. General inflation increases in demand for everyday services as the population grows.
 - b. Ending of contracting out of National Insurance.
 - c. National Living Wage.
 - d. Deprivation of Liberty Safeguards.
 - e. Business rates appeals.
 - f. Introduction of the Apprenticeship Levy.
 - g. The potential impact of the UK leaving the EU on the care workforce.
 - h. Impact of the housing cap.
- 3.6. The need to make savings to counteract the scale of such pressures will undoubtedly impact on funding for adult social care in the years ahead. We know this to be the case in 2016/17 as the 2016 ADASS budget survey shows that adult social care departments are planning savings of £941 million this year. This is 7 per cent of net adult care budgets and 28.5 per cent of total council savings.

Historical underfunding of adult social care

- 3.7. In the 2010 Spending Review, £7.2 billion additional funding was made available for social care (through additional Formula Grant and the NHS transfer), arguing that

this was sufficient to prevent a funding gap developing. That money may well have had a positive effect if councils were operating without wider pressures. Local government was not operating from such a stable position. The pressures councils faced, allied to the requirement to make savings in light of major reductions in government funding, meant that adult social care was not immune to the impact of reductions overall.

3.8. Our analysis shows that adult social care had to deal with a funding gap of £5 billion from 2011/12 to 2015/16.⁷⁶⁵ Half of this came from savings and service reductions within adult social care, with the other half coming from savings from other council services including library and youth services (in other words, savings above the trend that general council funding changes would have implied).

3.9. Additional funding will only be of benefit if we are operating in a settled environment, which we are not. Furthermore, and as the ADASS budget survey highlights, councils overspent their adult social care budgets by £168 million in 2015/16. Social care therefore unquestionably enters the new Spending Review period from extremely unstable funding foundations.

The 2015 Spending Review

3.10. The 2015 Spending Review announcements for social care (council tax social care precept and additional funding allocated through an ‘improved BCF’) and a helpful recognition from Government of both the importance of adult social care and the significant pressures facing councils. However, the value of the council tax precept which, according to the Government’s own analysis is worth £1.8 billion by 2019/20, not £2 billion⁷⁶⁶ is based on a number of important assumptions that cannot be guaranteed. These assumptions are that:

- *All councils will use the precept to the maximum amount.* Not all councils used the precept this year (144 out of 152 councils implemented it, generating £382 million income) and it is difficult to predict how many will use the option in future years.
- *The number of Band D equivalent dwellings eligible for full council tax will rise by 7.8 per cent or 1.3 million over the four year period.* At council level this varies from a 0 per cent increase to a 25 per cent increase, suggesting that some councils may struggle to match the forecast.
- *Core council tax will increase by CPI each year.* It is difficult to say with any real certainty what level councils will set their council tax at in future years.

3.11. There are also important considerations associated with the additional funding for social care through the BCF.

- a. *£800 million of the total £1.5 billion by 2019/20 will come from planned savings to the New Homes Bonus (NHB).* If this level of savings is not realised it is not clear what implications this may have for the funding earmarked for social care. It would be helpful to have Government assurances that the full £1.5 billion will be made available to social care in the event of the full NHB savings not being achieved.

⁷⁶⁵

<http://www.local.gov.uk/documents/10180/5854661/Adult+social+care+funding+2014+state+of+the+nation+report/e32866fa-d512-4e77-9961-8861d2d93238>

⁷⁶⁶ See [here](#) for information on core spending power.

- b. *The additional funding for social care allocated in the BCF is back-loaded.* There is no money available this year and only £105 million available in 2017/18, despite acute pressures impacting on the care system today. This is why we continue to call on the Government to bring forward £700 million of funding (the proportion of the £1.5 billion that is not dependent on savings being made to the New Homes Bonus) to help tackle immediate challenges.

3.12. As a result of these considerations, we question the likelihood of councils seeing the full £3.5 billion promised by 2019/20.

The LGA position

3.13. It is important to clarify what the LGA said in its Spending Review submission 2015 particularly in relation to the figure of £2.9 billion, which the Government has referred to on several occasions.

3.14. This figure was an estimate of the funding gap created solely by core demand and inflation pressures and some of the pressures posed by both the new National Living Wage and the existing National Minimum Wage. We made clear that the estimate of the gap was an ‘absolute minimum’ and that the calculation of the component elements was ‘intentionally cautious.’

3.15. Additionally, our Spending Review submission identified a number of other pressures that were not included in the calculation of the gap. These included Deprivation of Liberty Safeguards (£172 million per year), winter pressures, pressures on providers, the cost of recruiting and retaining an adequately skilled workforce, the cost of on-going implementation of the Care Act, and additional pressures associated with the National Living Wage and National Minimum Wage. Our submission also pointed out that, for example, the number of pupils with learning disabilities is expected to grow by at least 26 per cent from 2014-2023, more than double the speed of increase in overall pupil numbers.

3.16. The Government’s position is that adult social care is not underfunded and that councils will benefit from £3.5 billion additional funding announced in the 2015 Spending Review. Based on the evidence, we do not support this interpretation of the funding position for care and support. We remain extremely concerned about the state of funding for one of our most vital public services. The 2016 ADASS budget survey⁷⁶⁷ adds further weight to those concerns, demonstrating that:

- a. Funding does not match increased needs for, and costs of, care for older and disabled people. To maintain care at the same level as last year would according to ADASS require more than an extra £1.1 billion this year.
- b. The social care precept this year raises a total of £380 million – less than two thirds of the calculated cost of the National Living Wage (£520 million, plus a further £92 million to be compliant with the National Minimum Wage). Local government has to find savings of more than £941 million.⁷⁶⁸
- c. Councils are increasingly unclear where this funding will come from; the majority of councils are overspending on social care, the scope for further efficiencies is decreasing, and directors’ confidence in the ability to make continued savings is diminishing.

⁷⁶⁷ <https://www.adass.org.uk/budget-survey-2016>

⁷⁶⁸ <https://www.adass.org.uk/budget-survey-2016>

- d. The continuity of the care market is under threat. 80 per cent of councils report that providers are facing immediate financial difficulties and many are selling up, closing homes, or handing back contracts.⁷⁶⁹
- e. Investment in prevention is being squeezed further; this year councils will be spending 4 per cent less on prevention than last year.⁷⁷⁰

Future outlook

3.17. The LGA supports the conclusion reached in the ADASS budget survey: ‘Social care is essential but the investment isn’t there’. We also note with concern the ADASS survey’s finding that just 36 per cent of directors are fully confident of delivering all their statutory duties this year, dropping sharply to only 8 per cent next year.⁷⁷¹

3.18. Councils also have a statutory duty to balance their books. As many councils have now reached the point where efficiencies alone will not bridge the funding gap they have no option other than to reduce services. This clearly impacts on people and the availability of services. As the ADASS budget survey demonstrates, while demographic pressures, such as people living longer, is increasing costs by 3 per cent per year, the number of people actually receiving services has not increased, suggesting growing unmet need.⁷⁷²

3.19. The pressures, and their impacts, will inevitably compound some of the structural weaknesses in the provision of care services:

- a. Without adequate increases in fee levels to providers councils will see a growing shortage in adequate supply in domiciliary care and further challenges in maintaining a well-trained and supported workforce that is able to deliver quality care.
- b. The situation in residential care will continue to be as demanding. Many providers are already at marginal viability and others are only able to accept local authority prices by cross-subsiding from paying clients to council ones. Some providers are withdrawing from the public sector market to concentrate on the self-funder market and the likelihood is that costs will have to rise more than planned if failure in supply is to be avoided.

4. Workforce: including supply, retention and skills. How can an adequate supply of appropriately trained healthcare professionals be guaranteed? Are enough being trained and how can they be retained? Do staff in the NHS have the right skills for future health care needs?

4.1. The Emergency Care Improvement Programme (ECIP) and LGA identify the need to strengthening whole system leadership. This needs to happen across the hospitals (acute and community), CCG, community services, care providers. System Resilience Groups (SRGs) and Health and Wellbeing Boards (HWBs) are also important

⁷⁶⁹ http://www.local.gov.uk/web/guest/briefings-and-responses/-/journal_content/56/10180/7750338/ARTICLE

⁷⁷⁰ http://www.local.gov.uk/web/guest/briefings-and-responses/-/journal_content/56/10180/7750338/ARTICLE

⁷⁷¹ <https://www.adass.org.uk/budget-survey-2016>

⁷⁷² <https://www.adass.org.uk/budget-survey-2016>

partners.

- 4.2. In many places, people are being prevented from leaving hospital which is having an adverse impact on their health outcomes, due to an insufficient supply of quality care and support in community hospitals, residential and nursing care and domiciliary care to support people in their own homes.
- 4.3. The ECIST programme, now ECIP, is well established and there is a clear understanding of ‘what good looks like’ in a high performing hospital which can demonstrate good outcomes for its patients. A support offer has been developed and is the basis of improvement work driving the programme this winter and beyond.
- 4.4. Strong and common characteristics of the local social care ‘economy’ are emerging via the diagnostic exercises being run across the four ECIP clusters. These include:
 - a. The need to strengthen whole system leadership across the hospitals (acute and community), CCG, community services, care providers and the local social care / local government partners
 - b. Ensuring the ‘whole’ health /social care system fully understands the importance of making sure people are not stranded in hospital and fully committed to working closely together to prevent this happening.
 - c. Health commissioning – there is strong evidence that an insufficient supply of quality care and support in community hospitals, residential and nursing care and domiciliary care to support people in their own homes, is preventing people leaving hospital and having an adverse, or sometimes tragic, impact on their health outcomes. For example, in July 2016, the number of delayed days were 184,188, for July 2015 there were 147,005 days. This represents a 25 per cent increase over the last year.⁷⁷³

5. Models of service delivery and integration: How can the move be made to an integrated National Health and Care Service? How can organisations in health and social care be incentivised to work together?

- 5.1. Bringing together health and social care to provide high-quality and sustainable services to improve health and wellbeing outcomes has been a constant and dominant policy theme for the past decade. Many places across the country are already demonstrating the potential to transform health and social care services so that they are person-centred and focused on the needs of the local area.
- 5.2. Integration, however, is not an end in itself, or a panacea for the system’s financial challenges. Its primary purpose is to shift the focus of health and care services to improving public health and meeting the needs of individuals. It should involve drawing together all services across a place for the greatest benefit, and include investment in services which maximise wellbeing throughout life.
- 5.3. At a local level, many leaders across health and care systems are assessing their present effectiveness and making the improvements needed to be fit for the future.

⁷⁷³ <https://www.adass.org.uk/budget-survey-2016>

Integrated systems can take many forms, depending on local need and circumstance. Transformation, where successful, is iterative and requires trial and error, incremental change, and sustained effort and commitment. Nevertheless, there are key elements and characteristics that need to be addressed in order to succeed.

- 5.4. In June 2016, the LGA with sector partners, NHS Confederation, NHS Clinical Commissioners and ADASS, published a joint vision for a fully integrated health and care system. [Stepping Up To The Place](#) sets out the essential characteristics of an integrated system to bring improved health and wellbeing for local populations, covering the development of shared commitments, shared leadership and accountability, and shared systems.
- 5.5. This vision is supported by a [self-assessment tool](#), which the LGA developed and launched with partners in July 2016. The tool supports local health and care leaders to assess their capacity and capability to lead integration and the transformation of their local system.
- 5.6. Since March, the establishment of 44 Sustainability and Transformation Plans has continued apace, with each required to draft proposals to transform local health and care services and bridge the three gaps of health and wellbeing, care and quality, and finance. Local government including health and wellbeing boards have been involved throughout. These draft plans were submitted on 30 June 2016.
- 5.7. Each area is required to submit a revised plan on 21 October, including details of the financial workings and delivery plans underpinning their overarching proposals. Individual NHS organisations within each footprint are also required to submit in November 2016 two-year operational plans which are aligned to their Sustainability and Transformation Plans objectives, with contracts for the period due to be signed by December 2016.
- 5.8. There needs to be a new strategic approach to investment in preventative services to ensure the NHS is strong and sustainable, and to enable a shift from acute to preventative services, refocusing services around individuals, and redrawing the boundaries between economic policy and social reform.

Integration by 2020

- 5.9. In the 2015 Spending Review, the Government committed all local systems to integrate health and care by 2020, and to prepare integration plans by March 2017. This commitment secures a long-held policy ambition of the LGA, and we continue to work to influence the development of the underpinning policy framework. It is intended that local areas can develop locally appropriate integration models which could include integrating commissioning functions beyond the current scope of the Better Care Fund, pursuing greater devolution of health functions or developing integrated care organisations.
- 5.10. Sustainability and Transformation Plans provide a framework to pursue these ambitions, and many draft plans include proposals for the greater integration of health and care services. It is important to ensure alignment of these inter-related programmes and policy frameworks, ensuring that their objectives do not conflict or undermine overarching goals to improve the health and wellbeing of citizens, their

experience of care and the sustainability of the system.

- 5.11. During the development of the ‘Stepping up to the Place’ vision and tool, we have worked with the Department of Health, the Department for Communities and Local Government, and NHS England to ensure alignment across policy frameworks. The LGA is now working with the departments and others to ensure that forthcoming policy guidance on 2017 integration plans is closely aligned to the LGA’s ongoing support work with local system leaders on the commitment, leadership and local capacity for integration.
- 5.12. Whilst the current footprints of Sustainability and Transformation Plans do not match any other footprint such as Health and Wellbeing Board areas or devolution deal areas, we acknowledge that there will always have to be planning at a variety of levels for different services and there is no single right answer. We have welcomed the pragmatic approach taken by senior NHS leaders to recognise that planning and delivery of a range of services will continue at different levels and that Sustainability and Transformation Plans should focus on those issues where they can add maximum value.

Supporting whole-system change

- 5.13. The LGA has been supportive of the goals behind Sustainability and Transformation Plans. We have been keen to engage in the process as equal partners, and see the plans as a significant step in reshaping local health and care services for the benefit of local communities, keeping people out of hospital and improving the quality and experience of care.
- 5.14. The plans need to recognise the huge financial pressures facing social care. Investing money into the NHS while councils have to make cuts to social care services is a false economy. An adequately funded social care system is essential to alleviating the pressure on the NHS.
- 5.15. Sustainability and Transformation Plans need to ensure adequate investment in community and preventative services to transform the quality and experience of care, rather than simply focusing on the reconfiguration of acute services. It is useful that the Sustainability and Transformation Plan guidance has now recognised the crucial role which social care and local government have to play in this process. We are working hard with NHS partners to try and ensure full engagement with local government is made a reality in every area.
- 5.16. Local government has a track record in innovation, of working with their communities, public sector partners and business, to find solutions, including new revenue sources, which meet our citizens’ needs and aspirations with fewer resources. Councils and the LGA continue to work with NHS partners to explore alternative channels to bring investment into the system, including use of One Public Estate to maximise the benefit derived from the public estate.
- 5.17. Sustainability and Transformation plans, if designed well, should be a significant tool to support integration of health and care systems. They, however, are not the end point of integration and we will continue to press for Sustainability and Transformation plans to ensure that the transformation of services are built around the needs of individuals, taking a preventative approach to maximise health

and wellbeing.

Political leadership and accountability

- 5.18. For Sustainability and Transformation plans to be effective, councillors and communities must be at the heart of the planning process. Health and wellbeing boards, as the only place where local political, clinical and professional leaders come together, can be pivotal in driving change, if they are involved fully in the process.
- 5.19. Local government recognises the scale of the challenge that most Sustainability and Transformation plans are facing, and we have consistently argued that councils can help partners engage with communities, but only if they have an opportunity to discuss and contribute to proposals. It is vital that time is invested in engaging councillors and MPs in the development stage of Sustainability and Transformation Plans, to ensure that communities' wishes are understood, and to minimise the likelihood of challenge or delay to proposals.
- 5.20. Councils, as leaders of their communities, are best placed to advise Sustainability and Transformation partners on how best to engage councillors. At a minimum, it is expected that each footprint evidence in its October 2016 submission that it has held meaningful strategic conversations with local politicians. This could involve formal channels of the health and wellbeing board, the health overview and scrutiny committee, or council cabinet and/or informal or specially convened arrangements to address the needs of the footprint, based on the advice of councils. The LGA also continues to highlight the importance of ensuring that Sustainability and Transformation Plan partners consider how health overview and scrutiny committees are supported to discharge their statutory oversight responsibilities.

Community engagement

- 5.21. Engagement with councillors is not a substitute for community engagement. The LGA continues to call transparent process to engage the public on the challenges facing the NHS and social care and the changes that need to be secured to improve health and wellbeing, people's experience of care and system sustainability. This cannot amount only to consultation on pre-determined solutions.
- 5.22. We have urged that councils, with their strong links into their communities, are best placed to lead these conversations. The LGA, alongside councils, has also called for all Sustainability and Transformation Plans to be shared with the public in some form. As a minimum this must include publishing a summary of the plan. We also recommend that all Sustainability and Transformation Plans, with the support of councils as partners, develop ongoing engagement strategies about the future of health and care services, and to show clearly how proposed changes will lead to better health and wellbeing outcomes, better services and better use of public resources.
- 6. Prevention and public engagement: How can people be motivated to take greater responsibility for their own health? How can people be kept healthier for longer?**

- 6.1. In the 21st century, a huge part of the burden of ill health is avoidable. About a third

of all deaths are classed as premature – that is they could have been prevented by lifestyle changes undertaken at an earlier time of life. That equates to 44 years of lost life per 1,000 people or 2.6 million years each year across England and Wales.⁷⁷⁴

- 6.2. The modern day health challenges are significant. One in five children in Year 6 is obese. Most people will reach a retirement age of 68 with a disability. Sick days cost our economy £14 billion a year. Long term conditions account for 70 per cent of hospital bed days. The country faces a rising tide of need, as people live longer but spend more of those years in ill-health, largely because of preventable chronic diseases.⁷⁷⁵
- 6.3. Local government wants to do more to tackle obesity, alcohol misuse, mental health and physical inactivity. They want children to get the best start in life and older residents feel safe and connected. They also want to be empowered to make local decisions on fast food, alcohol, tobacco and other public health-related policy and regulatory decisions that go further and faster than national statutory frameworks.
- 6.4. Recent public health reforms have radically shifted power to local authorities, empowering them to invest and innovate to improve the health of their communities. The reforms reflect a confidence that local communities are best placed to respond to local needs, rather than central government.
- 6.5. The recent announcement of devolution in Greater Manchester places councils centre stage in the battle to improve population health and reduce inequalities. Devolving control of social care and health spending to Greater Manchester is good news for the people who live there and now needs to be replicated for people across the rest of the country.
- 6.6. With greater control over spending on hospitals, GP surgeries and drop-in centres, local areas can fully integrate their funding for health and social care to help people live independently at home longer into their older years and support people with long-term conditions. It is right that local areas should have the powers to make decisions that affect their residents at the most appropriate local level. This is vital to improving care and alleviating the wider pressures on the health service. But there is still more that can and should be done.
- 6.7. Crucially, true devolution to English local areas needs to be backed up by the promise of genuine financial freedoms for local government. In light of this, we are concerned that reductions to the public health budget will have a significant impact on the essential prevention and health protection services provided by councils. Given that much of the local government public health budget pays for NHS services, including sexual health, drug and alcohol treatment and NHS health checks, this will be a cut to the NHS in all but name.
- 6.8. At a time when the Government has issued its firm commitment to the NHS Five Year Forward View, with prevention put at its heart, to make significant cuts to the public health budget over the next five years sends entirely the wrong message and could undermine the objectives we all share to improve the public's health and to

⁷⁷⁴ [http://www.local.gov.uk/documents/10180/6869714/Prevention+-+A+Shared+Commitment+\(1\).pdf/06530655-1a4e-495b-b512-c3cbef5654a6](http://www.local.gov.uk/documents/10180/6869714/Prevention+-+A+Shared+Commitment+(1).pdf/06530655-1a4e-495b-b512-c3cbef5654a6)

⁷⁷⁵ [http://www.local.gov.uk/documents/10180/6869714/Prevention+-+A+Shared+Commitment+\(1\).pdf/06530655-1a4e-495b-b512-c3cbef5654a6](http://www.local.gov.uk/documents/10180/6869714/Prevention+-+A+Shared+Commitment+(1).pdf/06530655-1a4e-495b-b512-c3cbef5654a6)

keep pressure off the NHS and Adult Social Care.

6.9. To put this in context, public health funding will be cut by 9.7 per cent by 2020/21 in cash terms of £331 million, on top of the £200 million cut in-year for 2015/16 announced in November 2015.

6.10. It is crucial that councils are given a free hand in how best to find the savings locally and we would seek the Government's reassurance on this point. Anything less, will make the task of finding the reductions more difficult. Councils are best placed to decide how reduced resources should be used to meet our public health ambitions locally.

6.11. It is vitally important that this dialogue continues to address challenges which arise over the coming months and years, and to secure sufficient ongoing funding to ensure all local authorities can continue to meet their new public health

6.12. In future, we want to ensure greater certainty of funding for longer periods to enable local authorities to make strategic decisions in commissioning public health services. We need to look at the impact of the changes on the ground, and it is vitally important that this dialogue continues to address challenges which arise over the coming months and years, and to ensure sufficient ongoing funding to ensure all local authorities can continue to meet their new public health responsibilities beyond 2015/16.

7. Digitisation, big data and informatics: How can new technology be used to ensure sustainability of the NHS?

7.1. Across localities, there is growing use of care and health technologies by professionals, carers and those individuals receiving care. This includes the use of:

- a. Technology-enabled care to support people to stay in their homes for longer and help them maintain their independence and wellbeing.
- b. Mobile technologies to aid professionals to improve the way care is delivered.
- c. Shared information between health and care professionals to enable effective care coordination.
- d. The use of online channels which enable citizens and their carers to both help them to make decisions about their care and to engage with services online.

7.2. Over the last 18 months the LGA has been working to deliver a joint programme with ADASS to promote such innovation and good practice and work with national organisations to help address challenges and barriers.

7.3. Councils are committed to integrating health and social care so that care is coordinated across organisations for citizens and their carers. Digital innovation is already playing an important role in supporting this agenda through:

- a. *Joined up information to support the care of individuals:* Local areas are now making rapid progress in the delivery of integrated information across health and social care. In June 2016 Clinical Commissioning Groups (CCGs) were asked to complete Local Digital Roadmaps which outline how local health and care organisations will move towards joined up systems. Many councils have been part of that process (which

form part of the broader Sustainability and Transformation Plans) although there is further work to be done to ensure the plans are truly place-based and incorporate a greater focus on social care providers and, the voluntary and community sector.

- b. *Technologies which support people to maintain their independence:* Telecare has for some time played an important role in the delivery of care to individuals and the majority of councils commission telecare services. However, there is an increasing move away from what has traditionally been 'reactive' technologies towards technologies which support more 'proactive' forms of support. In addition, there is an increasing move towards integrated forms of commissioning such as assistive technologies across health and social care. Such technologies are now increasing to help provide medication reminders, detect falls through the use of movement sensors in the home, alert family or carers to unexpected movements outside the home through the use of GPS sensors, and help people connect people with friends and family.
- c. *Technologies to support care professionals and integrated working:* There is an increasing move towards integrated teams and enabling more remote and mobile working for health and care professionals. Digital and technology has a key enabling role to play in allowing care professionals to work from 'any base, at any time' as well as supporting more effective forms of working across organisations.
- d. *Analytics which support integrated commissioning and enables care coordination for those most in need:* As we move towards more integrated forms of commissioning across health and social care (such as new forms of integrated payment models) there is an increasing need for commissioners to access linked client level health and social care data (but which has been suitably anonymised). This has been recognised by the recent publication by the National Data Guardian. Similarly, local areas are benefiting from technologies which enable much more targeted forms of support through risk awareness, which enables care to be delivered to those in most need.

7.4. Alongside the integration of services, digital and technology is acting as a key enabler in the transformation of adult social care services. Significant local progress has been in five main areas:

- a. The provision of personalised information and advice
- b. Online needs assessments
- c. Online financial assessments
- d. E-marketplaces and personalised commissioning
- e. Care apps for community accountability.

7.5. Despite innovations in this area there remain barriers and challenges to support local delivery. These are as follows:

- a. *A national lack of funding which specifically supports innovation in social care:* There is a national commitment to support the development of information and technology across health and care through the National Information Board (one of the Five Year Forward View Boards). The Secretary of State for Health has committed £4.2 billion to a programme of work over the next five years. The LGA is calling for a significant emphasis on those programmes to focus on enabling local delivery and to support the move towards health and care integration (including for care providers), rather than solely funding digital adoption in the acute sector.

- b. *Challenges to information sharing*: The challenges to information sharing have been cited in many previous reviews and the LGA welcomes the recent National Data Guardian consultation. There are positive local examples of where information sharing is taking place locally and where there has been strong engagement with citizens. However, more should be done to address the challenges to information sharing and support the effective delivery and commissioning of local health and care services.
 - c. *Broadband coverage*: The LGA has called for better broadband speeds and phone coverage in rural areas. Access to faster and reliable broadband is a key way of enabling residents who are housebound to live independently, which can help to reduce social isolation particular in rural areas. Greater broadband coverage has significant benefits for community healthcare and telehealth, for example ensuring GPs have access to patient medical records or they can check the availability of medicines when necessary. Good digital connectivity is a vital element of everyday life for residents and can help them cut household bills, shop online for cheaper goods, stay in touch with distant relatives and access their bank accounts. As central and local government services increasingly become 'digital by default,' it will become increasingly important for more people to have faster and more reliable speeds.
 - d. *Leadership and cultural change*: With significant progress being made in the digital and technology sector, there is an opportunity to transform health and social care and most importantly, to achieve greater integration between services. To build on this progress, we are calling for whole system leadership to create greater awareness of the benefits of technology for health services. The LGA has been working with councils to highlight areas of best practice and we have called for system leaders within the health and social care system to build on this momentum. We want to see a culture change in health and social care whereby technology is used to enable innovative and transformative programmes, to improve the service for patients and the wider community, as well as ensure better value for money in the health and social care system.
- 7.6. Of course, digital technology is not the only area where councils (and their partners) are taking innovative approaches to the design and delivery of care. The final [report](#) of the LGA's Adult Social Care Efficiency Programme highlights a range of work being undertaken across the sector to maximise the use of resources. The 'Innovative Councils' section of the LGA [website](#) holds a wealth of material showcasing councils' work across the care and health agenda; from integrated care and collaborative approaches to helping older people remain independent at home, to Health and Wellbeing Board best practice in engaging with providers and integrated commissioning.

23 September 2016

Macmillan Cancer Support – Written evidence (NHS0030)

Macmillan Cancer Support is a registered charity providing support for people affected by cancer. Macmillan wants every one of the 2.5 million people living with and beyond cancer in the UK today to get the highest standard of care and support, so that they can have the best possible quality of life.

Macmillan has a track record of championing health innovations which dramatically improve patient experience, outcomes and value for money. In the past decade Macmillan has invested £320 million (in today's values) in the NHS and plans to invest a similar amount over the next 10 years.

Key messages

- Demand for cancer services is growing at ten times the rate of NHS funding. To ensure cancer services are sustainable, the investment committed to the NHS in the 2015 Spending Review needs to be used in part to fully fund implementation of the Independent Cancer Taskforce's Strategy for England 2015 (the England Cancer Strategy). This includes measures such as a recovery package for people living with cancer. We have yet to see details of the level of funding and where it will be spent.
- One of the key recommendations in the England Cancer Strategy was that Health Education England (HEE) should work with NHS England and other stakeholders to conduct a strategic review of the cancer workforce. Given the importance of this review, it is vital that the Department of Health works closely with HEE to ensure that it is ambitious and delivered on time. Progress remains slow, however.
- The Government and its system partners must keep their commitment to improving choice and quality in end of life care, and ensure the necessary funding over the coming years to give people the care and support they need at this crucial time.

1. Context

Demand for cancer services is growing at ten times the rate of NHS funding. More people are being diagnosed with cancer, and more people are living longer with and beyond cancer, often suffering from the consequences of cancer and its treatment. This presents a major challenge to the NHS to respond to the growing and changing demands cancer places on the system.

Cancer services appear to be under increasing pressure. This is most visible in the cancer waiting time statistics – in more than two years, the 62-day target has been met in just one month.⁷⁷⁶

This is against a background of an increasingly stretched NHS. The consensus from think tanks and commentators appears to be that the NHS is on track to receive a historically small increase in its funding over the course of the previous parliament and this parliament (0.9% per year). This has left much of the NHS struggling to make ends meet in the face of a triple challenge of rising demand, ambitious efficiency targets, and aspirations to make transformational changes to care. Much of the recent funding increase has been needed to fill the provider deficit, rather than going into transformational new care models. In light of these financial challenges, it is unclear whether the health system can get back on track with meeting existing targets, including missed cancer targets such as waiting times, within the current budget.

The National Audit Office's 2015 report⁷⁷⁷ into the severe financial situation facing many NHS trusts is further evidence that urgent investment is needed to equip NHS services for the future. The report states:

- The Department of Health and its arms-length bodies are in agreement that there will be a £22 billion gap between resources and patient needs by 2020-21, but it is not clear how the NHS will close this gap
- NHS England has estimated that demand and efficiency gains of 2%–3% a year are needed to make savings of £22 billion. However, the NHS has achieved a much lower rate of efficiencies in recent years
- Expected financial savings from the Five Year Forward View (FYFV) will not help the immediate financial position of trusts, as estimates suggest these will not be realised until nearer the end of the five years.

Improvements in outcomes and better value for money cannot be achieved by the NHS alone, and the seven arms length bodies must all work together to deliver the FYFV. However, recent cuts to the non-NHS parts of the Department of Health budget, and the even greater pressure facing social care and public health budgets, has to some extent undermined these efforts.

2. The England Cancer Strategy

NHS leaders are often focused on meeting short term targets and 'control totals'. Macmillan believes the government should support the health service to take a longer-term view, and

⁷⁷⁶ NHS England 2016/17 Monthly Provider Cancer Waiting Times Statistics

<https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-prov-cwt/201617-monthly-prov-cwt/>

⁷⁷⁷ Sustainability and financial performance of acute hospital trusts NAO 16.12.15 <https://www.nao.org.uk/wp-content/uploads/2015/12/Sustainability-and-financial-performance-acute-hospital-trusts-Summary.pdf>

provide capacity to make more strategic use of resources. Cancer is one such area in need of this long-term thinking and improvement capacity.

The health service currently spends more than £500m a year on emergency care for people with the four most common cancers alone, which indicates that the system is not working. Emergency care should be a last resort for people living with cancer and such a vast amount of emergency care spending is symptomatic of a system that is not geared towards helping people take control of their health.

In December 2015, Macmillan Cancer Support released figures showing that costs of treating the consequences of cancer treatment alone will rise to £1 billion by 2020.⁷⁷⁸ This cost will only grow as more people are diagnosed with cancer in the years to come, and the NHS is tasked with caring for the often lifelong needs of people living with cancer.

As well as short-term action to protect the services we have now, we will also need a long-term, sustainable approach to funding to improve care in the future. The need for cancer care is only going to increase as the number of people with a cancer diagnosis in England soars from 2 million in 2015 to at least 3.4 million by 2030. Each of these 3.4 million people deserves the best quality care and long-term support.

NHS finances and cancer care quality are intertwined. The plan to deliver better cancer outcomes will also help to put the NHS on a firmer financial footing. The FYFV projections indicate that expenditure on cancer services will need to grow by about 9% a year to keep up with demand, reaching £13 billion by 2020/21 – between two and three times the rate of other health spend, and ten times faster than the rate of funding increase between 2010-2020.^{779,780,781}

And as more people than ever before are surviving cancer, many are left with devastating consequences of treatment and require support for the rest of their lives. If the government and the NHS do not take action on cancer now, the strain on the NHS will increase, and people's chances of a good recovery and long-term quality of life will only deteriorate.

As shown by the low proportions of people who survive cancer in good health, the resources the NHS allocates to long-term care and support are not sufficient to help most people with cancer to recover well and have a good quality of life. For example, routine follow-up care for people with cancer costs around £250 million per year. This is usually

⁷⁷⁸ Macmillan Cancer Support: Cancer Cash Crisis – the cost of care beyond treatment. Dec 2015

<http://www.macmillan.org.uk/Documents/Campaigns/Cancercashcrisisreport-MacmillanDecember2015.pdf>

⁷⁷⁹ FYFV forecasts were based on a Technical Annex published in December 2013, which included assumptions indicating that budget lines related to cancer are likely to grow by around 9% per annum over the next five years, in the absence of any efficiency savings. Described further in the 2015 Cancer Strategy: Independent Cancer Taskforce (2015), *Achieving world-class cancer outcomes: A strategy for England, 2015-2020*, p. 6. Available at:

http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

⁷⁸⁰ Nuffield Trust (December 2012), *The funding pressures facing the NHS from 2010/11 to 2021/22*. Available at:

http://www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report_1.pdf

⁷⁸¹ Nuffield Trust and King's Fund estimate the annual real increase in funding from 2009/10 to 2020/21 to be 0.9% per year. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Spending-Review-Nuffield-Health-Kings-Fund-December-2015_0.pdf

delivered via a ‘one-size-fits-all’ medical model based around repeat outpatient consultations, despite there being a lack of evidence to support the effectiveness of this approach.⁷⁸²

NHS England’s National Cancer Transformation Board has now published its implementation plan for the England Cancer Strategy.⁷⁸³ This announcement to drive forward the Strategy is welcome, and we hope that the added investment in early diagnosis that accompanied the plans and the setting up of Cancer Alliances will play an important part in tackling recurring problems, such as missed waiting time targets. In general we were pleased to see commitments in the plan to ensure more people benefit from personalised care after treatment. However it is not clear how these parts of the strategy will be funded over the next five years.

The government and NHS England must set out how they propose to fund this essential part of the England Cancer Strategy if the improvements described in the plan are to be delivered. NHS England must also guarantee that necessary funding will be ring fenced in future budgets to ensure the plan can credibly be put into action.

3. Sustainability and Transformation Plans in the NHS

The NHS planning guidance, published in December 2015, produced a framework for delivering the visions of the NHS FYFV, tasking local areas with developing collaborative, place-based Sustainability and Transformation Plans (STPs) built on the needs of local populations.⁷⁸⁴

NHS England’s board says it has allocated £560 billion of NHS funding to back the guidance. This will include a Sustainability and Transformation Fund which will be used to stabilise NHS operational performance and continue delivery of the new care models or ‘vanguard’ programme and other FYFV development areas. In 2015/16, more than 80% of this fund has been used to cover provider deficits rather than making improvements in care.

The STPs are a means of bringing local leaders together to develop “a shared vision with the local community”. In theory this has the potential to be a positive step forward in ensuring the transformation of services locally with the patient voice at the centre. However Macmillan would like to see STPs made public as soon as possible to increase transparency, increase opportunities for collaboration across the third sector and provide for consultation with local communities on the detail of plans and their implementation. And as set out below, it is essential that all STPs set out the improvements they will make to cancer care.

The ‘must dos’ for cancer and end of life care

⁷⁸² NHS Improving Quality. Stratified cancer pathways: redesigning services for those living with or beyond cancer. October 2013. www.nhs.uk/media/2431915/12_0020_proven_publication_stratified_cancer_pathways_1.6_final.pdf

⁷⁸³ Achieving World-Class Cancer Outcomes: Taking the strategy forward <https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf>

⁷⁸⁴ Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

The guidance for STPs covers indicative ‘national challenges’ to address by 2020, including:

- How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?
- How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

The implementation plan for the Cancer Strategy for England sets out how local health systems will deliver improvements in key areas, for example, ensuring the growing number of people living with and beyond cancer have their needs supported through local delivery of a Recovery Package.⁷⁸⁵ STP guidance from NHS England makes clear: “STPs should set out how the [cancer strategy] taskforce’s core recommendations will be translated into local action.”

In addition, the government recently published its vision for reforming end of life care.⁷⁸⁶ This makes the following commitment: “STPs should fully take into account the contribution that sustainable, efficiently designed end of life care services can make to achieving better outcomes for dying people.”

It is therefore crucial that all STPs set out how they will deliver the much-needed reforms to cancer and end of life care that the government has promised. Through this, they will be better able to respond to the needs of their local population and so ensure their services are sustainable for the future.

Concerns about transparency

A significant concern has been the transparency of the STP development and assessment process. This extends from the development stage to the NHS England assessment phase, to a lack of clarity on the publication of STPs. This has been prominent in recent media reporting and it is therefore essential that the next steps of implementation are open and transparent.

This uncertainty about the content of local plans means that while we have been involved in national strategies, we are unable to have a comprehensive view of the future direction of cancer services and support at a local level. STPs are required to set out how they will transform cancer services in line with the Independent Cancer Taskforce report. This is a significant ask of local areas given the taskforce report has 96 recommendations.

For these reasons NHS England should work with the STPs to make them public as soon as possible, increasing opportunities for collaboration with the third sector and enabling local communities to be consulted on the detail of plans and their implementation.

⁷⁸⁵ Achieving World-Class Cancer Outcomes: Taking the strategy forward <https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf>

⁷⁸⁶ Our Commitment to you for end of life care The Government Response to the Review of Choice in End of Life Care https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536326/choice-response.pdf

4. Workforce

There are a number of challenges currently facing the cancer workforce, many of which were outlined in the England Cancer Strategy. For instance, we are currently facing severe shortages in key professions. In 2010, Macmillan estimated that the gap in posts such as Clinical Nurse Specialists (CNS) was around 3,400 across the UK,⁷⁸⁷ and we know that many people with cancer still do not have access to this expertise.

In addition, the complex and changing needs of people affected by cancer means that whilst addressing gaps in key professions will be important, we also need to look more widely at how a workforce with the right mix of skills can support more person-centred holistic care. This may be through retaining and developing the skills of the current workforce, increasing the awareness and capacity of the non-cancer workforce, enabling better working across sectors and professional groups and supporting carers to be equal partners in care where this is their wish. The current workforce is not designed to address the changing needs we face, leaving many patients without the right support at the right time. Without addressing these challenges, we will not be able to deliver the ambitions of the England Cancer Strategy.

One of the key recommendations in the England Cancer Strategy was that Health Education England (HEE) should work with partners including NHS England and third sector organisations to conduct a strategic review of the cancer workforce. This represents a huge opportunity to begin addressing some of the key challenges facing the cancer workforce, however this will only be possible if the review is ambitious enough and has enough authority to drive change at a local level.

Earlier this year, Macmillan worked with Cancer Research UK and around 20 other organisations across the cancer community to develop a shared vision, which was a set of eight principles setting out what the review should cover.⁷⁸⁸ This included the fact that the review should consider: both current and future workforce; how to improve the coordination of care; the use of different roles; and education and training. Most importantly, it stated that the review should consider how to focus the delivery of care on the needs and experiences of the individual person.

Despite its central importance to the sustainability of the cancer workforce and cancer services, we are increasingly concerned that the review is not developing at a pace which will enable it to deliver an ambitious and strategic plan in time to support the implementation of the England Cancer Strategy. One of the key issues is a lack of accountability around the delivery of the review and uncertainty around responsibility for strategic workforce planning.

⁷⁸⁷ Macmillan Cancer Support (2013) Working Together: Challenges, opportunities and priorities for the UK's cancer workforce

<http://www.macmillan.org.uk/documents/getinvolved/campaigns/weareaforeceforchange/workforcediscussiondoc.pdf>

⁷⁸⁸ Macmillan Cancer Support and Cancer Research UK (June 2016) A shared vision for a strategic review of the cancer workforce <http://www.macmillan.org.uk/documents/getinvolved/campaigns/weareaforeceforchange/a-shared-vision-for-a-strategic-review-of-the-cancer-workforce-june2016.pdf>

Given that the England Cancer Strategy is a key priority for the Department of Health, Macmillan would like to see the Department hold Health Education England to account for delivery of an ambitious and strategic review of the cancer workforce, and should include this in its mandate to HEE for 2016/17 (which has yet to be published).

5. End of life care

Three million people will die over the course of this Parliament and millions more will be bereaved. Yet we still see significant variations in the quality of care that people experience.⁷⁸⁹

This isn't just about 'doing the right thing'; reforming end of life care would also put health and social care on a more sustainable footing. With the right support, we know that 73% of people with cancer would prefer to die at home - but only 29% actually do. Research by Macmillan shows that the NHS in England could save £69 million by providing community care that would allow cancer patients to die at home, instead of in hospital.⁷⁹⁰

For this reason, Macmillan is pleased to see the Government's response to the Independent Choice Review of End of Life Care published after extensive campaigning by Parliamentarians and Macmillan.⁷⁹¹ The commitments in the response will make a big difference to the lives of people affected by cancer, such as by introducing a care-coordinator role; piloting community nursing provision; and creating new metrics to measure patient experience in a transparent way.

Macmillan believes wherever you are looked after, the most important thing is that you get the care you need, you are comfortable, and your pain is controlled, so that you can die in the place and manner of your choosing. Together with the End of Life Care campaign (a coalition of major charities representing and supporting people at the end of life) Macmillan will continue to campaign on this issue and seek support to ensure that the Government and its system partners keep their commitment to improving choice and quality in end of life care, and are given the necessary funding over the coming years to give people the care and support they need.

6. Carers

The growing incidence of cancer and growing number of people living with it means that the need for unpaid cancer carers will only increase. Since 2011, we have seen the number of cancer carers rise from 1.1 million⁷⁹² to nearly 1.5 million⁷⁹³ which is an increase of 27%.

⁷⁸⁹ Health Committee, *End of Life Care: Fifth report of session 2014-15, March 2015*.

<http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/805/805.pdf>

⁷⁹⁰ Can we live with how we're dying? Advancing the case for free social care at the end of life. Macmillan report 2014 <http://www.macmillan.org.uk/documents/getinvolved/campaigns/endoflife/endoflifereport-june2014.pdf>

⁷⁹¹ Our Commitment to you for end of life care The Government Response to the Review of Choice in End of Life Care https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536326/choice-response.pdf

⁷⁹² Macmillan Cancer Support/Ipsos MORI. More than a Million: Understanding the UK's carers of people with cancer. 2011.

They are also providing more care and undertaking more complex tasks, often without any training or guidance. This increase and the changing nature of the care that cancer carers are providing indicates that their support needs will grow. The NHS and social care systems rely heavily on the support provided by carers across the UK which Carers UK have estimated is worth £132 billion a year.⁷⁹⁴

The support needs of carers must be factored in when considering the financial future of the NHS. The strain of caring often means that carers develop their own physical and emotional health care needs. Without appropriate support this can lead to carer breakdown and in extreme cases the carer and/or the person with cancer being admitted to hospital.

We are calling for the new government Carers Strategy to ensure that carers are routinely identified, signposted to support and recognised as an equal partner in care by health and social care professionals. This may require investment for example into staff training and services for carers but is absolutely essential that carers are recognised and supported to continue caring if this is what they want to do.

19 September 2016

⁷⁹³ YouGov and Macmillan Cancer Support Cancer carers study (Phase 1). 6,487 people aged 16 and over in the UK were interviewed via TNS' face-to-face omnibus service in phase 1. Data weighting and all analysis was conducted by YouGov. Fieldwork was undertaken between 26th February and 22nd March 2016.

⁷⁹⁴ Valuing Carers 2015 – the rising value of carers' support [2015] University of Sheffield, University of Leeds and CIRCLE, published by Carers UK

Lord Macpherson of Earl's Court – Written evidence (NHS0177)

SOME THOUGHTS ON HEALTH SPENDING AND HYPOTHECATION

This note considers the case for five year budgets for the NHS and social care, funded by a hypothecated tax.

Five year budgets

Providing funding certainty to programmes will generally result in a better allocation of resources: the more so if combined with "end year flexibility", the right to shift resources between financial years. Since inflation was brought under control in the 1990s, there has been a tendency to move away from annual spending reviews. For example, the 2015 spending review set budgets for the five years from 2016-17 to 2020-21. And there are a number of examples of governments singling out specific programmes for greater long term certainty. In his 2002 Budget, Gordon Brown set five year spending totals for the National Health Service, when other programmes were only settled for three years. There was also – briefly – a ten year transport plan. And more recently the defence equipment budget has been set for a ten year period, with varying degrees of certainty for the outlying years.

However, greater funding certainty means less flexibility for the finance ministry. In principle, the more public spending that is protected, the less easy it is to deal either with a cyclical or structural deterioration in the public finances. The 2007 spending review provided admirable clarity for public sector managers for the years 2008-09 to 2010-11, which coincided with unprecedented economic uncertainty. But at the same time the fact that those plans weren't reviewed until 2010 left the Government with a higher deficit and higher debt than was probably desirable. Similarly, in the last parliament and this, government protections for health, schools, overseas aid, defence equipment and above all the "triple lock" have made fiscal consolidation extremely difficult and has probably resulted in sub optimal settlements for "unprotected" programmes such as justice and local government.

Providing Government can divest itself of the biggest commitments, in particular the triple lock, I see much to be said for agreeing funding for the NHS for a five year period at the beginning of each Parliament, informed by manifesto commitments, tested by General Election debate and ideally by an independent assessment by the Office for Budgetary responsibility. This should be underpinned by full "end year flexibility", and, in principle, could be reinforced through legislation.

One problem with tying spending commitments for a Parliament is that as the Parliament progresses they provide diminishing certainty. If this is not addressed, it is arguable that any certainty in the early years of a Parliament will be more than offset by increased uncertainty in the later years. A solution to this would be to set, say in the third year of the Parliament, indicative budgets for the first three years of the next Parliament. These need not have the same statutory force, though clearly the more indicative they are the less certainty they will provide.

Such a commitment could only apply to England. But the other countries of the U.K would benefit from any increases in health spending in England through the Barnett formula. It will be up to the devolved governments whether also to enter into a five year funding commitment. Previous experience suggests that the devolved governments tend to increase health spending broadly in line with England.

It would also be necessary to resolve whether to include social care spending in the five year commitment. Historically, governments have tended to prioritise the NHS over social care, partly because it is a central government responsibility and partly because all voters feel they are likely to use the NHS; many feel they can avoid long term care.

The case for including social care in any long term commitment is as follows. NHS and social care expenditure is interrelated. Social care spending has been less well funded than the NHS. And demographic pressures are most likely to impact on the social care sector. The case against is that the model of social care provision is very different from that of the NHS: social care is not provided free at the point of use. It is largely provided by the private sector, and any public sector commissioning is largely done by local government.

Hypothecation

Conceptually, it is possible to sign up to a budget covering a Parliament – as the present Government did in 2015 – without introducing hypothecation.

But the introduction of hypothecation could strengthen public understanding of the trade offs between taxing and spending at least in relation to health spending. And it might make more palatable the likely tax increases which will be necessary to deal with the demographic pressures which are likely to become increasingly visible during the course of the 2020s. At a time when trust in government has declined, and many citizens feel a disconnect between the taxes they pay and the services they receive, it could help revive citizen engagement. This would be the case especially at election-time, when political parties would have a chance to set out their plans for any hypothecated tax and health spending as a whole.

The case against hypothecation is that it is inherently inefficient. Governments need the flexibility to allocate resources as they see fit, unconstrained by trends in individual taxes, some of which are more buoyant than others while others are more cyclical. It would also constrain changes to the hypothecated tax for wider economic and distributional reasons.

Certainly, the UK has never stuck with hypothecation for any length of time: the hypothecated Road Fund between the wars did not survive the depression. And although the link between national insurance and contributory benefits remained reasonably strong until the 1970s, it has weakened in recent decades.

There are a range of ways of giving effect to hypothecation.

"Soft hypothecation" involves a commitment to spend any additional revenues from a given tax or change in tax to a specific cause. Thus, Gordon Brown committed to spending the additional revenues from his rise in employee and employer NICs to spending on the NHS in 2002.

Harder hypothecation involves assigning a proportion of a given revenue stream to a programme or country. Hence, the Royal Household currently receives 15 per cent of the Crown Estate's income in the form of the Sovereign Grant. (The percentage is reviewed every five years). And under the 2016 Fiscal Agreement, receipts from the first 10p of the standard rate of VAT (and the first 2.5p of the reduced rate of VAT) in Scotland will be assigned to the Scottish Government.

"Full hypothecation" involves allocating all the revenue from one tax to a specific programme. The benefit of full hypothecation is that citizens have complete assurance that the revenue from the tax is spent on the service in question. In principle, the tax rate could be changed year by year to ensure

the requisite level of expenditure could be achieved. But a simpler and more stable way forward, as Richard Layard and others have suggested, would be to set the tax rate at the beginning of each Parliament to cover the desired level of expenditure, and then seek to keep the fund in balance through a grant from, or repayment to, the Treasury.

In practice, only income tax, national insurance contributions and VAT raise sufficient revenue to be plausible candidates for a hypothecated tax for health spending.

National Insurance Contributions (NICs) are in my view the strongest candidate. Most taxpayers already think NICs fund the NHS, which seems to me a good starting point if we want to encourage debate about the level of taxation and spending. And in this they are partially right: some 20 per cent of NIC revenues⁷⁹⁵ (£21 billion in 2014-15) are allocated to the NHS, the rest going into the National Insurance Fund to pay for contributory benefits, such as the state retirement pension.

If it were decided to fund the NHS out of National Insurance, there is a good case for reviewing its base. Unlike income tax, NICs are not paid on savings income or benefits in kind, and the employee's marginal rate declines from 12 per cent to 2 per cent once earnings exceed £827 a month. More importantly, the obligation to pay NICs stops when the taxpayer reaches retirement age. For a hypothecated tax to be seen as fair, as many adults as possible should pay it. Since old people are likely to be the main beneficiaries of increased spending on the NHS, and in any case are as likely to be well off as people of working age, there is a strong case in fairness for bringing the NICs base more into line with income tax. However, this would have major distributional implications, and the revealed preference of successive governments has been to tread carefully when it comes to the integration of income tax and NICs.

A more second order issue would be what to do with the National Insurance Fund, if NICs were paying for the NHS rather than Contributory benefits.

And it would also be necessary to think about the interrelationship with Scotland, Wales and Northern Ireland. NICs are a UK-wide tax; health spending is devolved. One way forward would be for the NIC rate to be set to fund health spending in England plus the baseline in Scotland, Wales & Northern Ireland plus the Barnett Consequentials of any increase in spending in England. It would then be a matter for the devolved governments whether to allocate these to health. However, in the case of Scotland, there is the option of devolving National Insurance altogether.

Conclusion

I see considerable benefits in a fixed five year budget for health spending: indeed, it is arguable that that is the status quo, subject to the Government reintroducing "end year flexibility".

In my view, hypothecation merits further examination.

Moving to "full hypothecation" of NICs to health spending would be challenging. But it is the only form of hypothecation which would give taxpayers complete assurance about where the national insurance they paid was going. It is the option most likely to legitimise a tax funded increase in health spending.

⁷⁹⁵ Between the wars, national insurance was as much about health insurance as social security and so the relationship has a long history.

Lord Macpherson of Earl's Court – Written evidence (NHS0177)

However, in considering its costs and benefits, I would suggest that it is considered alongside softer forms of hypothecation – for example, allocating an increase in NIC rates to health or assigning a fixed proportion of income tax to health expenditure.

5 November 2016

Dr Nick Mann – Written evidence (NHS0028)

No Health Service within EU or OECD countries has been shown to be better value for money in terms of cost-effectiveness and efficiency than the NHS system, taking into account quality and outcomes. If the UK has the fifth or sixth largest economy in the world, it also has a moral public duty to provide a health service funded to levels commensurate with that economic wealth.

It must be accepted by government that, if England is to continue to benefit from high quality healthcare for its population, it must commit adequate funding from taxation to the NHS in order to maintain that provision. This is not happening. To maintain sustainability, funding should at least achieve parity with average spend as %GDP compared to countries with similar economies and healthcare systems eg EU/OECD.

Current Health spending per capita, %GDP spend on Health in England, and acute care beds per 1,000 population are all the lowest of fourteen comparable OECD countries⁷⁹⁶.

If UK Govt continues its current policy of funding for the NHS to 2049, England will still have not reached the EU14 average funding levels for 2016⁷⁹⁷.

The current £30bn NHS funding gap projection was modelled on the basis of flat funding for the NHS (0.85% increase per year 2015-2020) while health inflation continues at its historical level of 3% to 4% per year. The £8bn funding settlement was the absolute minimum required to close the gap, provided another £22bn of efficiency savings were found⁷⁹⁸.

The King's Fund have dismissed productivity gains worth £22bn as unachievable. They have clearly stated that current provider deficits are not the result of provider organisation mismanagement; rather they are the consequences of a health system buckling under the pressure of demand without sufficient funding.

The claimed “£10bn extra” for the NHS 2015-2020 is in fact only £4.5bn of new money⁷⁹⁹. The other £5.5bn is money transferred from non-NHSE (NHS England) budgets and granted to NHSE instead. Although earmarked for “sustainability and transformation” infrastructure funding, the majority of this money will be used to backfill existing holes in NHS budgets caused by six years of underfunding.

The arguments for unsustainability of the NHS are false. The “ageing population” and “health tourism” have become shibboleths but are simply misrepresented. Approximately

⁷⁹⁶ 2015 International Profiles of Healthcare Systems; Commonwealth Fund Jan 2016.

http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf?la=en

⁷⁹⁷ John Appleby, Chief Economist, King's Fund Research Thinktank. Evidence to Lords Select NHS Sustainability Committee, 6th Sept 2016: <http://parliamentlive.tv/event/index/b14da2fc-5179-49f6-b374-c4726c7944dc?in=10:50:11>

⁷⁹⁸ Five Year Forward View, NHS England. <https://www.england.nhs.uk/wp-content/uploads/2016/05/fyfv-tech-note-090516.pdf>

⁷⁹⁹ Deficits in the NHS 2016; King's Fund, July 2016.

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Deficits_in_the_NHS_Kings_Fund_July_2016_1.pdf

40-60% of health inflation costs are attributable to rising technology and drug costs. The ageing population will account for less than 1% increase of GDP spending over the next forty-five years⁸⁰⁰. In fact, when the extra contribution to the economy of baby boomers - people working healthier for longer - are taken into account, the balance is a positive one for the health economy⁸⁰¹. The additional strain of provision for the ageing population falls squarely in the social care sector, which has seen cuts to budgets of 31% since 2010⁸⁰². 'Health tourism' costs to the NHS are estimated to be around £70-300m annually⁸⁰³.

By controlling drug acquisition costs from pharmaceutical companies, a substantial proportion of NHS health inflation costs could be mitigated. It is important to note that, although pharmaceutical companies claim that their pricing reflects their research and development costs, many of the drugs brought to market have initially been developed by public sector research institutions and are later acquired by the private sector. The public purse thus pays twice. New treatments for Hepatitis C are a case in point; while undoubtedly cost-effective, drug pricing exceeds – by up to a factor of ten times - linkage to research and development costs⁸⁰⁴.

The immediate crisis in the NHS, and Trust deficits, did not exist in 2012. The causes of the current crisis have been static funding and staffing levels since 2009. In addition, there have been cuts to 57% of total hospital beds since 1987, including 72% cuts to beds for Mental Health⁸⁰⁵.

Although the number of FTE (Full-Time Equivalent) Consultants in England has increased by 25% since 2009, there has been almost equivalent reduction in the numbers of FTE Junior Doctors (all grades). FTE GP numbers have reduced by nearly 3,000 since 2009. The number of Nurses + Health Visitors has increased by just 2% since 2009. District Nursing FTE numbers have reduced by 48% nationally 2000-2014. Accounting for 5% population rise since 2009 and without any proportional increase in numbers compared to 2009, England has a current running deficit of 4,500 GPs, 3,000 Junior Doctors, and 7,800 Nurses + Health Visitors⁸⁰⁶.

NHSE's 5YFV (Five Year Forward View) and current STPs (Sustainability and Transformation Plans) are predicated on cost savings by "New Models of Care" and "Care Closer to Home". These premises include centralised models of acute provision, commissioning and support services. Models of "Integrated Care" include greater use of 'self-care', a downskilled primary care workforce backfilled with IT remote monitoring and remote consultations,

⁸⁰⁰ Spending on Health and Social Care Over the Next Fifty Years: Prof John Appleby, King's Fund 2013. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Spending%20on%20health%20...%2050%20years%20low%20res%20for%20web.pdf

⁸⁰¹ Population Ageing: the timebomb that isn't? J. Spijker; BMJ 2013;347:f6598 doi: 10.1136/bmj.f6598 (Published 12 November 2013).

⁸⁰² ADASS survey, 2015 <http://www.publicfinance.co.uk/news/2015/06/social-care-funding-cut-third-2010-adass-survey-finds>

⁸⁰³ Department of Health Commissioned report; Authors' letter: May 23rd, 2015. BMJ 2015;350:h2660

⁸⁰⁴ Betting on hepatitis C: how financial speculation in drug development influences access to medicines. BMJ 2016; 354 doi: <http://dx.doi.org/10.1136/bmj.i3718> (Published 27 July 2016)

⁸⁰⁵ Bed Availability and Occupancy, NHS England; <https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

⁸⁰⁶ Workforce Statistics NHS Digital 2016; [https://www.google.co.uk/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=nhs-work-stat-may-2016-nat-hee-tab%20\(1\)](https://www.google.co.uk/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=nhs-work-stat-may-2016-nat-hee-tab%20(1))

financed by the sale of NHS estate which will entail the closure and selling off of England's existing hospital infrastructure. There is incoherence between the visions of 5YFV and their implementation under STPs. While 5YFV's vision of success is predicated on an upscaled primary care workforce, at least one published STP includes the reduction of the FTE GP workforce by one third by 2020 (accounting for population increase, a real terms reduction of 50% of the GP workforce by 2020)⁸⁰⁷.

In context of NHS England's drive for major reconfiguration of services in England, it is important to note research evidence has shown that major acute sector reconfigurations do not save money⁸⁰⁸. In addition, transfer of care out of hospital and into the community may improve patient satisfaction, but it will not save money either, and may even lead to worse outcomes. The success of centralisation of specialised services for stroke, trauma and heart attacks was specific to those specialties and it was carried out with evidence-based strategic planning which was medically-led. These successes are not transferable to other medical disciplines.

It is likely that some productivity savings and quality improvement may be achieved by the RightCare programme, which has focused on evidence for reducing unwarranted regional variation in processes/outcomes of care by implementing population systems and programme budgeting, but any such savings will be very slow to evolve and almost certainly much less than the £11bn envisaged by Prof Sir Muir Gray⁸⁰⁹.

Therefore it is likely that 5YFV and STP will not save money in themselves, and any substantive savings will only be achieved by further cuts to an already overstretched existing workforce and infrastructure. Future sustainability predicated on further shifting care into the community cannot be achieved while the same plans diminish an already impoverished primary care workforce, and cuts to social care have already deprived 26% of older people of their home care packages. The NHS does not need further structural reforms and the system cannot bear further cuts to its infrastructure or workforce. The NHS needs adequate funding to provide a workforce, beds and infrastructure to a level commensurate with the UK economy, with comparable countries, and with the standard of care which citizens are entitled to expect in England.

The financial position of the NHS has deteriorated catastrophically since the inception of the Health and Social Care Act 2012. Research has shown that competition, marketisation and privatisation of health services have not improved outcomes for patients or proven to be cheaper for the NHS. Estimates of the costs of administering the market process itself show increases from 6% to approximately 14% of the entire NHS budget, including £5bn recurrent annual costs, but not including the financial and human costs incurred by the many failed

⁸⁰⁷ Transforming Services Together; Part 3 - High Impact Changes;
<http://www.walthamforestccg.nhs.uk/downloads/aboutus/publications/governingbodymeetings/2016/TST-Part-3-High-impact-changes.pdf>

⁸⁰⁸ The King's Fund Responds to Reports on Sustainability and Transformation Plans, August 2016;
<http://www.kingsfund.org.uk/press/press-releases/kings-fund-responds-reports-nhs-sustainability-and-transformation-plans>

⁸⁰⁹ RightCare Programme: commissioned by Dept of Health under QIPP programme;
<http://www.rightcare.nhs.uk/index.php/programme/>

outsourced private contracts to date⁸¹⁰. There is no credible evidence that the private sector can deliver health care to an equal or better standard for less money.

Some reduction in healthcare costs and demand may be anticipated in the longer term by prevention strategies. These are chiefly related to obesity and healthy eating, smoking, alcohol, and poverty/inequality. These factors are clearly the remit of government policy at a population level for public health and some require legislation to mitigate deleterious effects of industry-driven consumption.

Big data and informatics may improve quality of health research, provided that commercial interests in data acquisition do not over-ride privacy and confidentiality issues inherent in data sharing. Technology-driven remote monitoring and remote consultations have been shown neither to reduce healthcare demand nor costs, nor to improve outcomes for patients⁸¹¹⁸¹²⁸¹³. Further investment in NHS IT should therefore be restricted to that which improves data processing and connectivity between healthcare organisations and for medical research purposes.

The future sustainability of the NHS in England therefore depends on a government which is willing to commit to funding the health service commensurate with the level of quality which it expects to be provided. Future savings and cost controls need to be directed at the major sources of health inflation ie technology (against which one must balance the benefits of improvements in healthcare resulting from progress in technology) and spiralling drug costs (for which the NHS needs to maintain a strong position with respect to acquisition from the private sector).

Summary of measures for sustainability:

1. Halt implementation of STPs pending detailed public review of strategic planning and costings.
2. Halt further market tendering until Health & Social Care Act outcomes are properly evaluated.
3. Government must commit to adequate level of NHS funding that is commensurate with need.
4. Government to consult King's Fund on causes of health inflation and its mitigation.

Dr Nick Mann MBBS, MRCGP, MLCOM

17 September 2016

⁸¹⁰ Centre For Health and Public Interest, report by Calum Paton, 2014; <https://chpi.org.uk/wp-content/uploads/2014/02/At-what-cost-paying-the-price-for-the-market-in-the-English-NHS-by-Calum-Paton.pdf>

⁸¹¹ Cost effectiveness of telehealth for patients with long term conditions (Whole Systems Demonstrator telehealth questionnaire study): nested economic evaluation in a pragmatic, cluster randomised controlled trial. *BMJ* 2013; 346 doi: <http://dx.doi.org/10.1136/bmj.f1035> (Published 22 March 2013)

⁸¹² Effect of Telecare on Use of Health and Social Care Services; Nuffield Trust, 2013

<http://www.nuffieldtrust.org.uk/article/effect-telecare-use-health-and-social-care-services-findings-whole-systems-demonstrator-clus>

⁸¹³ Telehealth for patients at high risk of cardiovascular disease: pragmatic randomised controlled trial *BMJ* 2016; 353 doi: <http://dx.doi.org/10.1136/bmj.i2647> (Published 01 June 2016)

Mr Peter Marsh – Written evidence (NHS005)

The NHS will be sustainable for as long as there are people of good-will prepared to pay, fairly, for it.

The NHS can make good use of data if Parliament would pull its finger out and resolve data-governance issues.

The NHS can fix its staffing problems if Parliament will stop frightening EU colleagues about sending them home, decide on the bursary issue, sort out a single national curriculum for nurses and return doctors training to some semblance of 'belonging' and the firm.

The NHS can solve innovation and integration issues if Parliament kicked over the boundaries of health and social care and rewarded innovation as Parliament rewards itself for the upkeep of tradition.

The NHS cannot resolve demand issues but funded properly, focused and put centre stage Public Health England might. Where is the Childhood Obesity Strategy?

The NHS is very busy right now and palavering about with inquiries into the obvious are time wasting, distracting and a nuisance.

Sustainable? Yes, of course, but not if funding stays at 2000, levels... behind Greece and on a par with Slovenia.

It's about the money Lord Naren Patel.

25 July 2016

Professor Alison Metcalfe – Written evidence (NHS0147)

The future healthcare system

Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

- 1. With an ageing population there needs to be a greater emphasis on individuals remaining as independent for as long as possible, and for families to take an increased role in caring for their older members. This will mean developing the skills of health professionals but particularly nurses to educate and support family members in caring for and supporting each other. Therefore there will be a greater need change the focus of nurse education so that nurses have a more systemic role in supporting patients and their families.*
- 2. We will not be able to sustain providing large numbers of nurses and care assistants to assist with all the physical care needs, this means enabling family members with the skills to manage and care for people where possible will become more of a priority. Rather than simply trying to provide many more nurses from a population that will have a reduced labour force as it ages and less people are available for other work roles.*

Resource issues, including funding, productivity, demand management and resource use

To what extent is the current funding envelope for the NHS realistic?

- 3. Probably unrealistic when you compare it with other health systems. We need an intelligent debate with the general public about whether we should increase taxes or request more services are offered at a cost. Many people value the NHS and if they understood more about how other health systems were funded and the huge costs to the individual, many people are likely to recognise the NHS's value. Perhaps the debate could be led by an 'independent body' rather than politicians, which might give people more confidence in the arguments as they are presented.*

Does the wider societal value of the healthcare system exceed its monetary cost?

- 4. See above*

What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

- 5. A more integrated model of health and social care, budgets that run over several years rather than a single tax year which means that the ability to invest in change is a disincentive and only short-lived projects stand any chance of success. Perhaps franchises can be introduced which given NHS Trust x number years of funding, then long term planning can take place.*

What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

6. Why not simply a tax at the point of earning, with taxes increased for those things which contribute to poor health similar to alcohol and tobacco at present, and incentives (tax breaks) for companies that produce goods and services that promote health including healthy eating and exercise programmes.

Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

7. Free at the point of use by patients but we should look at the evidence to ascertain what should be funded – there are probably many procedures taking place that are unnecessary.

8. Greater emphasis should be placed on promoting health – too many health professionals are trained to manage and treat disease.

Workforce

What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

9. There are currently insufficient numbers of academically prepared nurses, midwives and allied health professionals. Although the NHS (via NIHR) prepares a small number each year (approx. 30 across England) this is far too few to prepare for the future.

10. There has been much debate whether non-medical clinicians should become more academically focused, however if you want these people to manage, support and educate people in very complex situations where they have long term conditions, with limited socio-economic capital, older age and with varied family arrangements, it is essential that the health professionals can function in these rapidly changing environments and optimise the best outcomes for patients and families. To provide the health professionals you need committed, clinically focused academics who can respond and work with change so that they can educate this workforce to be equally as informed and responsive.

What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

11. Not sure we can keep increasing numbers but having well educated health professionals leading and developing skilled teams is essential. Overseas recruitment not likely to be a strong option because many countries are facing large demographic changes with increased older age populations, and economic changes in these countries make it more likely nurses will stay there or go to many of the other countries experiencing nurse shortages. Increased supply will also come with better remuneration for nurses particularly more junior ones – having better career prospects, salary and supportive environments will keep more graduate nurses and midwives as part of the workforce for longer.

What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

12. Unknown – depends on salary and conditions – many health workers are willing to migrate for a good salary and improved prospects.

What are the retention issues for key groups of healthcare workers and how should these be addressed?

13. The stress of the current NHS system means that workers, particularly nurses and midwives do get burnt out. Nurses and midwives are predominantly female and many will be providing care at home to children and elderly relatives as well as providing care professionally. To keep nurses engaged and healthy we should consider giving them paid sabbaticals eg 6 months paid off work every 5 years. This would also make nursing a more attractive profession and bring in overseas workers too. – See Australia work contracts as an example.

How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

14. Mechanisms to incentivise the uptake of new technologies but most of all introduce them in ways which show the benefits – sometimes they are brought forward too early. First hand experience has shown me that what improves outcomes for patients is not always the priority sadly, managers are unwilling to use their budgets if their own specialty does not see a benefit, and it is another dept who will benefit. Therefore technologies that might prevent problems or detect them early are not used if they do not benefit the dept where they need to be implemented.

What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

15. Developing a well-educated, valued workforce will assist them in having the resilience (the adaptability and resourcefulness) to cope with changes between one patient's differing care needs and the next. They will be able to work through complex care delivery, recognising the multifactorial aspects of care provision. Greater emphasis on managing both mental and physical health as a shared entity, too often they are seen as separate issues. Nurses need to have the skills to provide physical health care and assessments but equally recognise the implications for the psycho-social aspects. It is often changes to the psycho-social aspects of a person through their poor health that most affects their well-being, sometimes more than the physical health problem in question. This is well known, yet still we do not education health professionals or medics to take this into account sufficiently in planning and developing care.

What investment model would most speedily enhance and stabilise the workforce?

Models of service delivery and integration

What are the practical changes required to provide the population with an integrated National Health and Care Service?

How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

How can local organisations be incentivised to work together?

How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

16. For community services there should be less emphasis on GPs and doctors leading the provision of care, which again focuses too much on illness and disease. Community services should be encouraged to emerge from different groups of health and social care professionals that people can access as and when they require it. Especially with the development of the electronic record, patients should be able to move more freely between different types of services. This is important as approx. 80% of GP consultations do not really involve medical issues but more likely to involve socio-psychological or economic issues as the underlying problem.

Prevention and public engagement

What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

17. Focus more socio-psychological care in the community. Set down care pathways for those with long term conditions so that there is more co-ordinated care and encourage people to reflect on what health care they really want – care is currently siloed into disease systems and each treating doctor is only interested in the body system they are specialised in and there is possibly over treatment in some areas and under treatment in others – we need health professionals who can consider the patient as a whole. We also need clinicians who are skilled in having difficult and challenging conversations about what it's reasonable to provide and treat, and often to get to underlying socio-psychological issues that if better managed might assist patients to cope better. For example obesity, many people are obese because of psychological distress rather than physical illness, however rather than helping people manage that, we sometimes resort to expensive and radical surgical interventions that do not assist the person in the long-term.

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

c. Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

18. We spend many £billions on research in the UK but it is often focused on developing treatments and medications, that 55% of patients then do not use or take inappropriately. Why not spend funding on looking at developing psycho-social, behavioural and service developments that might improve the health and well-being of people and / or disease prevention.

19. The vast majority of illnesses and disease are caused by social ills; loneliness, poor mental health, poverty, limited education, poor start in life, difficult family relationships and prejudice. Doing more to innovative in these areas rather than drugs and technologies are more likely to yield greater benefits for patients and the health care system.

d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

e. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

f. What are the barriers to taking on received knowledge about healthy places to live and work?

g. How could technology play a greater role in enhancing prevention and public health?

7. What are the best ways to engage the public in talking about what they want from a health service?

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

20. Check what patients themselves really want – are they likely to want continuous monitoring, will we all being willing to be monitored 24 hours per day for wearable technologies. Not sure that these questions have really been answered and yet we continue to pursue them.

21. With genetic / genomic medicine – huge financial resources have gone into these developments yet we still have not seen any major benefits for patients. These genomic benefits might come in time for small groups of patients but it's not clear that there's any real benefit to the wider population. Meanwhile many people who are affected by life limiting and life threatening genetic conditions have limited access to effective, and coherent programmes of care. As a result the mental health of family members can deteriorate, putting a greater demand on health care systems. We have spent over £500million on Genomics England in the last 2-3 years focusing entirely on sequencing the 100k human genomes, with benefit for a small number of patients likely to emerge in the next 5 years, and this is mainly getting a diagnosis rather leading to treatment. In contrast there has been no research into how this technology might be integrated into health care, whether large numbers of patients and families are likely to welcome this technology and what are the risks associated with it?

22. The risk information produced from genomic sequencing has consequences not only for the individual whose genome is sequenced but also all blood relatives – this can have significant repercussions for family and put an enormous strain on relationships if not managed. Yet little or no research has investigated the effects of this technology on society, and the potential impacts for better or worse, reducing the opportunity for debate about where NHS resources should be focused. In the meantime many families affected by genetic conditions have very poor access to healthcare and they often describe long and arduous battles with health and social care providers to get even basic needs met.

21. Health related research should focus more on improving care and well-being and less on blue skies research, which is the role of medical research council and pharma etc...

- b. What is the role of 'Big Data' in reducing costs and managing demand?
- c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?
- d. How can healthcare providers be incentivised to take up new technologies?
- e. Where is investment in technology and informatics most needed?

23 September 2016

Professor Karen Middleton – Written evidence (NHS0191)

1. What impact do you expect changing patterns of disease, demography and medical advances to have on the model of care in 2030? What does this mean for the roles of the healthcare workforce that you represent?

We need to shift more services into primary care

The ageing population and the increasing numbers of people with multiple long-term health conditions are increasing the need for services that support successful, sustained recovery, the maintenance of health, and that enable people to be active and independent.

In order to support the changing demographic successfully, a more preventative, self-managing model of care is required. We need to develop more roles at all levels outside hospitals. This is needed if we are to make General Practice teams more versatile and able to support people with long-term conditions and frail elderly people more effectively within the community.

On a small scale, this is already happening successfully. The barriers to scaling up are the lack of development funding overall in the health and care system, and the perverse incentives that make it difficult to divert resources from secondary to primary care without creating financial destabilisation.

All parts of the workforce need to be enabled to work to height of their capabilities
Role development needs to be based on the principle that all parts of the workforce should be working to the height of their capabilities. This involves delegating more where this results in equally safe, effective and is more cost-efficient. For example, there are tasks that registered physiotherapists could delegate more routinely to support workers, and support workers could work with carers and volunteers to do. Equally, there are tasks currently performed by doctors that could be carried out by physiotherapists, nurses, pharmacists and others.

This is starting to happen in General Practice: advanced practice physiotherapy roles are emerging to improve musculoskeletal (MSK) health in primary care. This has the effect of moving expert advice and support to the 'front end' of service delivery, enabling individuals' needs to be met more quickly and responsively and averting more expensive care being needed at later points, while also efficiencies and benefits in how GPs' time is deployed.

Forty per cent of Clinical Commissioning Groups (CCGs) are now piloting these physiotherapy roles and it has been a success story – for patients, GPs and NHS budgets. The CSP has joined forces with the Royal College of GPs and British Medication Association to issue joint guidance on implementation. The challenge now is to mainstream these roles at scale. <http://www.csp.org.uk/professional-union/practice/primary-care>

2. What are the most significant workforce issues for the members you represent?

Services over-stretched and the physiotherapy workforce is too small to meet demand
Physiotherapy and rehabilitation services are over-stretched and there are significant problems of recruitment to physiotherapy posts across all sectors. CSP members are concerned about the impact this has on their patients – what they are provided with, how long they have to wait for appointments, and the impact this has on recovery, mobility and independence, and levels of unnecessary disability.

This situation of physiotherapy workforce shortage is caused by growing patient/service demand and workforce supply failing to keep up with this, due to workforce planning decisions and student place commissions. In 2015, the CSP developed a workforce data modelling tool to project physiotherapy workforce requirements in relation to changing population and patient needs (using population health data). This found that in England we need at least 500 more physiotherapists each year from 2017 to 2020 (<http://www.csp.org.uk/professional-union/practice/evidence-base/workforce-data-model>).

This shortage will get more severe as demand continues to increase. It is also at risk of being exacerbated if access to the international workforce is restricted. Currently, c.14% of individuals registered to practise as a physiotherapist in the UK qualified overseas, 7% of registrants being from European Economic Area countries.

But it is not just about numbers: we need to get the supply right to do things differently, not more of the same, including to optimise how the physiotherapy workforce can form a key workforce solution to delivering services differently.

We are not ensuring sufficient physiotherapy training places

There is no shortage of people wanting to be physiotherapists: pre-registration programmes are over-subscribed in England, with 3.6 applicants for every student place. There is also a high translation of physiotherapy students to registration, with physiotherapy student attrition rates very low compared to other professions at 2.1%.

While there is some indication of movement from the NHS to the independent sector, the main problem is not one of retention and with members of the profession continuing to contribute strongly to delivering patient care across the health and care system.

The problem is that there have not been enough physiotherapy student places to keep pace with workforce demand. While the number of places had increased in recent years up to 2016/17, this was not sufficient to meet demand. This situation has been made worse by the Health Education England decision to cut physiotherapy student places by 6.2% for 2016/17. This was against evidence of need and based on partial projections of need.

We need to fix workforce planning

As highlighted above, workforce planning is currently flawed and un-strategic. It is based on projected workforce needs just within NHS providers, and not the full range of providers that deliver within the public sector (including NHS-funded services delivered outside the NHS) and the wider health economy. It is also based on assumptions that models of service delivery will not change.

A new approach is needed so that strategic decisions can be made about workforce size and profile, based on changing population need, systems modernisation and a plurality of providers and taking account of the shifts in funding arrangements for healthcare education and students from 2017/18.

Given the context of significant changes and the multi-faceted nature of the levers that will shape workforce supply going forward, this new approach is more of an imperative than ever.

This approach needs at national and STP level guide decision making on distribution of the practice education tariff to providers by Health Education England, distribution of funding to universities by the Higher Education Funding Council, decisions about additional financial support to students, and local initiatives to stimulate supply – including through apprenticeship schemes, the training and development of the existing workforce, and supporting return to practice.

Government accountability for physiotherapy workforce expansion and stability
Changes to healthcare education and student funding in England have the potential to expand provision of physiotherapists in line with demand/need – but only if this is an explicit goal, and only if the current shortfall in numbers is recognised, understood and addressed.

Since the goal for the additional 10K health care student places (for allied health professions and nurses) by 2020 was announced in the 2015 Comprehensive Spending Review, there has been a lack of national leadership and accountability for this.

The combination of changing healthcare education funding, fundamental changes in how health and social care are delivered via the Sustainability and Transformation Plans, and the ambition set by the government for the apprenticeship agenda are all creating additional volatility and competing pressures.

A recommendation from the Committee on ways to achieve stability and growth in physiotherapy workforce supply in this context would be extremely useful, as would a recommendation to keep the combined impact of changes on workforce supply under review.

Responsibility of the current workforce

An expansion of student places and developing new roles and services requires action by all sections of the workforce to increase and diversify practice education capacity. In the coming months, the CSP will be working with our members to ensure all parts of the physiotherapy workforce play their part in this.

3. What changes to the skills mix of the workforce do you think need to happen over the longer-term? To what extent will this mean developing or extending the scope of existing roles within the health workforce?

Optimisation rather than extending scope

In relation to physiotherapy, the issue is not one of needing to extend scope, but rather to use the workforce fully and encourage it to develop in line with population and service needs. For example, to optimise the value that General Practice physiotherapists bring, more need to be trained as independent prescribers and more need to be able to order imaging/investigations. We also need to enable physiotherapists to issue Fit Notes. All of these examples are within current scope.

Skills of increasingly importance

The workforce increasingly needs skills in multi-disciplinary working across settings; supporting individuals with multiple and related physical and mental long-term conditions; supporting individuals to implement self-management and behaviour change strategies; and building capacity and health literacy of patients, carers and volunteers through training, coaching and community education.

The nature of physiotherapy and existing services means that these are all core strengths in the physiotherapy workforce. Physiotherapists are autonomous practitioners, which requires a base of knowledge, skills, understanding and professionalism required to deal with complexity, risk and uncertainty. This provides a strong basis from which to develop these skills further within the physiotherapy workforce and for the physiotherapy workforce to share expertise to up-skill other parts of the workforce.

Workforce flexibility

The physiotherapy workforce, as with all parts of the workforce, needs to work differently. I am really proud how well understood this is in my profession and by the CSP's investment in a leadership programme to support this,

The need to adapt how the profession works includes working more flexibly, recognising areas of overlapping capabilities within multi-disciplinary teams, while maintaining professional expertise and distinctness.

Within the health professions, we have a tendency to equate specialism with expertise. A cultural change is necessary so that we value and increase higher-level generalist skills to make the improvements to primary care that are needed. This is an issue not only for medics, but also for the physiotherapy profession.

Investing in the existing workforce

Physiotherapy is a young workforce, with the majority of the current workforce still practising by 2030. There needs to be an investment in their development – to support a transition of services and the workforce out of hospitals, advanced practice development across non-medical professions and optimisation of the contribution of the support workers.

Training and development in the NHS has traditionally been geared towards doctors, with 60% of the budget spent on 12% of the workforce. Currently there is a lack of infrastructure or investment in for career development for the professions other than doctors. This gap is starting to be recognised for nurses (Shape of Care Review). The same is now needed for physiotherapy and other professions.

4. In order for the NHS to be sustainable over the next 15 to 20 years, will the healthcare (and social care) systems need to be organised differently? If so, how?

Modernising access

Individuals should be able to access more professional expertise directly – putting them in the driving seat of their care and reducing unnecessary delays and duplication.

Self-referral as a model of access is tried and tested with physiotherapy for musculoskeletal disorders. All the evidence shows this is cost effective. It also shows that contrary to fears, we can trust patients to refer appropriately. For example, a University of Keele randomised control trial, due to be published in the British Medical Journal and involving 10 thousand patients indicates there was neither an increase in patient demand, nor inappropriate referrals.

This model of access needs to be mainstreamed and extended within physiotherapy and to a wider range of physical and mental health support in primary care.

Rebalancing resources

As a result of medical advances, and improvements in access to acute care, there are many conditions with which more people now survive. However, we are not putting nearly enough focus on what happens to them next – to reverse damage, maximise recovery and maintain health; nor are we putting in place sufficient support that would prevent problems developing in the first place.

Primary services and community rehabilitation services have been a poor relation for far too long, and the desperate state of social care is well understood. Services are forced to act as gatekeepers rather than making it possible to resolve most health issues within the community. As a result, people are needlessly disabled, develop other health conditions and are driven into the most expensive parts of the health and care system.

A fundamental shift in ethos

If we were to be successful in making our model of health care more sustainable by 2030 it would be more preventative, rehabilitative and empowering for people to manage their own health. This requires a shift from dependency on the medical model of treating illness and disability to providing people with the right support and expertise at the right time to enable them to confidently manage their health and wellbeing.

The core values of physiotherapy, what it does and why it works, have a strong correlation with the changes needed for the future health and care system.

This change is critical to making the health system sustainable in the long term and is the responsibility of all of us.

5. What is your key suggestion for a change this Committee could recommend which would support the long-term sustainability of the NHS?

Our key suggestion is for the urgent reform of how workforce planning is done, so that it moves from being based on a narrow assessment of the status quo among NHS providers to becoming strategic, based on changing population needs, goals for system transformation and the integrated workforce needs of the whole health economy. Such reform needs to take strong account of changing structural and funding arrangements (relating to the health and social care, higher education and skills development – including the impact of the apprenticeship agenda). This is essential to ensure that workforce supply contributes to the long-term sustainability of the NHS, rather than continuing to compromise it.

Specifically, the CSP would welcome attention to be drawn by the Committee to the shortfall in supply of physiotherapists, which is limited the potential for the profession to deliver the changes required to make the NHS sustainable in the long term.

Further information about the physiotherapy workforce

- Physiotherapists and physiotherapy support workers are experts in movement, exercise and rehabilitation, all essential to helping individuals recover from illness and accidents, manage long-term conditions and sustain healthy living
- These are critical skills to shift the NHS from where it is now to where we need it to be for future sustainability and to meet changing population needs
- There are 52 299 registered physiotherapists in the UK. 41% work for NHS employers. The remaining 59% work across all other sectors (independent, charity, social care, MoD, public health). They form the largest of the allied health professions.
- All physiotherapists qualify with at least a Bachelor's degree, with a third of their programme comprising practice-based learning in clinical settings. Many go on to gain postgraduate qualifications once practising
- Physiotherapists are autonomous practitioners who don't require medical supervision. Many have advanced practice skills, e.g. able to prescribe medicines independently, give injection therapy, manage high-level complexity and risk
- Support workers (also known as rehab assistants and technicians, equivalent to health care assistants) are an important part of the physiotherapy workforce, working with patients individually and in groups on tailored therapeutic exercise
- Some support workers focus on physiotherapy, and some go on to train to become registered physiotherapists. Many work generically with physiotherapists and other professions (other AHPs, nurses) on multi-disciplinary teams.

14 December 2016

Dr Elizabeth Sinclair Miller – Written evidence (NHS0138)

Dr Elizabeth Sinclair Miller AKC, FRCS, MRCGP Dip Occ Med, retired early from NHS General Practice in January 2016. She qualified in 1979, began her career as a neurosurgeon and has practiced as an NHS GP since 1994 alongside working part-time in Occupational Health since 2005.

Summary

1 - Resource Issues

- Greatest challenge for healthcare is increasing Health Gap between rich and poor
- Funding and distribution model : money following the patient.
- Technology led service, with access to Health Care Professionals only when needed

2 - Workforce

- Greater flexibility and mobility between specialties in medicine and between different types of health care professionals
- Dependent on greater range of Healthcare and medical qualifications
- Medical degrees available at most Universities, using simulation technology
- Clinical conversion courses for those wishing to continue into clinical medicine

3 - Models of Service Delivery and Integration

- Distribution of resources following patient demand,
- Patients carry their own notes – Smart/contactless card technology access
- Retail/Banking model of healthcare distribution abandon the GP Surgery ‘Corner Shop Model’. Instead patients/customers access healthcare according to their own needs

4 - Prevention and public engagement;

- Health literacy taken into schools, as part of the core National Curriculum with school level qualifications in medicine, nursing, physiotherapy, anatomy and human biology

5 - Digitisation of services, Big Data and informatics.

- Better understanding and use of existing data
- Wearable tech for early detection, monitoring and management of preventable health conditions

1 - Resource issues, including funding, productivity, demand management and resource use

6 – The following assumptions are made with respect of Medical innovation; Demographic changes; and changes in long term conditions.

- **Medical Innovation**

7 - Widespread availability of Wearable Technology monitoring basic physiology with algorithms to detect early physiological change. Wider availability of medical technology, and medical imaging for earlier diagnosis. Reducing cost of health technology

Demographic changes

8 - Larger numbers of individuals with poor health at both extremes of life, with multiple morbidities. Other individuals living longer into a healthy old age.

Changes in long term conditions

9 - Increasing health gap between different segments of the community, reducing social mobility and a “poor health trap” maintained by health (sickness) benefits, poor understanding of health and lack of spare physical or mental capacity to improve circumstances.

10 – Obesity, metabolic syndrome and other lifestyle conditions continue to increase amongst poorest and least educated

11 – Increase in syndromes such as chronic fatigue, medically unexplained symptoms, chronic pain syndromes and joint replacement surgeries

2 a. Does the wider societal value of the healthcare system exceed its monetary cost?

12 - The principle of universal coverage, free at the point of delivery is the hallmark of a civilised society. The NHS, in its current state, is highly unlikely to be able to fulfil this ideal

2 b. What funding model(s) would best ensure financial stability and sustainability?

13 - A model (vis education) where money is focuses on individual need and follows the patient / customer, rather than distributed through CCG and NHS GPs

14 – Patient held records, using smart cards, mobile phones or other device. Healthcare distributed through a network of health care professionals rather than a specific doctor, retaining the option to see a specific doctor when requested.

15 – Patients determine the time and location when they would like to appointments and are not limited to particular surgeries and their opening hours. Current model not useful for a busy mobile population

16 - Review of the relevance of General Practice and its Gatekeeper function

17 - Development of a separate Paediatric Health Service, because of paucity of paediatric training with the community and the specialist nature of Child Health

18 - Where ever possible push technology ahead of the patient conserving scarce Health Care Professionals for work where their skills are appropriate.

19 – Abandon the model where 9,800 small businesses compete for government funding

2 - Workforce, especially supply, retention and skills

3 What are the key requirements of the future workforce going to be?

20 - Greater flexibility and mobility around healthcare by providing a greater range of healthcare qualifications.

21 – Develop a medical degree, independent of medical schools, using simulation technology, including virtual reality simulators, models of patients, eg Resuscitation Annie, and patient actors (vis MRCGP examinations)

22 – Degree available at most University, not necessarily leading onto a clinical career but possibly in medical technology, education, or research

23 – Clinical Conversion course for those graduates wishing to continue onto clinical medicine, nursing or other clinical career

24 – This compares to the availability of legal degrees outside legal practice

3a – Options for increasing the supply of key groups of health care workers

25 – The need is for greater flexibility within the medical profession, depending upon greater mobility between different specialties

26 – At present it is difficult to transfer between specialties being all but career suicide. Greater career flexibility would enable doctors to more easily transfer into General Practice after a few years in hospital medicine

27 - The GMC is addressing this issue, and should be encouraged to enable greater flexibility within the profession and facilitate mobility between specialties. This enables the medical profession to respond better to the changing demands and needs of a Health Service.

28 – Specialty training takes on average five years within that specialty. However doctors in training are useful members of the Health Service and fulfil NHS service requirements in a manner similar to consultants. Thus retraining in different specialties will not lose the service commitment of NHS doctors.

29 - A greater choice of specialties and freedom within the profession is likely to increase staff retention, through more varied career options. It could encourage doctors to return to practice after a career break, if they had the option to return to a different, possibly less acute specialty than that of their original training. It could help doctors become more mobile, around the country to fill vacancies in areas and specialties where there is a shortage of doctors

4b

30 - Key requirements of a workforce and population are health literacy. This is unlikely to be met through the current system of education and qualification

31- Universal Health Education broadening the levels of medical education within the community. Health literacy considered as important as any other type of literacy and numeracy, including offering GCSE, A'Levels NVQs in a range of subjects that include medicine, surgery, Human Anatomy, and pharmacology.

32 - Introducing the medical curriculum into schools and colleges, provides student wishing to enter health care professions with a grounding in their subjects prior to study at University. Including subjects such as high blood pressure, cancer, diabetes and obesity as well as the underlying physiology, biology, anatomy and nutrition. These qualifications might be as much part of the core curriculum as English and Maths.

3 - Models of Service Delivery and Integration

5 – Practical Changes required to provide an integrated Health and Care Service

33 - Move away from the 'corner shop, small business' model of General Practice. Patient held records, using smart cards, mobile phones or other device. Allow patients to access services at the point of demand, where the patient requires the service, rather than being limited to local practice, within limited appointments, regardless of patient employment and family commitments, preparedness to travel and seriousness, or otherwise, of condition. Important to consider other models of resource distribution, including Banking & Retail sectors as well as usefulness of online service delivery

34 - Money follows the patient - rate for service provision for consultations, procedures and ongoing monitoring of patient collected data

35 - Update GP content management system from EMIS to a one that is fit for purpose. EMIS is used by the majority of GP practices. It was developed by two GPs in the 1990s to record basic patient information, to enable GPs to claim capitation and other fees. Audit, time management and review of consultation model of GP practice, to ensure best value for money within the GPs surgery and GP service

36 - Review of the relevance of General Practice and its Gatekeeper function, given the referral for specialised services, beyond those that can be provided by District Nurses - treatment of simple infections and referral for specialist opinions within the hospital services. This could be undertaken by a better understanding of GP practices as with

i - Audit of services provided by GP practices - individual GPs

ii - use of time / time management to improve use of GP time

iii - actuarial audit of practice outcomes - by comparison with expected mortality from patient demographics

37 - Development of a Paediatric Health Service, in depend of current General Practice to serve all children and teenagers until the age of eighteen. This would be separate from Adult General Practitioners who can have limited training and experience in Paediatrics.

Management of children's and adolescents' health is a different and separate speciality from that of adult medicine, requiring a different mindset, skills and training.

38 - Where ever possible technology needs to pushed ahead of the patient. Health Technology is likely to continue to become more widely available, and significantly less costly than Health Care Professions. For example, patients should have a full health technology work up before seeing a doctor, including pulse, blood pressure, blood sugar, basic blood tests, ECGs, oxygen saturation and scans. These are simple and cheap compared to the cost of time from a Health Care professional

39 - Greater flexibility in delivering services has to be combined with a better business model for the provision of these services.. It is uneconomical to run almost 10,000 small business, where. For example, a significant proportion of services can be delivered on line

40 – This needs to be combined with more efficient service delivery within the surgery itself and development of outcome focused 21st century models of consultation

4 - Prevention and Public Engagement

6 – Key Changes?

41 – Patient held records, with greater individual responsibility for their own health,

consulting health professionals only when required and health data shows abnormal results or an individual develops symptoms

42 – Greater use of health technology, including Ultrasound at the point of first clinical contact, MRI, and blood tests. We have to stop being precious with technology and allow it to serve the community

43 – Greater reliance on health technology, rather than scarce, highly trained, expensive health care professionals

5e

47 - There is currently no incentive for existing healthcare providers to keep people healthier for longer, because their business models are based on sickness and profit from illness.

48 - New Healthcare providers with a different mind set are needed in order to change the model of care (vis – the Internet, dominated by new companies, such as Amazon and Google, compared to those not 'raised' to the new online environment)
With a change in approach from treatment to prevention, must come a new breed of company and new generations of health professionals capable of taking on this agenda.

49 – Wearable tech provides the means to make prevention rather than treatment the order of the day. It needs to be unnoticeable part of the day, and as integral to lifestyle as brushing one's teeth

5 - Digitisation of services, Big Data and informatics.

8a

50 - Update NHS It systems to something fit for purpose. EMIIS developed almost 40 years ago,, for a very different clinical environment

51 – Existing Healthcare providers unlikely to be incentivised to work with a health promotion and sickness prevention model

53 - Patient Based Records - through Smart cards, Cloud, and mobile phones - health records associated with the individual, rather than specific hospitals, or general practices

54 - Over the last ten to twenty years, the quality of medical records have improved significantly, majority of information held electronically at the level of General Practice

55 - Adoption of electronic records by hospitals, beyond the pathology laboratory as has happened with GP records - electronic recording of all patient data - including clinical notes, linked to Pathology, Pharmacy, Radiology such that all records referring to specific patients are linked to that patient, not to departments, hospitals or General Practices.

Dr Elizabeth Sinclair Miller – Written evidence (NHS0138)

56 - Over the last twenty years, computing power and data storage has reduced in price and is now more widely available

23 September 2016

Mind — Written evidence (NHS0179)

1. What are the key issues in the provision and delivery of mental care services?

Key message: Demand has grown rapidly but supply hasn't kept up. Services are overstretched and under-resourced right the way through from community services to hospitals.

- **Referrals to community mental health teams have risen nearly 20%** over the past five years. But of the approximately 14 million people who experience mental health problems in a given year in England, less than two million are in contact with specialist mental health services.⁸¹⁴
- **The latest Adult Psychiatric Morbidity Survey found that two –thirds of people with common mental health problems such as anxiety and depression receive no appropriate treatment** (compared to 25% of people with physical health problems) – this is up from 75 per cent, and the increase is chiefly down to access to IAPT.
- The 2015 NHS Benchmarking report into the state of mental health services found a **10% increase over the past year in the numbers of people being admitted to hospital under the Mental Health Act**⁸¹⁵ – an indicator that people are becoming more unwell before they are able to receive hospital care.
- Mental health **bed occupancy rates have reached their highest ever level at 94%**, whilst there has been a 24% reduction in bed numbers over the last 3 years.⁸¹⁶
- More people are being sent out of area to find a bed. Community Care reported recently that there has been a **23% rise in the number of mental health out of area placements**, with some people being sent over 300 miles because of bed shortages.⁸¹⁷
- **UK suicide rates are at the highest since 2004.**⁸¹⁸ According to the National Confidential Inquiry into Suicide and Homicide's recent report, there is a direct link between out of area placements and suicide: they recommend that 'Acute

⁸¹⁴ Mental Health Minimum Dataset (MHMD) Annual report 2013-14 (England)

<http://www.hscic.gov.uk/catalogue/PUB15990/mhb-1314-ann-rep.pdf>

⁸¹⁵ NHS Benchmarking, Press Release, 5 November 2015

⁸¹⁶ NHS Benchmarking, Press Release, 5 November 2015

⁸¹⁷ <http://www.communitycare.co.uk/2015/07/15/mental-health-patients-sent-hundreds-miles-beds-area-placements-rise-23-per-cent/>

⁸¹⁸ http://www.samaritans.org/sites/default/files/kcfinder/branches/branch-96/files/Suicide_statistics_report_2015.pdf

admissions out of area should end – they are likely to make care planning more difficult and to add to suicide risk at the time of discharge.⁸¹⁹

Key message 2: There have been welcome commitments, but overall funding is insufficient and we are concerned that new allocations are not reaching frontline services.

- Mental health problems cause **23% of all illness in the UK but mental health care receives only 11% of our health spending.**⁸²⁰ Mental health services have historically been underfunded and considered an easy option for cuts at a local level. **Funding was cut in real terms by 8.25 % in the last parliament (2010-2015 at a time of increased demand.**
- There have been welcome commitments to more funding: The 2015 Spending Review included extra £600m for mental health crisis care, psychological therapies and maternal mental health services. £1.4bn has been promised for children and young people’s mental health services from 2015 to 2020, and a further £1bn pa by the end of the five year period has been agreed to fund implementation of the FYFVMH.
- However, **given the letter to the recent Exchequer from the Health Select Committee** (31st October 2016) we are concerned about whether this money will be delivered, and whether it will be sufficient without investment in social care, public health and training alongside it.
- Evidence suggests that **funds intended to deliver improvements in mental health care have been diverted to alleviate the financial pressures facing acute services**, where 98% of the NHS’s estimated £1bn deficit lies:
- The [NHS Providers](#) revealed in May 2016 that **only half of the 32 mental health trusts they spoke to – 55% of the total – had received a real-terms increase in their budgets in 2015-16.** Only 25% said they expected CCGs to increase the value of their contracts for 2016-17, even though the 209 CCGs have seen an average 3.4% rise in their budgets this year.
- 90% of trusts and 60% of CCGs did not think the extra £1bn for mental health by 2020-21 recommended by NHS England’s recent taskforce would be enough.
- We see this as a missed opportunity because this sort of focus on mental health comes once in a lifetime. **Investment in mental health will ease pressure on**

⁸¹⁹ <http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/n326N210715.pdf>

⁸²⁰ Department of Health (2011) No health without mental health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215808/dh_123993.pdf

physical health services too – people with mental ill health use more emergency hospital care than those without mental ill health. In 2013/14, this was 3.2 times the accident and emergency (A&E) attendances and 4.9 times the emergency inpatient admissions. People with mental ill health had 3.6 times more potentially preventable emergency admissions than those without mental ill health in 2013/14.⁸²¹

- In addition, **people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent.** Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.⁸²²

2. What progress has been made in delivering the recommendations of the Mental Health Taskforce?

Key message: Mixed picture. Some ALBs have responded positively, others are lagging behind and the Government is yet to publish its response.

- Most notably **NHSE has accepted all of the recommendations in the taskforce**, and published its detailed implementation plan in July 2015. Mental health services will see additional **investment of £1bn per year by 2020/21** to achieve the recommendations. <https://www.england.nhs.uk/mentalhealth/taskforce/imp/>
- As part of the new CCGIAF and mental health dashboard, **new data and ratings on mental health have just been published** which sets the baseline and **gives a level of transparency we have never had before.** Some of this covers specific spend in mental health.
- However, we are concerned about **lack of progress and a plan for implementation of the cross-governmental recommendations.** As yet there has not been any public comment on it although we understand that there are discussions going on behind the scenes.
- **Delivery of the recommendations is entirely dependent on upskilling and increasing the mental health workforce.** HEE is due to deliver a workforce strategy on its plans for the mental health workforce by the end of the year – it's critical that

⁸²¹ Health Foundation and Nuffield Trust, Quality Watch, focus on People with Mental Ill Health and Hospital Use, October 2015

⁸²² Five Year Forward View for Mental Health, February 2016

they get this right, in terms of numbers, skills mix and appropriate training if the service improvements envisaged in the FYFVMH are to be delivered.

- **Ultimately, it is for local commissioners and STPs to deliver on the FYFVMH. This requires a change of mindset locally with an expectation that service improvements will be delivered** – we need commissioners, and providers, to be more ambitious for mental health services and to show leadership locally, setting an expectation that change will happen and that the promised funding will be delivered.

3. What impact are mental health problems having on the overall health of the nation?

Key message 1: Poor mental health, social problems and low incomes often go hand in hand; the fact that so few people with mental health problems are in treatment inevitably puts huge pressures on the wider economy and services such as employment and housing.

- **Mental health cost the economy £105.2 billion per year in England in 2009/10⁸²³**. The figure includes the costs of health and social care for people with mental health problems, lost output in the economy, for example from sickness absence and unemployment, and the human costs of reduced quality of life.
- Almost **half of the 1.8M people on ESA** are claiming primarily because of a mental health problem.
- Over a third of people with mild to moderate mental health problems, and almost **two-thirds with SMI, are unemployed**.
- People with mental health problems are **three times as likely to be in debt** as the general population; for people with SMI this is four times as likely.
- As many as 9 out of 10 people in prison have a mental health, drug or alcohol problem.
- Common mental health problems are twice as high amongst people who are homeless compared to the general population, and psychosis is 15 times as high.

Key message 2: people with mental health problems are at greater risk of poor physical health; people with long term physical conditions are at greater risk of poor mental health

⁸²³ Centre for Mental Health, 2010, Economic and Social Costs of Mental Health Problems

- Physical and mental health are closely linked – **people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier** than other people – one of the greatest health inequalities in England.
- Two thirds of these deaths are from avoidable physical illness including heart disease and cancer, many caused by smoking.
- There's also a **lack of access to physical healthcare for people with mental health problems** – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.
- The **FYFVMH makes a number of recommendations** on this topic, starting with defining the national reduction in premature mortality we want to see, and developing an operational plan from 2017/18 including prevention. It states that **by 2021, 280,000 more people living with SMI should have their physical health needs met by early screening.**
- Mental health problems are also more common in people with physical health problems, and having both physical and mental health problems delays recovery from both⁸²⁴. **People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven times more likely to have depression**⁸²⁵.
- By interacting with and exacerbating physical illness, **co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and a co-morbid mental health problem.** This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – equating to between £8 billion and £13 billion in the England each year⁸²⁶.
- There are a wide range of interventions which can help people's mental health and their physical health⁸²⁷ but we remain a long way from these being routinely accessible and available.

⁸²⁴ NICE (2009), *Depression in adults with a chronic physical health problem: treatment and management*, NICE clinical guidance 91

⁸²⁵ NICE (2009), *Depression in adults with a chronic physical health problem: treatment and management*, NICE clinical guidance 91

⁸²⁶ The King's Fund and Centre for Mental Health (2012), *Long-term conditions and mental health: the cost of co-morbidities*

⁸²⁷ Joint commissioning panel on mental health (2013), *Guidance for commissioning public mental health services*

4. Do you think the ambition of parity of esteem between mental and physical health services can be achieved? What progress has been made so far?

Key message: Significant progress has been made at a policy and Government level, but we are yet to see the impact of many of these policy changes on the ground. The FYFVMH sets out the direction we need to take now, but it will take much longer than five years. Its ambitions are fairly limited.

- **The 2012 Health and Social Care Act legislated for parity of esteem** by placing explicit duties on the SoS regarding both physical and mental health care. The government requires NHS England to work for parity of esteem to mental and physical health through the NHS Mandate.
- In October 2014 the government announced **waiting time standards for some mental health services** – the first time such targets had been set for mental health. **Since April 2015 waiting times have been measured for two types of service:** psychological therapies provided through the Improved Access to Psychological Therapies programme and early intervention services for people experiencing their first episode of psychosis.
- The **Crisis Care Concordat**, launched by the Department of Health in February 2014, triggered joint agreements at the local level between the police, social care, mental health and ambulance services to improve how professionals work together. **Significant achievements have already been made, including a 80% reduction in the number of people being detained in police cells** during mental health crises, since 2011.
- Attitudes towards mental health have improved thanks in part to the Time to Change campaign. Our evidence shows that, compared to where we started in 2008, there are now 3.4 million people with improved attitudes, which is an improvement of **8.3% between 2008 and 2014**. We have also seen much more openness amongst celebs, politicians, sports stars and so on, and a whole army of campaigners and activists who are speaking openly and calling for better treatment.
- The **FYFVMH sets out the direction** for the next five years with clear recommendations, targets and costings. NHSE has accepted all of its recommendations and committed £1bn to deliver. But **we do not expect to have achieved parity by 2020 – it will be the work of generations**. FYFVMH ambition include:
 - NHS England should increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more

adults with anxiety and depression can access care (and 350,000 complete treatment) each year by 2020/21.

- By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met.
- By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.
- By 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it

5. Can you outline any issues that relate to the mental health workforce that you think are having a significant impact on patients?

Key message 1: too often NHS staff are ill equipped to support people with mental health problems and stigmatising attitudes are commonplace.

- The taskforce report and subsequent recommendations is clear that **the staff across the NHS need better training to help them understand mental health** and to treat people with dignity and respect.
- Today (1st November) we launch **our primary care campaign which highlights how difficult it can be for patients to find the words to ask GPs for help, with the average appointment lasting just 9 minutes.** Although we heard about lots of really positive experiences and fantastic GPs and practice nurses, we also heard about patients not being taken seriously, or feeling scared/anxious because staff had not explained things clearly.
- Trainee GPs are faced with a narrow choice of training placements, and limited time and resources to complete them. **Less than half (46 per cent) of all trainee GPs in England and Wales receive placements in a mental health setting, which is usually a psychiatric unit.** GPs have told us psychiatric unit experience can be helpful but differs greatly from their day to day work in practice treating people with mental health problems.
- **We want Health Education England and the Wales Deanery to ensure every trainee GP is able to undertake a rotation in a mental health setting.** We want the General Medical Council to specify a set proportion of annual CPD credits for GPs to undertake which have a mental health focus.
- At the most severe end there are worrying stories of **people being treated inhumanely by crisis care services and in inpatient settings, as our Crisis Care report set out in 2013.** In 2011/12 there were almost 1000 incidents of physical injury following restraint in mental health services.

Key message 2: we simply need more staff.

- The Kings Fund reported that **almost half of community mental health teams had staffing levels judged to be less than adequate** in 2013/14.
- Data from HEE shows a **6.3 per cent vacancy rate for NHS consultant psychiatrist posts**, and over 18 per cent of core training posts in psychiatry are vacant.
- Between 2014 and 15, referral rates increased five times faster than the CAMHS workforce grew. In some areas one in ten appointments were cancelled because of staff shortages.
- **Staff shortages have contributed to deaths on inpatient wards** according to the 2015 national Confidential Inquiry into Suicide and Homicide.
- The **FYFVMH recommends that HEE works with NHSE, PHE, professional bodies and others to develop a costed, multi-disciplinary workforce strategy**. It must address training needs for both new and existing staff, and should report by the end of this year. It should include clear projections for staff numbers to 2021, core training, and tailored curricula around shared decisions making, prevention, empowering people, and carer involvement. We hope that this report will be delivered on time and will be sufficiently broad in its scope.

6. What is your key suggestion for a change this Committee could recommend which would support the long-term sustainability of the NHS?

- Given the Letter to the Exchequer from the Health Select Committee, we need real clarity and transparency about how much money is being committed to the NHS, and how it is being spent, and we need accountability in the system so that Government can act when, inevitably, funding is lost at local level.
- Funding for social care and public health also critical in keeping people well and able to live independently in the community.
- We need providers to have confidence that the money will arrive, so that they can plan for wholesale changes and improvements.

Professor James Morris – Written evidence (NHS0007)

Professor James A Morris
Consultant Pathologist
Department of Pathology
Royal Lancaster Infirmary

Viewing the future through the retrospectroscope

Sir,

Stephen Hawking is right; time travel is possible. Indeed initial steps have been taken and a batch of correspondence from the next century has been recently uncovered. The following letter, from the batch, will be of interest to your committee.

1st April 2107

Dear Mum,

I am enjoying this term. We have a special module on the history of medicine. This is because it is 100 years since the foundation of our Medical School. I didn't realise how little they knew at the start of the 21st century.

We are taught the golden rule: "*germs cause disease, genes act in complex networks to prevent disease*". It works for everything except trauma. When we see a patient we are supposed to ask ourselves: "how have the germs done this?" We then investigate accordingly. A key part of the investigation is to analyse specimens of urine using proteomic techniques, especially mass spectrometry. Microbial peptides formed during episodes of bacteraemia and viraemia are found in the urine and allow a diagnosis to be made in most cases. Apparently they didn't know about the golden rule 100 years ago.

Degenerative disease of the vascular system, atherosclerosis and arteriosclerosis, used to be common and was the major killing disease in the western world. Because there was fat in the atherosclerotic plaques the medics thought that it must be caused by too much fat in the diet and in the blood. They didn't realize it was caused by bacteraemia due mainly to *Staphylococcus aureus*. Bacteria invade the blood every day. They are quickly cleared by neutrophils and their toxins are neutralized by antibodies. But they do a little bit of damage and this accumulates over a lifetime. That is why we have to be so careful after we shower to apply the creams and powders that ensure our skin flora is mainly colonized by *Staphylococcus epidermidis* or *Corynebacteria species*. The episodes of bacteraemia were diagnosed by the detection of bacterial toxins in the urine using mass spectrometry. The toxins are neutralized by antibodies in the blood stream but the immune complexes that form are secreted by the kidney. It was a medical student in our Medical School that first demonstrated this phenomenon – the immune complexes are too big to be filtered but they do appear in the urine, so they must be secreted.

At the beginning of the 21st century there was concern about an epidemic of senile dementia. The main concern seems to have been the cost of looking after the elderly rather than the devastating effect it had on their life. Even though it was called an epidemic nobody realized it was due to germs. It was mid century before the medical profession worked out that the condition was due to bacteraemia and control of the skin flora brought the epidemic to an end. Once again it was the proteomic analysis of urine that provided the vital clue.

There was also an epidemic of obesity. Everyone in developed countries seemed to be getting fatter and fatter. It was attributed to gluttony and sloth. The penny didn't drop that the word epidemic was a clue. In fact the idea that sin was the cause of disease and penance the cure was still prevalent, at least subconsciously, in the minds of the medical profession at that time. Whenever they were presented with something they did not understand they invoked sin as the cause and looked for someone to blame; usually the patient or the patient's mother. We now know that obesity is due to certain sub-types of *Escherichia coli* present in the gastro-intestinal tract. The bacteria secrete toxins which interfere with the regulation of appetite. The result was that people in sedentary occupations who had access to plenty of food tended to become fat. It took the medical profession a surprisingly long time to realize that intensive farming methods designed to cause rapid weight gain in animals would select for bacteria that impaired appetite control. The answer of course was to control exposure, making sure our own flora and that of farm animals had the right sub-types of *E. coli*.

The psychiatrists resisted the idea that germs cause disease for longer than the rest of the medical profession, even though everyone thought that they were the clever ones. Schizophrenia and manic-depressive psychosis are genetic diseases but acute exacerbations are due to bacterial toxemia; a consequence of bacteraemia and our old enemy *S. aureus*. Two percent of the population carry the genes for psychosis but very few experience these diseases in our enlightened 22nd century; once again because of optimization of the microbial flora. The mysterious diseases irritable bowel syndrome, chronic fatigue syndrome and anorexia nervosa also caused a big problem. They occurred mainly in women and the onset was usually in the late teens, the twenties or the thirties. They did not start in childhood or in old age. Male medics who regarded women as the weaker sex in both body and mind had little difficulty in explaining these "imaginary diseases" as the product of stress to which the stronger male did not succumb. Female medics were more likely to blame their hormones. These diseases are in fact due to auto-antibodies to neuronal proteins induced by molecular mimicry with bacteria of the body flora. These conditions still occur in young women but we quickly identify the bacteria that are causing the problem and replace them by filling their ecological niche with closely related sub-types that lack the offending molecules. Molecular analysis has been such a boon.

Diabetes mellitus is an interesting example of how everyone missed the obvious for so long. It was divided into type 1 and type 2. Type 1 occurred in children and was due to excessive hygiene. Type 2 occurred in adults and was a consequence of obesity i.e gluttony and sloth. The sin was with the mother in type 1 and the patient in type 2. In the pancreas there are collections of endocrine cells which form the islets of Langerhans. There are several different types of endocrine cell but only one secretes insulin. It is the insulin secreting cell

which is damaged and destroyed in both types of diabetes mellitus. When bacteria invade the blood they have a growth advantage if the blood glucose is elevated. There is, therefore, an evolutionary advantage to those bacteria that secrete molecules which directly damage insulin producing cells or interfere with insulin function. That is how our old enemy *S. aureus* caused diabetes mellitus. It is obvious to anybody who understands evolutionary principles, but for some reason not to those running medicine 100 years ago.

Cancer was also very common in the bad old days. It was regarded as an inevitable consequence of growing old. Stem cells acquired mutations by chance when they divided and it was only a matter of time before one stem cell acquired the specific set of mutations which led to uncontrolled cell proliferation. Leading geneticists argued this was pure chance and there was nothing that could prevent it. A vast amount of money was spent trying to find a molecular cure but to no avail. The situation looked hopeless until some simple logic saved the day. We produce 200 billion red cells, 100 billion neutrophils and 50 billion other cells each day. There are more stem cell divisions in the red cell series than in all other cells put together. But cancer in the red cell stem cells (erythroleukaemia) is very rare. Cancer is not an inevitable consequence of stem cell division. We now know that each cancer has a cause. The causal factor damages stem cells locally and they proliferate. These proliferating cells accumulate mutations and several malignant clones arise. One of the clones outgrows the others and becomes the tumour. The cause of cancer, the process that damages the stem cells in the first place, is infection or trauma. Bacteria damage the stem cells in the stomach and colon. But viruses are the culprit in most epithelial tissues. The stem cells of the red cell series are not a natural place for viruses as they cannot be passed on, but epithelia, such as the breast, are a staging post in the virus life cycle. Once more controlling exposure to bacteria and viruses and optimizing the microbial flora has greatly reduced the incidence of cancer of all types.

I now realize why you insisted that I take that pill every day. I knew it was good for me but I did not know why. The key to preventing disease is low dose, early mucosal exposure to all the bacteria and viruses which we are likely to meet in our lifetime. If we meet them at the right dose, in the right place at the right time then we will develop immunity without suffering disease. The enteric coated pill delivers a precise dose of germs to the small intestine. The composition changes daily so that we meet most organisms in year one and then are re-exposed throughout life to maintain immunity. We also have to apply creams and powders to optimize the skin flora and reduce the incidence of those awful diseases that I have been reading about. New viruses arise from time to time but they are quickly recognized and the surrounding population is exposed to a low dose to stop the spread. All those coughs and colds are a thing of the past.

My generation is very lucky. We are the first to have had the pill since birth and we are likely to live into a healthy old age. But we will grow old and die probably in our 11th or 12th decade. Death is inevitable because our cells accumulate mutations throughout life and the golden rule still applies: *germs cause disease, genes act in complex networks to prevent disease*. The accumulation of mutations gradually impairs our response to infection and the germs will get us in the end. Most people now die quietly in their sleep of sudden death in old age syndrome. It is caused by bacterial toxins, usually produced by *S. aureus*, which interfere with cardio-respiratory control. The mode of death is very similar to that which

used to occur in another mysterious condition called sudden infant death syndrome. It took them a very long time to sort that one out as well.

I am glad I live in the 22nd century but part of me does envy those early graduates of our medical school. They lived through a golden age of medical discovery to which many of them contributed. They are the generation that discovered the golden rule and learnt to optimize the microbial flora. They developed and perfected the pill. They transformed medicine from diagnose and treat to understand and prevent. Imagine their excitement when they discovered that bacteraemia is the hidden factor in disease. That it not only accelerates the rate of aging by directly damaging endothelial cells, but also triggers the production of immune complexes and auto-antibodies thereby explaining many of those otherwise mysterious conditions of young and middle age. One of the reasons for their success was that they were the generation of doctors that re-engaged with medical research. The previous generation had increasingly concentrated on clinical work and teaching and had left research to health scientists and bio-medical scientists. Our medical school played a role in this change by insisting that all research was jointly supervised. This meant that bio-medical scientists worked on problems directly relevant to clinical disease and there was always a medically qualified scientist on the team. Those medics and the bio-medics together brought about the transformation. They discovered that research is about originality and flair, not money and bureaucracy. It was small projects done by students that brought about those leaps in understanding. The big projects were at best confirmatory and at worst an expensive waste of time. The previous generation was still collecting massive amounts of data but all it produced was an impenetrable fog. The new generation learnt to ask precise questions, based on theory, and then plan simple decisive experiments. They weren't afraid of failure and as a result they rarely failed. Theory became respectable and data acquisition without a question was derided as stamp collecting. Perhaps most important of all nobody was forced to do research, they did not need it for their career. They did it because they wanted to.

It is amusing to consider some of the predictions that were made about the future of medicine in the pre-enlightenment era (circa 2010). They thought information technology would be transformational; it wasn't. They thought robots would replace doctors; they haven't. They thought the health service would crash because of increasing disease in old age and the cost of drugs; it didn't. They thought that genomics would lead to personalized medicine; it couldn't. They thought that health science and medical science were different things; they weren't. In fact they got many things wrong but they did realise the importance of molecular biology, they did learn to analyse the proteins that cause disease, and they did, somewhat belatedly, start to analyse urine by mass spectrometry. Three cheers for proteomics.

Lots of love,

your daughter.

9 August 2016

Mr Malcolm Morrison – Written evidence (NHS0010)

Malcolm Morrison
Retired Orthopaedic Surgeon

“THE FUTURE OF THE NHS”

Introduction

1. The NHS is ‘critically ill’ and needs ‘radical surgery’ if it is to survive.
2. One cannot properly plan for the future without examining, and understanding, the past.
3. The NHS is, rightly, revered throughout the land. It was born out of a noble idea – that no one should be denied treatment because of their inability to pay for it; but it was based on a false premise – that, by treating those with disease, the nation would become healthier and, so, the need for health care would diminish.
4. Britain in 1948, when the NHS came into being, was very different from the Britain of today.
5. Prior to the NHS, people had to pay to see a doctor (except for those on ‘The Panel’ – workers, but not their families). Many postponed going to the doctor because they could not afford the fee; so only presented when their disease was well advanced. In hospitals, Lady Almoners enquired about the patient’s financial state and ‘suggested’ a suitable donation – though the poor were ‘allowed’ free treatment. GPs relied on their fees from patients (though it is said that some waived their fees for the poor and charged the ‘well off’ more!); and hospital consultants relied on their fees from ‘private patients’ (though they were not so-called then) and ‘gave’ their services to the ‘voluntary’ hospitals (sometimes getting a small ‘honorarium’ – they were ‘honorary’ consultants). In some major teaching hospitals, House Officers (then, almost all ‘Housemen’!) were unpaid (their ‘reward’ being free board and lodging!) and had little, if any, time off.
6. In those days the main diseases (infections (particularly Tuberculosis), heart disease and cancer) were all killers – or, as we would say today, ‘life-threatening’. There were few drugs; they were not very effective but had few side-effects; and they were cheap. Antibiotics were just coming in (anti-tuberculous drugs came a few years later); digitalis was about the only ‘heart medicine’; and radical surgery was the treatment for cancer (with some getting post-op radiotherapy) – but there was no chemotherapy.
7. How times have changed! Today, most treatments are ‘life-enhancing’ rather than ‘life-saving’. There are myriads of medications for all manner of diseases; they are very effective but have serious side-effects; and they are expensive. Most surgery is

aimed at preserving function; we now have joint replacements, arterial stents, by-passes and grafts, organ transplants and various forms of 'reconstructive' surgery. 'Oncology' (a new specialty, for the treatment of all forms of 'cancer') now encompasses restricted surgery, reduced doses of highly-focussed forms of radiotherapy and an ever-increasing variety of chemotherapeutic agents – with gene therapy on the horizon.

8. All this, together with better housing, better food and better hygiene, has led to people living longer. But, the longer we live, the more likely it is that we will develop a disease that can benefit from one (or more) of these truly 'wonderful' treatments – and, so, enjoy a better 'quality of life'.
9. BUT, the problem is that this 'increased demand' puts a strain on the NHS – and all who work in it. The 'cost' of the NHS continues to rise; but the 'resources' (both of manpower and money) are restricted – by the political decision of how much Parliament chooses to spend on it by way of the NHS budget.
10. Of course, this is not new; it has been building up over the years - indeed since the inception of the NHS.
11. One of the 'founding principles' of the NHS was that it should be 'free at the point of delivery'. However, it soon became apparent that treating the 'pool of disease' in the population at the birth of the NHS did *not* reduce demand; it increased it! The fitter people are, the less will they tolerate 'minor ailments' – especially when the treatment is 'free'! And so, **in 1952, the first 'charges' were introduced** – for dentistry, spectacles and the prescription charge; and this led to the resignation of Nye Bevan (the 'founder' of the NHS and then Secretary of State for Health) and Harold Wilson (then a junior minister) because of the breach of this principle.
12. Over the years, successive governments, Secretaries of State, and all politicians have buried their heads in the sand and refused to face up to the basic problem. Instead of 'dealing with the underlying disease' they have applied 'palliative medicine' (attempted to 'treat the symptoms') by a series of reorganisations! The problem has become more acute in recent years due to the financial restraint brought about by the banking crisis – together with the increased longevity of the population and the proliferation of effective, but expensive, treatments.

The Problems

13. The main problem is simple – 'demand exceeds supply'. Thus, there are only two possible solutions – reduce demand or increase supply (or a mixture of both). These are **political** (not medical) decisions; but the profession may 'advise' politicians of their options – but **they** must make the 'choice', even if politically unpalatable!
14. A secondary problem is the burgeoning of 'bureaucracy'; with too many 'senior managers' at local level; and too many 'national' organisations (many of them

QANGOs – Quasi Autonomous National Government Organisations) at ‘central’ level, as well as the Department of Health!

15. These ‘central’ organisations are all ‘expensive’ (and have yet to have their ‘cost-effectiveness’ evaluated!); their main priority appears to be ‘financial’ rather than ensuring a good, effective, ‘clinical’ service to patients. They all seem to want to ‘micro-manage’ the local scene; and interfere with the ‘clinical judgement’ of doctors (which is not their role)

The Solutions

16. Reducing demand would entail a form of ‘rationing’ (well understood in 1948!) whereby certain conditions or treatments would **not be available** on the NHS (this principle is already being applied, in minor form, by NICE – National Institute for Health and Clinical Excellence). Increasing supply means putting more money into the service – either by raising taxes or by imposing charges for some (or all) forms of care/treatment (which is also being applied in the form of the prescription charges and payment for some appliances).
17. Clearly such choices will be painful for all – but they are now necessary. It is interesting that no other nation has copied our NHS in having everything ‘free at the point of delivery’. We certainly do not want to return to the ‘bad old days’ of pre-NHS when people ‘couldn’t afford’ to go to the doctor; but there are ways of protecting the (really) poor from the effect of charges.
18. I am sure there will be different opinions on the details of *how* to deal with the basic problem. It is time that an ‘independent committee’, such as this House of Lords one, should examine the issues – devoid of party political dogma. So I am grateful for the opportunity to be able to submit my ‘evidence’. I trust that the Committee will take ‘evidence from **all** the ‘caring professions – nurses, physiotherapists, occupational therapists, speech therapists, clinical psychologists and, of course, from the representatives of **all** doctors in both general and hospital practice.

To address some of the specific questions posed by the Committee

1. The future of the healthcare system has been dealt with above
2. Resources: The current funding of the NHS is unrealistic.
 - a. The wider societal value of the healthcare system far exceeds its monetary cost. It is ‘invaluable’.
 - b. See above.
 - c. I think there is little scope for the use of the taxes mentioned. It is a **national** health service, so should be ‘funded’ on a system that applies across the nation – though the ‘distribution’ may need to be developed to take account of differing circumstances in different localities (such as large cities, rural areas, seaside resorts and university towns with fluctuating populations etc.)
 - d. See above – but ‘yes’.

3. Workforce. There is going to be an increasing need for more clinical, professional staff to deal with the ageing population and complexity of treatments. There is an increasing ‘demand’ for more flexible working by both women and men to meet the needs of current ‘family life’. For far too long we have not produced enough ‘home-grown’ doctors and nurses; and have had to rely on ‘overseas’ staff (often attracting them away from their home countries where they are needed more than in the UK). Shorter working hours (than in ‘the good old days’), particularly the introduction of the EWTRs (European Working Time Regulations), were never ‘matched’ by an increase in numbers ‘on the front line’.
 - a. There needs to be a considerable increase in the number of doctors and nurses (I do not know enough about the numbers of other professionals) trained in this country. The ‘conditions of work’ have to be attractive enough to produce adequate recruitment (and retention) – but, although the number of applicants for places at medical school have declined over the years (as I have read), there are still more applicants than places available; but, after qualification, there is recent evidence that there has been a decline in recruitment for both general practice and hospital specialty training posts. However, there will always be a need for doctors from abroad to come here for training (just as ours will wish to go abroad for the same reasons).
 - b. Leaving the EU (European Union) will make it easier to recruit from countries outside the EU – particularly from Commonwealth countries.
 - c. Retention (for **all** staff) depends on having ‘conditions at work’ that are acceptable. **Nobody** can work constantly ‘under stress’ without some effects – many suffer from physical or mental illness, and some ‘leave’ (retire early, change career, or emigrate). Obviously ‘conditions at work’ include pay – but most professionals have put up with persistent ‘restrictions’ on pay, over many years, because of their ‘dedication to duty’ (or sense of ‘vocation’). ‘Management’ (and politicians) **must not interfere** in the clinical care of patients – that is not their function (which is to facilitate the professionals to provide the clinical care). The various Review Bodies that determine pay must be allowed to be truly ‘independent’ – and their ‘recommendations’ should be ‘accepted’ by politicians unless there is ‘a compelling need’ (nationally) to do otherwise (only on one or two occasions, since the introduction of the Review Body for doctors in the 1950s, have their recommendations been accepted by the government of the day without some ‘adjustments’!).
4. Clinical care of patients is, essentially, a practical skill; so training of **all** clinical staff should be a balance between acquiring theoretical knowledge (in ‘the classroom’) and practical training (‘on the job’) **under proper supervision** (at present, the former ‘apprentice-type’ system has fallen by the wayside). Managers should be trained to recognise that the delivery of healthcare is **not** the same as ‘running a business’; their primary function is ‘facilitate’ the delivery of healthcare; their problem is trying to ‘marry’ this with ‘balancing the books’ on a ‘limited’ budget (which is not ‘constructed’ on need). The costs of providing such training must be based on need. Many clinicians already work ‘flexibly’ with nurses (and other therapists) taking over tasks formerly performed by doctors; but they need appropriate training to do so – and can never ‘replace’ them (one must realise that most patients want to ‘see’ a

doctor, initially, because they know they have a ‘broader’ knowledge of possible diagnoses than ‘specialist’ nurses).

5. To provide an ‘integrated’ care service we **need** ‘common budgets’ between ‘health’ and ‘social’ care; only this will allow the appropriate transfer of patients from ‘the community’ to acute hospital and back again (and into nursing and residential homes). The present provision of mental health services is appalling in most areas; there is far too long a ‘wait’ to be seen by a psychiatrist (or psychiatric nurse) – due a shortage of them.
6. Whilst ‘prevention is better than cure’ is a good slogan, it is worth remembering that we all have to die of something, sometime – the only thing that carries 100% mortality is birth! So, one may well prevent some illnesses by some preventive measures, but one will never ‘eliminate’ all disease! It is also worth remembering that the NHS was created to ‘treat disease’ (in those days ‘Public Health’ departments of local government were responsible for ‘prevention’). So, although ‘prevention and cure’ need to walk hand in hand, funds should **not** be taken from NHS budgets to mount ‘public health’ campaigns.
7. The best way to encourage ‘the public’ to engage in giving their views is to ‘advertise’ that their views would not only be welcomed, but will be **listened to**. All too often government (both central and local) ‘consultations’ are conducted in such a manner that the public have come to believe that “It doesn’t matter what I say, they have made up their minds already”. These days, surveys need to be conducted using the internet and social media.
8. Many, if not most, of the ‘computer programmes’ that have been introduced in the NHS have been very expensive disasters! They have, almost always, been designed to meet ‘management’ needs rather than ‘clinical’ needs; they are often ‘too big’ and not designed to meet ‘local’ needs. What they have failed to do is to improve ‘communication’ between the various groups of professionals who ‘need to know’ about a patient’s needs – so, too often, doctors, nurses (and other professional) have to spend time ‘at their computers’ rather than ‘with the patient’. There is an awful lot of ‘data’ that seems to be ‘required’ that are clinically irrelevant and appear to be collected **only** to meet the needs of accountants and the lawyers (for fear of litigation – which is an ever-growing ‘cost’ to the NHS; and though ‘relevant’ to the cost of healthcare, appears to be beyond the scope of this inquiry).

Finally

I hope your ‘radical surgery’ does not come too late to ‘save the patient’ – the NHS.

24 August 2016

Dr James Murphy – Written evidence (NHS0036)

Declaration of Interest

I am submitting this report as an individual, both as a professional doctor and a patient of the NHS. The views expressed are my own, and I am not campaigning or being encouraged to submit this by any other party or parties. I would regard my politics to be generally centrist, but have sympathies with some of the other parties' policies also.

Introduction

I will reference some of the material I refer to; however most of this is based on accepted evidence, current concerns, and my own experience. I appreciate that you will have a lot of material to consider. As a consequence in addition I will 'bullet point' some of the material, especially where it is accepted ground, because this is often easier to scan than full paragraphs. I will try to minimise the number of arguments. However this is a complicated subject; and there are also significant risks of over-simplification.

About me

I have worked for almost 35 years in the NHS, qualifying from Bristol University in 1977, and working in the South-West as a GP, GP Trainer, Clinical Assistant at the Local Psychiatric Day Hospital, in Occupational Health, and latterly as the Gloucestershire Academy (University of Bristol) Unit Coordinator for the Medical Ethics teaching to Bristol Medical Students locally in their 3rd year. I have also taught clinical skills in General Practice to 3rd Years, and Foundation Year 2 doctors in their GP attachment. As a GP I also was involved in Minor Surgery, Child Health, GP Obstetrics, GP representation, and had an interest in GP based psychiatry, managing as many cases as I could in surgery. I was also approved under Section 12 of the Mental Health Act to conduct Psychiatric assessments with a view to committing under section patents to hospital where a second doctor was not available locally. I retained most of these roles including teaching and psychiatry in General Practice until very recently, and retired from clinical work last year, though I still organise and teach medical ethics locally for the students and have an active interest in medical science.

In addition, with particular relevance to this consultation, I was actively involved in Commissioning Services with the health authority and Gloucestershire Primary Care Trust (PCT), as it was, for many years until the role was taken over by another colleague in the practice. After that time the informal commissioning group I was involved with (before commissioning became more widespread) eventually evolved into the more representative Clinical Commissioning Group (CCG). Therefore I feel I have experience of the 'Market NHS' - tendering and competing for devolved packages of work - which has evolved as the accepted model for an economic NHS. We were a First Wave GP Fundholding Practice under the Margaret Thatcher Conservative Government, which continued until abolished by the incoming Labour Administration in 1997.

From the time of my appointment as a partner we provided a 24 hr, 7 day service as a practice until we joined an out-of-hours GP cooperative in 2005, for which we continued to provide a representative number of shifts.

I have an interest therefore:

- As a frontline GP (sometimes called a 'gatekeeper') with on call responsibilities
- As an educationalist and assessor of standards in clinical care
- As a hospital based psychiatric practitioner
- As an ethicist concerned with justice of provision and professionalism
- As a commissioner
- As a provider
- As a GP Fundholder
- As a patient
- As a negotiator with patients who might feel their needs are not being met

Basis and development of the NHS

The subject has been fully reviewed and rehearsed elsewhere, and so I want to pick out some main points that are relevant to the arguments.

- The NHS was conceived by Nye Bevan as a post-war necessity following an assessment of the Nation's health after the Second World War. Poverty, the relative demise of the aristocracy in favour of a growth of the middle class, combined with the health needs of the working class who had lost houses, had poor diet, and were at risk of epidemic illness necessitated on public health grounds alone the establishment of an accessible and free medical service to cover all basic needs.
- Though resisted initially by practitioners, remuneration and the promise of better facilities, referral systems, hospitals and emergency and routine care won round most of the doctors' support.
- Most doctors have belief and conviction that the NHS can and should survive. Many doctors may engage in private practice, which remains a choice some patients can make.
- Education and assessment of skills is essential to maintain standards and efficiency.
- Service provision is the element most often considered in assessing efficiency and productivity.
- There have been many reorganisations since I started my training in 1972, of which the Health and Social Care Act has been the most recent. All have been disruptive to the service, and many have been reversed by succeeding political administrations.
- Over recent years there has been an increase in investment for new services coupled with downward pressure on some existing services.
- Despite some persisting issues, the NHS remains the most efficient service of its kind in Europe, and has no equivalent in the developing world (see 'International Comparisons' below).
- General Practice arguably provides the most efficient Primary Care in the world; and increasingly has sought to enable 'Secondary Care in the Community', with both medical and surgical clinics and services provided in GP surgeries often by General Practitioners with a Special Interest or GPSIs ('gypsies') or visiting specialists.

One over-simplification which concerns me greatly is that it is apparent that many of the changes proposed over the years (but particularly more so recently) seem to be suggested

as a result of the experience of providing (or attempting to provide) good health care in Urban situations, with a general bias towards the problems of conurbations, and a specific bias towards London. Solutions and economies and examples of good care may not necessarily be transferred without consideration to other parts of the country. In addition, rural health provision in the community has a very different set of problems to resolve. Making this assertion may on the face of it be 'stating the obvious' - but when Acts are passed by Parliament they of necessity have a broad brush approach which 'on the ground' or 'at the front line' may not be applicable or even a hindrance. On the other hand there is certainly a need to listen to the concerns of Public Health consultants who point out quite rightly that the urban (and rural) poor also risk being under-resourced and that there are significant differences between the North and the South, and the risks of 'post-code lottery' services.

Justice requires equal access, and practitioners value an individual approach which varies from situation to situation. This report will give examples from practising and working within a semi-rural environment in the multicultural City of Gloucester with the local hospitals of the Gloucestershire Hospitals NHS Foundation Trust. These are examples of the way in which local services have developed to serve the needs of the community, but it must be remembered that they are not always applicable to other situations, in other parts of the country.

Current Issues for the NHS

In the last 20 years most managers and employees have become increasingly aware that without adequate funding the service will reach breaking point. As I write this a number of Trusts are risking bankruptcy and significant public figures have expressed concerns about the 'Tipping Point' which may be imminent.

Most of my observations here are as a General Practitioner, some from contact with hospital work, particularly Psychiatry.

Measures that have been tried in this time include GP Fundholding, for which we were a First Wave Practice and continued until the scheme was removed after the 1997 election. Our experience was that the information was clear, the workload relatively high (we had a good manager), but that the returns financially were modest. General Practice receives fees for services out of which costs including staff salaries have to be taken. The profitability of the practice dictates therefore the pay of the General Practitioner. There are some salaried GPs who work for health authority premises, but they are the exception rather than the rule. The provision of Secondary Care in the Community continued after 1997, but the clarity was poor, and the tendering and appointing of contracts often prolonged and frustrating. This practice was refined, and there were in the last few years of the Labour Administration an number of annual priorities for Primary Care which attracted remuneration. Remuneration was necessary because in order to administer this work either staff were appointed or GPs were taken out of surgery consultations to do the work. Eventually the remuneration genuinely suffered as part of the spectrum of austerity cuts imposed by the Conservative administration in the last 5 years.

Most GPs are genuinely concerned about reduction of funding in relative terms for provision of Primary Care. The removal of out-of-hours and a funding element for this has been used

polemically by politicians and some of the media in ways that that are out of proportion to actual GP income for many years. The day-time commitment of GPs increased with an emphasis on prevention (which has been effective), Secondary Care in the Community, tendering for contracts in a Market NHS, computerisation of GP consultations, and involvement with audit and revalidation related to a closer scrutiny on GP competence following the Shipman Enquiry -resulting in significant increases in administration. Similar trends have also increased the administration workload of GP attached staff and hospital based doctors.

It was judged increasingly unsafe for GPs to have a full and additionally loaded day consulting and then regularly or continuously provide an out-of-hours service from their own premises for their own patients in addition. The cooperative was a sensible solution to this workload problem. However in subsequent years there has been an increase in unremunerated work that is expected of GPs including submission of assessments and investigations prior to referral to hospital clinics, public awareness campaigns, and advice to 'discuss with your GP' any topical subject. GPs are keen to support and inform their patients in any way they can; but large scale public information could be conducted more efficiently and reliably outside the GP surgery in other ways that do not impact on GP workload.

Costs have increased despite increased funding for the following reasons:

- Research means that more treatments are available.
- Expensive optional and non-essential treatments have because of social pressure become part of routine hospital care. A limited amount of funding is made available in each health authority for appropriate infertility treatments and cosmetic and transgender surgery. Most doctors would support the principle of access to this, but it is almost certainly not part of the original post-war vision of the NHS.
- Referral of patients to and from the UK primarily as part of an EU based exchange may stop as a result of 'Brexit'. While criticised as 'health tourism' there may be defensible reasons for these domestic referrals to centres of excellence in other countries or from other countries to centres of excellence in this country. The value of these provisions needs to be reviewed as part of the post-Brexit situation.
- Training of indigenous staff, and the importing foreign national staff, and threats to availability of staff as a result of Brexit.
- Privatisation of services within the NHS - I will review this as a separate section.
- Morale and Conflict, and impact on patient care - I will also review this as a separate section.

International Comparisons

- In comparison with the healthcare systems of ten other countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and USA) the NHS was found to be the most impressive overall by the Commonwealth Fund in 2014.
- The NHS was rated as the best system in terms of efficiency, effective care, safe care, coordinated care, patient-centred care and cost-related problems. It was also ranked second for equity.
- However in the category of healthy lives (10th), the NHS fared less well.

- Current health expenditure in the UK was 9.78 per cent of GDP in 2015. This compares to 16.91 per cent in the USA, 11.08 per cent in Germany, 11.01 per cent in France, 10.76 per cent in the Netherlands, 10.59 per cent in Denmark, 10.16 per cent in Canada, 9.05 per cent in Italy and 9.00 per cent in Spain.
- Current expenditure per capita (using the purchasing power parity) for the UK was \$4,015 in 2015. This can be compared to \$9,451 in the USA, \$5,343 in the Netherlands, \$5,267 in Germany, \$4,943 in Denmark, \$4,614 in Canada, \$4,415 in France, \$3,272 in Italy and \$3,153 in Spain.
- The UK had 2.8 physicians per 1,000 people in 2015, compared to 4.1 in Germany (2014), 3.9 in Italy (2014), 3.8 in Spain (2014), 3.5 in Australia (2014), 3.4 in France, 3.0 in New Zealand and 2.6 in Canada (2014).
- The UK had 2.7 hospital beds per 1,000 people in 2014, compared to 8.2 in Germany, 6.2 in France, 3.0 in Spain, 2.8 in New Zealand and 2.7 in Denmark.
- Average length of stay for all causes in the UK was 6.9 days in 2014. This compares to 16.9 in Japan, 9.0 in Germany, 7.8 in Italy, 7.6 in New Zealand (2013), 6.6 in Spain and 5.6 in France.⁸²⁸

Privatisation of the NHS

Privatisation of the NHS is politically topical; and is of concern to many sectors of the NHS employees. Tendering by the business sector has raised concerns generally about the risk of a poor outcome which may be hazarded by top slicing budget for profit, accountability, employment security, employee morale, risk of lack of continuity in reappointment the same provider, and risk of cutting 'unprofitable' (expenses versus profit in) services instead of seeing a service as a humanitarian need and essential for social cohesion.

My experience of Fundholding, and later Commissioning, is that an assessment of the need for a service or increase where current services may be deficient or entirely lacking, in advance of applying a business case for tendering for such a service. That business case should be based on the conclusion that the service is required and how it should be best provided, not whether a provision would be the most cost-effective (though it should not be wasteful). Current contracts are increasingly squeezed by austerity measures to the point where they are based on a business case for what can be afforded to provide an essential or reduced service to meet minimal requirements (for instance to meet health service guidance on child protection and vulnerable adults, and other risk). Such limited aims are undoubtedly essential, but are very much a reduced vision of the public health arguments over wellbeing guiding the formation of the service in 1946-8.

In addition the appointment of private companies as opposed to tendering initially from within the health and social service community, including health related organisations, means that the same principles of accountability and audit do not apply to the service if ultimately it is provided from outside the health community. Therefore it may not be possible to assess whether the new private service (which may be cheaper) will provide comparable standards, especially if different criteria and assessments are applied to those audits in private companies. The decision to appoint by cost-effectiveness according to a

⁸²⁸ NHS Confederation: Key statistics on the NHS: updated 2/9/16 <http://www.nhsconfed.org/resources/key-statistics-on-the-nhs>

business plan will appoint by necessity the cheapest service, but does not necessarily appoint the most clinically effective or acceptable one.

I am aware that these assertions make tendering within the health community sound like a 'closed shop' or counter-free-competition argument. However my concern is with the quality of care. When involved with commissioning myself, it was possible to choose a provider on the basis of track record and quality. Now private companies are perfectly capable of applying litigation to secure their appointments⁸²⁹. This is allegedly placing an additional burden financially on the authority who have now to apply a full procurement process to find alternative providers for patients whose practices have closed. Our local Health Trust has announced today that where they had expected to make a £5M positive balance on their accounts this year they may make a £11.1M loss, and they are now applying for up to a £20M loan from the government to balance the books.⁸³⁰

There is objective evidence that patient experience of increased use of private sector provision by NHS Boards can be associated with a significant decrease in direct NHS provision in 2008/09 and with widening inequalities by age and socio-economic deprivation.⁸³¹

An Institute for Fiscal Studies Study showed that, since the introduction of independent surgical centres doing NHS work the demand for elective hip replacements has increased but health inequalities in access to hip replacement widened: 'Between 2002/03 and 2010/11, the number of hip replacements in the least deprived 10% of areas grew by 67%, almost three times the rate in the most deprived 10% of areas.'⁸³²

There are great concerns that that excessive private 'cherry picking' of lucrative and uncomplicated procedures into centres outside the NHS distorts hospital morbidity rates and deskills and disincentives professionals, however I support 'sensible' market forces that help savings, and would certainly make the case that independent health professionals and health economists should be involved in any commissioning of providers, tendering and the acceptance process which should include a health and social case as well as a business one. I also believe that that 'unwise' fracturing of the health service will simply lead to failure of services and suffering patients. Inevitably if a service fails the 'media court' claims immediately that either clinical or administrative staff must be responsible. Sometimes they are, but equally if a service is underfunded to the point of failure then the process of budgetary provision must itself be at fault.

The key statistics quoted above certainly confirm increased funding. However with the expansion of medical goals and knowledge and increased expectation, the demand also increases. New discoveries, for instance in Diabetes and Neurology, will certainly reduce mortality. There is evidence that quality of life has also improved through prevention

⁸²⁹ Health Investor article <http://www.healthinvestor.co.uk/ShowArticle.aspx?ID=4643>

⁸³⁰ BBC 'Points West' Morning News 20/9/2016

⁸³¹ Kirkwood G., Pollock A.M.: Patient choice and private provision decreased public provision and increased inequalities in Scotland: a case study of elective hip arthroplasty *J Public Health* (2016) doi: 10.1093/pubmed/fdw060 First published online: July 28, 2016 <http://pubhealth.oxfordjournals.org/content/early/2016/07/28/pubmed.fdw060.abstract>

⁸³² Kelly E. and Stoye G. New Joints: Private providers and rising demand in the English National Health Service (IFS) August 2015 <http://www.ifs.org.uk/uploads/publications/wps/WP201522.pdf>

measures in Primary Care; however with increased life expectancy the health care burden of chronic illness, treated cancer and follow-up, and dementia, puts new strains on the Health Service which were not apparent when I first started in practice. It is undoubtedly better that middle aged men do not die as frequently of heart disease and stroke; and that women survive breast and other women's cancers. Everybody wants this to continue, but it will get more expensive.

Elderly Care and the growth in demographic and morbidity

Housing strategy for the population doesn't plan well for reduced mobility. The amount of single floor accommodation for the aging population is poor, though at least part of the problem is an educational one. Most people want to 'hang on' in their familiar environment as long as possible or 'until they take me out of here in a box'. This means that they age to a point where change is not only hard but even more traumatic; and the decompensation that occurs in people with even mild degrees of memory impairment when dislocated later in their illness leads in many cases to rapid physical and cognitive decline. It is difficult to put evidence here on this topic, but I would submit that it is commonly expected experience for anyone with aging relatives, and it has been in part supported by research such as Ian Donald's (One of the Gloucestershire Elderly Care Consultants) which is covered below.

Locally the Older Peoples' Assessment and Liaison (OPAL) service aims to work with community services to support elderly patients in the community to avoid admission to hospital with sub-critical medical problems.⁸³³ Early comprehensive geriatric assessment (CGA) means that (and I quote) 'senior geriatricians can decide diagnoses, avoiding admissions and ensuring that more patients are supported in their own homes or move to intermediate care/community hospitals for rehabilitation. For patients who are admitted, early CGA means they receive specialist care, which should improve the quality of their care and reduce how long they stay'.

Many elderly patients will still be admitted as emergencies or hospitalised despite home care. In October 2015, the Gloucestershire Hospitals NHS Foundation Trust published their Emergency Pathway report and **key risks for delivery of emergency department services** were identified:

- Demand exceeding both the contractual plan and historical levels.
- The number of patients medically fit for discharge occupying an acute hospital bed.
- Despite recruiting additional consultants, gaps in Emergency Department doctors' rotas, especially at middle and junior grades, and now nursing staff, continue to remain the biggest risk to delivering Emergency Department performance.
- Enhanced performance is dependent on a number of countywide projects to streamline the urgent care system to manage Emergency Department demand, as well as speed up discharge processes at the Trust. This involves close working with

⁸³³ Older People's Assessment and Liaison (OPAL) Service at Gloucestershire Hospitals NHS Foundation Trust
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459207/Gloucestershire_.pdf

health and social care partners. (Details of these projects are contained in this report).⁸³⁴

Evidence for early intervention in the community was provided by local geriatrician Ian Donald's research into the effects of hospitalisation on the ultimate prognosis of acute illness in the elderly: this concluded (and continues to show) that, for the same level of illness morbidity and frailty, patients who are maintained in the community (where possible) do better than those admitted to hospital. Community care does save money in the hospital budget and free hospital beds within the hospital, but it is not 'free' or 'cheap', there are community costs, and I will consider these below.

Ian Donald, as a result of his work and research and well researched understanding, was interviewed on behalf of the British Geriatrics Society by the BBC in 2012 and said:

'I meet many families who are anxious about the time gaps between home visits from carers, and especially the long gap through the evening and night. We need to find ways of not just meeting basic needs but improving wellbeing, reducing loneliness, and restoring some pleasure to their life. A fall or other incident can go unnoticed for hours, and soon a crisis such as immobility is created.'

Some have suggested that the solution lies in technology - telecare with devices "keeping watch" for the unforeseen crisis or fall. But this generation of older people grew up before the computer, and technology should be at most an adjunct to personal care. So many patients will stay in hospital longer than they need while we assess, review, and try to find more care to support them again.'

None of this of course is to criticise social services - they have made it quite clear for some time that their resources are stretched too thinly to support the many frail or confused older people who wish to remain in their own homes. Some may point the finger at families neglecting their duty, but my experience is that the family are usually doing all they can, often from a considerable distance away.'

We need to find ways of not just meeting basic needs but improving wellbeing, reducing loneliness, and restoring some pleasure to their life.'

Commenting on the *Social Care for Older People* report, RCP president Professor Jane Dacre very recently in 2016 said:

'This sobering report highlights the perilous state of our social care services. At a time of their lives where they should be confident that they will be looked after compassionately and comprehensively, older people should not be bearing the brunt of cuts to social care.'

⁸³⁴ Gloucestershire Hospitals NHS Foundation Trust: Emergency Pathway report: <http://www.gloshospitals.nhs.uk/SharePoint2/Board%20Papers/2015/October%202015/Item%2014%20-%20Emergency%20Pathway%20Report%20-%20Complete.pdf>

The report describes the ‘increasingly threadbare safety net’ for those relying on council services alone, a situation which also highlights increasing inequalities in health in the UK. The report identifies that cuts to primary and community care are undermining attempts to keep people independent and in their own homes.

When these systems fail, it often results in prolonged hospital admissions, creating a vicious circle. The NHS also faces a daily struggle to find appropriate services for older people who no longer need to be in hospital. We must all work together to create joined-up, properly funded and organised services to give older people the care they deserve.⁸³⁵

This illustrates how concerned and expert observation, however completely and rationally given and in the full public domain with publicity has seemingly had a very limited effect on government policy. There has been increase in funding, but the current level of fiscal allowance is not sufficient to meet the needs of a society which is in other ways leading the world. Government organisation seem not to accept the evidence from charities, and pastoral and voluntary organisations which recognise the full picture that dementia and decline in the elderly is a public education, and social and fiscal issue as well as a medical one. My experience as a practitioner is that problems can simply be passed around from health to social care and back again to primary care; no resolution is possible until an holistic and intelligent approach is made to this impending crisis.

It is clear that care in the community is not well sufficiently funded. Ian Donald made this point in the 2012 Interview with the BBC:

‘(We need to find ways of not just meeting basic needs but improving wellbeing, reducing loneliness, and restoring some pleasure to their life.)

This of course requires more time, and the development of friendship between carer and client, which is not possible in 15 minute segments of care.’

The issue over providing carers through commercial organisations rather than the NHS Community Care system is that these schemes are funded by the NHS Budget but have to make a profit for the organisation providing the service. House-bound people and their families, in my experience, value greatly the care that is given, and make a good relationship with the carer. However it is often a concern that the carer has a large workload which prevents them spending more time with the patient or client. In recent days a case has been brought to light of carers being allegedly employed with poor terms and conditions. It is too soon to say what that outcome will mean for other organisations; however it is clear that commercial organisations may in future pull out of contracts, or not renew them, if the profit margin for them is so slight or they may even lose money. Commercial contracts for this work are appropriate in many cases, but there has to be an adequate attention to both tariffs and quality of delivery. Where work occurs outside the NHS, as I have already stated, there are less checks and balances. Having to go to court (whether it is carers or junior

⁸³⁵ Social care for older people: RCP comment on King's Fund and Nuffield Trust joint report: <https://www.rcplondon.ac.uk/news/social-care-older-people-rcp-comment-kings-fund-and-nuffield-trust-joint-report>

hospital doctors who are concerned) adds to anxiety and uncertainty, causes loss of job satisfaction, and severely affects recruitment.

Unreasonable financial constraints simply make the system less efficient, and the problems remain hidden as far as possible (though not that hidden), and ignored for as long as possible by the authorities who have the means to resolve them, public bodies and politicians.

Morale and Conflict in the NHS

Which leads me briefly to the Junior Hospital Doctors' Dispute. Without rehearsing all the arguments (and I am not a militant about this), it is helpful to look at the dispute in the light of the threats to the NHS.

I very much supported the Junior Hospital Doctors in the strikes, as did their senior colleagues (who volunteered to cover the work willingly in support, not just 'bailing them out'). Now however, the conflict seems more borderline. The hours issue was apparently resolved, actually without Jeremy Hunt's help. But if as a junior hospital doctor (which I remember well) you are overstretched, it would be genuinely worrying to have a '7 day NHS' imposed, which means working a normal week with about 5/7 of the medical staff, to increase numbers at weekends. Doctors and nurses already work 7 days a week, and many departments already have a policy of working at weekends to catch up with work. The extra strain of working like this is making newly qualified doctors seek experience abroad rather than start rotations in the UK, hoping things will improve. Unless government attitudes change, the NHS will fail; and that will leave the way open for more extensive privatisation. This would not help, money will be taken out of the NHS and services and quality will suffer. Striking doesn't help, but nobody in power is listening to the rational and reasoned arguments the clinical professions are making!

The public needs to know that emergencies and serious illness are already covered well by 24/7 on call hospital staff, GP Out-of-hours and GP Centres. Doctors' accurate statistics have shown that the morbidity and mortality only rises * After * the weekend, not during the weekend as the government consistently and inaccurately claims. The reason may be that people believe they should not, or could not, get emergency care - and therefore delay seeking help. There may be more serious problems at weekends in some places, perhaps London, but this is simply not true for most of the country. The government wants everyone to be able to see their own doctor etc, all weekend for routine work. The clinical staff are concerned that the trend is to introduce a 7 day routine service at the same level at weekends as well as the 5 days of the week, without additional staffing and resources. This makes no organisational sense. The NHS is not a corporate business, is a 'service' - as the name suggests. We all have a stake in ensuring its success. I had hoped that terms and conditions including the salary for part time female doctors issue had been settled by the previous agreement, and it seems they were not. But the workload issues also have not, if 7 day routine working is pursued without additional resources. I think further strikes would be disastrous, but senior staff should ensure safety. As a PR exercise to gather support from the public it is a non-starter. However, instead of the government and media stating the ethical

concerns (of which there are many) and condemning the action, there needs to be much clearer thinking about what has brought about this situation, and ultimately what the public want to happen and how we afford it, not to be distracted by politicians who just seem constantly to need to tick their election promises boxes in time for the next general election.

Philosophy of Provision

In 2014 NHS England published their Five Year Forward View which proposed better integration and therefore a more holistic service:

'Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.¹⁸³⁶

The Kings Fund reacted positively to this but warned that in order that these services can be developed, adequate funding must follow.⁸³⁷

NHS England has also attempted to address the issue of justice over provision versus personally tailored and regionally responsive programmes, the Vanguard sites.⁸³⁸ It has also specified training, use of IT, innovative and local solutions to service delivery issues, and a number of other principles which should guide development of the service.⁸³⁹

The BMA in 2015 called for more transparent debate about the NHS funding issues:

'The BMA believes that there should be a public debate on health service funding, around how to reconcile increasing demand with universal and comprehensive care, without harming patients and the quality of care or targeting the terms and conditions of NHS staff. This means no more games around inadequate funding and the BMA calls for an explicit

⁸³⁶ 'NHS England: Five Year forward view, Chapter 3: What will the future look like? New Models of Care' (2014) <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-fore/>

⁸³⁷ 'No escaping the financial challenge facing the NHS: our response to NHS England's Five Year Forward View' (2014). <http://www.kingsfund.org.uk/press/press-releases/no-escaping-financial-challenge-facing-nhs-our-response-nhs-englands-five-year>

⁸³⁸ 'New care models: Vanguards – developing a blueprint for the future of NHS and care services' (2015) https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

⁸³⁹ NHS England: Five Year Forward View, Chapter four: How will we get there? <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-fore/>

commitment to stop NHS cuts and restore funding to the level of our comparator countries. The NHS budget is currently insufficient to deliver a service of consistently high quality for an ageing and growing population. Increased demands on the health service make it impossible to deliver the same quality of service without additional resources'. **General Election 2015**⁸⁴⁰

There have been many, many attempts by well meaning and well informed committees to resolve the funding issues around NHS services. I have been involved locally in many of those discussions. These remarks are not aimed at denigrating those efforts by those clinicians, managers and politicians to resolve them. However I think most informed observers would agree that economy measures, election promises and reorganisations are aimed at temporary solutions to a critical problem, and are not really addressing the holistic concerns of the workforce and the general public. These solutions will not in the end resolve the impending crisis, and they do not effectively address the main questions. In other words we do not have a long term plan on affording a good service, even though NHS England has very good ideas about how solutions may be considered and taken to fruition. Most importantly politicians do not share a common goal in terms of political ideals and the country does not have an agreed definition of the NHS from which those goals can be agreed and realised.

From my point of view, Commissioning seemed to be working towards a rational provision of services using the strengths of both the 'Welfare State' and 'Business' models. Certainly my practice sought realisable income from allowances and current schemes but also provided staff and services at a cost to the practice budget where we could prove that this enhanced an all-round, birth-to-death service by the practice for their patients. We received praise from patients, from fellow professionals during GP Training Inspections, from the Primary Care Trust and Clinical Commissioning Groups in turn, and from the Care Quality Commission on their inspections. It is possible to maximise business efficiency in NHS services but that is not the prime aim. If it is a Service that is offered it should be the goal, and (at risk of being trite) the clue is in the name.

The Demise of the NHS

Sustainability of the NHS is therefore more than a financial argument. If it is agreed that for public health purposes that the NHS should be sustained, it is critical now to look at the current factors which will inevitably lead to its demise.

The factors I have identified include:

- Financial shortfall for essential services
- Lack of a holistic vision and definition.
- Budgetary constraints affecting training
- Workload levels affecting morale

⁸⁴⁰ 'BMA launches major campaign against 'point-scoring' in run-up to the election': Pulse (16/2/2015)
<http://www.pulsetoday.co.uk/news/political-news/bma-launches-major-campaign-against-point-scoring-in-run-up-to-the-election/20009210.fullarticle>

- Brexit measures potentially affecting recruitment from EU Countries (though not affecting recruitment beyond the EU)
- Workload issues and morale affecting general recruitment of clinical staff
- Inflexible devolved budgets
- Increased expectations of Service users
- Advances in science offering real but expensive improvements in quality of life
- Increased life expectancy
- Associated long term morbidity
- Pressure on acute beds for admissions because of problems discharging patients
- Lack of suitable housing for an increasing elderly population, particularly social housing for those with low levels of pension
- Lack of 'planning ahead' for retirement and housing requirements

Added to these could also be:

- Increased mental health problems related to social factors in modern society, particularly in child and adolescent mental health
- Related reduction in provision for Health Visitors and other professionals involved in parenting behaviour education, resulting in prioritising for crisis intervention and not prevention
- Drug and Alcohol abuse (which also has social effects) leading to long term disability
- Lack of decisive action on homelessness which leads to chronic alienation and poor health
- Lack of a systematic approach to ethnic minorities and their health needs, though many areas (including Gloucestershire) have identified needs and have action plans and investment in place.

My concern as a practitioner is that a very great deal of money has been spent on reorganisations which have infrequently consulted front line staff, or dismissed that consultation. General Practitioners (among others) are in a position to identify shortfalls in provision of services and, until commissioning, were not able to highlight them. CCGs have lay and other professional representation and offer a rational approach to the regional provision of services. This is a workable model which should stay.

The Socialist Health Association and others have documented the huge number of reorganisations and policies applied since the first major reorganisation of the NHS in 1974. All of this has happened during my professional training and career. Much has been achieved, but much also of achievement swept away by another administration's policies. Fundholding wasn't always approved, but it was clear. Labour changes included some very good ideas but often it was unclear what a policy actually required of us. More recently, Conservative policies of austerity have come to have an effect on many areas of public expenditure including the NHS, and ultimately the impression is that of obstruction and poor communication, with imposition of policies which lead to dispute and lowering of morale. I am not pretending that dissatisfaction with change has not always happened (It certainly did happen with the 1991 GP contract), but those disputes certainly have come to a head as a lack of confidence has grown in the Health Secretary's commitment to an ongoing publicly funded service.

The anxiety (and there has been little attempt to reassure the public and professionals alike) is that a failure of the NHS through funding deficiencies and collapse of service provisions of various kinds around the nation could clearly be used as an argument for all elective work to be health insurance based - and that would lead to a very much more wasteful private system as seen in the USA and even emerging economic countries that have extensive poverty and deprivation, which arguably would be our destination if that happened. Nye Bevan's Vision was not only Socialist, but a Social one which people of other political colours deemed right at the time. There is still a Public Health and an arguably increasing social need for a free NHS service.

It is well-recognised that patients from lower socio-economic groups, mental health patients, children and the elderly are the most frequent users of the service. They also have the higher level of illness, and are more at risk. The problem frequently considered in recent years was of inappropriate use of the service by anyone, but mainly of those groups.

My own experience has been that patients use General Practice services quite well, but there are exceptions. The inappropriate use of Emergency Services is a problem which can be enhanced by a perceived difficulty in getting a GP appointment, violence related injury, alcohol and drug related problems, and mental health patients who are not currently receiving an effective treatment programme.

In Gloucestershire we have looked at 'frequent fliers' (patients who use the service to a greater extent). I looked at admissions from our practice following self-referral and GP referral and they seemed appropriate in the main, with exceptions. In some areas around the country there is a much higher inappropriate use of hospital services. An education campaign and adequate funding of community services and Primary Care would seem to be the way forward with this, however this is beyond the scope of this submission.

One has to consider alternative funding, of course.

Possible Alternative Models of NHS funding

- Introduction of additional charges for services such as a fee to attend a GP appointment (Australia and New Zealand model), perhaps a fee for reinstatement of a missed hospital appointment for a routine (not a serious) referral, and a partial cost fee for elective surgery not deemed essential, or for additional services such as those mentioned earlier not included in the original NHS Vision, exemption for Medical Exemption Card holders (as for prescriptions at this point)
- Introduction of compulsory Medical Insurance and expansion of the Private Sector
- Maintenance of a state funded service but with introduction of either flat rate or means tested Taxes to pay for NHS services
- Removal of certain procedures from the NHS completely, which would have to be paid for privately
- Continued state funded NHS with limited private sub contracting (Commissioning Model)

There are I am sure others, but this selection will throw up the problems associated with such solutions. Firstly we have to ask - is this cost effective? The introduction of additional charges carries a cost, and if we exempt certain patients on a means, age, or chronic illness (which we would ethically need to do), would this save a significant amount of money? I suspect that the additional cost of collecting fees (and time taken by receptionists and management and administrative staff) would make it an expensive procedure. It may deter patients from booking a GP appointment or re-booking a hospital one for instance, but this might mean missed diagnoses and increased morbidity - an unethical way to manage illness - and would affect Public Health. It is accepted policy in Australia and New Zealand but would probably be resisted in the UK.

There have been calls for introduction of a compulsory private Medical Insurance Scheme. This would take us back to the pre-war years where many patients were treated informally because they could not afford insurance. Most would now of course have a Medical Card, and this is the model which is applied in the Republic of Ireland and the USA. The Private Medical System has been shown potentially to waste money in some other countries. It works well for the small number of patients who use it in this country and one can only assume that having a parallel NHS system with set tariffs for treating NHS patients in private hospitals also limits the extent of Private overcharging and over investigation. My own experience of Private Health Care in Gloucestershire is that it works at an ethical and economic level compared to those services in other countries. The consultants seem to work with the same principles as they do in the NHS. Introducing a Private Medical Insurance Scheme for all patients who would then claim against insurance might remove these checks and balances.

The introduction of an NHS Tax which was means tested seems almost the same as the current Taxation system, except that the proportion of Tax paid to NHS services would be highlighted in a different way. It wouldn't increase funding and it might involve wasted additional work.

The exclusion of some elective procedures would be problematic:

- Many conditions (Hernia, Skin Surgery, Correction of squints, blocked tear ducts, eyelid surgery, small procedures and large procedures for arthritic joints and so on) might on the face of it be non-urgent, but may lead to further suffering or complications if untreated.
- Who could or would decide which problems were more 'minor'?
- On a principle of Justice, why should one person's life altering problem be less important than another's?
- The public would find such a decision arbitrary, and inevitably different regions would apply different rules, enhancing the post-code lottery conundrum.
- Procedures at the moment deemed unnecessary in NHS provision such as removal of ganglions (local policy) are so deemed on the basis of clinical evidence - and clinicians can still perform those procedures under the NHS if it can be shown that this would avoid or ameliorate an actual adverse effect on the patient's life. All of this can be defended on ethical grounds, but exclusion cannot.

- Patients would need to take out private insurance or pay privately for procedures necessary for their mobility, their ability to work, or their ability to parent, all of which potentially impacts the economy in terms of social service provision and unemployment - a cost much greater than the procedure itself.
- It would be unpopular and a false economy.

For myself the Commissioning Model still remains good. However there is a need for government to recognise the true cost of failing to fund the National Health Service adequately and to resist large scale privatisation for the very good (and non-political) reasons I have given. There needs to be honesty with the electorate, and resistance to constant reorganisation. Most importantly the government needs not just to consult but to listen! (no offence intended). If the government is not seen to respond reasonably and openly to the legitimate concerns of professionals, other staff, patients, and bodies such as the Kings Fund they will be responsible for the failure of services.

Ultimately, framing the NHS in terms of a 'Business' rather than a 'Service' model (admittedly with economies and correct management in mind) is short-sighted, restrictive, destabilising and unwise.

20 September 2016

National Community Hearing Association – Written evidence (NHS0105)

NHS ADULT HEARING SERVICES

1. The National Community Hearing Association (NCHA) represents community hearing providers in England. NCHA members are committed to good hearing for all and have an excellent record of outcome, safety, and patient satisfaction⁸⁴¹. We welcome this opportunity to comment on the long-term sustainability of the NHS.
2. The NHS adult hearing service provides a case study for the committee's inquiry. This is because despite the Department of Health, NHS Improvement and NHS England knowing how improve access, standards and value for money, this is not happening. Local NHS commissioners continue to ignore evidence and guidance from Monitor (now NHS Improvement) and NHS England, and as a result continue to pay more for less. This lack of transparency and accountability makes many NHS hearing services unsustainable. Without reform, the current system will continue to fail patients and taxpayers. With greater transparency and accountability in the hearing service, the NHS can do more for less.
3. **Scale of the challenge:** 11 million people have a hearing loss, and this will rise to 15 million by 2035⁸⁴². Adult hearing loss is the third most common long-term condition and the 6th leading cause of years lived with disability in the UK⁸⁴³. Age-related hearing loss is the main cause of hearing loss, accounting for 9 out of 10 cases. **Impact:** unsupported hearing loss significantly increases the risk of depression⁸⁴⁴, isolation⁸⁴⁵, premature retirement⁸⁴⁶, reduced quality of life⁸⁴⁷, loneliness⁸⁴⁸ and cognitive decline⁸⁴⁹. **Benefits of intervention:** hearing intervention and ongoing support improves quality of life by reducing the psychological and social effects associated with hearing loss⁸⁵⁰. Early

⁸⁴¹ NCHA (2015) Hearing Care Closer to Home <http://www.the-ncha.com/data/>

⁸⁴² <https://www.actiononhearingloss.org.uk/supporting-you/policy-research-and-influencing/research/hearing-matters.aspx>

⁸⁴³ Global Burden of Disease Study Collaborators, June 8, 2015, Lancet [http://dxdoi.org/10.1016/S0140-6736\(15\)60692-4](http://dxdoi.org/10.1016/S0140-6736(15)60692-4)

⁸⁴⁴ Acar, B. et al. 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. *Archives of Gerontology and Geriatrics*, 52(3), pp. 250-252.

⁸⁴⁵ Hidalgo, J. L. et al. 2009. Functional status of elderly people with hearing loss. *Archives of Gerontology and Geriatrics*, 49(1), pp. 88-92

⁸⁴⁶ Helvik, A. 2012. Hearing loss and risk of early retirement. The Hunt study. *European Journal of Public Health*, 23(4), pp. 617-622

⁸⁴⁷ Appollonio, I. et al. 1996. Effects of Sensory Aids on the Quality of Life and Mortality of Elderly People: A Multivariate Analysis. *Age and Aging*, 25(2), pp. 89-96.

⁸⁴⁸ Cacioppo JT, Hawkley LC, Norman GJ, Berntson GG. Social isolation. *Ann N Y Acad Sci*. 2011;1231:17-22

⁸⁴⁹ Lin, F. R. et al. 2011 Hearing loss and cognition in the Baltimore Longitudinal Study of Aging. *Neuropsychology*. 2011; 25(6):763-770.

⁸⁵⁰ Chisolm, T. et al. 2007. A Systematic Review of Health-Related Quality of Life and Hearing Aids: Final Report of the American Academy of Audiology Task Force on the Health-Related Quality of Life Benefits of Amplification in Adults. *Journal of the American Audiology*, 18(2), pp. 151-183; Davis, A. et al., 2007. Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. *Health technology assessment*, 11(42) pp. 75-78; Acar, B. et al. 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. *Archives of Gerontology and Geriatrics*, 52(3), pp. 250-252.

intervention can also reduce pressure on health and social services by reducing the risks associated with unsupported hearing loss⁸⁵¹.

4. Since 1988 the leading patient group for people with hearing loss has called for adult hearing services to be provided out of hospital and in community-based settings. This has been supported by the Department of Health since 2007. Finally in 2012, under the Any Qualified Provider (AQP) initiative, half of Clinical Commissioning Groups (CCGs) introduced community-based hearing services. This provided a natural experiment, and allowed the NHS to assess the impact community-based hearing services have had since 2012.
5. In March 2015, Monitor (now NHS Improvement) did this review and published its findings in, *NHS adult hearing services in England: exploring how choice is working for patients*. It found that in areas where community providers are commissioned using the AQP initiative, the NHS had been able to improve standards, transparency, access to care and value for money⁸⁵² - e.g. the NHS by using AQP (referred to as choice in Monitor's report) saved 20% to 25% per patient. Monitor noted, *"For commissioners, the introduction of choice has strengthened the opportunity for them to achieve better value for money. In areas with choice [i.e. AQP], commissioners have often put in place more robust or higher service specifications that raise expectations of providers. In some cases, commissioners have also established locally determined prices that are 20–25% lower than the national non-mandated tariff...The introduction of [AQP] has also made services more transparent. In areas without [AQP], adult hearing services are often provided as part of a block contract without service outcome reporting requirements, so it can be difficult for commissioners to tell how good services are, or even how many people are being treated and at what cost."*⁸⁵³.
6. The same report acknowledged that regions that used AQP to commission the adult hearing services allowed, *"...commissioners to treat more patients for the same spend and/or release additional funds that commissioners can spend on meeting other patients' needs"*⁸⁵⁴. This success should have been celebrated and community-based hearing services implemented nationally. The reality is, unfortunately, very different. Far too many commissioners have ignored evidence and guidance, and continue to pay more for less. In addition to failing to secure the best services at the best value, some commissioners are also trying to ration NHS hearing care – again failing in their agency role to put patients and the NHS first. This lack of accountability and transparency makes the current system unsustainable.
7. Commissioners must be held to account for delivering hearing care closer to home and commissioning services from the most efficient providers. Only this will help the NHS

⁸⁵¹ Hjalte, F. et al. 2012. Societal costs of hearing disorders: A systematic and critical review of literature. *International Journal of Audiology*, 51(9), pp. 655-662. Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients.

⁸⁵² Monitor (2015) NHS adult hearing services in England: exploring how choice is working for patients, p. 5

⁸⁵³ Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients.

⁸⁵⁴ Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients.

remain sustainable. There is an urgent need for a more accountable and transparent model of commissioning, and one that genuinely puts patients first.

RESPONSES TO SELECTED QUESTIONS

Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

8. The three most important actions to ensure the health and care system can cope are: delivering more care out of hospital, taking preventative and public health more seriously, and holding system leaders to account.
9. **Delivering more care out of hospital** has been a policy goal since the 1980s, but one that experts accept the NHS has failed to deliver⁸⁵⁵. NHS leadership must now shift services that do not have to be delivered in hospitals into community-based settings – e.g. today hospitals report doing more than 1.1 million hearing aid repairs each year, this is not an efficient use of hospital capacity. With finite capacity in hospitals, failure to act will result in an unsustainable health and care system much sooner than 2030.
10. **Take preventative and public health seriously.** Helping the population to age well should be the main priority. Policy documents from 2007 and 2014 state the importance of preventative and public health, but as the Five Year Forward View makes clear the NHS has not delivered on these pledges and is now “*on the hook*” because of this⁸⁵⁶. Commissioners should be required to demonstrate what preventative and public health interventions they are focussing on, and be challenged if they fail to act.
11. **Hold system leaders to account and increase transparency.** It is important to hold system leaders, both at a national and local level, to account when scarce resources are wasted. The adult hearing service provides one example of how despite a national review and guidance, NHS commissioners across England continue to spend over 25% more than they have to. This is only possible due to a lack of transparency and accountability in the system.

To what extent is the current funding envelope for the NHS realistic?

12. The NHS funding envelope is realistic for certain services, provided NHS commissioners and providers are held to account when they ignore/bypass existing regulations. NHS

⁸⁵⁵ O’Cathain, A. et al., 1999. Shifting services from secondary to primary care: stakeholders’ views of the barriers. *Journal of Health Services Research & Policy*, 4(3), pp. 154-160; Singh, D., 2006. *Making the Shift: Key Success Factors*. Coventry: NHS Institute for Innovation and Improvement; Ham, C. et al. 2008. Making the shift from hospital to the community: lessons from an evaluation of a pilot programme. *Primary Health Care Research & Development*, 9(4), pp. 299-309; Harvey, S and McMahon, L., 2008. *Shifting the Balance of Health Care to Local Settings: The SeeSaw Report*. London: The King’s Fund; Munton, T. et al. 2011. *Evidence: Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community*. London: The Health Foundation

⁸⁵⁶ NHS England, 2014, Five Year Forward View

hearing care is one example. Despite the NHS regulator (Monitor) and NHS England knowing standards can be improved and marginal costs dramatically reduced, little has been done to ensure local commissioners deliver these savings. Simply increasing expenditure without demanding greater transparency and accountability will not help.

What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

13. NICE currently decides on the market entry of medicines and devices. This is the right approach because health technology assessments are costly (time, resources and skills required). However, NICE is absent when it comes to decommissioning/rationing existing NHS interventions, even though this is arguably a more difficult task (time, resources, skills required and political pressures). In our view, NICE must do more in terms of priority setting for existing interventions.
14. If NICE finds that an intervention is not cost-effective for the NHS, but is effective, then alternative models of financing for that intervention must be explored. This might include for example a model that is similar to dentistry, pharmacy and primary eye care – e.g. means tested.

Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

15. Although we support local decision-making, this does have limitations. The most obvious example is when significant resources are required to answer a question that will have the same answer nationally – e.g. it cannot be a wise, or efficient, use of NHS resources for 209 CCGs in England to repeat a review of the evidence in order to decide which services are no longer available on the NHS. This is why any decision to remove procedures from the NHS should be done, or at least supported and overseen, by experts at NICE. This will help minimise any impact on health inequalities. For example, in 2015 commissioners in North Staffordshire CCG were the first and only to ration access to NHS hearing care, and they did so without regard to the impact this would have on health inequalities. The CCG's analysis was also flawed. This is why what is removed from the NHS, and how it is funded, should be undertaken by experts in health economics and evidence-based health care at NICE.

What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

16. Hearing loss is a major public health challenge. The Department of Health and NHS England's Action Plan on Hearing Loss (2015), Monitor's review of choice in adult hearing care (2015) and NHS England's National Commissioning Framework for hearing services (2016) all explain that addressing unmet hearing need is a public health priority. Despite these publications in recent years, little has changed. Unless barriers to change –

specifically the lack of accountability and transparency – are addressed, it is unlikely the NHS will be able to deliver on its promises in the Five Year Forward View to radically upgrade its approach to public health.

23 September 2016

National Health Action Party – Written evidence (NHS0094)

Summary

The aims and objectives of this submission are:

Resource issues

- to ensure that the Lords evaluate the future of the NHS within an evidence based framework which includes a full publicly provided service as a substantive option
- to demonstrate that issues of sustainability, which we understand to be defined as providing a service within set financial constraints, are best addressed by public ownership and provision with full public funding
- to demonstrate that the costs of marketisation and competition within the NHS are a barrier to maintaining efficiency, integration and cost control within a public service

Public engagement

- to address issues arising from the use of language which we believe forms a barrier to public understanding of what is happening and consequently a barrier to meaningful consultation
- to argue that the primary purpose of the NHS is to provide a comprehensive, universal and accessible high quality service free at the point of need and use for both rich and poor people without discrimination. Its principles are equitable, that is to say that money will not gain advantage, nor will poverty disadvantage anyone. It is clinical need, including ability to benefit not ability to pay, which determines care.
- To argue that any fundamental compromise to these principles should be made explicit to the public.
- To recommend that the beginning of any process which embeds a fundamental change to the principles of the NHS should include a change of name so that the public are clear what is happening. The creation of a two tier service, one self-paid the other state funded, is not the NHS.

The future healthcare system

The NHS was designed as a comprehensive, universal and accessible high quality service where public ownership and delivery provided the means to make it accountable and optimally cost-effective (value for money). This accountability is essential in any public service but particularly those where the funding represents such a high proportion of the country's spending. We believe that these are the principles which must continue to define the NHS of the future.

Therefore in looking forward to 2030 and beyond it is imperative that meaningful comparisons can be made over time to evaluate which costs are liable to fluctuation or increase and their impact on the wider health services, including social services.

The Lords' Committee guidance on submissions requires that evidence be forward looking, not backward or present day, but we will argue that current assumptions must be subjected to critical scrutiny, or any evidence will draw false conclusions and render any analysis inadequate to its task. Furthermore, learning lessons from the past is essential.

Significantly we wish to state that the NHS should be comprehensive, universal and accessible and ask to what extent the administrative changes of the last 30 years have contributed to any deviation from those principles. To look to the future without asking how we arrived at this point and the effect of changes currently being implemented avoids the question 'Will the future NHS still be comprehensive, universal and accessible'. This question is an essential precursor to the question of sustainability – or affordability – as the public need to know in any consultation process exactly what they are being asked to comment on.

In 1948 the NHS was created and, in order to run this at low cost, hospitals were brought into public ownership and the service was publicly provided. Addressing issues of inequality and accessibility were specific objectives. The service has been subject to change over time but since 1983 those changes have successively altered the spending priorities of the NHS and undermined its founding principles, especially since 1990. The sole criterion which is repeatedly used by politicians and think-tanks is free at the point of need. But exactly what is being provided is of crucial importance to the public.

Faced with severe funding restrictions since 2010, which are set to continue, we are requesting the Lords' Committee examine the option of returning the NHS to a full public service in contrast to current structures as being more suited to providing a low-cost comprehensive service to 2030 and beyond.

We believe that the evidence indicates that to achieve the primary objective of providing the health needs of the NHS in England within a constrained funding envelope, public provision would outperform a mixed provision competitive market.

Is the effect of medical innovation, demographic changes and changes in the frequency of long term conditions the most important set of conditions shaping the future NHS?

In this list of contributory conditions which impact on the affordability of the NHS, the costs of the market and competition are absent. We wish to address this as we are concerned that the questions predicated on these conditions, about alternative sources of funding, removing procedures from the NHS or means testing, directly challenge the principles of universal and comprehensive provision. Following this route would formalise the two tier service which is already appearing throughout the NHS well before 2030.

The relative spend on the NHS as a percentage of GDP shows a marked increase at the point of the creation of the internal market in 1990.

Transaction costs

In 2010 the House of Commons Health Select Committee produced a report on commissioning. They reported: *“Whatever the benefits of the purchaser/provider split, it has led to an increase in transaction costs, notably management and administration costs. Research commissioned by the DH but not published by it estimated these to be as high as 14% of total NHS costs. We are dismayed that the Department has not provided us with clear and consistent data on transaction costs; the suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS trusts. We recommend that this deficiency be addressed immediately. The Department must agree*

definitions of staff, such as management and administrative overheads, and stick to them so that comparisons can be made over time.” (House of Commons Health Committee, Commissioning, Fourth Report of Session 2009-10, Vol 1, printed 18 March 2010)

The changes made subsequently to the structure of the NHS from the Primary Care Trusts and Strategic Health Authorities to the full arms’ length commissioning system of NHS England and the Clinical Commissioning Groups added more layers of complexity and opacity to the commissioning and billing system.

Cost of Clinical Commissioning Groups and Commissioning Support Units

Clinical Commissioning Groups

The CCGs make decisions locally about what services they will commission. This is creating uneven provision around the county, which undermines the principle of a comprehensive national service.

One in three CCGs (34%) have at least one policy that denies patients access to surgery if they smoke or have a high body mass index. More than one in five CCGs (22%) are restricting hip and knee replacements for obese people, up from 13% in 2014. Three-quarters of surgeons in a survey in December 2015 said they had seen rationing happening in their area, and 89% blamed it on NHS cost-cutting.

In October 2015 some CCGs were offering GPs incentives not to refer for tests including, in some cases, for cancer.

Bedford NHS Trust’s website was advising patients for their laser (dermatology) clinic to check with their CCG whether they were still funding the patient’s particular treatment as some had changed their criteria. They offered self-pay and insurance options if the NHS CCG had removed funding.

Commissioning Support Units

The Clinical Commissioning Groups do not, on the whole, have the skills necessary to run commissioning, so they employ Commissioning Support Units (CSUs). In their first year of operation 2013/14 CSUs won £96 million in new business delivering an overall margin of 5%. They have a collective income of £808 million. According to NHS England CSUs are designed to be self-sustaining entities in a competitive market.

The companies on the Lead Provider Framework have won the status of pre-approved contractors to the NHS in England, so they no longer need to compete except in limited circumstances. This affords them the advantage of not having the additional costs of submitting tenders, unlike the hospital trusts, which have no such protected status. The trusts may bid for a contract and fail to win it, but still have to bear the costs as well as the loss of income from the contract for services. This disrupts long-term planning capabilities as well as the cost implications. This is a prime consideration in a system which needs to work on integration and co-operation to deliver quality at best value.

NHS England describes the Lead Provider Framework as a money-saving exercise for both commissioners and suppliers.

“Where the terms laid out in the framework agreement are detailed enough then the authority can award the contract without re-opening competition. Having to go through the tender procedure once rather than several times, will obviously reduce tendering costs.....

The reduction to tendering costs will also apply to suppliers, as going through the tender procedure is costly and time-consuming for suppliers too. Obviously, the main advantage to suppliers of being on a framework agreement is the chance of being awarded valuable business opportunities.”

Whilst external suppliers to the NHS have always existed, the work that is covered by the CSUs includes: healthcare procurement and market management; non-clinical purchasing; communications and patient engagement; bespoke services such as individual funding request management, infection prevention, governance and quality. In a future publicly run system these tasks would be the normal function of appropriately trained NHS management and the additional tasks of running the competitive tendering for clinical services would not exist, as it would be a planned system, not a healthcare market.

PFI and Estate management

PFI

Allyson Pollock, Professor of Public Health and Policy at Queen Mary University has done extensive work on the PFI agreements in the NHS.

In an article in the *Telegraph* on 18 July she said: *“The high cost of PFI services and debt repayment has had a serious impact on NHS services by creating an affordability gap. There is a correlation between large PFI building projects and hospital deficits and reductions in services and staff.”*

The article continues, *“The biggest PFI deal, considered widely to have been a mistake, was to build new hospitals on the sites of two old ones – the Royal London in Whitechapel, east London, and St Bartholomew’s two miles away. The rebuild cost £1.1 billion but, under the terms of the PFI, the final cost will be more than £7 billion with the Barts Health NHS Trust making payments until 2049. The trust, paying £143.6 million this year in repayments, runs a budget deficit of £90 million.*

It was placed in special measures in March after it received one of the worst inspection reports handed out by the Care Quality Commission (CQC), which found understaffing, serious concerns over patient safety and a track record of cancelled operations because there were too few beds. One and a half floors at the Royal London Hospital have remained vacant because there wasn’t enough money to kit them out.”

Department of Health figures used by the *Telegraph* showed that in 2015/16 104 Trusts were paying £1.96 bn between them and that 4 private firms alone were being paid approximately half of that, and would be paid £39bn over the course of the deals.

In 2009, Professor Pollock calculated that the original capital expenditure on PFI deals was £12.2bn. A Treasury bond issue at 2% over 30 years would have cost the public purse a total

of £17.4 bn. But the PFI rates at the time were calculated at £41.4 bn for the availability charge and £29.1 bn for the service charge. These rates have since been updated and the estimated combined payments will be nearer £80bn.

Compare this expenditure with the situation pre-1990 when hospitals paid no charge on their land, buildings and assets. Before any consideration is given to depriving patients – which the NHS exists to benefit – of treatments or levying additional charges this system must be put under scrutiny. Returning Trusts to public ownership and relieving them of this debt would make a substantial contribution to future affordability whilst refocusing the purpose of the NHS onto patient care for the long-term future.

NHS Property Services Ltd

In December 2011 NHS Property Services Ltd (PropCo) was formed, in advance of the Health & Social Care Act 2012, which (at clause 300.8) allowed the creation of such a company wholly or partly owned by the Secretary of State for Health.

PropCo was formed with a single £1 share, which is currently held by the Secretary of State for Health, and listed at Companies House.

The precipitous creation and particular legal form of this new organisation caused concern at the House of Commons Health Committee. The National Audit Office investigated and uncovered failures of good practice (Memorandum for the House of Commons Health Committee, Investigation into NHS Property Services Ltd, March 2014). It noted that the government had failed to properly consider forms of public ownership and failed to provide detailed operating objectives. The NAO noted that one of the outlined advantages of setting up a company was the possibility of a future complete sale to the private sector.

In April 2013 when Strategic Health Authorities and Primary Care Trusts were abolished every piece of NHS land or property deemed ‘surplus’ (including any administration buildings or clinics with more than 50% administrative use) were transferred to PropCo.

From April this year the PropCo started charging market rents to its NHS tenants with immediate effect. It is formalising commercial leases for all its previously publicly owned property. GP surgeries and Community Hospitals owned by PropCo will have to find in the region of £60million a year from their diminishing incomes. Some will be bankrupted by these charges. This is another step in aligning the NHS with the commercial and market practices which are undermining its public service ethos.

Again there are heavy costs both in terms of the legal and management fees attached to these lease agreements and on the eventual loss of ownership of the properties from the public estate.

Private provision within the Trusts

Some Trusts have formed companies to offer private health services. They advertise these services on their NHS websites. Since the 2012 Act the Trusts have been able to earn up to 49% of their income from sources other than the NHS services they provide. They have expanded their Private Patient Units (PPUs) and some have given contracts to private

companies to operate wards they can no longer afford to run themselves. Guys and St Thomas' Private Healthcare, which can be accessed on their NHS website, states that 'all profits from the provision of our private patient services are used to support the delivery of NHS care'. However all private provision within NHS hospitals compete for resources. There is a shortage of 70,000 clinical staff across the NHS in England, according to revised government estimates. Trusts which have private health companies are advertising for staff, in competition with their own NHS services. Funds are restricted from one side and demands from private sector services of one kind or another drain money and resources from the other.

Public engagement

Consultation must be meaningful and engagement with the public taken seriously in any attempt to change the nature and structure of the NHS. Removal of services, charging for services and closing of facilities have a direct impact of the quality of people's lives, the inequality of health and mortality rates.

Some of the decisions in hand will have long-term consequences for the provision of acute services, despite the stated aim being to provide care in the community. For example, the centralising of obstetric care will increase the routine use of caesarean section.

Engagement must happen before decisions are made and the consequences of such decisions explained in full. Ultimately the decisions made about the future of the NHS are political ones and the public is entitled to know the facts on an issue of such personal and national importance.

The evidence we have from campaign groups around the country is that this kind of engagement is not routinely part of the decision-making process. In the case of the Sustainability and Transformation Plans, Wendy Saviour, Director of Commissioning Operations, North Midlands said, *"STPs are not meant to be published at all. They should not go to board meetings. Some of them contain very radical things...they are highly political and highly contentious."*

As outlined in the previous pages, many of the costs which are disabling the NHS are related to the commercialisation of its processes, assets and structures. The effect of draining resources from the system in this way are already apparent, but their cause may be mis-attributed by the public if they are not made explicit.

These observations are not meant to imply that public health issues such as Type 2 diabetes (which is strongly linked to inequality and deprivation), changing demographics and technology are not important factors in the development of the NHS of the future, but that perhaps their relative importance is stated in such a way that the complex interrelation of other factors, such as the market and competition, is not made clear to the public.

We feel that if the public was presented with the facts in plain terms about the effect of the private sector involvement with the NHS they may see it as a very different issue. The question becomes: 'is the public is prepared to lose services or pay more in order to continue putting money into private profit making companies?'

The factors outlined above make clear that to continue the present trajectory and to reinforce it with further service reductions and closures will create a service that is no

longer comprehensive, universal or accessible. We would go so far as to say that it no longer should be called the NHS.

This is why we believe that this is the time to fundamentally review the NHS, whilst it is still in a volatile state, and to restore it to public ownership, accountability and provision. If the Lords' Committee fails to consider this option, it will be consigning the principle of comprehensive, universal and accessible health care to history not carrying it on to 2030.

Submission made by Dr Paul Hobday

Leader of the National Health Action Party

23 September 2016

Sir Robert Naylor – Written evidence (NHS0181)

I am grateful for your invitation to write to the committee with my views on the sustainability of the NHS. As well as being a subject that is close to my own heart, this is a matter of vital national importance, so I am delighted that your Lordships are examining the issues and the evidence in depth. I regret that, due to commitments overseas, I was unable to give evidence in person, but I hope this letter will support your deliberations.

As you know, I have worked in the NHS for over 40 years, during which time I have been a Chief Executive of major teaching hospitals for 31 years. Prior to that my father was today's equivalent of a Chief Executive since the beginning of the NHS, hence I have experienced its trials and tribulations in a personal and enduring way. The NHS is internationally regarded with great esteem and Nigel Lawson once observed that *'the NHS is the nearest thing to a national religion'* - long may it remain that way.

As one of the founding members of the Shelford Group, I contributed to the Group's submission to the committee of 23rd September 2016. I have also liaised with my fellow Shelford members, Sir Mike Deegan, Dame Julie Moore and Sir Andrew Cash, about the evidence they gave in person on 15th November 2016. I will not repeat that evidence at length but will seek to elaborate on some points about which I feel particularly strongly. I would like to touch on the following issues of current importance:

- overall sustainability of the NHS and social care
- Sustainability and Transformation Plans
- workforce pressures
- the potential for greater gains in productivity
- regulation and bureaucracy

The current spending trajectory of the NHS is unsustainable if the objective is to maintain quality standards acceptable to the British public. The long run average since 1948 has been a little under 4% annual real terms increases (Nuffield Trust, Health Foundation, King's Fund 2016). That average masks significant fluctuations, such as the lower levels of growth in the last two decades of the 20th century and the relatively high levels of the first decade of the 21st (Appleby 2015). However, at barely 1% per annum in real terms, the present decade has seen by far the lowest levels of growth for a sustained period in the history of the NHS. At the same time demand for operational services has grown at least as fast as the historical trends. The strain on health services right across the country is as severe as at any time I have known in my long experience, but standards and expectations are now far higher than during previous troughs in the 1980s and 1990s.

The reality is that if 10% of trusts have financial problems then it may point to concerns about local management, but if 90% are in deficit then it is clearly a systemic problem which needs to be addressed by the Government.

There is no inherent reason why the NHS could not be put back on a sustainable footing for the long term, as a largely tax-funded, free-to-use and high quality health service. This will

require spending levels to return to closer to their long run average, in the region of 3-4% p.a. (Office of Budget Responsibility 2016). That would require tough decisions about prioritisation of public spending, but would still mean our health system would consume only about 8-9% of GDP by 2030, which would be at the lower end of Western European comparators. It would certainly aid health system leaders and frontline managers if this trajectory could be both predictable and smooth to prevent the inefficiencies and uncertainties that come with managing 'boom and bust' funding levels.

In a keynote speech made to the *Reform* Annual Conference in 2014, I argued that the Government should consider an extension of hypothecated taxes for the NHS. I believe that the public would be more likely to accept an additional tax burden if it was directed towards improving healthcare rather than other priorities. I also argued that central taxation, rather than other methods such as insurance, was the most efficient way to fund healthcare.

There is clearly now a consensus emerging that adult social care in England is in crisis due to year on year real terms funding cuts (Nuffield Trust, Health Foundation, King's Fund 2016). This must be addressed as an urgent priority to support the many thousands of vulnerable people whose care needs are no longer adequately supported. It is equally urgent for the sustainability of the NHS, which is critically dependent on social services. Delayed Transfers of Care have rocketed in recent years and are gridlocking large numbers of hospital beds (NHS England 2016).

These themes have been covered thoroughly in the evidence presented to your Lordships already. The other dimension of financial sustainability that needs amplification is the lack of capital investment to support modern infrastructure for the NHS. I am leading a review for the Department of Health, due to report in December, about the optimal use of the NHS estate and opportunities for raising capital. The need for capital investment has been underestimated across the board; for primary, hospital and research facilities, and for IT infrastructure. The Spending Review seeks to hold NHS capital to a flat cash allocation of £4.8bn p.a. until 2020, which will reduce in real terms with inflation. Capital is now routinely raided to prop up insufficient revenue expenditure, with a quarter of the NHS capital allocation being transferred to revenue this year. The consequence is that buildings have become outdated and inadequately maintained, with a reported £5bn of backlog maintenance (which I believe to be a considerable underestimate). We have been unable to realise the potential benefits of IT to drive clinical improvement, integration of care and productivity gains, and we will not be able to invest sufficiently in the new models of care outlined in the *Five Year Forward View* (FYFV). The cost of implementing this strategy has yet to be calculated but is likely to exceed a further £5bn. My report is likely to point to the need for a minimum additional £10bn capital investment to bring the current estate up to modern standards and invest in the FYFV over the next five years.

However, my forthcoming review will also suggest that there are significant opportunities to raise capital for reinvestment in the NHS by selling off prime estate where the buildings are no longer fit for purpose and the land is exceptionally valuable. This not only makes sense financially, but could also improve clinical adjacencies. For example, we have some small, specialised hospitals in city centres, with woefully out-of-date buildings, which would benefit from being relocated to more modern buildings, co-located with major, multi-

specialty centres. This requires bold, strategic planning, but would generate substantial revenue savings and bring significant clinical benefits for NHS patients.

That leads on to the next topic I will address, which is Sustainability and Transformation Plans. In principle, the idea of place-based strategic planning across multiple years is sensible and has been lacking in recent years. Indeed, I am encouraged to see that many STPs are seeking to emulate Accountable Care Organisations for their populations, which I believe is a promising organisational model and the right direction of travel for the future.

There are, however, a number of challenges that STPs will need to overcome if they are to deliver the improvements that the NHS needs. The first is about governance and engagement. STPs have been set up relatively quickly, with multiple conflicts of interest and without a statutory basis. That will not give them the authority they will need to drive through difficult decisions about service changes and distribution of financial risks. They will be unable to deliver significant estate changes, including investment in primary care, because the majority of assets are ‘owned’ by the acute foundation trusts who are not responsible for the whole patient pathway. STPs will also need the time and space to engage more thoroughly with key stakeholders, such as clinical leaders, local government and, of course, patients and the public.

Their next challenge relates to the scale and pace of efficiency savings. It is not realistic to believe that STPs can deliver collectively £22bn of savings by 2020/21, without widespread reductions in service quality and access, which none of us want to see. We need a more realistic timescale for the return on investment in service change.

Lastly, we need to recognise the limitations of STP ‘footprints’. For some of the most specialised providers, such as University College London Hospitals (UCLH), we take patient referrals from a far broader geography than just Greater London. It is important that the planning of specialised services is not shoe-horned into an STP configuration that does not work for that purpose.

Healthcare is an industry that relies heavily on people, from the most specialised medical, surgical and scientific experts, to the hundreds of thousands of frontline staff who touch patients with their care and compassion every day in the NHS. There is a worldwide shortage of healthcare professionals, as supply fails to keep pace with demand. Hospitals spend up to 70% of their revenue on their people. Despite the scale and importance of this resource, the workforce needs of the NHS have not been well planned in recent years (Health Foundation 2016). We now have significant and worrying gaps for key clinical staff groups. For instance, the vacancy rate for junior doctors across London is 16% and for nurses it is 17%.

This has driven expensive increases in spending on agency and locum staff. The best way to address that problem is to increase supply. Brexit presents a particular risk in this regard. In UCLH, approximately 15% of its staff are from the EU. Around 10% is quite typical across hospital trusts in London and the South East. Social care is even more dependent than the NHS on EU staff, often in lower paid roles. It is crucially important that the Government and NHS leaders are fulsome in their support for current EU staff, and that we prioritise continuing mobility of health and social care professionals through the Brexit negotiations.

Otherwise the imbalance between supply and demand will grow larger still in the coming years.

Another workforce issue which is worthy of specific mention is the importance of developing NHS leaders. I chaired an independent commission on the future of NHS leadership last year (Health Service Journal 2015), which the committee might wish to review. We need greater support for emerging leaders in the current challenging environment if we are to develop a new, more diverse generation of talented leaders for the future of the NHS. It is quite clear that the organisational framework of the NHS has now created too many organisations, with too many boards, so that our leadership talent is spread thinly. Again, Accountable Care Organisations might be a part of the solution by consolidating multiple organisations within a single, population based organisation. As with the workforce overall, a clearer strategy for leadership, particularly for our clinicians, is urgently required.

One of the greatest strengths of the NHS is its partnerships with our world leading universities. In the UK we have four of the top fifteen universities in the world (Times Higher Education 2016). We have some of the best medical schools and a globally competitive life sciences industry. This nexus of health services and biomedical research should be one of the key pillars of the UK's forthcoming industrial strategy. Where possible, we should prioritise European collaboration for research in the Brexit negotiations, and we should also make life sciences services and products one of our major export priorities in global trade. Even as we attempt to engineer a health service that places more emphasis on prevention and chronic disease management, we should continue to invest in our major centres of clinical, educational and research excellence, which will design the health interventions and scientific breakthroughs of the future.

An important part of the equation for long term NHS sustainability must be stretching but realistic productivity improvements. The savings that have been required in recent years have been delivered in large part through years of pay restraint, with pay rises limited to 1% for the remainder of the Spending Review period. We must make step changes in productivity without hard working staff having to bear the brunt. The report of Lord Carter (Lord Carter of Coles 2016) and *Getting it Right First Time* (Briggs 2015) point the way to the opportunities for reducing variation in clinical practice, people management, medicines utilisation, procurement and back office functions. On behalf of the Shelford Group, I led the development of a strategy, which is now being rolled out, to save £200m across those ten trusts from better procurement. In general, I would support far more bold plans across the NHS to consolidate back office and procurement for economies of scale, especially for city or regional economies where it makes sense geographically. Many NHS organisations are still too protective of their own back office functions which could be provided more efficiently and effectively at a larger scale.

Lastly, I should like to address the issue of regulation and bureaucracy, which gives me significant cause for concern. One of the most successful NHS reforms that I have been involved with over the last 30 years was the foundation trust movement. This recognised that in any sector there needs to be a pioneering group of innovators who break new ground and set new standards of best practice for others to follow. Its regulatory

framework, whilst not perfect, appreciated that local organisations need space to operate and innovate in their own context. Inspection and regulation cannot *deliver* high quality care; that can only come from the energy and ingenuity of frontline professionals, high calibre leadership and a well-run organisation overseen by robust board governance. The limits of regulation should be to monitor that minimum standards at least are maintained in lower performing organisations. Regulation is important to reassure patients and the public, but should be proportionate so as not to stifle local innovation and freedom.

As more organisations have struggled financially, the regulatory response has been ever more reporting and inspection. The regulatory distinction between foundation trusts and other hospital trusts has been eroded (NHS Improvement 2016). But, as I have already argued, these problems are caused largely by systemic underfunding rather than poor local performance. Regulation and inspection cannot themselves address that underfunding. In fact, they can even contribute to the problem because the costs of regulation are being passed increasingly to NHS providers (Care Quality Commission 2016). In addition to the direct financial cost, there is the opportunity cost of professional time that could be better employed elsewhere. The Health and Social Care Act of 2012 has created a costly and confused landscape of regulation, which often distracts and diverts frontline organisations' attention from focusing on patient care because of the burden of reporting to central bodies. I understand the reluctance of the Government to entertain further legislation, but the current bureaucracy of regulation stifles almost all organisations, rather than being narrowly focused on those that are genuinely failing due to poor local management.

My Lord Chairman, I hope these observations are helpful in your committee's deliberations. I stand ready to support you however I can in charting a path to the long term sustainability of the NHS.

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18 November 2016

NHS England – Written evidence (NHS0111)

Thank you for your invitation to provide evidence to the NHS Sustainability Committee. When we met with the Committee on the 15 July, you asked us to provide you with the following additional information once you opened your call for evidence:

- The financial modelling technical briefing that we also provided to the House of Commons Health Select Committee (Annex A):
<https://www.england.nhs.uk/ourwork/futurenhs/>
- Further detail on our payment system reform strategy (Annex B)
<https://www.england.nhs.uk/resources/pay-syst/reform/>
- A note on the relationship between NHS and social care spending (see Annex C)
- The implementation plan for the *Mental Health Forward View* (Annex D)
<https://www.england.nhs.uk/2016/07/mh-imp/>
- The independent task force report for cancer (Annex E):
http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf
- The independent task force report for mental health (Annex F):
<https://www.england.nhs.uk/mentalhealth/taskforce/>
- The National Maternity Review (Annex G):
<https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/mat-review/>

There are a number of important areas where we do think about the NHS's longer-term sustainability.

- 1. Upgrading our prevention and public health infrastructure.** Initiatives such as the Diabetes Prevention Programme (DPP) will attract up to 100,000 referrals per year by the end of the decade. We have recently announced that this programme will also be delivered digitally, allowing more people to benefit. The DPP will have immediate benefits to patients. But it will also have longer term returns for the NHS by moderating demand for services. By investing in these and similar prevention initiatives (e.g. to address obesity and mental illness), we are seeking to 'bend the curve' of long term demand for healthcare. This core strand of the strategy set out in the *Forward View*

extends beyond 2020. It is about making investments for the NHS's long term sustainability.

- 2. Empowering patients.** In a similar vein, we have set in train programmes aimed at helping people and patients to take greater control of their health and healthcare. For example, our 'integrated personal commissioning' and personal health budget programme gives people living with complex conditions greater say over how NHS and social care expenditure is used to keep them independent and well. Personal health budgets have increased by 76% to 7600, and the programme is being expanded in areas including mental health, end of life care, wheelchair services and for people with a learning disability. By the end of the decade tens of thousands will benefit from this programme. But personal health budgets, along with other allied programmes, are part of a longer term aspiration to 'change the default' and to put people and patients in the driving seat.
- 3. Redesigning how health and care is delivered.** We currently sponsor 50 vanguard systems that are implementing new models of care including 'whole population health' models as well as hospital chains or groups. We expect these models to cover more than half of the country by the end of the decade, and to benefit most of the NHS over the longer-term. Their benefits are also long term. Although many are already showing promising results, we know from international experience that implementing new care models takes time and constancy of purpose. They will yield maximum benefit once we have worked through implementation challenges, learned how effectively to replicate them and they have replaced existing, less productive, models of care.
- 4. Investing in improving cancer, mental health and maternity services.** Major reviews (included as Annexes E, F and G) by Sir Harpal Kumar, Paul Farmer and Baroness Cumberlege were completed this year and are now being implemented. These reviews set out compelling long-term plans to improve these key services, with objectives that extend well beyond this parliament alone. To take one example, the cancer programme aims to improve one and five-year survival rates, comparable with the best health systems in the world. Doing so will in turn depend on a continued reduction in smoking and other unhealthy behaviours, as well as investing in early diagnosis. These improvements will benefit patients for many years to come.
- 5. Workforce.** You will have heard from Health Education England (HEE) that workforce 'supply' is planned over a longer time horizon than any single parliamentary term: many doctors take ten years or more to train. NHS England also has a strong interest in workforce. For example, as the *General Practice Forward View* described, together with HEE we are working to increase the number of GPs by 5,000 in 2020, to co-fund an extra 1,500 pharmacists working in general practice and to expand by IAPT with 3,000 more therapists in primary care. Although we are looking to make concrete gains in this parliament, the payoffs for these investments are intended to help restore the sustainability of general practice over the longer term. Similarly, the workforce redesign we are doing with our 'vanguard' systems – for example, creating 'extensivists' who actively care for people most likely to be hospitalised – is not for the short term alone.

- 6. Technology.** At the beginning of September, we announced a £100m fund to invest in centres of global digital excellence and drive forward better use of technology in health. Together with other initiatives to increase interoperability and expand digital services, these programmes are intended to help healthcare providers make the most of the digital revolution. Again, this is not only about making short-term change: we are aiming to create the digital infrastructure necessary to support a fundamentally more modern and productive health service over the next decade or more.

We hope this outline of some of the aspects of our longer term thinking is helpful to the Committee as it prepares its findings.

With best wishes,

Annex C: Relationship between NHS and Social care spending

The financial modelling behind the Five Year Forward View assumed that access to social care services was sustained relative to growing need. The Forward View made the point that the level of patient demand on the NHS is partly a function of the availability of social care, particularly for frail older people. The SR made some moves to hypothecate new funding streams for social care, but the overall funding quantum nationally and the distributional effects across England still imply a widening gap between growing need and available services. If unaddressed this would result in extra demand on GPs, community health services and hospitals over and above the FYFV NHS cost estimates.

Spending on adult social care has reduced by around 10% in real terms between 2010/11 and 2015/16. It is clear from a number of academic studies and experience on the ground that there are links between social care provision and demand for health services. The findings relate to several different types of NHS spending (e.g. primary care, inpatient, outpatient and A&E), both domiciliary and residential social care spending, and for specific social care interventions as well as broader expenditure. The ability to quantify accurately this impact is affected both by the lack of consistent and linked information across health and social care services and by the complexity of the way that patients flow through the system and interact with the entire range of primary, community and acute services as well as domiciliary and residential care services.

As the committee notes, it is important to develop our understanding of these complex system wide links and relationships so that we know more about where best to invest limited resources to best effect for patients and communities. NHS England is working with the Department of Health to undertake a programme of work to identify a fuller understanding of the linkages between health and social care services. We are aiming to undertake some detailed work at local level to exploit linked data where it is available to analyse more fully how changes and variation in the provision of social care impacts on health care services. A fuller national picture is likely to involve a longer term programme of work and a reliance on improving the potential to link information across the sectors

23 September 2016

NHS Clinical Commissioners – Written evidence (NHS0159)

Introduction

1.1 NHS Clinical Commissioners (NHSCC), the membership body of Clinical Commissioning Groups (CCGs), welcomes this opportunity to submit evidence to the Lords Select Committee on the Long-term Sustainability of the NHS. Established in June 2012, NHSCC has just over 91% of CCGs in membership and offers a strong national voice for our members on a number of national policy issues. We support our members to be the best they can be in order to commission effectively for their local populations.

1.2 Our evidence for this inquiry is based primarily on the views and perceptions of our members, where possible we have included wider research that supports our view. We therefore invite the Committee to read this submission as an insight from CCGs.

1. Main points for the Lords Select Committee to be aware of:

- The long-term future and sustainability of the NHS is at risk unless adequate resource is provided in the short-term. We do not believe there is currently enough funding in the system to cope with demand and create real transformation.
- The sustainability of the NHS over the long-term will only be assured if there is an increased focus on prevention and the role of public health in promoting population health and wellbeing to reduce pressure on the health and care system.
- In many parts of the NHS it is becoming increasingly less feasible for service levels to be maintained, only by reducing expensive hospital activity, upgrading demand management and shifting more care into community based settings will overall financial balance and real sustainability be achieved. Politicians should take responsibility for the action that is being taken, providing political “air cover” at both a local and national level, engaging with the public and media to support local system leader’s decisions.
- Transformation of the way in which care is delivered must be supported by long-term strategy and planning, with funding available in the short-term to support the establishment of these systems.
- Real transformation will not take place without an adequate workforce to support delivery; there needs to be a clear national workforce strategy addressing current shortages and ensuring that the requirements of future systems are being met.
- Integration offers a mechanism to support system change. In itself it will not deliver a significant improvement in the financial sustainability of the NHS but can support improved patient outcomes.

2. The future healthcare system

3.1 Our members are committed in the longer term to developing outcomes-based approaches to clinical commissioning that emphasise good health and wellbeing, and

support the prevention of ill health. In a period of unprecedented challenge, we believe now is the time for the health and care system to transform to meet its full potential of providing patients with the right services at the right time in the right setting. How the system is designed, how services are delivered and how patients and communities are supported to keep well needs to be rebalanced away from costly hospital based acute care. Inherent in this is further progress towards health and care integration in recognition of the realities of how people access and experience care and thereby how it is commissioned. Integration in itself, will not solve the financial challenges within the wider system⁸⁵⁷, but provides an opportunity to better organise services to address the holistic needs of patients and avoid unnecessary duplication by forging new ways of working across the health and care sector.

3.2 Real transformation to a sustainable health and care system through to 2030 must be founded on stability. We have repeatedly called for multi-year NHS planning cycles and recognise that attempts have been made to do so with the introduction of two-year planning cycles and publication of indicative allocations for the next five years. However, we believe this is still insufficient for clinical commissioners to really embed a widespread outcomes based approach into their commissioning approaches. We also think that system-wide, there needs to be an alleviation of centrally driven initiatives to empower the local health system to design and deliver services that are tailored to the needs of that place. While we recognise the value that recent national programmes are bringing, such as the new models of care and STPs, we also know of local health and care leaders who are driving change locally through service redesign, integration and joint planning of their own fruition and outside of these central initiatives. For example, NHS Camden CCG has developed an integrated model for the treatment of Diabetes and NHS Harrogate and Rural District CCG is working with partners to improve the local dementia review process ensuring that the best care is delivered for patients. We think that this local leaderships should be encouraged and supported by all levels of decision-making.

3.3 We do not currently see a reason to undertake a further top-down reorganisation of the NHS during the next 10-15 years, not least because we expect a diversity of organisational types and relationships to emerge that are led from the bottom up and are truly place-based. Multi-speciality community providers (MCPs), Primary and acute care systems (PACS), Primary Care Home systems and closer working at Health and Wellbeing Board level are some models that we expect will become increasingly widespread. We believe that when establishing place-based systems of care the system should build upon what has worked well, such as the role of clinicians in commissioning decision-making and the focus on localism with strong public accountability and local political involvement. In turn we would like to see a reduction in unnecessary administrative burdens upon commissioners and other parts of the local system, development of coherent communication between the arms-lengths bodies, and increasing flexibility of delivery locally.

⁸⁵⁷ LGA, NHSCC, NHSC & ADASS, [Stepping up to the place: Integration self-assessment tool](#), June 2016

3. Resource issues, including funding, productivity, demand management and resource use

4.1 There are considerable current financial pressures on the system as a whole with providers reporting a £2.5bn deficit in England by the end of the 2015/16 financial year⁸⁵⁸ and 31 CCGs finishing the year with cumulative deficits, caused by a range of factors both demographic and systemic.⁸⁵⁹ We are concerned that without a significant reduction in expensive hospital activity and a transformation in health and care delivery that makes better use of available resources the NHS will be unable to adequately respond to changing population needs. There is simply not enough available funding to deliver health and care in the way that this has been done in the past and potentially insufficient in the Sustainability and Transformation Fund to deliver service change if the majority (£1.8bn) is spent on addressing provider deficits.

4.2 The *Five Year Forward View* requires the NHS to deliver £22bn of efficiency savings by 2020/21 in order to ensure financial balance within the system. Due to the immediate pressure to deliver this, clinical commissioners are having to take steps to make difficult decisions about what can be funded by the NHS. This is not only to remain within budget but also because funding those services does not deliver value both in terms of clinical outcome and cost-effectiveness, for example, some types of purely cosmetic surgery and drugs of limited clinical value. These decisions are having to be made due to a political choice to allocate the current level of funding to the NHS. Politicians should take responsibility for the action that is being taken, providing political “air cover” at both a local and national level, engaging with the public and media to support local system leader’s decisions.

4.3 We believe that sustainability can only be delivered when the health and care service thinks longer-term, moving away from planning cycles linked to annual contracting or length of political office at a national or local level. It is only now that the NHS is beginning to put in place systems that will support multi-year planning and allow the service to focus on long-term improvements rather than short-term fixes. The introduction of a multi-year payment tariff, publication of indicative CCG allocations for the next five years and the introduction of a two-year planning cycle for 2017/18 and 2018/19 are first steps in supporting this process. However, these attempts are stymied by the immediate funding challenges, requirements on providers to deliver increasingly unrealistic efficiency targets and commissioners required to reduce rates of demand significantly in the next two years. Activity is growing by an estimated 3.1% per year. The health and care service is therefore struggling to plan for the long term and manage immediate challenges at the same time

4.4 The reduction in the funding and therefore necessarily the availability of social care services increases demand for health services, resulting in the needs of the population particularly frail and older people, going unmet. A recent report showed that 81% of local authorities cut their spending in real terms on social care for older people in the last five years⁸⁶⁰ and it was estimated that 400,000 fewer people accessed care from local

⁸⁵⁸ NHS Improvement, [Quarter 4 Sector Performance Report](#) NHS Improvement, May 2016

⁸⁵⁹ NHS England, [Our 2015/16 Annual Report Health and high quality care for all, now and for future generations](#) July 2016 p.49

⁸⁶⁰ The King’s Fund & Nuffield Trust, [Social Care for older people; Home truths](#), September 2016

authorities in the last parliament due to budgetary reductions.⁸⁶¹ Unless steps are taken to reverse this trend people will increasingly turn to the NHS to meet social care needs, increasing waiting times, delaying discharges from hospitals thereby increasing costs, and most significantly impacting on the quality of care that patients receive. Simon Stevens NHS England Chief Executive was clear in his speech at the NHS Confederation Annual Conference that any extra funding forthcoming from the government should be made available to social care.⁸⁶² This reflects the view and understanding within the NHS of the impact that social care can have on reducing demand, enabling transformation of delivery and ensuring that patient care is not compromised.

4.5 Our members increasingly feel that the delivery of the £22bn efficiency savings required by 2020/21 is impossible, particularly due to reductions in spending on public health and social care, and a failure to support the difficult decisions around prioritisation and service redesign that need to be made nationally.

4.7 In order to allow policy makers to ensure expected levels of service are matched by adequate resources in specific priority areas, the broader future of the health and care system should be determined following an honest conversation with the public about their expectations for the level of service that can be realistically delivered with the funding that is currently available. The sustainability of the NHS for the future is dependent on public understanding of what services can and cannot be delivered with the current level of allocated funding.

4. Workforce

5.1 The long-term sustainability of the NHS is entirely dependent on the training, recruitment and retention of a workforce that is sufficiently flexible to address the comprehensive needs of patients and will overcome the historic and ongoing challenge of staff shortages. The *Five Year Forward View* was clear that workforce redesign, innovative approaches, the development of local leadership capacity and effective workforce planning were essential to the delivery of a sustainable NHS. Our members report that in local areas there are insufficient GPs, community nurses and social care workers, particularly nursing and domiciliary care workers, to meet current demand and to support an increase in activity that will result in the shift of care delivery to community settings. These pressures are reflected in the acute sector with 93% of NHS trusts reporting registered nurse shortages.⁸⁶³ Without a suitable health and care workforce - essential to the delivery of new models of care, technological innovation and the delivery of a more sustainable service –the long-term sustainability of the NHS cannot be assured. In order to do so, HEE and other arms length-bodies involved in workforce development should ensure that they are aware of system-wide priorities when undertaking workforce planning. Without this we anticipate resources will become more scarce and the cost of the NHS workforce, which already accounts for approximately £45bn of the NHS budget, will increase.

5.2 Our members know that workforce of the future needs to be adaptive and able to work within a multi-disciplinary team valuing the input of all in order to ensure that a

⁸⁶¹ NHS Information Centre – Community Care Statistics, Social Services Activity, England 2013/14

⁸⁶² Full transcript available here <https://www.england.nhs.uk/2016/06/simon-stevens-confed-speech/>

⁸⁶³ NHS Employers, [NHS Registered Nurse Supply and Demand survey](#), December 2015

patient's holistic needs are met. Team-based approaches ensure that medical professionals are working at their highest level of expertise and ability and free up time and resources to support better communication and shared decision-making with patients. The increasingly ageing population with a range of co-morbidities will require an approach that focuses on care management and living well, rather than treatment and cure, which needs to be reflected in the training that healthcare professionals receive. The flexibility of the workforce should be matched by flexible opportunities to enter the workforce and in the way that training is delivered.

5.3 As members of the Cavendish Coalition NHSCC, including our members, are committed to ensuring a sustainable workforce for the future, valuing the contribution workers from the EU make to the delivery of health and social care in this country. We will be seeking assurances that not only those who currently work in this country are protected by law and feel valued by the organisations in which they work, but that there is opportunity for individuals in the future to join the workforce in the UK.

5. Models of service delivery and integration

6.1 CCGs have been at the forefront of the development and delivery of joined-up models of service delivery and the integration of health and social care services through formal structures such as Health and Wellbeing boards and through informal discussions and agreements at a local level, for example between NHS Sheffield CCG and the Local Authority. Our members are able to provide a perspective on the needs of the population and how these can be met by services in the local area. However, integration is not the solution that will solve the financial and workforce challenges system outlined above, although it will ensure that patients are receiving more joined-up, coherent and person-centred care. In order to effect this change, consolidation of some services and expansion of others will be required, in order to ensure the development of a system that adequately meets need and delivers financial sustainability for the long-term.

6.2 The Sustainability and Transformation Plans (STPs) offer a real opportunity to support the establishment of local relationships, deliver services at the most appropriate system level and integrate these locally where appropriate. The development of effective relationships across organisational boundaries, working towards a shared purpose to deliver effective care at the local level rather than within specific silos, is a model that will ensure the sustainability of the NHS in the future. The approach to the development of effective plans should be open and transparent, taking into account the views of both local organisations and local communities within each geographic footprint. The development of a shared view and assessment of quality across areas is essential to the delivery of this process, as all organisations can be clear on the joint goals to which they are working.

6. Prevention and public engagement

7.1 Our members are clear of the need to focus on preventing individuals from becoming unwell and addressing those factors that contribute to ill health such as smoking, obesity and excessive intake of alcohol, in order to reduce health and social care service costs by improving population health. This has been a priority for CCGs since their establishment and has been matched by innovative funding approaches, for example, in the North West between Liverpool CCG and the local authority. In this instance the latter is

heading the implementation of a central stream of the CCG-led Healthy Liverpool programme which aims to make the city the most physically active core city (the 8 largest UK cities outside of London) and improve the health outcomes and wellbeing of the local population. The joint programme was allocated £2.9 million of CCG investment as part of a pooled budget.⁸⁶⁴

7.2 The Health and Social Care Act 2012 conferred duties on local authorities to fund public health programmes through specific ring-fenced budgets. The 2015 Spending Review announced a 20.5% cut in Local Authority public health spending by 2020/21 amounting to £3.9bn annual real term reductions over five years, despite clear recognition in the *Five Year Forward View* of the need for a “...radical upgrade in prevention and public health”⁸⁶⁵. This has resulted in vital services locally becoming fragmented as reactive procurements are driven by cost saving as opposed to cost effectiveness for the local population. We believe that the government should commit fully the prevention agenda and the delivery of improved public health through the introduction of a sustainable multi-year funding settlement which would allow local authorities to plan and develop programmes with certainty, relieve pressures on the health and care services and improve the population’s health and wellbeing.

7.3 Patients and the public should be fully involved with decision-making as part of honest conversations around models of service delivery and the need to reform and reduce what is currently available. This empowers the public and gives them a clear role in determining the future of health and care services in their local area. CCGs through their establishment have acted as a conduit for the patient voice with the requirement for two lay members to serve on the governing body.

7. Digitisation of services, Big Data and informatics

8.1 There is significant potential for data and informatics to support the delivery of the new health and care system, however, in order to do so the quality and breadth of data that is available needs to be significantly improved. Commissioners and providers need to be assured that their services and services that they commission are delivering against specified outcomes. In order to do so the data and information that they collect needs to be accurate and robust. Without this information they will be unable to determine the efficacy of services and cannot be assured that they are meeting the needs of the local population. This is a particular area of concern in relation to mental health, where an individual’s full range of conditions may not be recorded when receiving treatment for physical injury.

8.2 Our members have reported that the best results from the digitisation of services, Big Data and informatics are attained when bespoke systems are developed that support the delivery of specific local priorities, for example the Healthy Liverpool programme. In the future, local areas should be encouraged to develop these systems and supported nationally in order to do so.

8. Conclusion

⁸⁶⁴ NHSCC “*Transforming healthcare in England’s core cities*”, p.6. <http://www.nhsc.org/wp-content/uploads/2015/09/NHSCC-core-cities-WEB.pdf>

⁸⁶⁵ NHS England, [Five Year Forward View](#), October 2014, p.3.

9.1 Long-term sustainability of the NHS will only be assured through increased focus on preventing illness and promoting wellbeing, thereby reducing demand for services. A recent lack of focus on this priority has meant that there are several immediate challenges that the NHS must respond to. These include the delivery of efficiency savings, in order to remain in budget by 2020/21, by transforming the way in which services are delivered; reducing the availability of some procedures and drugs; and developing a workforce that is both sufficient to meet increasing demand and is able to operate effectively in a transformed health service. An honest and open public debate on all these issues is crucial.

23 September 2016

NHS Improvement – Written evidence (NHS0107)

1. Introduction

- 1.1. In recent years, the NHS has achieved improvements in care and delivered efficiencies during a time of increasing financial pressure caused by slowing growth in the NHS budget and rising demand. The need to respond effectively to this continuing increase in demand during a period of limited funding growth was the key impetus for the NHS Five Year Forward View.
- 1.2. Part of the national response to the ambitious and stretching tasks highlighted in the 5YFV was to create NHS Improvement, reflecting that NHS trusts and foundation trusts face similar challenges. On 1 April 2016, NHS Improvement became the operational name that brings together Monitor, the NHS Trust Development Authority (TDA), Patient Safety, the Advancing Change Team and Intensive Support Teams. The specific legal duties and powers of Monitor and TDA persist. We are building on the best of what these organisations did but with a change of emphasis to one primarily focused on helping NHS trusts and foundation trusts to improve. We provide strategic leadership, oversight and practical support for the provider sector.
- 1.3. Our role is to support providers to give patients consistently safe, effective, compassionate care within local health systems that are financially and clinically sustainable. We will work alongside providers, building deep and lasting relationships, harnessing and spreading good practice, connecting people, and enabling sector-led improvement and innovation. We will stimulate an improvement movement in the provider sector, helping providers build improvement capability, so they are equipped and empowered to help themselves and, crucially, each other. Our aim is to help providers attain, and maintain, Care Quality Commission (CQC) ratings of ‘Good’ or ‘Outstanding’.
- 1.4. The challenges facing the system require a joined-up approach and increased partnership between national bodies. We are committed to working more closely with the CQC, NHS England and other partners, at national, regional and local levels.
- 1.5. Although NHS Improvement’s focus is the short to medium term, we are contributing to the delivery of the Five Year Forward View with our national partners to ensure the NHS is prepared for the challenges of the future. The following submission supports the written evidence submitted by the Department of Health and other arm’s length bodies in two areas: operational productivity, and future workforce

2. Operational productivity

- 2.1. Operational productivity and efficiency are key components to the sustainability of NHS services. Lord Carter’s [review](#) of operational productivity in English NHS

hospitals sets out how non-specialist acute trusts can reduce unwarranted variation in productivity and efficiency across every area in the hospital to save the NHS around £5 billion in efficiencies each year by 2020 to 2021. The report found that £55.6bn is spent each year across the non-specialist acute trusts. Of that £33.9bn is spent on pay, and £21.7bn is spent on non-pay. Unwarranted variation was found across every area, in every hospital. The report sets out 15 recommendations to reduce unwarranted variation.

- 2.2. There is scope to make around £3 billion of efficiencies through optimising clinical resources utilisation, including correct use of medicines, and the most appropriate deployment and management of the clinical workforce, thereby improving quality and efficiency across the patient pathway. Better engagement with the clinical leadership of trusts will be crucial to facilitate improved people policies and effective job planning.
- 2.3. A further obstacle to eliminating unwarranted variation in the deployment of nursing and healthcare support workers has been the absence of a single means of recording and reporting how staff are deployed. We have therefore rolled out Care Hours Per Patient Day (CHPPD) and better use of e-rostering. CHPPD is now (from May 2016) the principal measure of nursing, midwifery and healthcare support worker deployment. This data collection is an important first step in the journey to providing a single, consistent metric for NHS providers to record and report all staffing deployment. This metric is to be used as part of wider guidance on staffing levels to ensure that patients are getting the right level of good, safe care and the burden on nurses is reduced so they can provide their care to the patients who need it most. The data will become available from autumn 2016, and will feature on the Model Hospital nursing and midwifery dashboard we have developed. It will be reported as total nursing hours, split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix. CHPPD is the principal, but not the only, metric that nurses and managers will use in making judgements about their staffing arrangements. There are other factors that providers may want to take into account when determining the correct staffing levels.
- 2.4. Reducing unwarranted variation in clinical practice is central to achieving improvements in quality and productivity. Extending the 'Getting it Right First Time' (GIRFT) program under the leadership of Professors Briggs and Evans (respectively National Clinical Directors of Quality & Efficiency, and Productivity) to 24 clinical specialties and geographical areas (eg outpatients) following its success in Orthopaedics will engage the clinical workforce in the dual aims of improving outcome and value by demonstrating 'what good looks like' in a data-driven, evidence based fashion.
- 2.5. There is scope to save around £2 billion each year through optimising non-clinical resources, including better procurement and management of estates. Providers spend around £9 billion on procurement of goods. Significant variation was identified across the 22 providers examined, including 30,000 different suppliers, 20,000 different product brands and 7,000 people placing orders. However, there is

little comparable data available to help secure the best deals. NHS Improvement will be launching the NHS Purchasing Price Index tool this autumn to address this issue. The data for the tool will be updated on a monthly basis.

- 2.6. Furthermore, the total cost of running NHS estates is more than £8 billion a year, and there is significant variation in the use of energy, non-clinical floor space, food services and running costs. As part of the drive to optimise estates management, we are supporting providers in consolidating back office services in each of the 44 Sustainability and Transformation Plan (STP) footprints. Business cases will be in place by the end of October. This offers the NHS an opportunity to achieve economies of scale and reduce variations in running costs.
- 2.7. To support the reduction of variation in many of these areas, we have developed the Model Hospital prototype portal. This is a nationally available online information system, which will give providers information on key performance and productivity metrics encompassing quality, patient outcomes, people productivity and financial sustainability from board to ward and enable performance to be compared to internal plans, peer benchmarks and best practice. The Model Hospital aims to help providers identify where they can improve and reduce variation, with the aim of saving the NHS at least £5 billion each year by 2020/21. Currently there are more than 1,600 users across the healthcare system. Across providers, users include Chief Executives, Finance Directors, front-line clinical staff and managers. The Model Hospital portal will be the tool to support the entire hospital and its board to understand what good looks like and what areas of their hospital require improvement.

3. Future workforce

- 3.1. Health Education England is responsible for ensuring that the country is self-sufficient in respect of the health professional workforce. NHS Improvement is supporting the work of Health Education England by undertaking a project to explore the key drivers of nursing turnover and how retention can be improved.
- 3.2. The project has started quantitatively analysing the key drivers of turnover in provider organisations in England, and developing case studies of providers that have successfully improved nurse retention. We plan to present emerging findings to the NHS Improvement Clinical Advisory Forum in October, and expect to publish our final outputs in the autumn.
- 3.3. NHS Improvement is also planning to conduct a review of the drivers of medical workforce attrition and how retention can be improved. Furthermore, the GIRFT program will determine the skill set required and therefore training needs of the future workforce.

23 September 2016

NHS Partners Network – Written evidence (NHS0040)

Introduction

The NHS Partners Network (NHSPN), one of the NHS Confederation's hosted networks, is the trade association representing a wide range of independent sector providers (ISPs) of NHS clinical services, ranging through acute, diagnostic, clinical home healthcare, primary and community care and dentistry services. Our members are drawn from both the 'for profit' and 'not for profit' sectors and all are absolutely committed to working in partnership with the NHS and in accordance with the values set out in the NHS Constitution. More than 75,000 people are employed and contracted by NHS Partners Network members. Of these, over three-quarters are directly employed and the remainder are contracted, e.g. consultants with practising privileges. Over half of all directly employed staff are clinicians as are the majority of those who provide services for independent sector organisations on a contractual basis.

Since its inception in 1948, the NHS has been supported by independent providers in the delivery of patient services. For example, general practice, dentistry, optometry and community pharmacy services have a long history of being provided by independent contractors to the NHS. This partnership was strengthened in 2000 when the NHS entered into a historic 'Concordat' with private and voluntary providers of care, allowing commissioners of NHS care to negotiate and contract with private providers for the delivery of NHS services. As a result a dynamic domestic healthcare market has developed helping to increase overall provider capacity, reduce waiting times, invest capital and offer a greater choice of providers to patients.

Throughout this period of provision there has remained an absolute commitment to the founding principles of the NHS and, in particular, NHS care free at the point of need. Moreover, a recent poll⁸⁶⁶ found that 79% of the public agree it is fine for the NHS to use private companies to provide services to patients as long as they meet NHS standards, the cost to the NHS is the same or lower, and services remain free at the point of use.

Over 15 Years of the Concordat

Following the signing of the Concordat in 2000 there has been evolutionary but significant growth in the role of the independent sector in treating NHS patients. This includes, but is not limited to, acute elective, specialised, diagnostic, clinical home healthcare, community, primary, out of hours, NHS 111 and prison healthcare alongside the more traditional NHS services delivered by independent sector contractors since 1948.

Since 2011, the first time that comparable statistics were made available, the proportion of NHS patients admitted to independent sector providers has grown from around 70 000

⁸⁶⁶ <http://lordashcroftpolls.com/wp-content/uploads/2015/01/The-People-the-Parties-and-the-NHS-LORD-ASHCROFT-POLLS1.pdf>

quarterly elective admissions in 2011 to almost 120 000 in 2014, representing 8% of all elective admissions for NHS patients⁸⁶⁷.

High standards of safety have accompanied this growth in volume - the most recent State of Care report by the CQC included information about providers' compliance with its essential standards across five domains (respect and dignity, care and welfare, suitability of staffing, safeguarding and safety and monitoring quality) where the independent sector has had consistently higher compliance rates against all five domains⁸⁶⁸.

NHS patients also value the high quality care provided by the independent sector – 99% of inpatients say they would recommend independent sector services to their friends and family, compared with the NHS average of 94%⁸⁶⁹.

Case Studies

InHealth is a provider of diagnostic scans, tests and examinations to over 800,000 patients per annum in both hospitals and the community. InHealth currently works in Direct Access Diagnostics with 29 of the 32 London CCGs, with over 100,000 patients per annum scanned, tested or examined through these services. It provides fast access, offering patients a local appointment within a maximum 13 days from referral at a choice of time and location, 7 days per week. A full radiology report is made available directly to their GP within 48 hours of appointment.

Direct GP access to diagnostic services rather than consultant referral has enhanced the speed of the patient pathway with 70 per cent of patients remaining under primary care treatment pathways, thus avoiding more expensive interventions in secondary care.

Healthcare at Home have been working with the NHS for over 20 years and currently working in partnership with 18 NHS acute trusts to leverage their clinical, technological and logistical knowledge to support patients to receive their clinical care at home on “virtual wards”.

In 2014 HaH's virtual ward services enabled over 12,000 patients to receive their clinical care at home. This helped save the NHS over 130,000 bed nights, which is the equivalent to the capacity of a district general hospital. These services, which free up valuable hospital capacity and support patient flow, can be approximately 15–20 per cent cheaper than the bed night cost of hospital provision.

⁸⁶⁷ NHS England (<http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/quarterly-hospital-activity/>)

⁸⁶⁸ Data obtained from a FOI request

⁸⁶⁹ The average FFT recommendation rate for all inpatients treated by the independent sector, source: NHS England, 2014

1. The independent sector can offer much needed capital and capacity to help the NHS meet increasing patient demand and improve efficiency

- 1.1. For many years independent sector providers have offered a proven high quality service to the NHS, typically providing additional delivery capacity to NHS patients and commissioners at NHS tariff prices, without the need for the NHS to commit to additional fixed costs or capital investment in securing such capacity. Independent sector providers now also run and manage many out of hospital services including clinical home healthcare, out of hours, NHS 111, prison healthcare and the more traditional primary and community care services.
- 1.2. Extra capacity provided by independent providers – most notably in acute elective services and surgical and diagnostic treatments - relieves the burden on acute Trusts and FTs, generates enhanced efficiency and provides them with more targeted support at peak times. For example, over the winter of 2014/15 NHSPN members made available a total of 125,156 surgical procedures and diagnostic tests.
- 1.3. This support plays a crucial part in helping the NHS deliver against its key access targets - independent providers consistently outperform the national average on all available waiting time measures, including far fewer breaches of the 18 week limit and significantly lower mean and median waiting times.
- 1.4. Patient reported outcomes are also consistently higher on average for those treated by independent providers compared with the national NHS average. Well over three quarters of the top 20 hip and knee providers are independent sector organisations, as measured by average reported health gain⁸⁷⁰.
- 1.5. The independent sector can also help the NHS to become more efficient, particularly with regard to workforce staffing costs, which are currently the largest driver of financial pressure for providers. Some NHSPN members spend up to 30 per cent less on staffing agencies than NHS providers through leveraging purchasing power across a group structure and independent providers also leverage significant efficiencies through shared procurement approaches across national group structures. The NHS could therefore benefit from the independent sector's expertise in terms of leveraging improved contractual relationships with recruitment agencies, and developing new partnerships to allow struggling hospitals to benefit from the logistical and supply chain investments already made by the independent sector.

⁸⁷⁰ PROMs data for Apr 2014 to 2015 published May 2016. Source: Health and Social Care Information Centre

2. The independent sector is already investing and innovating to address many of the longer term challenges facing NHS and can provide much needed expertise

- 2.1. Too many health services are currently skewed towards treatment rather than prevention, causing demand pressures to build in acute settings with hospitals then struggling to discharge patients back into the community. The independent sector is playing an important role in innovating and developing new health models to address ill-health prevention and wellbeing and to deal with these challenges. For example, Nuffield Health is playing a leading role in promoting ill-health prevention and educational services, and is the UK's largest provider of corporate wellbeing services, working with more than 1600 employers (around 50 per cent of FTSE 250), benefitting 104,000 employees. Data shows that 75 per cent of people who use Nuffield's services improve at least one aspect of their health, such as reducing cholesterol or BMI.
- 2.2. The independent sector is also at the forefront of developing real and deliverable innovation in terms of disease prevention, research, treatment and diagnosis. Having already invested significantly in developing new health technology and fostering strong partnerships with leading international technology companies, independent providers will be pivotal in helping the NHS take advantage of the latest technological advancements to improve patient care. For example Alliance Medical Limited operates over 50 static imaging sites across the UK ranging from MRI units to multi-modality standalone imaging centres, as well as one of the largest fleets of mobile MRI, CT, X-ray, and portable ultrasound scanners. The introduction of this new technology has allowed a wider range and complexity of scans; as well as higher quality scans which result in speedier patient diagnoses.
- 2.3. NHS England have committed to improving prevention in the health service as part of their Multispecialty Community Provider (MCP) vanguard model which seeks to remove the traditional divides between primary, community, mental health, social care and acute services and provide more efficient, joined-up and preventative care. Such an approach will require new financial and business models and the independent sector has a considerable contribution to make to the development of MCPs. For example NHSPN member, The Practice, provides primary and community based care to the NHS, and conducted a six month pilot scheme across seven care homes to improve integration with primary care for the residents of care homes, aiming to reduce the number of patients unnecessarily admitted to hospital, particularly towards the end of life. The pilot focused on an integrated GP and medicine management service which provided care planning, routine visits and out of hours urgent care support, amongst other things. This innovative way of working resulted in a 40 per cent reduction in hospital admissions, a 17 per cent reduction in general prescribing, with 89 per cent of residents who died while the pilot was running doing so in their place of choosing.

3. The Future of health and care

- 3.1. The NHS faces a myriad of challenges in the coming years to which there will not be one single solution but rather a well-designed blend of incentives to help ensure free at the point of use healthcare for the future. This will require a balance of central programmes, improvements to the culture and capability around partnership working at Trust and CCG level, and the introduction of more competition in local contract tendering to drive change (just 5.5 per cent of NHS contracts are currently let by competitive tender).
- 3.2. Specific measures to put the NHS on more sustainable footing could include accelerating the use of the high performing independent sector in providing acute elective services by making patient choice the norm, particularly with regards to orthopaedic services which are in growing demand due to an ageing population. More could also be done to encourage independent providers with the necessary expertise to develop stronger partnerships with Trusts/FTs to help them generate efficiencies in areas such as workforce and procurement and to learn from domestic and international best practice in the management of hospital chains. Building on NHS England's vanguard programme, particularly with regards the MCP model, the independent sector can also play a key role in scaling up these local models of prevention, where local areas can take advantage of the sector's ability to make initial capital investment in new technology, for example self-monitoring, take some balance sheet risk and manage a complex logistical supply chain across their locality - integrating otherwise fragmented primary and community care services to ensure they meet the needs of patients across large population groups.

4. Conclusion

- 4.1. The independent sector have in recent years demonstrated its ability to provide high quality, innovative and patient valued care to NHS patients - easing pressure on the health service and helping the NHS to deliver against their key access targets whilst maintaining a service which is free at the point of use. It has also introduced much needed capital and capability in non-acute services and developed new models of care which can be made available to NHS patients.
- 4.2. Combining the potential of the NHS and independent sector in long term partnership working therefore provides the prospect to achieve real sustainability in the NHS, with a specific focus on new models of care, prevention and wellbeing, technological transformation and improving the quality of care for patients. This requires moving from the current largely complementary way of working and supporting existing care model delivery to co-creating new solutions with the NHS, investing funding, taking risk and transforming the way services are contracted.

21 September 2016

NHS Providers – Written evidence (NHS0110)

1. About NHS Providers

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS providers to deliver high quality, patient focused, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has 96 per cent of all trusts in membership, collectively accounting for £65 billion of annual expenditure and employing more than 928,000 staff.

2. Executive summary

- 2.1. **If we continue on the current trajectory of flattening investment in the NHS, the long-term sustainability of the health services on a universal, free at the point of need basis is at risk.** We fully support the work of cross-party initiatives, such as the work of this Committee, to help facilitate a necessary, realistic and transparent debate with the public about the funding options available to enable the NHS to remain sustainable for future generations
- 2.2. **Nationally, many policy aims and publicly available planning and resource information for the NHS are confined to the term of the current parliament.** This encourages a focus on short term operational requirements and can inhibit the sector's ability to pre-empt and adapt to meet changing population needs.
- 2.3. **The NHS Constitution, which sets out the principles and values on which the NHS operates, is refreshed over a longer period of ten years. However, it lacks the commensurate funding package over the same timeframe** and is underpinned by a 'handbook' setting out the access standards which patients can expect, reviewed every three years. While we understand the logic behind the use of a parliamentary window from a political perspective, we note that some sectors do achieve a longer term approach to planning, such as Defence and International Aid.
- 2.4. **Despite the limitations on nationally available information on which to base their plans, NHS foundation trusts and trusts and their partners are striving to move to sustainable models of care. Some are undertaking long-term strategic thinking** on all of the areas that the Committee is exploring in its inquiry, including investment in capital and estates and partnerships which will underpin new models of care to deliver better for patients.
- 2.5. **In our view, the future model for health and social care needs to be integrated and population-based, led and delivered locally in accordance with nationally agreed standards:**
 - 2.5.1. Whole system working will require a move to outcomes-based commissioning, financial risk sharing and require new governance mechanisms

which balance organisational accountabilities with collective responsibilities for improving services at local health economy levels

- 2.5.2. Community-based services should play a greater role; mental health services should have parity with physical health services and investment in prevention, and population based health and social care needs much greater consideration
- 2.5.3. New technologies have the potential to contribute to the sustainability of NHS, particularly in supporting patients to manage their own conditions
- 2.5.4. A multi-disciplinary workforce with more generalists will be needed to support our growing and ageing population; their development will depend on our ability now to coordinate across national NHS bodies to ensure supply meets future demand and to plan for, and develop the roles of the future.

3. Resources: To what extent is the current funding envelope for the NHS realistic?

The current context

- 3.1. We recognise that health spending has been protected relative to other public services in a time of austerity. However it is increasingly clear that the NHS is not funded to deliver what we ask of it in a context of rising demand and given the need to maintain standards of quality and access to care.
- 3.2. Give our ageing population⁸⁷¹ and the increasing prevalence of long term and complex conditions, the demand for services placed on NHS providers grows by approximately 4% every year⁸⁷². In addition, trusts (and their commissioners) need to find funds to transform healthcare services by investing in new technology, facilities and medicines and to deliver a number of laudable new policy commitments including seven day services, and the recommendations of the cancer and mental health taskforces. However, despite the need to both maintain and transform services, the NHS is expected to receive no more than 0.9% average annual increases in funding to 2020/21⁸⁷³ and the percentage of our GDP spent on health now also lags behind comparable EU-15 countries⁸⁷⁴.
- 3.3. The NHS cannot, and does not, duck responsibility for improving efficiency each year. NHS trusts and foundation trusts delivered £2.9 billion in cost improvement savings over 2015/16⁸⁷⁵ and have embraced the operational efficiency programme developed by Lord Carter of Coles.

⁸⁷¹ House of Lords Select Committee on Public Service and Demographic Change, *Ready for Ageing?*, March 2013. Available at: <http://www.publications.parliament.uk/pa/ld201213/ldselect/ldpublic/140/140.pdf>

⁸⁷² The Health Foundation, *A perfect storm: an impossible climate for NHS providers' finances?*, March 2016 p.2. Available at: <http://www.health.org.uk/sites/health/files/APerfectStorm.pdf>

⁸⁷³ Nuffield Trust, Health Foundation, *The Spending Review: what does it mean for health and social care?*, December 2015. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Spending-Review-Nuffield-Health-Kings-Fund-December-2015_0.pdf

⁸⁷⁴ The Health Foundation, *Accounting for Care*, May 2016. Available at: <http://www.health.org.uk/blog/accounting-care-0>

⁸⁷⁵ NHS Improvement, *Quarter 4 2015/16 provider sector performance report*, May 2016. Available at: https://improvement.nhs.uk/uploads/documents/BM1653_Q4_sector_performance_report.pdf

- 3.4. Unlike other public services, however, where the scope and quality of services has been reduced to meet the available financial envelope, the NHS has been asked to balance its books largely by maintaining the current service offer and delivering ‘more for less’ technical efficiency savings on an unprecedented scale. The *Five Year Forward View* proposed that the £30 billion funding gap in healthcare could be closed by 2020/21 through a combination of £8 billion in new funding, the protection of social care and public health services (which was not delivered in the 2015 Comprehensive Spending Review), and efficiency savings of 2-3% per year from the NHS, compared to the long-run average of 0.8-1% efficiency gains per year⁸⁷⁶.
- 3.5. The cuts to social care and public health services⁸⁷⁷, combined with inexorably increasing activity levels, has led to pervasive deficits and operational challenges throughout the NHS. The scale of the challenge shows clearly that this is a systemic issue (rather than a leadership or management failure on the part of a handful of trusts): in 2015/16 over 60% of NHS trusts and foundation trusts, and within that over 80% of acute hospitals were in financial deficit; only four of the 138 major A&E providers met the four hour waiting time standard between January and March 2016.
- 3.6. In recent years, the Department of Health has lived within its financial envelope by making technical efficiency savings, prudential accounting and under-spending on capital investment. Measures such as these will not address the underlying pressure the NHS faces, nor address the need to maintain constitutional commitments, invest in transformation for the longer term and live within budget.

What we need

- 3.7. The latest health and social care spending projection reported by the Office for Budget Responsibility (OBR) offers a helpful steer in identifying requirements for long-term financial sustainability. If spending on health and long-term care (around 7.9 % of GDP in 2016/17) were to more than double to a total of 19.1 % by 2061/62⁸⁷⁸, the OBR estimates that revenues would increase enough over this period to make this level of spending fiscally sustainable. This is based on current assumptions regarding total government spending, receipts and borrowing⁸⁷⁹.

⁸⁷⁶ NHS England, *Five Year Forward View*, October 2014, pp. 35 – 6. Available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

⁸⁷⁷ The King’s Fund and The Nuffield Trust, *Social care for older people: home truths*, September 2016, pp. 3-4. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf

⁸⁷⁸ The King’s Fund, *Spending on health and social care over the next fifty years: why think long term*, 2013, p.45. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Spending%20on%20health%20...%2050%20years%20low%20res%20for%20web.pdf

⁸⁷⁹ *Ibid*, p.47. Note however, “this would still mean that public spending on non-health and long-term care would shrink significantly as a proportion of total government expenditure and, depending on the spending area, could mean spending did not match growing needs”.

3.8. We believe there are four strategic choices that must be considered on a cross party basis to support the long-term sustainability of the NHS. We are also clear that any sustainable solution to NHS funding is dependent on sufficient and sustainable budgets for adult social care and public health.

3.8.1. **Increase funding**, to reflect the benefits a strong NHS delivers to the wider economy and society as a whole while maintaining the quality and access standards the public expects.

3.8.2. Reduce the **universality** of the NHS offer to fit the available financial envelope through means testing or running a two tier system with more self funded services.

3.8.3. Reduce the **comprehensiveness** of the NHS offer to fit the available financial envelope by rationing services based on clinical outcome.

3.8.4. Reduce the **quality** of the NHS offer to fit the available financial envelope by cutting staff, or relaxing access and other quality standards.

3.9. Public funding decisions, and the mechanisms for raising funds, are political decisions that must be made by elected officials. However, we are keen to help facilitate debate with provider boards and government about the options available. The nature of our membership of foundation trusts and trusts also provides us with a unique perspective on the potential impact of the main mechanisms:

3.9.1. *Increase in taxation*: A poll of providers conducted in 2014⁸⁸⁰ demonstrated that 64% of respondents considered that the public should pay more tax than they do now to support NHS services. 28% of respondents supported maintaining the level of taxes at that time and charging people for some NHS services. We therefore do not have any objections in principle to changes in the general taxation system to address the projected financial need for the healthcare system. We do note, however, that commentators have pointed out the potentially regressive impact of raising additional revenue through the national insurance system in particular.⁸⁸¹

3.9.2. *Generating income*: NHS providers, while committed to the ethos of the NHS, are not averse to looking at new ways of generating income. Trusts are adapting their approach to implement new policies on charging migrants and visitors for access to care for example, and have a history of raising revenue through private patient income.

3.9.3. *Co payments*: In theory, co-payments may raise revenue for services and change user behaviour to deter activity that is clinically unnecessary. National policy makers would, however, need to carefully explore the consequences for

⁸⁸⁰ The Foundation Trust Network and Sky News commissioned Ipsos MORI to survey 1,124 English adults aged 15 and over from October – November 2014. [Sourced from: Foundation Trust Network Press Statement, “*New FTN and Sky News poll indicates public and NHS staff confident in tackling NHS winter pressures*”, 18 November 2014,]

⁸⁸¹ Institute for Fiscal Studies, *Integrating Income Tax and National Insurance: An Interim Report*, December 2007, p.14. Available at: <https://www.ifs.org.uk/wps/wp2107.pdf>

equity of access to care across different patient groups, and the potential risks of deterring patients from accessing services. In addition, any ‘agreed exceptions’ to co-payment are likely to be difficult to define and implement consistently across the system, and the financial return may not outweigh the bureaucratic costs of running a co-payment system. Finally, there is relatively little support for co-payment nationally - under a quarter of the public support the introduction of charging for services such as a GP appointments⁸⁸².

3.10. Ultimately the scope of services that are free at the point of use will have to be more tightly drawn if government funding does not keep pace with the sum required to deliver clinically safe services.

4. Prevention and population health

The current context

4.1. Investment in population health, primary care and a more preventative approach is key to ensuring the long-term sustainability of the NHS. However, despite the increased focus in the Five Year Forward View around reducing health inequalities, there has not been sufficient investment to achieve these goals

4.2. In recent years there has been a move away from the focus on population health. Key to the sustainability of the NHS in the longer term will be refocusing on and investing in this concept which aims to improve the health of whole populations, by understanding what impacts their health outcomes. This is complementary to but distinct from a focus on prevention.

4.3. NHS Providers recently published a case study document⁸⁸³ in collaboration with NHS Confederation, NHS Clinical Commissioners and the Local Government Association to help spread the learning from areas which are focusing on prevention. We found some common success factors, notably the importance of data to provide in-depth understanding of the needs of the local population, working across organisational and professional boundaries, getting staff on board, and tapping in to the experience and skills of patients, carers, volunteers and third sector organisations.

What we need

4.4. As we have set out above, cuts to funding in public health and to local authorities will undermine aspirations to invest in a more preventative approach to care, which provides greater choice and ownership for individuals and supports a shift from acute, hospital-based ‘treatment’ towards community and home-based care.

4.5. A national and local focus on population health, and attendant investment will make a substantial contribution over the long-term to the sustainability of the NHS.

⁸⁸² In 2015, British Social Attitudes put this figure at approximately 25%.

(http://www.bsa.natcen.ac.uk/media/38925/bsa32_health.pdf). In 2015, Ipsos Mori put this figure at 16%.

(<https://www.ipsos-mori.com/researchpublications/researcharchive/3546/Polling-for-The-Health-Foundation.aspx>)

⁸⁸³ NHS Providers, NHS Confederation, NHS Clinical Commissioners and Local Government Association, *New Care Models and Prevention: an integral partnership*, May 2016. Available at: <https://www.nhsproviders.org/resource-library/reports/new-models-of-care-and-prevention-an-integral-partnership>

The government and national bodies have an important role to play in encouraging a shift in relationships so that members of the public have the information they need to make informed choices to protect their own health at the outset. Longer term prevention initiatives should be focused on keeping people well and helping them retain their independence rather than treating illness when it occurs.

5. Workforce

The current context

- 5.1. Given the changing needs of our ageing and growing population, many of whom will live for longer with multiple conditions, the future health and care workforce will develop a different skills mix and operate in different care settings to today. As the NHS seeks to deliver the *Five Year Forward View* and new care models, the importance of a much more integrated workforce has become apparent. As well as tackling gaps in recruitment of key professionals (such as nurses or A&E consultants), we will need more generalists and more care provided closer to home or in the community - for example the geriatrician who spends more times in care homes than on hospital wards or the physiotherapist who offers musculoskeletal consultations in primary care settings.
- 5.2. Trusts recognise the opportunities at hand to develop their workforce, and are proactively engaged in doing so. For example, Lancashire Teaching Hospital NHS Foundation Trust was the first in the country to launch a student-funded nursing degree course to develop more nurses for the future. Heart of England NHS Foundation Trust has developed the advanced care practitioners (ACPs) role for senior non-medical clinicians to support acute and emergency care services. In addition, Airedale NHS Foundation Trust has developed telehealth and pathways to provide specialist, geriatric clinical support to care homes and primary care.
- 5.3. There are, however, a number of improvements that could be made in the approach to national workforce planning to enable and support providers' efforts locally.

What we need

- 5.4. First and foremost we need a more coherent and strategic approach to workforce policy, including workforce planning, at the national level. Developing this strategic overview will be particularly important in identifying and training professionals to play new roles within the workforce, and in maintaining a national understanding of the NHS paybill (the biggest proportion of NHS provider spend by far).
- 5.5. We are particularly keen that greater co-ordinated effort be placed in maximising the supply of staff, for example access to overseas recruitment, use of apprenticeships, making the most of the move from bursaries to loans in healthcare education and greater integration of health and social care roles. While we expect, and support the principle of more locally led decision making, workforce is a critical area of policy where local providers and their partners require much better support from the national NHS bodies.

- 5.6. We note the Health Foundation's March 2016 report *Fit for purpose?*⁸⁸⁴ called for the creation of a National Workforce Strategy Board to be convened by the Department of Health. This would seem a good starting point in developing a single locus of strategic workforce planning. It would also help avoid the dilemmas trusts have face in recent years following mixed messages from the centre. Notably, being encouraged by the Department of Health and national bodies to employ more staff on quality grounds following the findings of the Mid Staffordshire Inquiry but then facing the prospect of the Home Office making it more difficult to recruit from outside of the European Economic Area and, more recently, suggestions from the regulators that staff numbers must be tailored to the financial envelope.
- 5.7. Secondly, it is important that the national bodies and local NHS and care organisations fully understand the impact of Brexit on workforce planning. Our survey of provider trusts⁸⁸⁵ revealed concern among provider boards about this issue, given the reliance of many trusts and social care partners on EU staff. This is reflected in 29 organisations coming together as part of the Cavendish Coalition to call for the EU staff in health and social care to have the right to remain in the UK post-Brexit.
- 5.8. Finally, national bodies, membership organisations such as ourselves, and the royal colleges will need to work together with local NHS organisations to: ensure that new roles remain attractive to ambitious professionals; support recruitment and retention; offer a fair contractual deal for individuals, which also meets the needs of the service; and provide development opportunities, sufficient reward and a career pathway for high calibre individuals.

6. Digitisation of services, Big Data and informatics

The current context

- 6.1. There are numerous examples of how embracing digital technology and harnessing the power of integrated health and care data are already changing how trusts deliver care to patients and service users, by harnessing real time data and crossing organisational boundaries. For example, in East London NHS Foundation Trust, diabetes clinics are increasingly delivered over Skype to improve productivity by allowing patients to access preventative care and clinical expertise closer to their homes. The introduction of mobile working infrastructure has also transformed the efficiency of community professionals, such as district nurses and community midwives, by reducing non-clinical time spent transcribing notes or travelling back to 'home base' to share clinical information.

What we need

⁸⁸⁴ The Health Foundation, *Fit for purpose? Workforce policy in the English NHS*, March 2016. Available at: <http://www.health.org.uk/sites/health/files/FitForPurpose.pdf>

⁸⁸⁵ NHS Providers survey of NHS trusts and foundation trusts on the impact of membership of the European Union on health policy, conducted between 28 April and 11 May 2016. Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/impact-of-membership-of-the-eu-on-health-policy-in-the-uk/written/33810.pdf>

- 6.2. Although the effective use of digital technologies and data sharing has improved considerably, there remains great variation in digital capability between local health economies and individual organisations. In light of this, NHS Providers welcomed the recent Wachter review of IT⁸⁸⁶ for its pragmatism. We support a phased approach to digitisation, but it is crucial that those trusts not able to deliver in a tight timeframe are appropriately supported, both financially and with the expertise to build capacity and reach digital maturity.
- 6.3. As past failures within the NHS have shown, the successful implementation of digital technology in health care requires long-term planning and commitment. Given the considerable competing demands on NHS provider boards, greater support is needed to build knowledge of how information technology can be used to deliver care in completely different and more productive ways. Information teams within NHS foundation trusts and trusts are high calibre but are often required to process large amounts of data to meet the requirements of regulators and central agencies, rather than allocating time to analyse and develop new data sets.
- 6.4. Building digital capability within NHS providers may also be challenged by a shortage in analytical expertise to use and interpret these data unless there is further investment in this area. There is also a pressing need to invest adequately in developing data and analytics for mental health and community services as part of the government's wider commitment to parity of esteem.
- 6.5. The prize of big data, informatics and increased digitisation of services is great, but our experience suggests that realising these benefits will take time, require capital investment and a comprehensive programme of support for managers, clinical staff, and indeed patients, to implement new ways of working.

7. Models of service delivery and integration

The current context

- 7.1. Aside from the commitments made in the *Five Year Forward View* and recent requirements for local health economies to develop sustainability and transformation plans (STPs), there is no clarity about how the government's commitment to integrate care by 2020 will be delivered and a real lack of vision and strategy for integration or service reconfiguration beyond this period to 2035. That said, while there is a need for national strategy and support, we would strongly advocate investment in locally-led solutions, rather than a top-down structural change to 'integrate' health and social care, and we set out some practical changes that can support this below.

What we need

⁸⁸⁶ National Advisory Group on Health Information Technology in England, *Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England*, September 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/550866/Wachter_Review_Accessible.pdf

- 7.2. Firstly, adequate sustained national investment is needed to deliver integration and implement new care models. While the NHS has struggled to sustain performance with rising demand, social care has been subject to ongoing and significant cuts in their funding. The Association of Directors of Adult Social Services (ADASS) has recently⁸⁸⁷ stated that the social care funding crisis is at tipping point, estimating that the funding gap in social services to be around £940m just to keep services operating at the same levels as last year. This prevents investment in new care models and integration. This urgently needs addressing, not only in this parliament to ensure the short-term sustainability of services but for the longer term future of the health and social care sector.
- 7.3. Secondly, moving to a population-based, integrated health and social care service will take time and require space and support. *The Five Year Forward View's* new care model programme and the introduction of STPs provide the potential for local health economy partners to come together and explore a longer term strategy to reconfigure services and integrate care at a local level. A number of areas are already making progress. However, in the existing policy framework, local areas are often confined to 'fixing' short term challenges. We need to adopt realistic expectations around the benefits and opportunities of implementing new care models and recognise that the evidence of integration delivering greater efficiencies is weak, relative to the more proven benefits for patient experience and some outcomes⁸⁸⁸.
- 7.4. To enable integration and collaboration, the national bodies must review current governance, accountability and contracting frameworks. Over time we expect the sector will need to move to a risk-share financial and contracting model with capitated budgets and outcomes-based commissioning for whole populations.
- 7.5. Lastly, alongside the formation of locally-developed solutions, the sector needs a long-term strategy for specialised services. A National Audit Office report published in April 2016⁸⁸⁹ concluded that the growing cost of providing specialised services within the current contractual and service model threatens NHS financial sustainability. It called for NHS England to develop an overarching strategy for specialised services to support providers to plan for the longer term.

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⁸⁸⁷ Association of Directors of Adult Social Services, *ADASS Budget Survey 2016*, July 2016. Available at: <https://www.adass.org.uk/media/5379/adass-budget-survey-report-2016.pdf>

⁸⁸⁸ The King's Fund, *The reconfiguration of clinical services: what is the evidence?*, November 2014. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf

⁸⁸⁹ National Audit Office, *The commissioning of specialised services in the NHS*, April 2016. Available at: <https://www.nao.org.uk/wp-content/uploads/2016/04/The-commissioning-of-specialised-services-in-the-NHS.pdf>

Dr Kristian Niemietz – Written evidence (NHS0034)

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1. Introduction

- 1.1 The basic problem with healthcare funding in the UK is that demographic changes – especially an ageing society – put upward pressure on healthcare costs while many of the potential measures to address this (tax hikes, cuts to spending, efficiency savings, rationing of services etc.) are either difficult to achieve or undesirable. A potential solution to this is the prefunding of healthcare expenditure – the building up of old-age reserve funds within the NHS. Such a system would not diminish entitlements already accrued. There is also a case for a cost-sharing scheme, with exemptions for low-earners and the chronically sick. This could raise additional revenue whilst simultaneously encouraging cost-conscious behaviour.
- 1.2 This response will begin by examining the current state of healthcare funding in the UK and the looming problem of an ageing population. It will then move on to exploring a possible diversification of funding under a cost sharing scheme, similar to the system currently in place in Switzerland. Finally, it will explore prefunding. While there are hardly any real-world examples of prefunded healthcare systems, the economic case for prefunding is well established. Such a system would resolve the most pressing problems of healthcare financing in the UK.

2. Sustainability of healthcare spending in the UK

- 2.1 In health economics, the magnitude of the effect of population ageing on healthcare costs is a matter of dispute. Some studies suggest that ageing, in isolation, only accounts for around one tenth of the increase in healthcare spending observed in recent decades (OECD 2015 p. 32-33 & 55-57). Other studies, however, suggest that ageing accounts for a much larger share, possibly around half, of spending increases. Part of the reason for the disagreement is the existence of interaction effects and feedback loops. A study may find that advances in medical technology have a bigger effect on healthcare costs than ageing, but then, advances in medical technology may not be age-neutral: ageing may drive demand for the adoption of expensive medical technologies. Either way, it is safe to say that the fiscal impact of ageing is not trivial.
- 2.2 According to an estimate specific to the UK, ageing will add about two thirds of a percentage point to the annual growth rate of healthcare costs until 2031 (Caley and Sidhu 2011). This estimate refers to the *net* effect of ageing; it is already corrected for the fact that the factors which increase longevity also have cost-decreasing effects. If average life expectancy in 2031 will be measurably higher than today, then a 75-year-old person in 2031 will typically be in a better state of health than a 75-year-old person today, so their healthcare needs will be lower.
- 2.3 The Office for Budget Responsibility forecasts only moderate increases in NHS spending as a proportion of GDP for the next half century, but this forecast is predicated on the assumption that the NHS will double its long-term productivity growth rate (OBR 2015 pp. 94-97). The OBR does explain where this sudden productivity shock is supposed to come from. They acknowledge, however, that their forecast is highly sensitive to changes in productivity assumptions, and that if NHS productivity growth remained unchanged, NHS spending would rise to over 13% of GDP over the next half century.
- 2.4 Either way, in the future, the healthcare costs of a relatively larger economically inactive population will have to be borne by a relatively smaller economically active population. In the UK, there are currently about 28 people aged 65 and over for every 100 people of working age (16-64). This figure, the old-age dependency ratio, is forecast to rise to 47:100 by 2064 (based on OBR 2015). The share of people aged 85 and over is forecast to rise from currently 4 for every 100 people of working age to 13 (ibid).
- 2.5 This will make it necessary to either hike the retirement age, cut back on healthcare entitlements, or raise the tax burden on the working-age population (or some combination of these). The problem with the latter two options is that, ironically, the same population ageing process which makes these measures economically more pressing also makes them politically less likely to happen. An increase in the old-age dependency ratio also means an increase in the political power of the 'grey vote', and thus in the ability of the retired generation to block policy changes unfavourable to them. This effect can be demonstrated in pension policy (Booth 2008), and there is no reason why it should not also apply to healthcare.

2.6 In previous decades, the retirement age has not increased at anything like the same pace as life expectancy. In the early 1970s, men spent, on average, around 12 years in retirement. Since then, this figure has gradually risen to around 17 years. The increase for women was of the same magnitude, but from a higher level (OECD 2011: 28-33).

3. Diversification of funding

- 3.1 There is good evidence to suggest that the UK economy is not too far away from reaching its maximum taxing capacities (Smith 2007; Minford and Wang 2011; Smith 2011). But given the deadweight loss of taxation, funding a healthcare system exclusively on this basis seems unwise anyway. Patient charges could be a sensible complement.
- 3.2 Patient charges are controversial in health economics. In theory, their impact could go either way, and the empirical evidence is mixed as well. Supporters argue that user charges discourage unnecessary demand and encourage cost-conscious behaviour (e.g. Drummond and Towse 2012; Kan & Suzuki 2010; Breyer et al. 2005: 263-267; Chiappori et al. 1998). Opponents argue that cost-sharing unfairly penalise the poor and the sick, and that the only savings they achieve are of the false economy variety (Holst 2010). The disagreement is, perhaps, unsurprising: cost-sharing schemes come in all shapes and sizes, and some work better than others.
- 3.3 An interesting health system, in this regard, is the Swiss one. In Switzerland, out-of-pocket payments by patients account for as much as a quarter of total healthcare spending (based on WHO 2015: 132-133), one of the highest shares in the developed world. And yet in the Commonwealth Fund study, the Swiss system obtains the same score as the NHS in the 'Equity' category (Davis 2014 pp. 23-25).
- 3.4 The Swiss cost-sharing scheme has two main components: a deductible and proportional co-payments. The deductible is an amount of medical costs that people have to pay out of pocket before insurance protection kicks in. It is set at CHF300 (≈£235) per annum, but people can voluntarily increase it to up to CHF2,500 (≈£1,950), in return for a premium rebate. Thus, at least the first doctor's visit per year is usually fully paid out of pocket.
- 3.5 Insurers then reimburse 90% of medical expenses above the deductible, leaving a 10% co-payment for the patient. Co-payments, in turn, are capped at CHF700 (≈£550) per annum. Welfare recipients are exempt from co-payments, as are selected patient groups such as pregnant women (Leu et al 2009: 21).
- 3.6 Healthcare expenditure of people on high-deductible plans are much lower than those of people on standard contracts. There have been various attempts to estimate to what extent the difference is due to self-selection (healthier people are more likely to choose high-deductible plans), and to what extent it is due to differences in incentives (Werblow 2002, Schellhorn 2002a, Schellhorn 2002b, Felder & Werblow 2003, Gerfin and Schellhorn 2005, Gardiol et al. 2005). Estimates differ

widely, but it is safe to say that there is *some* effect over and above what can be explained by self-selection.

- 3.7 Much of the disagreement on cost-sharing comes down to disagreements about the extent to which people can influence over their healthcare costs. If we see them as largely fixed, the case for cost-sharing is weak. By encouraging self-selection, the Swiss system of voluntary deductibles offers a potential way out of this conundrum. People who have little or no control over their healthcare costs will avoid high-deductible plans, and remain fully protected. Those plans will only be attractive to people who have a higher degree of control over their healthcare costs. This means that the people are most *able* to respond to financial incentives will also be the ones who *face* the strongest financial incentives to economise on healthcare.

4. Prefunding: the theory

- 4.1 Healthcare costs rise systematically over the lifecycle. They are relatively stable during, roughly, the first five decades of life, and begin to rise exponentially afterwards (see figure below). In the UK, per capita healthcare costs for people in the age group between 65 and 74 are almost two and a half times as high as for people aged 16 to 44. For people aged between 75 and 84, that multiple rises to almost four, and for people aged 85 and over it raises to over five (Caley and Sidhu 2011). From an economic perspective, this means that healthcare spending should lend itself to prefunding, just like pensions. The healthcare financing agency should build up a capital stock on behalf of people while they are of working age, and draw on it when they reach old-age. These old-age healthcare funds would work analogously to pension funds. The effect would be that over the course of a lifetime, every cohort would pay its way. There would be no systematic intergenerational redistribution. In the current pay-as-you-go (PAYGO) financed system, most healthcare spending represents a transfer from the working-age generation to the retired generation.
- 4.2 In a prefunded system, the capital accumulated to meet future healthcare needs would earn a rate of return, with interest and compound interest. In developed countries with low birth rates, prefunded systems are almost guaranteed to be more lucrative than PAYGO systems (Booth and Niemietz 2014 pp. 25-26).
- 4.3 The economic case for prefunding healthcare is well established, and there are various proposals for how the transition to a fully or partially prefunded model could work. Feldstein develops a proposal for prefunding Medicare, the US government insurance programme for the retired. Stabile and Greenblatt (2010) explain how Pharmacare, a Canadian insurance programme covering the cost of pharmaceuticals, could be put on a prefunded footing. The federal government of Canada also runs a programme of fiscal transfers to assist regional governments with the healthcare costs of their elderly populations. Robson (2002) outlines a proposal for prefunding this federal programme. In the German health system, there is a so-called 'risk structure compensation fund', which redistributes from health insurers that disproportionately cover good risks to health insurers that disproportionately cover bad risks. Felder (2003) comes up with a plan under which this

Risikostrukturausgleich would simultaneously become a custodian of an old-age reserve fund.

- 4.4 While there is an ample literature, real-world examples of prefunded healthcare are extremely rare. But they do exist: the so-called ‘PKV pillar’ of the German health system, which covers almost nine million people, is run of a prefunded basis. The PKV system is a system of actuarial health insurance premiums, which, on its own, would mean that premiums would be cheap for young and middle-aged people, but for the elderly, they would increase at an accelerating rate. In order to prevent this, German PKV insurers are required to smoothen premiums over people’s lifetime. They do this by building up an old-age fund on behalf on their policyholder while they are of working-age, and draw upon it in later years.
- 4.5 Taken together, the old-age reserves held by German PKV insurers taken together amount to about €170 billion, equivalent to almost €20,000 per PKV policyholder. Annual additions to the fund account for about 5 per cent of the country’s net savings rate (Schönfelder and Wild 2013: 28-29). Had the NHS built up the same amount of capital reserves per person, it could now have an old-age reserve fund of over £900 billion at its disposal.⁸⁹⁰
- 4.6 The NHS could be prefunded in a similar way. It could start building up old-age reserves for every member below a certain age. Each of these members would then have an old-age fund allocated to them.
- 4.7 For those close to retirement age or above, it is too late to build up reserves, so for them, healthcare should continue to be financed on a PAYGO basis. Most people will fall somewhere in between: there will still be time to build up *some* old-age reserves for them, but not enough to fully cover their old-age healthcare costs. For them, the NHS could still set up old-age funds, and the government could fill the accounts with government bonds in order to make up for the ‘missing’ reserves. This would represent a conversion of implicit into explicit debt. The current system contains an implicit promise to those of working age that when they reach old age, they will be entitled to (at least) the same standard of healthcare that the older generation currently enjoys. That promise is, in a sense, government debt, even if it does not appear in any national accounts. A transition to a prefunded system would, if nothing else, lead to more honest and transparent accounting, thus giving us a clearer idea of the state of the public finances.
- 4.8 During the transition, there would be a cash-flow deficit, as the young generation would have to put aside the funds to meet their own future healthcare costs, whilst still having to pay for the healthcare costs of the elderly. This transitional cost would have to be spread over several generations (Booth & Niemietz 2014). But there

⁸⁹⁰ This is an extremely crude back-of-the-envelope figure, which is only meant to give an idea of the order of magnitude. Demographic factors, medical input prices, the package of healthcare services and other relevant variables differ between the two countries, so one cannot simply extrapolate from the German figure in this way. But for the sake of the argument, if the NHS had built up old-age reserves averaging £15,000 per person, then for a UK population of 64.6 million, this would work out at £969 billion.

would also be a partial self-financing effect. In Chile, which began the transition from a PAYGO pension system to a prefunded one in 1981, the conversion of an implicit debt into an explicit one encouraged a political culture of fiscal prudence (Niemietz 2007).

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20 September 2016

Nuffield Trust – Written evidence (NHS0174)

Key points

- **New OBR projections suggest that public spending on health care in the UK could rise from 7.4% of GDP in 2015/16 to between 8.8% and 8.9% by 2030/31 – equivalent to a rise of just under £100 billion over the next 15 years, of which 60% would come from projected growth in GDP and the remainder from a combination of tax and reprioritisation of other public spending.**
- **Choosing a specific spending path for health** (such as the OBR’s ‘declining cost pressures’ projection) **would be a financially sustainable position** that would enable the quality and volume of health care to grow more or less in line with public expectations and medical technology.
- **Pressures to spend more on social care will inevitably also grow over time**, and other sustainability problems are inherent in this area given its funding sources and traditional separation from health.
- **The OBR’s ‘declining cost pressures’ projection for social care spending to 2030/31 would add a further 0.6% of GDP from the 2014/15 level. Around 30% of this increase would arise from projected growth in GDP, leaving around £16 billion to be found via a combination of tax and reprioritisation of public spending.**
- **We will end up paying more for social care one way or another** – either through higher taxes for improved services; directly from the public’s pocket; or through non-financial costs arising from reduced access to publicly funded services. The issue is **how to ensure extra spending delivers what we want** from social care, including, we argue, equal opportunity of access for equal needs.
- **A smoother, steadier spending path over the long term** would not only support the decisions health and social care need to take to be sustainable, but would increase the transparency for the public about the financial commitment they could be asked to make.
- The investigation into long-term health and social care spending and sustainability should not just be an ad hoc exercise. There is a need for **a wider-ranging independent review of the long-term future for care every three-to-five years to inform public and political debate.**

This note sets out the Nuffield Trust’s views on key questions concerning the Committee’s investigation of the sustainability of the NHS over the next fifteen years. It updates oral evidence given to the Committee on 6 September 2016 by Prof John Appleby, Director of Research and Chief Economist, in the light of a new survey of the literature on spending projections and, in particular, new projections for health spending published by the Office for Budget Responsibility on 21 September 2016.

Introduction

Worries about the affordability of the NHS have a long history. Almost as soon as it opened its doors, concerns were expressed about its cost. Then, in 1953, health minister Iain Macleod announced an independent parliamentary committee to investigate the long-term costs of the NHS and to make recommendations about possible structural and funding changes. Three years later, Claude Guillebaud's committee reported that the NHS was not particularly inefficient, that costs were not as high or rising as fast as feared, and that little structural reform was needed (Chester, 1956).

At the time of the report, the UK was spending around 3 per cent of its GDP on the NHS – equivalent to nearly £13 billion at today's prices.

Over the sixty years since Guillebaud's report, spending on the NHS has risen (as it has in other countries). While the economy has grown over four-fold since 1956, NHS spending has increased eleven-fold – taking its share of GDP from 3% to 7.4% – equivalent to around £1 in every £14 in the economy. And on average, NHS spending rose in real terms by around 4% each year. Key drivers of this increase included increasing national wealth, population growth and the expansion in medical technology.

If NHS spending as a share of GDP continued to grow at the rate it has done since the 1950s, by 2191 it would consume 100% of GDP. Clearly, on this trajectory, at some point between now and 176 years in the future, spending on the NHS will need to stabilise for it to be financially sustainable. The question is, when?

How we – the public, taxpayers, politicians – make the decision that 'enough is enough' will, among other things, involve choices between competing areas of public spending, the balance between taxes and private disposable income and how we value what health care and medicine has to offer in the future.

A crucial starting point for these difficult decisions is how NHS spending might evolve in the future based on how it has changed in the past, and how we think the drivers of spending – population changes, national income and so on – will shape spending decisions in the future.

1. Public spending projections on health care in the UK

Estimates of future health spending can be carried out either on the basis of 'policy neutrality' – what spending would look like given forecasts of the path of key spending drivers (such as population size and age structure) but not those related to changes in policy (such as the introduction of seven-day working for example) – or on a more positive basis in terms of specifying what sort of health care should be available in future and then estimating the cost of achieving such a vision. Most projections, both in the UK and in other countries and supra-regional organisations, are of the former kind. The estimates of future spending needs for the UK NHS carried out by, for example, Derek Wanless in 2002 was an example of the latter.

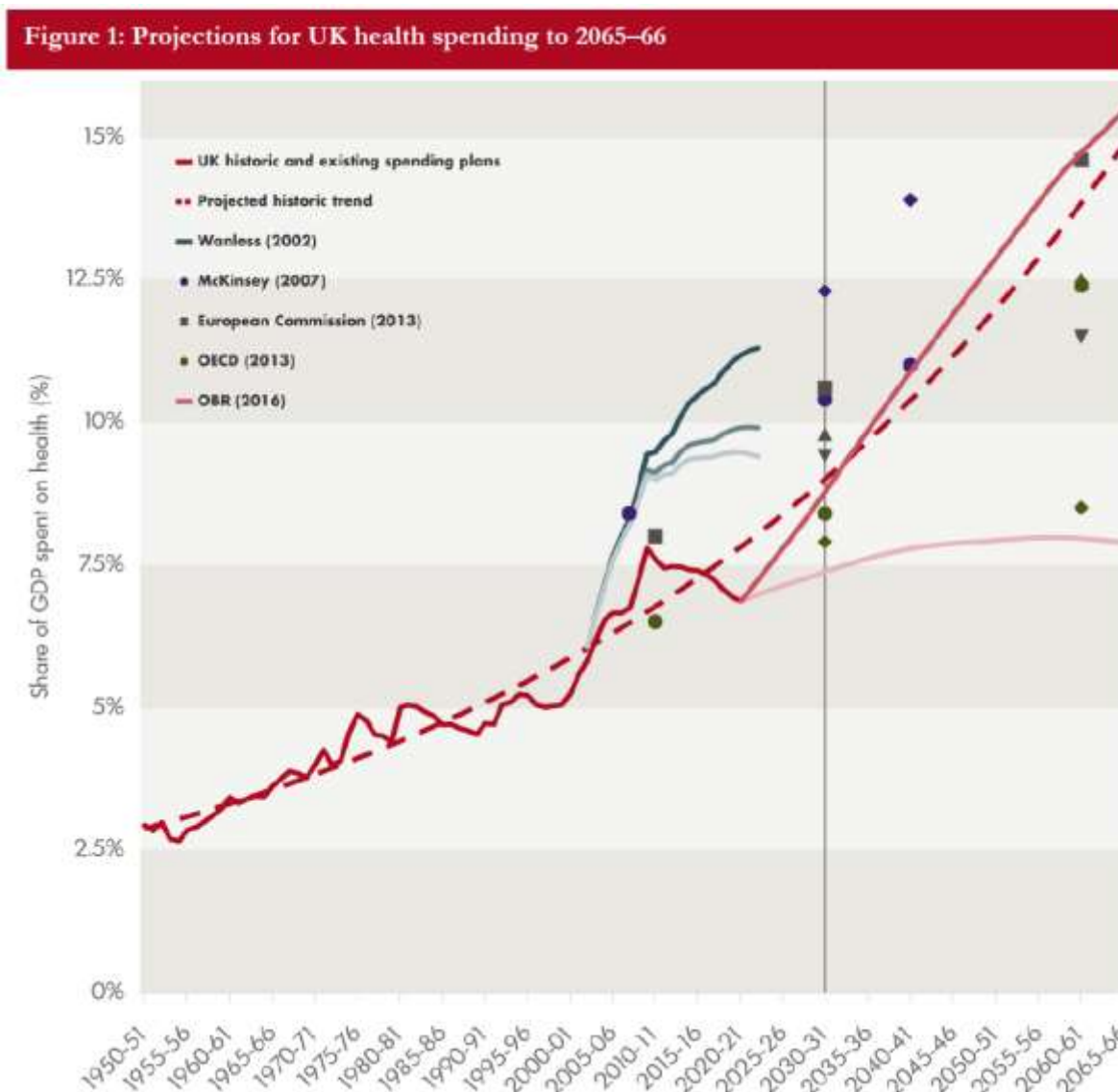
In practice, the distinction between these two perspectives can be blurred, and given uncertainties about the future, both approaches involve assumptions about the drivers of future spending (population changes, health system productivity and so on) with tests of the sensitivity of projections to variations in the underlying assumptions. So, where might spending on the NHS be headed over the next fifteen years?

Table 1 shows the latest estimates of UK health care public spending to 2030/31 from four organisations – the Office for Budget Responsibility, McKinsey Consulting, the European Commission and the OECD. All are essentially policy neutral, take slightly different approaches to the assumptions underlying their projections and vary in the extent of the testing of these assumptions. Table 1 also includes Wanless’s estimates of the costs of his ‘vision’ for the NHS up to 2022/23 for comparison. (Figure 1 shows more detail for these projections and provides the historical spending context. [An interactive version of this](#)

Table 1: UK health care public spend projections to 2030/31 as a percentage of GDP					
	Scenario	Baseline	2015/16	2022/23	2030/31
	Actual		7.4		
OBR (2016)	Declining ‘other pressures’		7.4	7.2	8.8
	Constant ‘other pressures’		7.4	7.2	8.9
	Low health care productivity (1.2% p.a.)		7.4	7.1	8.3
	High income elasticity (1.2 converging to 1)		7.4	7.1	7.9
	Low income elasticity (0.8 converging to 1)		7.4	6.9	7.3
	Slower expansion of morbidity		7.4	7.0	7.5
	Compression of morbidity		7.4	7.0	7.4
Wanless (2002)	Slow uptake		10.5	11.3	
	Solid progress		9.6	9.9	
	Fully engaged		9.4	9.4	
McKinsey (2007)	Baseline	8.4 (2007)			10.4
	High				12.3
European Commission (2013)	Cost pressure	8.0 (2010)			10.6
	High cost containment				9.4
	Low cost containment				9.8
OECD (2013)	Cost pressure	6.5 (avg 2006–2010)			8.4
	Cost containment				7.9

[chart is also available.](#))

Sources: Licchetta and Stelmach (2016), Kibasi and others (2012), Wanless (2002), EC (2013), OECD (2013). NB: McKinsey and EC 2030/31 are linear interpolations inferred from these studies’ longer-term projections (to 2040 and 2060 respectively) McKinsey analysis covers private as well as public spending.



Some data sources provide a high and low projection or high, central and low projections, so some plots diverge to show various outcomes. Sources: Licchetta and Stelmach (2016), Kibasi and others (2012), Wanless (2002), EC (2013), OECD (2013).

Across the four policy neutral studies, spending is projected to change from around 7.4% of GDP in 2015/16 to between 7.3% and 12.3% by 2030/31.

However, these are the extremes based on alternative assumptions about, for example, the ability of the NHS to contain growing costs (through higher productivity for example) or how health care needs might change in the future.

2. New projections from the Office for Budget Responsibility

Of more note – not least because the projections are the most recent and involve a change in assumptions – are those by the Office for Budget Responsibility (OBR).

A key change in the OBR’s assumptions about future spending is the inclusion (similar to the OECD) of a factor for ‘other cost pressures’. These are, in essence, the extra growth in costs over and above demographic change and any effects of growing national income (and

the desire to devote increasing wealth to health). This element of the growth in health spending is hard to pin down, but is generally recognised as an important driver of additional growth in health spending over time for all countries. The OBR's new 'cost pressures' growth projections suggest that public spending on health care in the UK could rise from 7.4% of GDP in 2015/16 to between 8.8% or 8.9% by 2030/31, depending on the extent of any containment of this element of growth.

Based on the OBR's 2015 projections for growth in GDP (OBR, 2015), these shares of GDP are broadly equivalent to a real increase in health spending of just under £100 billion over the next fifteen years (from £139 billion in 2015/16 to £237 billion, in 2015/16 prices).

3. What do current spending projections tell us about the long-term sustainability of the NHS?

Bearing in mind the inevitable uncertainty of any projections of health spending, taking the OBR's new projection of around 8.8% of GDP by 2030 (and bearing in mind projections from the OECD and EC), is it possible to draw a conclusion about the financial sustainability of the NHS?

The short answer is, yes, but the OBR's new projections do have implications for taxation and spending priorities across government.

To put the projection in some historical context, the increase of around £100 billion in spending over the next fifteen years implied by the new cost pressures projection (and projections of GDP growth) represents an average annual real increase of around 3.5%. This is less than the long-term (1950–2015) increase of just over 4%. Further, the increase in share of GDP of 1.4% over 15 years is also the same as the increase over just five years between 1999/2000 and 2004/5.

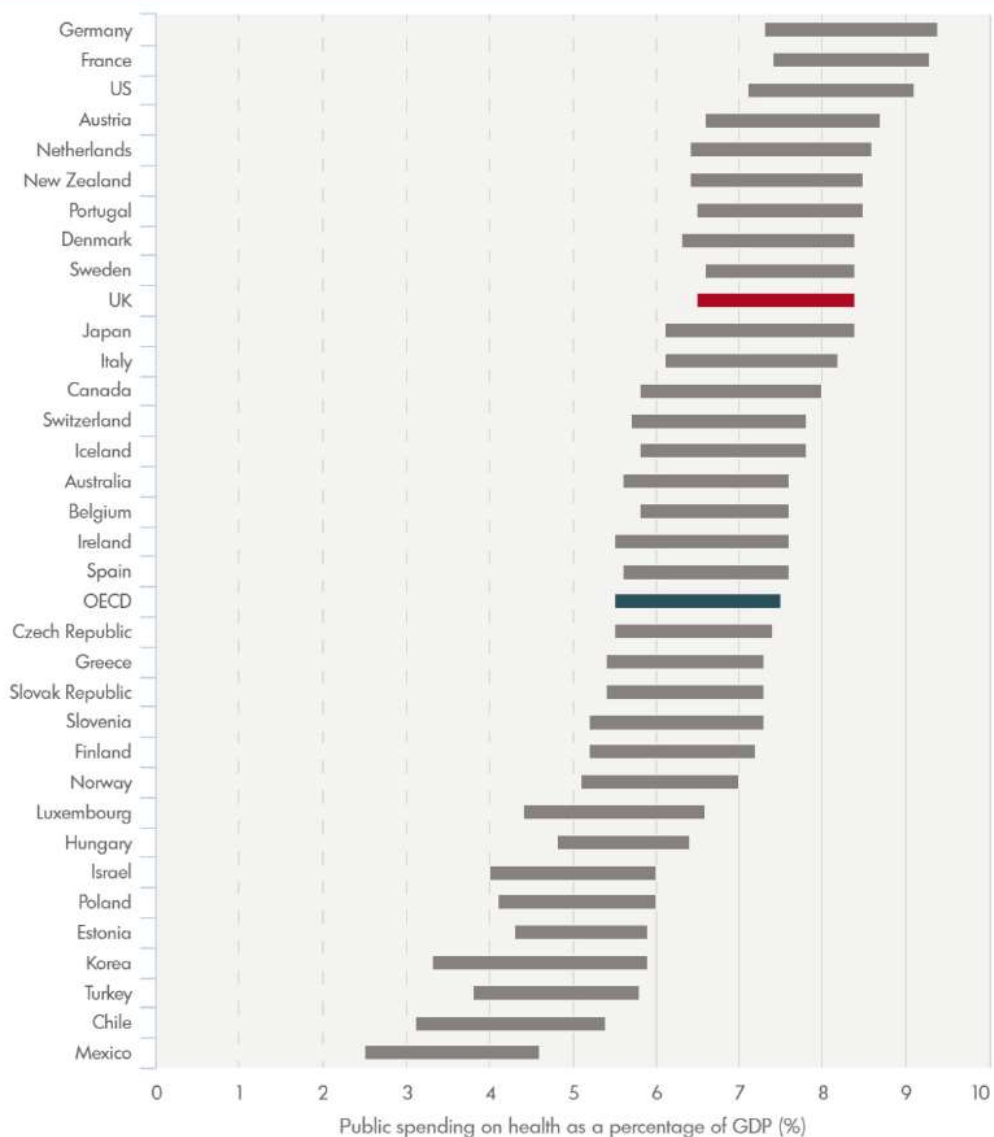
From this perspective, then, the increase in projected spending does not seem out of line with history – and indeed, slightly lower than the long-term growth in spending.

From an international perspective (caveated with warnings about the difficulty of making comparisons in health spending between countries), a national public spend of 8.8% by 2030 would take the UK to the levels of public spending for France, the Netherlands, Denmark, Sweden, Germany and Japan (and a little above Norway and the US) – in 2015. And in terms of where other countries are likely to be in terms of public spending by 2030, the OECD projections suggest that all countries' spending is likely to increase (see [Figure 2 – an interactive version of this chart is also available](#)), leaving the UK's relative rank on public spending on health essentially unchanged between 2010 and 2030.

In themselves (and possibly taken together) these triangulations of the UK's possible spending on health by 2030 do not provide a conclusive answer to the financial sustainability of the NHS over the next fifteen years. However, they do provide a strong

indication that – judged historically and across countries – spending increases are sustainable.

Figure 2: Public spending on health across OECD countries 2010 and projected to 2030



The left side of each bar represents public spending in 2010, and the right side the projected spend in 2030. Data: OECD (2013). Projections based on OECD’s highest cost pressures projection.

4. Higher health spending – but who pays?

Nevertheless, if the OBR’s cost pressures projection became the chosen spending path, this choice has policy implications. Not least is the question of where the extra money would come from. The choice, crudely, is between (or rather, some combination of) extra taxation and/or shifting government spending away from some areas and towards health.

It is important to bear in mind that a big chunk of the £100 billion increase implied by the OBR projection arises because the economy – and its measure, GDP – is also projected to

increase: even if the health spend share remained unchanged at its current rate of 7.4% (with all other government spend also staying the same as the 2015/16 shares), the NHS would grow by nearly £60 billion in real terms as GDP is projected to grow by just over 40% in real terms by 2030⁸⁹¹. This would leave around £40 billion (an extra £2.7 billion each year) to be funded through some combination of increased tax and reprioritisation of government spending.

Just for illustration, if the additional spending on health were split evenly between tax rises and reprioritisation of spending in non-health areas, given the sums involved and the time period for the increased spending, non-health spending could still increase in real terms (around 2.2% per year), even though reducing very slightly as a proportion of GDP (by 0.7 percentage points over 15 years – around one twentieth of a percentage point per year). The remaining additional health spending of around £1.4 billion each year is equivalent to a year-on-year increase across all income tax rates of around one fifth of a percentage point each year. We would emphasise that these are rough estimates only, but they give an idea of the scale of the opportunity costs involved in choosing the OBR's declining cost pressures spending path.

While the focus here has been on the costs (additional tax/reprioritisation) arising from pursuing a path to increase health spending, it should be noted that there is also an opportunity cost of not doing so. If, for example, health care spending only increased in line with GDP growth (that is, remained flat as a share of GDP), over time it is likely that the quality and volume of health care would increasingly diverge from the sorts of levels expected by the public, and with advances in medical technology becoming increasingly unaffordable within the global health care budget available.

Summary: Health care

On balance, and given the evidence of likely future cost pressures and the opportunity costs of meeting these, our main conclusion is that choosing a spending path (such as the OBR's 'declining cost pressures' projection) would be a financially sustainable position that would enable the quality and volume of health care to grow more or less in line with public expectations and medical technology.

5. Public spending projections on social care in the UK

As with health, there are a number of studies that project spending on social care/long-term care. Some are 'policy neutral' (e.g. OECD and the OBR), and while others introduce an allowance for deliberate policy to, for example, improve quality (e.g. the Barker Commission, Wanless) or extend coverage (e.g. the European Commission in one of its scenarios).

⁸⁹¹ These estimates depend on the rate at which GDP will grow in the future. The full impact of the Brexit decision on GDP for example remains unknown, but most projections indicate a reduction in the rate of growth of GDP into the future. This will clearly limit the choices available to future governments in terms of their tax and spend decisions.

Table 2 and Figure 3 summarise projections from five studies (an [interactive version](#) of Figure 3 is also available)

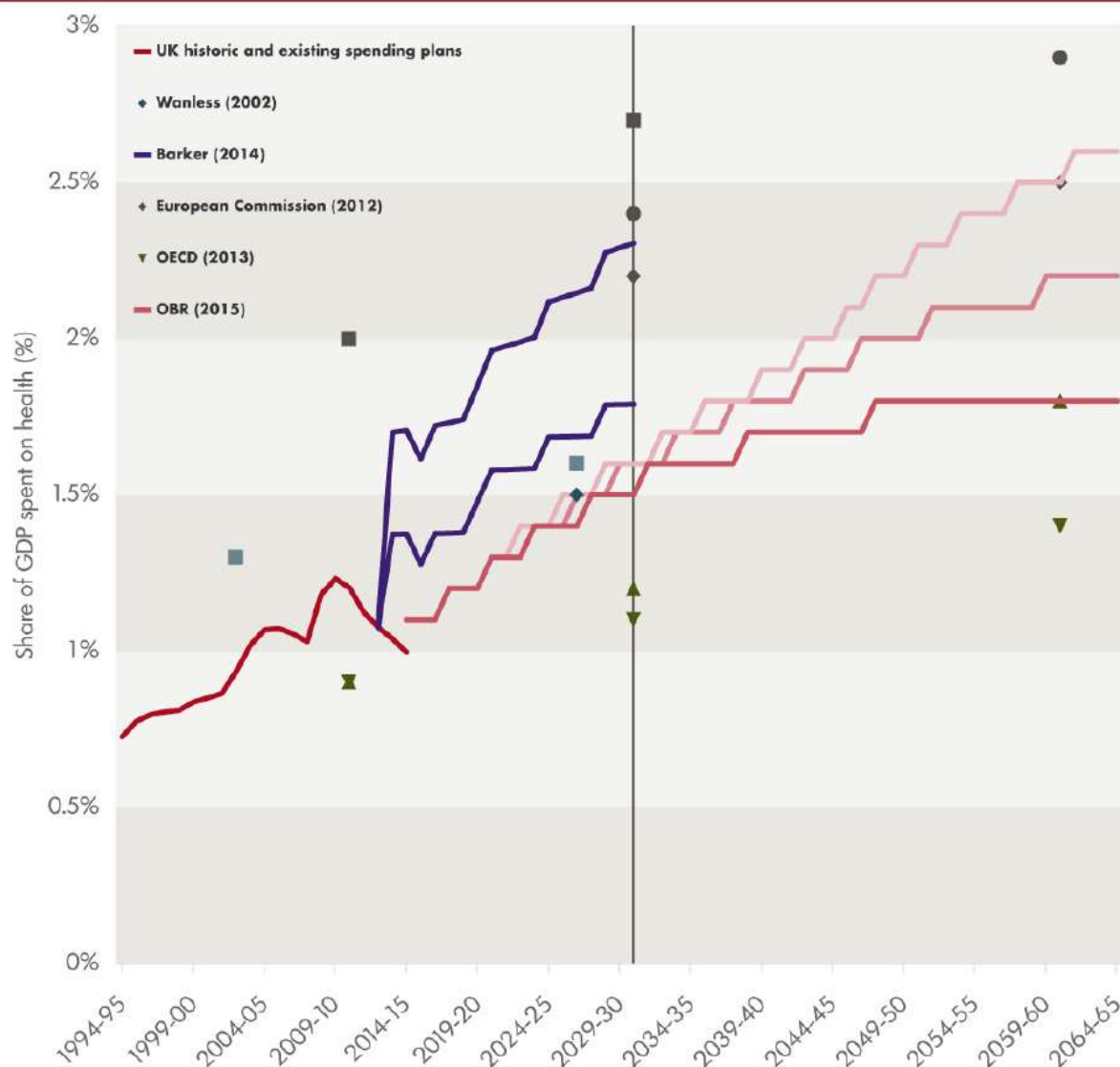
Table 2: UK long-term care/social care projections to 2030/31 as a percentage of GDP						
	Scenario	Baseline	2014/15	2015/16	2022/23	2030/31
	Actual		1.0			
OBR (2015)	Central projection		1.1	1.3	1.5	1.6
	Old age variant		1.1	1.4	1.5	1.6
	Young age variant		1.1	1.3	1.4	1.5
	High migration variant		1.1	1.3	1.5	1.6
	Low migration variant		1.1	1.3	1.5	1.6
	FSR14 restated (low migration variant)		1.1	1.3	1.4	1.5
	Higher initial health and education spending		1.1	1.3	1.5	1.6
	Lower health productivity growth		1.1	1.3	1.5	1.6
Barker (2014)	Critical and substantial needs eligibility only		1.4			1.8
	Moderate eligibility		1.7			2.3
Wanless (2002)	Core business	1.3 (2002)			1.5	
	Wellbeing				1.6	
OECD (2013)	Cost pressure	0.9 (avg 2006-2010) 2.0 (2010)				1.2
	Cost containment					1.1
European Commission (2012)	Base case					2.4
	Delayed dependency					2.2
	Cost convergence					2.4
	High life expectancy					2.4
	Shift to formal care					2.7
	Coverage convergence					2.7

Sources: OBR (2015), Wanless (2002), Lipszyc and others (2012), OECD (2013).

NB: OECD and EC 2030/31 are linear interpolations inferred from these studies' longer term projections (to 2060)

Depending on the study and the scenario, spending projections to 2030 range from 1.1% (OECD) to 2.7% (European Commission) of GDP. The OBR's projections were published in its 2015 Fiscal Sustainability Report and, unlike health, have not yet been updated this year.

Figure 3: Projections for UK long-term social care spending to 2064–65



Some data sources provide a highest and lowest projection or highest, central and lowest projections, so some plots diverge to show various outcomes. Sources: Wanless (2002), The King’s Fund (2014), EC (2013), OECD (2013), OBR (2015)

From a baseline spend in 2014/15 of around 1% of GDP (equivalent to £18.4 billion in 2015/16 prices), the OBR’s central projection suggests that population and other pressures would increase spending to 1.6% by 2030 – equivalent to around £42.5 billion at 2015/16 prices (a real increase of around 130%).

On the assumption of a need to boost quality and coverage of social/long-term care, however, the Barker Commission, for example, suggests spending by 2030 should range between 1.8% and 2.3% of GDP – equivalent to spending of around £48–£61 billion.

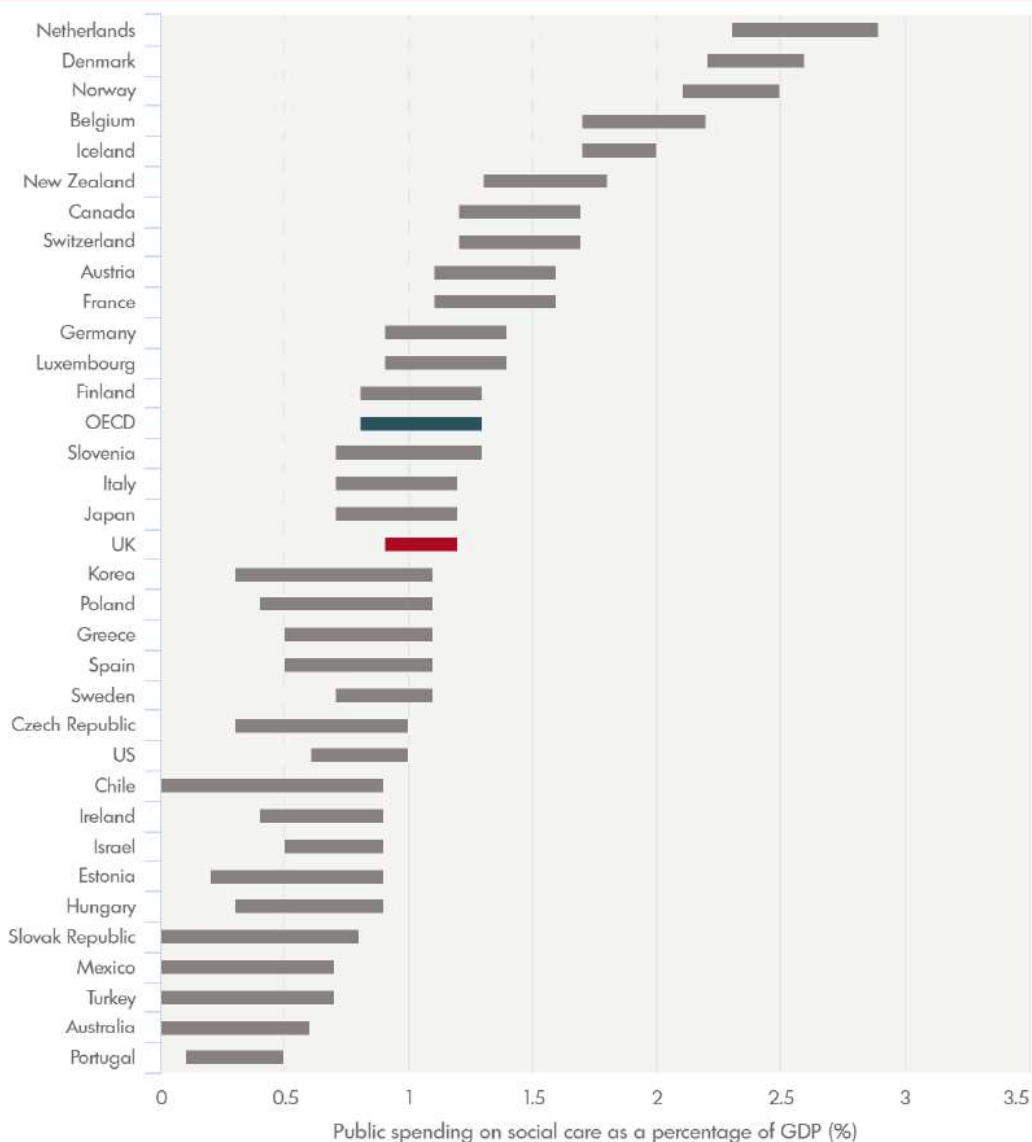
6. What do current spending projections tell us about the long-term sustainability of social care?

Historically, social care spending increased its share of GDP from 0.7% in 1994/5 to 1.2% in 2009/10 – equivalent to an annual real increase of 5.8%. Following real cuts to local authority budgets over the last six years, and despite their best efforts to maintain publicly funded social care, current spending on care has now fallen to a 1% share of GDP – back to the levels of over a decade ago – and equivalent to a real cut of round 0.6% every year from 2009/10 to 2014/15. It is also clear that funding cuts and tightening eligibility criteria to access social care has reduced the numbers of people with publicly funded care packages by over a quarter between 2009 and 2014 (Humphries and others, 2016).

In this context, the OBR's central projection would, over fifteen years, add a further 0.4% of GDP to the peak level in 2009/10 (and 0.6% over the level in 2014/15 – that is, taking 0.2% of GDP to catch up with the fall in share over the previous five years). On average, from 2015/16, this represents an annual real increase of 4.8% – between £0.5 billion in the early years to around £1 billion in the latter years (at current prices).

Internationally – and with a strong caveat concerning the comparability of data – the increase in social care spending projected by the OECD for the UK by 2030 would take it to just below the levels of spend averaged across 2006 to 2010 for Canada, Switzerland, New Zealand, Belgium, Iceland, Norway, Denmark and the Netherlands (which spent twice the proportion of GDP on long-term care in 2006/2010 that the UK is projected to spend over two decades later. And as Figure 4 shows, based on the OECD's upper projection, all OECD countries are expected to face increased spending pressures, leaving the UK's relative rank spending slightly lower by 2030 than in 2006/2010.

Figure 4: Public spending on long-term/social care across OECD countries 2010 and projected to 2030



As in the case of health spending, these historical and international comparisons provide an indication that additional funding for social care would be sustainable to 2030. And we would point out that around 30% of the increase in funding under the OBR’s central projection will simply arise from a growing GDP, leaving around 70% (~ £16 billion at today’s prices) to be found via a combination of tax and reprioritisation of public spending.

Again, on balance, while there will be opportunity costs associated with higher public spending on care, these do not seem to be unreasonable or particularly unaffordable over the period to 2030.

7. Higher social care spending – but who pays?

Given reductions in funding over the last six years (and, as with health, a further four years of further cuts) and the direct reduction as a result in numbers of people eligible to access publicly funded care (at a time of rising demand), it is hard to see social care as a sustainable quality service available to those in need on current – let alone declining – levels of funding.

While the decline in publicly funded care services are likely to have been filled to some extent through greater levels of self-funding and ad hoc provision (from friends, relatives and voluntary organisations), the exact extent of this is unclear – and there will be equity implications due to variations in income and access to support. There are some indications of knock-on effects to the NHS, however, with a significant increase in the number of patients delayed in hospitals for reasons attributable to social care and access to care packages at home (Humphries and others, 2016).

We would agree with Kate Barker's conclusion that, one way or another, as a nation and as individuals, we will need to pay more for social care in future (The King's Fund, 2014) and that this will inevitably mean higher public spending. However, it might also mean higher private contributions in one form or another. We also note that, over the last decade, there have been a number of significant reports on how we might pay for social care in the future (cf Commission on Funding of Care and Support, 2011; The King's Fund, 2006) – but to date there seems to have been a political reluctance to grasp the nettle on this issue.

Summary: Social care

It is inevitable that the pressures to spend more on social care will grow over time. Social care also presents other problems in terms of future sustainability due to its funding sources and traditional separation from health. But, as with health, one way or another we will end up paying more; financially, either through higher taxes (for better services) or out of pocket, or the non-financial costs arising from reduced access to publicly funded services of declining quality and for some, exclusion from privately funded care rationed on the basis of ability to pay.

The choice, therefore, is not whether to devote more of the UK's growing wealth to social care, but how to ensure extra spending delivers what we want from social care – including, we would argue, as with health, equal opportunity of access for equal needs.

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6 October 2016

Nursing and Midwifery Council – Written evidence (NHS0169)

About the Nursing and Midwifery Council

The Nursing and Midwifery Council (NMC) regulates nurses and midwives in England, Wales, Scotland and Northern Ireland. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.

We make sure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses and midwives who fall short of our standards. We maintain a register of nurses and midwives allowed to practise in the UK.

There are over 690,000 nurses and midwives on our register. Individuals work across a variety of settings in different roles including within acute trusts, mental health trusts, in the community and care homes.

Our [Code for nurses and midwives](#) sets out the professional standards that nurses and midwives must uphold. It is structured around four themes – prioritising people, practising effectively, preserving safety and promoting professionalism and trust.

Revalidation

Taking effect from April 2016, revalidation is the new process that all nurses and midwives in the UK will need to follow to maintain their registration with the NMC. All nurses and midwives are required to renew their registration every three years.

Revalidation is an important tool helping nurses and midwives to demonstrate that they practise safely and effectively. It strengthens the renewal process by introducing new requirements that focus on:

up-to-date practice and professional development;

reflection on the professional standards of practice and behaviour as set out in the Code; and

engagement in professional discussions with other registered nurses or midwives.

For nurses and midwives, revalidation is an important reflective process that supports continuing professional development. It helps to bring nurses and midwives into an environment where they will have the opportunity to engage in professional networks and discussions around their practice. Thus encouraging a culture of sharing, reflection and continuous improvement. Revalidation also encourages nurses and midwives to stay up to date in their professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals.

Our role in standards of education

Our Council has prioritised the education of nurses and midwives as a key area of focus for us over the coming years.

We are committed to delivering a programme of change for education between 2016 and 2020, to ensure that new nurses and midwives are safe, skilled and confident when working across a health and care system that is changing at an unprecedented rate. These standards will have an increased focus on public health and well-being, patient or person-centred care, and in helping nurses and midwives to help support self-care.

The health and care landscape is changing rapidly resulting in an increased blurring of professional boundaries. The use of multi-disciplinary and multi-agency teams is increasing, and there is a growing focus on person-centred care delivered closer to home. Nurses and midwives are being asked to take on additional professional responsibilities, with many required to undertake ever more complex roles across a range of settings.

It is critical that nurses and midwives of the future have the right knowledge, skills and professional attributes when they join the register, in a way that is not only fit for the present day, but also for the future.

Our work on our education standards is guided by the following vision.

As a professional regulator we will ensure education and evidence-informed practice is at the heart of safe and effective care in nursing and midwifery.

Patients, service users and the public will have a clear understanding of what nurses and midwives are competent to do because of our clear standards of education.

Our role in education will be trusted and respected because of our clear standards of education for nurses and midwives which will be supported by our framework of quality assurance.

We will ensure that nurses and midwives are consistently educated to a high standard, so that they are safe, skilled and confident; and fit for the future in a changing and dynamic healthcare environment.

We have committed to a number of projects already over the period 2016–2017, including:

the development of new, outcome-based standards of proficiency for the future graduate registered nurse;

the development of new standards of proficiency for the future graduate registered midwife. These have not started yet, but will do so imminently;

the development of an education framework setting out the requirements for institutions seeking to deliver approved nursing and midwifery education programmes;

an independent review of our quality assurance function; and

a review of some of our other standards including for medicines management, prescribing and return to practice.

We want to use our role in education to ensure that nurses and midwives are equipped to practise effectively in diverse, changing and in some cases, global, environments for now and into the future.

We recognise that in modern society more flexible routes into nursing and midwifery are needed. We are already supporting the development of more flexible education programmes, working with partners in the education sector. Such programmes include work-based learning and courses aimed at healthcare assistants which recognise prior learning and experience. Former nurses and midwives who wish to return to the professions after a career break can also take a return to practice course.

Professional regulation

The Department of Health is currently considering how to reform professional regulation so that it offers a more flexible, proportionate and cost-effective approach. We are fully involved in these discussions alongside the other professional regulators and the Professional Standards Authority.

Nursing associate

Health Education England's (HEE) Shape of Caring review, which was co-sponsored by the NMC, recommended the development of a defined care role which would act as a bridge between healthcare assistant and registered nurse.

HEE has since consulted on the creation of a new nursing associate (NA) role. This included consideration whether the new role should be regulated and if so, by whom. The consultation indicated strong support in favour of regulation. The new role will be piloted starting from January 2017.

It is right that changing demands on our health and care services should give rise to new models of care and new roles in the delivery of care. Professional regulation needs to be responsive to such developments, with the flexibility to protect the public where public confidence demands that new roles should be regulated.

If regulation is deemed necessary for nursing associates, we have said that we believe that we are the right body to take on regulation and we are confident that we can do so effectively. Any extension of our regulatory remit to include nursing associates would require changes to our legislation.

Following a request from the Department of Health and Health Education England, our Council has agreed to provide expert input into the development of the nursing associate role. Pending a Government decision on regulation, our involvement in this initiative has been motivated by a need to ensure there is alignment between our new standards for graduate nurses and the framework for nursing associates, which is intended to provide a progression route to nursing as well as being a role in its own right.

Nursing apprenticeships

The Government has committed to achieving a target of three million apprenticeships by 2020. The Government consulted on the NHS contribution to that target in January 2016, with a view to 100,000 apprenticeships in healthcare by 2020. We have been involved in discussions with Department of Health (DH), Department for Business, Innovation and Skills (BIS) and Health Education England (HEE) on a higher level apprenticeship for nursing which will provide an opportunity for suitable employees, for example healthcare assistants, who aspire to progress their career to learn while they earn. The development of the apprenticeship standard sits with an employer-led Trailblazer Group, as required by the apprenticeships framework. The Trailblazer Group has submitted a draft higher apprenticeship standard to the Government for approval.

The nursing degree apprenticeship initiative has similar aspirations to the NA proposals in terms of seeking to widen access to the nursing profession. The NMC has been actively involved in the Trailblazer Group and has had regular meetings with officials to ensure the alignment of our pre-registration nursing standards and the requirements of apprenticeships.

If the apprenticeship standard is approved, NMC approved education institutions wishing to offer an apprenticeship route would need to modify their programmes to meet some additional requirements that are part of the apprenticeships framework. We hope that it may be possible to recruit to nursing apprenticeship programmes from 2017.

Conclusion

The role of the professional regulator is absolutely essential to ensure the protection of the public. With the changing nature of the health and social care landscape, we are working hard to ensure that professional regulation for nurses and midwives is fit for the 21st century and sustainable for the future.

29 September 2016

Nutricia: Advanced Medical Nutrition – Written evidence (NHS0101)

Introduction

1. This document outlines Nutricia: Advanced Medical Nutrition's (Nutricia:AMN) response to the inquiry launched by the House of Lords Committee on the Long-Term Sustainability of the NHS in July 2016.
2. Our submission response focuses on what we can, as a third party, do to help support the following themes in guaranteeing the sustainability of the NHS:
 - Resource issues, including funding, productivity and demand management; and
 - Models of service delivery and integration.
3. At Nutricia:AMN we are constantly innovating both our products and systems of delivery. Through working in partnership help reduce avoidable costs and improve patient outcomes at a time when the NHS has to meet challenging financial targets.
4. In this response, we set out how the integration of medical nutrition within patient pathways presents a logical 'invest to save' case by reducing costs, including in-patient time, readmissions and complications. Moreover, we illustrate how our innovative Homeward Nursing service provides a cost-effective local model of care which supports patient-self management.
5. By relieving pressure on hospitals and promoting self-management, medical nutrition helps to tackle looming long-term challenges for the health service, and ensures the sustainability of the NHS.

What is medical nutrition?

6. Medical nutrition, otherwise known as medical foods, distinct from normal healthy foods, describes a special category of foods designed to meet the needs of patients whose disease or health concern requires medically determined nutritional support. Medical nutrition is scientifically formulated and available in many different formats, including liquids for drinking or being fed through a tube, powders and spoonable products. Medical foods are backed by a significant body of evidence, are available on prescription, reimbursed by the government, and must be administered under the supervision of a healthcare professional.
7. High quality medical nutrition care is important to helping people manage long-term conditions, improve experiences of care and quality of life. Liquid or tube feeds can

be used across care settings and form an important resource in management plans for diseases such as stroke, dementia, chronic obstructive pulmonary disease (COPD), bowel & colorectal cancer, intractable epilepsy and cerebral palsy in addition to supporting the management of pressure ulcers, amongst others.

8. Oral Nutritional Supplements (ONS) may be prescribed, for example, to those who find it difficult to get adequate nutrition from a normal diet alone. The nutritional composition of ONS is based on extensive scientific and clinical research, and in many cases its use is recommended in international, national and professional guidelines. Products are generally available in the form of a powder or liquid drink containing energy, protein, vitamins and minerals. Medical nutrition products are usually prescribed by a healthcare professional and must be used under medical supervision.

Resource issues, including funding, productivity and demand management

9. Through increased healthcare interventions, malnutrition is estimated to cost £19.6 billion in the UK annually, equating to 15% of the health and social care budget⁸⁹². According to a BAPEN/NIHR report, 30% of patients admitted to hospital and 35% of those admitted to care homes are malnourished⁸⁹³. ONS are a clinically and cost effective way to manage malnutrition⁸⁹⁴. It has been estimated that a total net saving of £126 million could be achieved if medical nutrition was to be fully integrated in patient management for malnutrition, meaning it is now more expensive not to treat malnutrition⁸⁹⁵. NICE ranks nutrition support as the third most cost effective of its clinical guidelines, saving an estimated £71,800 per 100,000 patients⁸⁹⁶. Moreover, figures from the Malnutrition Taskforce and British Association of Parenteral and Enteral Nutrition (BAPEN) have indicated that medical nutrition could save the NHS £849 per patient due to reduced use of antibiotics and fewer complications, meaning a shorter stay in hospital.
10. However, despite clear evidence to support the cost-effectiveness of medical nutrition in supporting those at risk of malnutrition, including patients living with chronic obstructive pulmonary disease (COPD) and bowel cancer, many Clinical

⁸⁹² **The cost was calculated from the proportion of healthcare activity due to malnutrition and the cost for this activity, which in some cases was uplifted to take into account additional known effects of malnutrition, such as prolongation of length of hospital stay.** BAPEN and NIHR Southampton, The cost of malnutrition in England and potential cost savings from nutritional interventions (full report), <http://www.bapen.org.uk/pdfs/economic-report-full.pdf> p1

⁸⁹³ BAPEN and NIHR Southampton, The cost of malnutrition in England and potential cost savings from nutritional interventions (short report), <http://www.bapen.org.uk/pdfs/economic-report-short.pdf> p4

⁸⁹⁴ Stratton RJ and Elia M. A review of reviews: A new look at the evidence for oral nutritional supplements in clinical practice. *Clinical Nutrition Supplements* 2, 5-23. 2007.

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research/Ourresearchandimpacts/Impactcasestudies/ThecostofmalnutritionintheUKeconomicreport.aspx

⁸⁹⁶ NICE, NICE support for commissioners and others using the quality standard on nutrition support in adults, <https://www.nice.org.uk/guidance/qs24/resources/support-for-commissioners-and-others-using-the-quality-standard-on-nutrition-support-in-adults-252372637>

Commissioning Groups (CCGs) are instigating prescribing reviews. In order to meet efficiency targets, some CCGs are restricting access to medical nutrition with a view to reducing costs. This not only promotes a “postcode lottery” of healthcare disparity but is also a false economy. Adoption of medical nutrition within patient pathways presents a logical ‘invest to save’ case by reducing costs including in-patient time, readmissions and complications. By relieving pressure on hospitals and promoting self-management, medical nutrition helps to tackle looming long-term challenges for the health service, and ensures the sustainability of the NHS.

11. In practice, restrictive prescribing of ONS could mean that patient access to medical nutrition could be curtailed in an effort to make short-term savings, despite NICE clinical guidelines which mandate its inclusion within care pathways for specific diseases. This will impact patient outcomes and quality of life. It will also have a negative impact on funding for the health service.
12. Given the benefits to both patient outcomes and the financial position of the health service, we believe medical nutrition should be formally recognised by the NHS and local prescribing pathways as a key facet which is evidence based in NICE clinical guidelines as a key facet of the treatment pathways for diseases such as intractable epilepsy, cerebral palsy, chronic obstructive pulmonary disease, amongst others.

Innovative models of service delivery and integration: The Nutricia Homeward Nursing Service

13. The Nutricia Homeward Nursing Service is a successful example of an innovative local model of care which supports the delivery of whole-person care and helps to bridge the gap between acute and community nutritional services for those suffering with long-term conditions, malnutrition or other diseases.
14. Nutricia:AMN employs more than 100 nurses who support more than 25,000 adults and children who feed at home throughout the UK through our home enteral support suite of services, Nutricia Homeward. We are dedicated to making a difference to the lives of people who tube feed at home and their families and carers. The Nutricia Homeward service delivers prescribed enteral tube feeding products, pumps and ancillary items direct to NHS hospitals and patients’ homes.
15. We are committed to helping the health service deliver integrated health and social care: Nutricia Homeward supports people who will be tube feeding from the time they prepare to leave hospital throughout the duration of their tube feeding journey at home. Nutricia: AMN work closely with dietitians and other healthcare professionals to adapt our services to the needs of each individual patient and to continually improve and innovate our services.

16. In 2015, the service made over 350,000 Homeward deliveries, processed 261,000 prescriptions and registered nearly 12,000 new patients.
17. Nutricia Homeward provides services across the spectrum of patient need, from those who require tube feeding from point of discharge, to an integrated approach in community care. In addition, the service provides a dedicated coordinator and nursing support to ensure that patients and carers are able and confident enough to be nutritionally independent at home.
18. The Nutricia Homeward Service model was shortlisted for the HSJ Clinical Efficiency Award in 2013, and has been promoted by the NHS Alliance as a good example of integrated care, supporting people to self-manage in the community.
19. The model promotes a better quality of life for patients living with a range of illnesses, promoting improved outcomes and preventing avoidable costs. Equally, this model offers an example that promotes a high level of value to local authorities and health services by ensuring patients avoid costs from earlier discharges, provides monitoring in the community setting, a lower risk of readmission due to complications, good prescription management, and specialist nursing provision.
20. It is also in line with the NHS and local authority commitment to deliver better integrated care, innovate in patient pathways and support patient self-management. This service looks after not only patients, but their carers too, giving them more flexibility, allowing more control over how medical nutrition fits around their lives.
21. We are particularly keen to resource the Homeward Nursing Service with digital tools, to further enhance this very personal model of care. We recently launched a state of the art digital interface between Nutricia:AMN and the NHS. We are particularly keen to champion this aspect of our service.
22. Nutricia:AMN has also developed an award winning Dietetic App for handheld devices which allows healthcare professionals to calculate a patient's nutritional requirements using a variety of methodologies and compare requirements to feeding regimens. It also puts the entire Nutricia: AMN product compendium at their fingertips.
23. Digital innovation and further commitment to improving patients' lives through innovative approaches should be a priority for the NHS to continue to deliver integrated health and social care.

Conclusion and recommendations

24. With the growing challenge that comorbidities and the ageing population present to the NHS, we believe medical nutrition can form a key part of an innovative transition from hospital to community treatment. Adoption of medical nutrition within patient pathways presents a logical 'invest to save' case through reducing costs including in-patient time, readmissions and complications.
25. An integrated programme of medical nutrition can help to reduce complications across a spectrum of conditions, and has been proven to reduce hospital admissions and readmissions by 30%⁸⁹⁷; reduce average length of hospital stay by 4.5 days and reduce overall complications such as pressure ulcers and infections by over 50%⁸⁹⁸. By relieving pressure on hospitals and promoting self-management, medical nutrition helps to tackle looming long-term challenges for the health service, and ensures the sustainability of integrated health services. Given the benefits to both patient outcomes and the financial position of the health service, we believe medical nutrition should be formally recognised by the NHS as a key facet of the treatment pathways for long-term conditions.
26. We believe that the Government and NHS England should encourage greater awareness of good nutritional management. They should also ensure that medical nutrition is available, by increasing accountability for good prescribing practices at a local CCG level to reduce avoidable pressures on urgent and emergency care.
27. At Nutricia:AMN, we feel that with the right regulatory and commissioning support, innovative health solutions including medical nutrition can be part of improving the quality of life for patients, play a key role in the transition from acute to community care and ensure a sustainable future for the NHS.

About us

Nutricia: AMN, part of Danone, a FTSE4GOOD listed company, is the market leader in the UK's medical nutrition sector. Committed to helping people live healthier and longer lives, Nutricia AMN seeks to integrate medical nutrition into all national care pathways for long term conditions to ensure better outcomes and faster recovery. Nutricia AMN is proud of its role in pioneering nutritional discoveries that help millions of people live longer, healthier lives. Please visit <http://www.nutricia.co.uk/>

23 September 2016

⁸⁹⁷ Cawood AL, Elia M, Stratton RJ., 'Systematic review and meta-analysis of the effects of high protein oral nutritional supplements.' Ageing Research Review 2011

⁸⁹⁸ Cawood AL, Smith A, Pickles S, Church S, Dalrymple-Smith J, Elia M et al., 'Effectiveness of Implementing 'MUST' into care homes within Peterborough Primary Care Trust, England.' *Clinical Nutrition (Supplements)* 2010; 4(2):81

Mrs Susan Margaret Oliver RN, MSc, FRCN, OBE – Written evidence (NHS0006)

Nurse Consultant Rheumatology (Retired) Specialised in service re-design within the field of Rheumatology.

1. The need for change for the future healthcare system is pivotal to the long-term sustainability of the NHS. The changes can be a root and branch review of all services and re-design them OR consider changing the service providers more radically, OR undertaking a national community agreed approach to identify ‘priority non life threatening care issues’

Firstly, we have to ensure that there is a balance between ‘rights’ to access all aspects of healthcare and receive treatment with ‘responsibility’. John Major’s government introduced patients rights but without the balance of ensuring a sense of responsibility into the use of healthcare. This issue of ‘rights’ has continued despite inappropriate use of healthcare systems.

The National Institute of Health and Clinical Excellence (NICE) have struggled with restricting expensive treatments as different groups lobby etc. We need to find a process that allows the community to become involved in what is appropriate for the NHS to fund. A similar project was carried out many years ago in Oregon (USA) where the community were educated and given information of risks, benefits and treatments and then asked to prioritise health needs for that community. In this day and age where nobody accepts the opinion of anyone it will probably need some modification but there needs to be a frank and honest review of treatments we should;

- a) Decommission services shown to be of minimal or no evidence.
- b) Fall outside the remit of ‘health care’ and there should be precluded from routine care
- c) Consider General Practitioners being employed as part of the NHS rather than as independent contractors. So that when and where they work could be more flexible.
- d) Part of the programme to induct/educate new members of our community to adjust to life in the UK – all new arrivals should be given an educational programme about the NHS and how it can be used, equally in the pre-liminary phase of the arrival should receive an NHS special card that enables their care and treatments to be tracked (as many people end up moving around). Equally as part of this issue it is vital that the new arrivals to this country have to be strongly encouraged to learn English. In my experience in many different parts of the country the language barrier, costs of time and resources to employ not always ideal translators, or even more complex a member of the family acts as a translator is a major problem in terms of decision making, costs, honesty of reporting etc.
- e) Chronic disease management needs a strong and pro-active consistent approach to care. This should include prompt specialist nursing telephone guidance and rapid access to nurse led clinics. The biggest threat as I see it to the current NHS delivery is the loss of specialist nursing – they are the hidden workforce, who over the years have been downgraded, loss posts and increasingly lack recognition. The reason for

this is simply put – the NHS does not sufficiently capture the data related to nursing activity in this area. These nurses prevent patients returning to A&E for emergency treatment, provide guidance that will result in them not requiring a further GP appointment or coming in as an emergency via ambulance. They keep them safe on their drugs treatments and yet stop them when they monitor and see they are in danger of side effects. They are also ‘brokers’ for the patient – acting as a negotiator to make the process of working their way around the complex healthcare system, waiting times for things like MRI etc less stressful. They are the chronic disease patients lynch pin.

There are models delivered by the Israeli government, which has extremely efficient chronic disease management packages. These are possible in Israel as they fund all healthcare delivery through 4 large nominated insurance providers who then have to compete to deliver the best packages of care to get patients electing to go with them. However, the way chronic disease is managed in Israel is impressive and puts patients in the driving seat of their care.

Equally there are the Scandinavian models but these require the population to have (as the Swedes do) a very altruistic view of care and resources.

- f) Health Professionals (nursing specifically but also other non-medical staff) should provide a significant proportion of identified patient groups who do not require expert or complex management. This can be achieved with the use of appropriate guidelines and pathways with ‘red flags’, which highlight a patient at risk, or complex signs that requires more advanced management. Nurse and HPs should receive the same focus on education and training as doctors do, as should their activities and patient outcomes/data collection/evaluation of services. A stronger focus on a good career pathway, particularly at senior level should be review.

2. Question: Resources issues, including funding, productivity, demand management and resource use.

- a) Yes, the wider societal value of the healthcare system does exceed its monetary cost. However this is not fully recognized nor appreciated. We need to train all those in healthcare to be good ambassadors of the NHS the most destructive attitudes I see are by disillusioned and disempowered NHS staff who then convey their views to their patients, fostering a view that the NHS is failing and incompetent.
- b) Funding models to ensure financial stability. This is a difficult one. However, in a small way the approach of de-commissioning services who were not delivering and had poor quality /or entrenched consultants (e.g. orthopeadics in 2006) were changed following the introduction of independent treatment centres. Although it caused a big outcry in fact it changed the orthopeadics’ approach to addressing problems within their service after that. This means that people who do not work effectively are replaced within three /five years, unlike recalcitrant services within the current NHS.
- c) On a large grand scale, we should increase the contribution that we all pay towards NHS and social care. I do not think Scandinavian models will work in the UK and models such as those in Israel would require a significant and huge change in the

management of the NHS. Co-payments to me seem fraught with challenges, with many itinerant travelers, immigration and others who will not be able to currently be tracked down to pay. We need a good and effective Computer System for the NHS and this has to be integrated with General Practice (another reason to want GPs to be part of the NHS rather than independent practitioners)

- d) Yes – we need to decommission many more ineffective services. Equally we should also tighten those treatments that are not seen as directly related to health or non-life threatening/changing to be decommissioned.

3. Workforce

- a) We need greater investment into all workforce members, in initial training but in regular updating and advancing of proactive. We need to be enhancing the roles of HPs to fill large gaps in care (when we have sufficient workforce).

The greatest challenge in HPs workforce is that the career pathways are so poor and limited that we lose many university graduates or potential trainees as why would they choose the NHS. We need to build a way of valuing our workforces.

I have had personal experience whilst caring for my dying mother of seeing the excellence service given by Spanish nurses who were compassionate and warm, yet this option may change with BREXIT. We need to be mindful of where and how we bring in foreign students because a lot of care is based upon the social norms of that community and needs to be learning, as well as effective language skills.

In the short term I think a good way for nursing is bring back a rapid access, funded short term return to nursing programme, this would need to be co-coordinated with the Nursing and Midwifery Council to re-register some...they have the majority of skills and could provide an immense workforce who may need to get some additional funding for pensions etc but are capable and experienced.

4. Workforce

For nurses and HPs I think much more 'on the job' mentorship and training should be undertaken. This can be delivered by well-trained clinical staff that can provide a role model to the students as well.

Technology is vital and we should advance all models that have been demonstrated to be of value and ensure appropriate investment is made in this area....This should include:

1. Computer systems that allow virtual meetings, with slides etc – so staff can train on site or have meetings when appropriate – rather than travel.
2. Telephone/computer system that allow nurse specialist and consultants to undertake telephone interviews or consultations with patients, record the details, track the data electronically. In Israel this approach is well used and enables patients who have long term conditions not to travel as many electronic aids are used by the patient (following training) to monitor etc (Tele-health approaches).

3. Greater encouragement for nurse led telephone reviews and recorded and booked as timed, clinical sessions. This reduces hospital visits etc and yet maintains people on drug therapies following assessment and re-assurance.
4. Nurses should be given support of clerical teams and a health care assistant under their management, so they are adequately trained and supported yet supporting the actual work of the nurse. Rather than the approach of introducing another type of HP into this complex mix with no regulatory authority, no clear pathway etc (e.g. physicians' assistant).
Nurses and HPs should be encouraged and funded to deliver care in all care settings without barriers and threats to their organization. Many teams would wish to do more in different settings but the money does not follow the patient and therefore they are dissuaded.

5. Models of service delivery and integration:

- b) We need to unlock the challenges related to hospitals losing income generation and incentives reductions in activity
- c) If we can find a way – the same as above .

I would also like to add that in my 12 years of working with teams on service re-design is that unless you get people to actually 'map' what is truly happening in their services, they all believe they are doing better than they are and do not see the 'true' complex and frustrating, time consuming journey the patient has to undertake to receive adequate care, particularly in long term conditions management. We need to explore much more about the day-to-day reality of how these complex journeys triple costs of care.

Prevention and public engagement

No specific comments/expertise

8 Digitisation of services.

- a) See earlier comments about workforce. Technologies and training in technologies will be vital to the success of the NHS. Denmark, Sweden etc have these well-developed basic systems. We lag way behind. All of these technologies will reduce the need to attend outpatients, and empower patients to understand their conditions better.
- b) Big Data – is vital but I have no more specific comments other than throughout this document – nor is it specifically my area of expertise.
- c) Barriers are related to investment of the right technologies that are well trialed and endorsed plus training time with the appropriate prepared organisations guidance and monitoring of equipment.
- d) Funded, but also incentivize savings rather than activity.
- e) Chronic disease management would probably make a significant impact and be a good place to start.

[1]

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8 August 2016

Optical confederation and Local Optical Committee Support Unit – Written evidence (NHS0085)

About Us

As the voice of UK optics, the [Optical Confederation](#) (OC) represents the 13,000 optometrists, 6,000 dispensing opticians, 45,000 support staff and 7,000 optical businesses in the UK who provide high quality and accessible eye care services to the public. We are a coalition of five optical representative bodies: the [Association of British Dispensing Opticians](#) (ABDO); the [Association of Contact Lens Manufacturers](#) (ACLM); the [Association of Optometrists](#) (AOP); the [Federation of Manufacturing Opticians](#) (FMO) and the [Federation of \(Ophthalmic and Dispensing\) Opticians](#) (FODO). As a Confederation, we work with others to improve eye health for the public good.

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to Local Optical Committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

1. Introduction

1.1 The Optical Confederation and Local Optical Committee Support Unit welcome this inquiry of the House of Lords long term sustainability of the NHS select committee. The NHS faces a very uncertain future with increasing demand on services as the population ages, and finances continuing to cause considerable concern.

1.2 The demand for eye health services is rising linked to the growth in the ageing population. The number of people aged 65+ is projected to rise by over 40% (40.77%) in the next 17 years to over 16 million⁸⁹⁹. Advances in medicines and treatments have meant that many eye conditions that have led to blindness in the past, such as Age-related Macular Degeneration (AMD) and Diabetic Maculopathy are now treatable. However, this has increased the demand on hospital eye services. The demand for hospital eye services has increased by 8% from 2013/14 to 2014/15⁹⁰⁰, with 7,073,064 eye related eye patient appointments in 2014-15⁹⁰¹. It is estimated that 78% of hospital attendances for eye care could be better managed within primary care⁹⁰².

1.3 The impact of the ageing population on national eye health will be significant. The recent Foresight Project Report⁹⁰³ on the potential impacts of technology on the UK optical sector to 2030 projected the prevalence of blindness or partial

⁸⁹⁹ National population projections for the UK, 2014-based, Office for National Statistics, 2015

⁹⁰⁰ NHS Digital, Hospital Outpatient Activity - 2013-14. <http://www.hscic.gov.uk/catalogue/PUB16722/hosp-outp-acti-2013-14-all-atte-tab.xlsx>

⁹⁰¹ NHS Digital Hospital Outpatient Activity 2014 -15 <http://digital.nhs.uk/catalogue/PUB19608/hosp-outp-acti-2014-15-all-atte-tab.xlsx>.

⁹⁰² Minor Eye Conditions Service (MECS) Pathway. LOCSU. 2015.

⁹⁰³ 2020 Heath (2016), Foresight Project Report: A discussion of the potential impact of technology on the UK optical sector to 2030: <http://www.abdo.org.uk/news/foresight-project-report/>

blindness increasing over time. In the 20 year period between 2010 and 2030 it estimated that AMD will have an 80% increase, Cataract a 64% increase, Glaucoma a 52% increase, and Diabetic Retinopathy a 28% increase.⁹⁰⁴

1.4 With pressures on GPs increasing, and the NHS systematically moving towards a more multi-disciplinary and holistic way of treating patients, community optical practice can and should be playing an important role within a multi-disciplinary approach to the NHS of the future.

2. Workforce – Including supply, retention and skills

2.1 The optical workforce is flexible and responds to the supply and demand for eye care services within a specific area. With workforce becoming an increasing issue across other parts of the NHS in secondary and primary care, the optical workforce could be utilised more effectively to help relieve workforce pressures elsewhere in the NHS.

2.2 Hospital Eyes Services (HES) are under enormous pressure and the ophthalmologist workforce is not increasing. The community optical workforce skill-set is significantly under-utilised within primary care services. Currently, there are 2.6 million eye related GP appointments.⁹⁰⁵ Most of these appointments could be better managed by optometrists and dispensing opticians who are experts in eye health care in the community.

2.3 A lot of routine work currently performed in hospital ophthalmology departments could be safely transferred to the community. This would not only be more convenient and accessible for patients – and result in far fewer people not attending appointments, but would relieve pressure on hospitals and GPs.

2.4 Ophthalmology oversight and/or training for optometrists and dispensing opticians beyond core skills are required in some areas for more specialist services that can be provided in primary care. Support for this can be provided by Health Education England working through Local Eye Health Networks (LEHNs) and Local Education and Training Boards (LETBs).

3. Models of service delivery and integration

3.1 Integration of services and better commissioning for acute and chronic conditions based on the needs of the population will be vital if the NHS is to have any chance of being sustainable in the future. Vanguards, Sustainability and Transformation Plans (STPs), and Devolution in Manchester and other regions, are first steps in moving to a more joined-up integrated and holistic approach to commissioning health and social care. The progress of these initiatives will need to be closely monitored and evaluated so that best practice can emerge.

3.2 It is clear that some of the procedures and outpatient services which are currently delivered by ophthalmologists will need to be delivered outside of the

⁹⁰⁴ *ibid*

⁹⁰⁵ Sheldrick JH, Wilson AD, Vernon SA, Sheldrick CM. Management of ophthalmic disease in general practice. *Br J Gen Pract.* 1993 Nov;43(376):459-62.

acute sector as they are already running at capacity in many cases. Much of this can be delivered in the community by an up-skilled optical workforce that has been MECS accredited and/or with the Independent Prescribing (IP qualification). Pathways for the commissioning of community eye services have been developed by LOCSU and the Clinical Council for Eye Health Commissioning as below:⁹⁰⁶

- Children’s Vision Pathway⁹⁰⁷
- Pre and Post Operative Cataract Service⁹⁰⁸
- Glaucoma Repeat Readings and OHT Monitoring Pathway⁹⁰⁹
- Community Eyecare Pathway for Adults and Young People with Learning Disabilities⁹¹⁰
- Low Vision⁹¹¹

3.3 Some of these are currently commissioned by some CCGs on a case by case basis. The level of transformation is slow, with many people missing out on these services due to the fractured nature of commissioning. While we recognise that CCGs are now well established at the heart of the English health landscape, significant savings could still be achieved across the system by agreeing a national pathway with common standards, outcomes and experience measures that all areas would implement – ideally at one fixed fee to save commissioning costs.

4. Prevention and public engagement - How can people be motivated to take greater responsibility for their own health? How can people be kept healthier for longer?

4.1 There is a widely held consensus that a radical upgrade in prevention is the most important factor for ensuring a sustainable future health and social care system; indeed, this is one of the central tenets of the 5YFV. This will require a radical shift in culture among both professionals and members of the public. Government and NHS alike will need to encourage members of the public to take a greater responsibility for their health and wellbeing, cutting the number of medical interventions.

4.2 Currently in England the General Ophthalmic Services Contract (GOS) delivers 12.8 million sight tests a year, leveraging approximately a further 5.9 million private sight tests at a cost of £250 million to the taxpayer⁹¹². This makes the national NHS sight testing service one of the best value public health service in

⁹⁰⁶ Clinical Council for Eye Care Commissioning, Community Ophthalmology Framework, <http://www.college-optometrists.org/en/utilities/document-summary.cfm?docid=04657CE1-1824-4058-B8C6ADC4E40A9A76>

⁹⁰⁷ <http://www.locsu.co.uk/community-services-pathways/childrens-pathway/>

⁹⁰⁸ <http://www.locsu.co.uk/community-services-pathways/cataract-referral-and-post-op/>

⁹⁰⁹ <http://www.locsu.co.uk/community-services-pathways/glaucoma-and-oht/>

⁹¹⁰ <http://www.locsu.co.uk/community-services-pathways/community-eye-care-pathway-for-adults-and-young-pe>

⁹¹¹ <http://www.locsu.co.uk/community-services-pathways/low-vision/>

⁹¹² NHS Digital, general ophthalmic services activity statistics England 2014-15, <http://digital.nhs.uk/catalogue/PUB17930/gene-opht-serv-acti-eng-year-end-mar-15-rep.pdf>

the NHS, with sight-testing under GOS playing an important public health role in providing vision correction for those needing it. The early detection of sight-threatening and other health conditions through the eye examination is essential to reduce avoidable sight loss. It is absolutely vital that the NHS funds the sight test appropriately and acknowledges its importance in managing the burden of disease that the NHS increasingly faces.

4.3 Optometrists and dispensing opticians can also participate in public health preventative services such as smoking cessation. There is a well-established link between smoking and AMD and between smoking, obesity and diabetic retinal disease. Smokers double their risk of developing AMD and usually develop the condition earlier than non-smokers.⁹¹³ Optical professionals can advise on a range of other issues which can negatively affect both eye health and wider health and wellbeing including harmful alcohol consumption and obesity. The recent Healthy Living Optician initiative launched in Dudley⁹¹⁴, which follows the established Healthy Living Pharmacy programme, provides a framework for the commissioning of a portfolio of valuable public health services under one ‘label’ together with a robust accreditation process.

5. Digitisation of services, Big Data and informatics

5.1 Currently community optical practice suffers from poor connectivity to the rest of primary care and acute services. The aim for a more holistic integrated health services will need robust IT systems in practices, integrated with general medical practice and hospital systems, so that patient data can be exchanged safely and efficiently. This will be key in the future successful expansion of primary eye care services.

5.2 All that is needed to achieve this in eye care is secure and cost-effective IT connections and more realism about effective and proportionate information governance. NHS England needs to make a relatively small but significant investment to transform the way community optical practices are integrated with the wider NHS and social care in the future and ensure that primary eye care services are fit for the challenges of the future.

23 September 2016

⁹¹³ RNIB, smoking and sightloss factsheet: <http://www.rnib.org.uk/eye-health-looking-after-your-eyes/smoking-and-sight-loss>

⁹¹⁴ Dudley Optical Practices to offer health checks in pioneering pilot Dudley Optical Practices to offer health checks in pioneering pilot <http://www.locsu.co.uk/communications/news/?article=163>

Dr David Owen – Written evidence (NHS0003)

1. I am a MRC funded Clinician Scientist at Imperial College London. I am writing entirely in a personal capacity.
2. I would like to comment on question 3C: “What are the retention issues for key groups of healthcare workers and how should these be addressed?”
3. From personal experience of working as an NHS doctor since 2004 I have seen first-hand how the relationship between doctors and the government affects morale and then has knock on effects on retention of medical staff. When I started as a 1st year doctor in 2004, the concept of dropping out of medicine was very rare. 12 years later, in the current crop of 1st year doctors, everyone talks about it and the dropout rate is much higher.
4. As has been well documented, morale is extremely low. I attribute this partly to the fact that the message we receive from the government is that we are overpaid and workshy. Doctors are very well paid compared to the general population. But we not well paid compared to our peers at university (lawyers, bankers etc) who have comparable education, working patterns and responsibility. For most of us this is balanced entirely by the satisfaction and enjoyment of such a rewarding career. But when the message from government is that we are the problem, it has a pernicious effect.
5. My view, therefore, is that if you want to retain doctors, stop making us feel we are the enemy.
6. Perhaps more important is when the same argument is applied to Question 2 (productivity). Having also worked in non-NHS environments, it is striking how committed most NHS doctors are, and how much work the tax payer gets for “free” (ie doctors going well over and above paid contractual hours and duties). I can only speculate on what state the NHS would be in if all doctors actually stuck rigidly to their working hours. Again, I believe we do this because of the good will associated with working in a job which we feel is of immense value to the public, and one in which we also feel valued. But in the time I have worked in the NHS, I have seen there is less good will now, and I attribute this in large part to staff feeling undervalued from the recent seemingly permanent fight with the government. This of course is hard to measure, but I would bet it is having a real effect on productivity and I think it will get worse.

23 July 2016

Oxfordshire Keep our NHS Public – Written evidence (NHS0023)

Submission to the Select Committee on the Long term sustainability of the NHS By Oxford Keep our NHS public, a civil society non-governmental organisation concerned with the long term sustainability of the NHS

1. We consider the best way to change so that demographic and technological changes can be embraced is to bring the NHS back into public ownership and make it accountable to the public – with adequate planners empowered to look to the long term and to work in close co-operation with other government bodies such as housing and social care. We have had decades of cost shunting – health to social care, social care to families, health to housing, social care to health – when we need to consider our communities' needs as a whole to get the best preventive and treatment arrangements. Successive governments have tackled parts of this problem (overlap areas between services eg intermediate care) but there have been few bold regional solutions.

In our view the introduction of privatisation, with a proliferation of short and long term contracts and subcontracts in the NHS, has vitally reduced the flexibility and vision needed to meet the challenges of the rapid expansion in the retired population and the rapid advances in health and medicine. Without the vast and costly distraction of procurement and contractual arrangements, it would be possible to use the money for public services (including training) to the optimum. (note – being clear about the services and monitoring them in our view remains critical – but in a publicly run and publicly accountable way, not one which includes many complicated layers of private and contracted out companies)

Pooling budgets across a broad canvas – from community cafes, healthy living initiatives and self care through housing social care and exercise to the most advanced tertiary care – can reduce costs, and reducing the contractual costs of private sector contracts ditto, but we would also see that there will be a need to increase taxation to cover the expanding costs of the service (up to at least the equivalent GDP % of our Western European neighbours) – and consider the alternative (to NOT increase funding) would lead to a situation which would be unacceptable in a wealthy and privileged country such as ours – namely, that people would be left to suffer and die untended.

2. Resource issues, including funding, productivity and demand management;
 - a) In our view having a free healthcare system in the widest sense of health is a fundamental part of our society and should be funded accordingly. This will mean increasing the % of GDP spent on all the determinants of health (see our answer to 1 above)⁹¹⁵

⁹¹⁵ Commonwealth Fund research findings (2010 & 2014) show NHS still offers the best in funding/outcomes/satisfaction when measured with other similar countries.

- b) The funding should come directly from the treasury to the regions to allow housing, health, social care, and leisure services to work together to maximise health outcomes for the population; transparency and accountability, with CCGs, LAs, HOSCs, Health Watch and CQC given more powers to lever change, should ensure public money is spent wisely.
- c) A hypothecated tax, such as the one Dilnot proposed and is currently proposed for the NHS, might help the immediate acceptance of increased taxes; however the most important thing is to get a tax scale proportionate to wealth, including plugging offshore and inheritance loopholes. A 'sin' tax is not appropriate when many of the reasons for ill health from drink, tobacco and obesity lie at least partly at the doors of industry and government policies which increase inequalities⁹¹⁶
- d) What is free at the point of use should actually be expanded to include teeth, podiatry, treatment for debilitating conditions such as varicose veins, social care, and swimming.
- e) Demand management is best served by a full complement of well trained GPs who can give the time and have the skills to refer patients to appropriate specialists/treat them/refer to therapists or district nurses. Currently the NHS is starving the GP service and has a reduced number of HV, Nurses, and physios/OTs. This needs remedying in the interests of our NHS long term sustainability.

3. Workforce, especially supply, retention and skills;

a-c) Increasing the number of training places for all levels of health housing and social care staff with career pathways free training, affordable and accessible housing and good pay and progression, available in all regions, would be a start. In the short term we need to ensure post brexit that there is an easy access route for overseas nurses, midwives, assistants, and medical practitioners to come and work here. Across the UK there have been examples, in both health and social care, of successful schemes to recruit and retain super care assistants (on more than minimum wage and with good training and support with prospects) nurses, social workers; and with nurse practitioners, and community 'matrons', and an increase again in district nurses, GPs and Jr Doctors who are properly supported and paid with decent terms and conditions, all employed in the public domain, we would ensure a workforce flexible enough for the long term future. What we have at the moment is 'driving in the wrong direction'. The training will need to include visionary exemplars of all the best in new models of patient care including appropriate telemedicine

4. Models of service delivery and integration

a) By pooling budgets through existing organs such as partnership boards it would be possible to just get on with integrated arrangements – there are many examples of best practice that have been initiated over the last 2 decades, many of which have been disbanded due to 'pulling up the drawbridges' between services and attempts

⁹¹⁶ Note – this is a suggestion to increase general taxation not national insurance which falls disproportionately on those who can least afford to pay it

to 'cost shunt'. Devolution, as currently conceived, puts power into the hands of a board shut away from public accountability; what is needed, instead, is money in the hands of joined up and publicly accountable boards. Currently all the incentives encourage competition and cost shunting. This could be changed.

5. Prevention and public engagement

a) real public engagement needs to be trained for, staffed and paid for and is the responsibility of national and local organs; currently the population suffers from frustration and powerlessness; even those engaged in PPGs find the 'engagement' hollow and experience powerlessness (eg the current STP round) and the general population are at best bewildered and at worst alienated. However, if we are to have good flexible visionary health and social care services, 'joined up' with all the preventive measures necessary in employment, housing, and leisure this will rest on a huge shift in the understanding and engagement of the general public

6. Digitisation of services, Big Data and informatics.

Technology has its place; but often, in health and vulnerability, face to face will continue to play a crucial part in prevention and treatment. Where IT and technology are used it is key they are owned and provided by the public authorities – all the evidence from '111' services, IT integrated systems, etc provided by private firms shows this as a disastrous and dangerous waste of money

15 September 2016

Paediatric Continence Forum – Written evidence (NHS0054)

Background to the Paediatric Continence Forum

1.1 The Paediatric Continence Forum (PCF) is an expert group of patient representatives and healthcare professionals campaigning to improve services for children with continence problems (sometimes called bladder and bowel dysfunction, or bedwetting, daytime wetting and constipation/soiling) in all settings across the UK. Established in 2003, it works closely with the national charities ERIC (The Children’s Continence Charity) and PromoCon (Promoting Continence through Product Awareness) and with representation from the Royal College of Paediatrics and Child Health, the Royal College of Nursing and the Community Practitioners’ and Health Visitors’ Association.

1.2 One of the key goals of the PCF is for every area in the UK to have a proper community-based integrated paediatric continence treatment service, led by an expert paediatric continence professional, with a clear system of referral and care pathways across primary and secondary NHS care, education and social services. Better paediatric continence services will help support NHS England’s Five Year Forward View by delivering savings for the NHS and improvements in the quality of care for children.

1.3. In 2014, the PCF published guidance, accredited by the National Institute of Health and Care Excellence (NICE), for the commissioning of integrated paediatric continence services, which can be found at www.paediatriccontinenceforum.org/resources. This was updated in October 2015.

1.4. UK-wide data suggests that about one in 10 children have a continence problem, with NICE estimating in 2010 that 900,000 children between the age of five and 18 in the UK suffer from bladder and bowel dysfunction⁹¹⁷. The figure in 2016 is likely to be higher, with academic research finding that referrals for constipation and bedwetting and daytime wetting in one region are overtaking “traditional” health problems like asthma⁹¹⁸.

Executive summary

2.1 This submission argues that if a long-term view of financial planning is not assumed in the NHS, the delivery of paediatric continence treatments and other community services will continue to be undermined, thereby costing the NHS more overall. Short-term financial considerations have resulted in cuts to public health and community services, which has already negatively impacted on the provision of school nurses and health visitors able to quickly identify and treat paediatric continence issues. If these services are not properly funded, it will undermine the principles of the Five Year Forward View by reducing the availability of cost-effective treatments in the community and increase pressure on general

⁹¹⁷ NHS Modernisation Agency (2003) Good practice in paediatric continence services – benchmarking in action. London: Department of Health

⁹¹⁸ Thompson, E. Todd, P. Ni Bhrolchain C. (2013) “The epidemiology of general paediatric outpatients referrals: 1988 and 2006” *Child Care Health Dev.* 2013 Jan;39(1):44-9

practice, as well as increasing incidences of unnecessary and costly treatments at secondary and tertiary level.

Workforce

2.2 As a general comment, we would argue that a rapid increase in the number of administrative, and particularly secretarial support, for hospital consultants and GPs would reduce the time they spend on non-clinical administrative chores and thereby improve their efficiency as clinicians. Increasing the numbers of nurses in training would also increase the number in that workforce in three to four years.

Question 3c: What are the retention issues for key groups of healthcare workers, and how should these be addressed?

2.3 The loss of nursing bursaries will only discourage people from training as nurses, and their reintroduction should be prioritised. There should be a more transparent career pathway for nurses and other healthcare professionals, particularly encouraging them to retain clinical roles, rather than having to move into management if they wish to advance their career and earning potential. This has been achieved by senior doctors, most of whom have significant managerial and other roles alongside retaining an active clinical practice.

2.4 The PCF would also note the ability of nurses to provide excellent paediatric continence services in the community, reducing or avoiding referrals for bladder and bowel problems to GPs and expensive secondary care services which are becoming increasingly commonplace. The Paediatric Continence Commissioning Guide, a document produced by the PCF and accredited by NICE, highlights that while the hourly rate of nursing top band 6/mid band 7 was £17.66 an hour in 2014/15, the average cost of an outpatient attendance was £108, the average cost of an A&E attendance was £114 and the average cost of a day case was £693.⁹¹⁹ If the nursing workforce is not sustained in the long-term, the number of children with continence issues receiving treatment in more expensive secondary care settings will increase, thereby driving up costs for the NHS in an unsustainable manner.

Question 4a: What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

2.5 The Royal Colleges and many other groups representing healthcare professionals are producing e-learning and other programmes, which can be used to train the health and social care workforce. The PCF has also been involved – along with the United Kingdom Continence Society – in producing documents such as the Minimum Standards for Paediatric Continence Care in the UK.⁹²⁰ This document signposts a range of other documents, websites and e-learning programmes which can help healthcare professionals in their development.

Models of service delivery and integration

⁹¹⁹ Paediatric Continence Forum (2015), Paediatric Continence Commissioning Guide, p.46.

⁹²⁰ Paediatric Continence Forum (2016) on behalf of the United Kingdom Continence Society, Minimum Standards for Paediatric Continence Care in the UK, available at <http://www.paediatriccontinenceforum.org/wp-content/uploads/2016/07/MINIMUM-STANDARDS-FOR-PAEDIATRIC-CONTINENCE-CARE.pdf>.

Question 5a: How could truly integrated budgets for the NHS and social care work, and what changes would be required at national and local levels to make this work smoothly?

2.6 The PCF's focus is campaigning for major improvements to Community Paediatric Continence Services (CPCS) across the country. A Freedom of Information survey of all CCGs and Health Boards in the UK, carried out by us in 2014, found that only 27% commission an integrated service for bladder and bowel problems in children, which is needed to ensure that these issues are treated "under one roof" with consideration for other health needs. Two further studies (Scarlett 2015, Pal 2016) also confirmed that at least 10% of appointments in a paediatric urology and paediatric bowel clinic could have been managed by a Community Service, at less cost to the NHS and inconvenience to the family. These integrated services should be a national aspiration, which would need to be driven by a recognition of the problem by national policymakers which is then filtered down to commissioners at a local level. The PCF's campaigning activities are consistently aiming to instigate this change in mindset.

Question 5b: How can local organisations be incentivised to work together?

2.7 We believe that CCGs and local authorities should receive predicated funding to improve community services, where they are inadequate, some of which could be repaid if it is shown that these services produce savings by reducing referrals to secondary and tertiary services.

2.8 A major hindrance to development of these integrated paediatric continence services is that – especially in large conurbations – referrals made to tertiary units may be funded by NHS England and thus, paradoxically, be cheaper to CCGs than providing the services locally. However, the cost of this to the NHS overall is considerably more: it costs between £160 and £220 for a first appointment with a consultant, compared with £85 for an assessment by a specialist nurse.

Question 5d: How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

2.9 As stated above, the balance between hospital and community services could be addressed by reducing the financial incentives for CCGs to avoid paying for community services by displacing referrals to secondary and tertiary services.

3.0 With regards to the balance between mental and physical health and care services, it is worth mentioning that there is an identified link between continence and mental health problems in children with bladder and bowel problems. A preliminary report by Dr Carol Joinson from the University of Bristol notes the experiences of young people affected by incontinence, many of whom felt 'different' or 'abnormal' due to the stigma associated with continence problems.⁹²¹ There was previously a perception that mental health problems caused continence problems such as bedwetting, but there is now a recognition that

⁹²¹ Dr Carol Joinson and Dr Katie Whale (2016), Exploring Secondary Impacts of Incontinence on Young People, p.23. Bristol: University of Bristol.

continence problems cause mental, social and educational issues. Addressing the root causes of continence problems will therefore have knock-on effects for other health and social care services.

Prevention and public engagement

Question 6: What are the practical changes required to enable the NHS to shift to a more preventative, rather than acute, treatment service?

3.1 With regard to children’s bowel and bladder problems specifically, the transfer of responsibility for commissioning school nurses and health visitors to local authorities – as part of the transfer of public health responsibilities from CCGs to local authorities – combined with the reduction in local authority and public health budgets, has been disastrous. School nurses and health visitors provided much of the support for children with bladder and bowel problems, especially in areas with poor CPCS, acting as a first point of contact for concerned parents. Public Health England has now stated that “... clinical support enuresis [bedwetting] and incontinence lies with NHS England”, thus resulting in many school nurses and health visitors having continence removed from their responsibilities. This can only aggravate the already difficult situation described in points 2.6-2.8.

Question 6a: What are the key elements of a public health policy that would enhance a population’s health and wellbeing, and increase years of good health?

3.2 For children with continence problems, universal provision of an effective Community Paediatric Continence Service – in accordance with the PCF’s Paediatric Continence Commissioning Guide – is key to ensuring the health and happiness of these children. NHS England’s Excellence in Continence Care document states that “Effective community-based continence services can save valuable NHS resources whilst restoring dignity to people and improving quality of life”.⁹²² It should be stressed that this applies equally to children with continence issues as adults: there is a tendency to focus on continence issues as affecting elderly people in the later years of life, and while this should not be forgotten, equal consideration should be given to the health and wellbeing of children affected by continence problems.

Question 6b: What should be the role of the state, the individual, and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

3.3 With regard to children’s bladder and bowel problems, teachers and parents need easy and rapid access to school nurses so that continence problems are recognised early, and those school nurses need to be able to rapidly refer children to effective CPCS. This is in the context of recent reports that 70% of primary school teachers have noticed an increase in the number of children experiencing wetting and soiling problems, along with previous reports on the increase in the numbers of children starting primary school not toilet trained.

⁹²² NHS England, Excellence in continence care: Practical guidance for commissioners, providers, health and social care, p.9.

Resolving these problems early will improve the child’s social and emotional wellbeing, and reduce expensive referrals to hospital care. Health visitors and nursery nurses also need to be supported in encouraging and educating parents in toilet training.

Question 6c: Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

3.4 The PCF would certainly agree that there is a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment. Continuing cuts in public health and local authority funding, especially where this provided CPCS being provided is ultimately costly for the NHS. However, money needs to be invested upfront in local services before the savings to hospital services will be achieved. We expect this will be the opinion of many other public health stakeholders responding to this consultation.

Question 7: What are the best ways to engage the public in talking about what they want from a health service?

3.5 With regard to paediatric bladder and bowel problems, inclusion of an effective assessment of continence problems in primary (and perhaps secondary) school entrance assessments is essential. This would raise the profile of continence problems and awareness that they are a common issue, and subsequently of the need for CPCS. However, the current arrangements in some areas – where school nurses cover a number of schools, so these assessments are delayed by several months – is counter-productive.

Digitisation of services, Big Data and informatics

Question 8b: What is the role of ‘Big Data’ in reducing costs and managing demand?

3.6 The PCF has been working with the National Child and Maternal Health Intelligence Network (ChiMat) for several years in producing the Continence Needs Assessment tool, which indicates the prevalence of paediatric bladder and bowel problems by local authority and CCG. In Public Health England’s own words, ChiMat “provide[s] information and intelligence to improve decision-making for high quality, cost effective services.” If used effectively, this can then notify local commissioners of the need to commission additional services to address paediatric continence issues in the community. The NHS Atlas of Variation should also allow poorly performing areas to learn from those with more effective services.

22 September 2016

The Patients Association – Written evidence (NHS0170)

1. Introduction:

1.1 The Patients Association welcomes the opportunity to contribute to a transparent and principled debate on the future of the healthcare system. Any discussion on the sustainability of the NHS should be seen as an opportunity to improve patient experience, reduce health inequalities and differences in outcomes.

1.2 We recognise the affordability challenges within the NHS but urge that discussions about sustainability must not pit patients against one another; there must be parity of esteem among patient groups and among conditions. This only becomes more pertinent around discussion of affordability of treatment.

1.3 We have answered a selection of the Committee’s consultation questions below, based on where the Patients Association is best placed to offer insight.

2. The Patients Association

2.1 The Patients Association is a health and social care charity which, for over 50 years, has advocated for better access to accurate and independent information for patients and the public; equal access to high-quality health care for patients; and the right for patients to be involved in all aspects of decision-making regarding their health care.

From the contacts we receive via our Helpline, we capture thousands of accounts each year from patients, carers, family members and friends about people’s experiences of the health and social care service. We use this knowledge to campaign for real improvements across the UK.

2.2 The Patients Association produces independent reports and provides the secretariat to the All Party Parliamentary Group for Patient Safety and the All Party Parliamentary Group for Patient and Public Involvement in Health and Social Care.

3. Summary

3.1 The Patients Association is significantly concerned that the current funding level for the NHS is affecting the quality of care patients receive. We hear from patients on our national helpline, who everyday are drawing a direct correlation between the lack of access to services and the NHS’s current funding envelope. NHS funding must be able to meet the demands of patient need, we are deeply troubled by cuts to local authority public health allocations and adult social care funding.

3.2 For the NHS to become a system focused on prevention, patient engagement will need to be strengthened, this will require a focus on increasing health literacy of the population and providing adequate resources for strengthening means of engagement such as Patient Participation Groups. Increasing public knowledge of the NHS Constitution will be vital for the sustainability of the NHS, in an era of increasing demand for NHS services patients must fulfil their responsibilities as set out in the NHS Constitution.

Patients must take greater ownership of the care they receive and this must involve patients being seen as expert partners in their own care; where patients are engaged they are more likely to follow a course of treatment.

- Any change in funding model must guarantee high quality patient care.
- Addressing the challenges of NHS workforce must remain a priority to ensure the sustainability of the NHS due to the length of training required for the clinical workforce.
- Workforce planning will need to end silo working and workforce planning that addresses the delivery of patient care closer to patients' homes must be prioritised. Brexit negotiations must focus on workforce sustainability for the NHS.
- The decision to remove NHS bursaries and replace them with repayable loans must be reviewed. The NHS must seek to maximise the potential of its current staff by growing and developing their current skill level.
- Better exchanges of information about staff retention will need to be shared beyond a trust level, systematic information on why NHS staff are leaving the NHS is key to the sustainability of the NHS.
- The current discharging system is letting some of the most vulnerable patients down.
- The NHS will need to better manage the variation in outcomes of long term conditions and improve patient access to screening and diagnostic services.
- Sustainability and transformation plans represent a real opportunity to integrate the national health and care services but the Patients Association is alarmed at the lack of meaningful public consultation. A higher premium must be placed on any future public engagement. The public must be involved in developing a shared vision of any such plan and these plans must seek to do more than address the deficit, the Patients Association remains sceptical that innovative models of care can be achieved with the level of finance available.
- Further investment in the future workforce and NHS finance is urgently required for high- quality care that meets safe staffing levels, and if the Government's pledge for a 7-day service is to be achieved without compromising patient safety.

4. Resource issues, including funding, productivity, demand management and resource use

4.1 To what extent is the current funding envelope for the NHS realistic?

4.2 We believe, on the basis of increasing evidence, that the current funding envelope for the NHS is wholly unrealistic. We are consistently hearing from patients who draw a direct correlation between their lack of access to services and increased waiting times to the unrealistic funding envelope. The NHS is consistently missing performance targets, Quarter 4 2015/16 NHS performance against the accident and emergency standard was the worst since records began over a decade ago. The total elective surgery waiting list stood at 3.7 million in March 2016 according to NHS England estimates the highest level since 2007.

The Patients Association's annual report into elective surgery waiting times found the largest year- on-year increase of 79.5% since we started collecting data in 2010. 92,739 patients waited for over 18 weeks in 2015, compared to 51,388 patients waiting over 18

weeks during 2014.⁹²³ Trusts also selected identified equipment shortages and/or lack of beds were as being the most common reasons for cancelled surgery on the day in 2015.⁹²⁴

Quotes from callers to the Patients Association’s helpline on their experience of waiting for elective surgery include:

“I had to just keep my fingers crossed and hope my symptoms wouldn’t worsen when in actual fact they did and I was rushed to hospital”, Patrick waited over a year for a gall bladder removal.

“Because my surgery has been left so long it’s going to be more invasive. When I was first seen by the doctor he told me that I couldn’t wait any longer because of the risk of further damage. Patients are being put at risk by long waiting times, it means it’s a much longer and riskier surgery.” Krishna is still waiting for a hip revision. He was first referred in November 2014 and he was not told about his rights under the NHS Constitution.

4.3 Patients and the public want and deserve a properly funded NHS, and cannot accept a further decline in NHS performance. The NHS has seen the fastest deceleration of funding in its history, with almost nine out of ten hospital trusts ending the last financial year in a deficit. NHS funding in England will have risen by an average of 0.9% per year in real terms between 2009/10 and 2020/21. Yet the projected growth in demand on NHS providers is around 4% every year due to a growing older population and the fact that many older people have multiple conditions requiring care and treatment. The increase in demand must be matched by an increase in funding, otherwise more patients are going to suffer the consequences of delays, cancellations and poor standards of care. The deterioration in health care is increasing impacting on the most vulnerable people in society, including older people and those suffering from mental illness. The Patients Association welcomed the increase in public funding for adult social care following the spending review in 2015, but at an average planned increase of just 0.6% per year in real terms between 2015/16 and 2019/20, the Patients Association believes this again, will not meet rising demand. There should be a significant increase in funding to match the growing need for adult social care.

4.4 Sufficient levels of funding for mental health services are, and will continue to be crucial for the sustainability of the NHS and for patients receiving the care they need while achieving true parity of esteem.

4.5 Despite Government commitment to increased mental health funding, only half of the 32 mental health trusts had received a real-terms increase in their budgets in 2015-16.⁹²⁵ At least 73 local areas will see their GP mental health budgets cut in 2016/2017.⁹²⁶ The Patients Association is also concerned about the increasing disparity between the highest and lowest spends of CCG budgets on mental health. Patients cannot continue to suffer the consequences of past under investment.

⁹²³ Waiting Times Report: Feeling the Wait. London: The Patients Association, 2016

⁹²⁴ Waiting Times Report: Feeling the Wait. London: The Patients Association, 2016

⁹²⁵ “Funding Mental Health at Local Level, Unpicking the Variation”. NHS Providers and the Healthcare Financial Management Association (HFMA). May 2016.

⁹²⁶ Data obtained by Labour MP Luciana Berger cited by Gill, Martha. “Government to Slash Mental Health Funding Again, Figures Show”. The Huffington Post. Sept 2016. http://www.huffingtonpost.co.uk/entry/government-to-slash-mental-health-funding-again-figures-show_uk_57e29667e4b004d4d8618eb3

4.6 The Patients Association recognises the need for greater efficiency and supports the recommendations made in Lord Carter’s review into unwarranted variation in English NHS acute hospitals.⁹²⁷ These variations also create clear inconsistencies in patient care such as the disparity in rates of deep wound infection. Savings made as a result of Lord Carter’s recommendations alone will not make up the severe funding gap. This would require a bigger gain in productivity than at any point in the NHS’s history.

4.8 Does the wider societal value of the healthcare system exceed its monetary cost?

4.9 Yes but only if properly funded. An accessible well-funded NHS that delivers safe and effective care is vital for a fair society. Adequate investment in health and social care can deliver long lasting benefits to health and wellbeing and enable citizens to play their full part in society, employment, family life and contributing more widely to their community.

4.10 What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

4.11 With any new funding model, high-quality patient care should be guaranteed along with a responsive NHS. Any changes in the NHS funding model will need to be communicated effectively to the public, and ensure through consultation and subsequent improvement that their healthcare and access would be improved under these systems. Patient representative groups must take a key role in this process.

4.12 The current lack of knowledge about the NHS Constitution means that patients are not aware of their rights and entitlements and how to assert those rights effectively.⁹²⁸ Meeting the expectation of patients’ rights and entitlements as set out by the NHS Constitution must remain a key priority of any change in funding model. Any change that would reduce, rather than improve, patient access to health and social care would not be supported by the Patients Association.

4.13 Proposed changes to the current funding streams, such as introducing a hypothecated tax or co-payments, must be explained clearly to the public, setting out the pros and cons of each proposal so that people can make a meaningful contribution to the debates and make informed choices on the basis of comprehensive information.

4.14. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

4.15 The Patients Association has always supported an NHS free at the point of delivery for all patients, without means-testing. While we recognise there will always be a need to re-evaluate what services and medicines can, and should, be provided by the NHS for both financial and medical development reasons, it is essential there is an opportunity for patients and the public to be consulted. Patients and the wider public will be let down if

⁹²⁷ Lord Carter of Coles. “Operational productivity and performance in English NHS acute hospitals: Unwarranted variations”. Independent report for the Department of Health. Feb 2016.

⁹²⁸ NHS Constitution Patient and Public Awareness. London: The Patients Association, 2016

there is anything but an open and honest debate which seeks to set out a comprehensive range of options for future health and social care provision. NHS care must always reflect a patients' ability to benefit from treatment, there must be frank conversations with patients around their care and how treatment options can benefit their quality of life.

Workforce

5. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

5.1 The NHS's workforce remains its greatest strength and addressing key challenges will be paramount to the sustainability of the NHS. Further investment in the future workforce is urgently required for high-quality care that meets safe staffing levels, and if the Government's pledge for a 7- day service is to be achieved without compromising patient safety.

5.2 Addressing NHS workforce challenges must be a focal point in any discussions on sustainability particularly due to the length of training time required in much of the NHS's clinical workforce. There is a pressing need to address workforce challenge now in order for the NHS to remain sustainable and adapt to the changing demographics of the population. The fundamental issues of the increased demand for agency staff need to be addressed in order to achieve a reduction in agency staff cost. The Patients Association believes that using Agency staff filling the current staffing gaps is unsustainable; in 2013-14 the NHS spent £3.3 billion on agency staff the cost of agency staff rose by 27% (£0.7bn) in 2014/15 this is coupled with significant overtime costs. The Patients Association is worried about the unsustainable pressure being placed on GPs and the effect of increased demand on NHS staff morale.

5.3 Future workforce planning will need to end the reliance on silo working. There will need to be a nationally shared vision for the NHS workforce in England that allows for innovative and collaborative solutions to meet the needs of patients. A thorough analysis of the needs of patients in the context of changing demography should form the basis of workforce planning. When the needs of patients and changing disease patterns are mapped, the workforce planning should be approached to meet these needs. Public health and prevention expenditure has been severely reduced in recent years. This expenditure needs to be reinstated and increased to enable prevention of ill health, using evidence-based approaches. All NHS and social care staff should be provided with initial and ongoing training that is relevant to meeting the needs of patients. For example, staff must be supported to improve their understanding of long-term conditions, particularly dementia, and to increase their confidence in promoting the health literacy of patients. We must facilitate workforce planning which addresses the delivery of care closer to patients' homes, while ensuring that time allocation for home care is realistic to enable effective care delivery.

5.4 What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

5.5 To increase supply there should be the further utilisation of community roles and the development of a more flexible workforce. The Patients Association calls for a review of

the decision to remove the NHS nursing bursary and its replacement with repayable loans. There remains a lack of detailed or proper assessment of the impact of this funding structure. We remain deeply concerned that the removal of NHS bursaries will negatively impact the future supply of nurses, midwives and allied health professionals. London Economics estimate the cost savings to the exchequer are more likely to be £88 million per cohort; far lower than the £534 million estimated by Government.⁹²⁹ The expected decline in numbers entering nursing, midwifery and the allied health professionals is likely to increase agency staffing costs, with an estimate that there will be an additional £100.3m cost incurred by Trusts per cohort.⁹³⁰ There needs to be an adequate review of whether the removal of bursaries will limit the quality of applicants and have a negative impact on certain groups of applicants such as Black and Minority Ethnic students. A decline in the numbers entering nursing, midwifery and allied health professions is not just a threat to the sustainability of the NHS but it is a significant patient safety risk.

5.6 Developing a tangible career path for workers within the NHS is vital to the retention of healthcare workers. The NHS should seek to maximise the potential of current staff and all staff to grow and develop their skills. This may involve initiatives such as the creation of new roles that allow existing staff to grow and develop their skills through developed career paths, for example, the recent introduction of the role of ‘nursing associate’.

5.7 What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

5.8 Focusing on the morale of EU healthcare workers will remain important, their contribution to the NHS should be continually acknowledged throughout the post-referendum negotiation period. Visa issues may now mean a change in the supply of healthcare workers or the perceived need for staff to return home. As such, it is vital that communication with EU staff provides them with a clear understanding of their status and celebrates their value to the NHS and the health of the whole UK population. Brexit may mean that new solutions for international recruitment will be required, so the focus on European staff retention and recruitment for the NHS must remain a key issue in Brexit negotiations. The NHS and social care relies on staff from the EU to provide the current level of health and social care. If it cannot continue to recruit from the EU, plans will need to be made to recruit from overseas (non-EU countries).

5.9 What are the retention issues for key groups of healthcare workers and how should these be addressed?

5.10 The NHS faces significant issues with low morale, and this is likely to continue given current funding challenges, rising demand and difficulty in meeting performance targets. All organisations need to do more to engage their staff and make them feel valued. A focus on training and development are positive steps towards retaining staff.

5.11 Staff retention also requires a continued commitment to a culture free from discrimination where diversity is valued. The NHS still has much more to do to ensure there

⁹²⁹ Conlon, Gavan, and Ladher, Rohit. “The Impact of the 2015 Comprehensive Spending Review on Higher Education Fees and Funding Arrangements in Subjects Allied to Medicine”. London Economics, Unison, and National Union of Students. May 2016.

⁹³⁰ Conlon, Gavan, and Ladher, Rohit. “The Impact of the 2015 Comprehensive Spending Review on Higher Education Fees and Funding Arrangements in Subjects Allied to Medicine”. London Economics, Unison, and National Union of Students. May 2016.

are enough black and minority ethnic leaders and that the makeup of staff adequately represents the communities it cares for.

5.12 There is a need to develop better data on staff retention and to create better exchanges of trends in clinical staff leaving the NHS. Thematic analysis needs to be undertaken of exit interviews at organisational levels to create sharing beyond trust level. A third party may be able to create a more accurate representation of staff retention issues, and a methodology similar to patient satisfaction surveys could be deployed. Systematic information on why clinical staff leave the NHS is essential to future workplace planning.

5.13 We must also recognise that we all have a duty to celebrate achievement and great quality care within our NHS. We should encourage patients to share positive feedback and celebrate truly exceptional staff, and the Patients Association will support these efforts.

5.14 How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

5.15 Future training must be based on addressing the needs of patients, which is best achieved on a competency basis. As the models of care change, training must be developed at the same pace, particularly for new roles. In particular, there will need to be continued training and support to care homes and better communication between patients and healthcare professionals about end of life care. We know that for the majority of patients they want to die at home⁹³¹ but for too many their wishes are not granted.

5.16 What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

5.17 As patients play a greater part in identifying their health care needs, the workforce will need to be trained in new technologies and the appropriateness of new technologies for individual patients, for example in regard to remote consultations. Gaps in data on the NHS clinical workforce will need to be addressed to make them more comprehensive to support workplace planning.

5.18 What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

5.19 Health and social care systems need to be joined up, where different sectors are not chasing the same funds for a patient. This will require working collaboratively not in competition. Future service delivery will require the involvement of teams working across traditional boundaries that are truly centred on the population.

5.20 What investment model would most speedily enhance and stabilise the workforce?

5.21 Delivering adequate services with the same workforce funding as is in place currently is not sustainable. The current lack of funding and the knock on effects, such as longer waiting times, cancelled operations is leading to greater inefficiencies. Patients who wait too long for services such as elective surgery experience greater morbidity, need more

⁹³¹ "End of Life Care". National Audit Office. Nov 2008.

extensive treatment and care and take longer to recover.⁹³² Reducing demand and treating patients at the right place at the right time with suitably trained staff is the only way to reduce costs.

6. Models of service delivery and integration

6.1 *What are the practical changes required to provide the population with an integrated National Health and Care Service?*

6.2 Sustainability and transformation plans (STPs) represented an opportunity to integrate the national health and social care services. However, the Patients Association remains concerned that there has been no meaningful consultation with the public. The patients should be at the centre of plans to transform and sustain treatment and care. The STPs have been developed with little involvement of relevant groups and individuals; they are being implemented in parts of the country before any consultation has taken place. Instead the STPs are being introduced as fait accompli. This does little to facilitate the sense of ownership by staff, patients and the public generally that is necessary to make a success of their implementation. Commissioners should, albeit belatedly, seek to reach a shared vision arrived at through public involvement rather than a binary choice at the end of a secretive planning process, with little attempt to increase public understanding of a changing system.

6.3 There is severe underfunding of adult social care funding for public provision for adult social care fell in real terms by an average of 2.2% per year between 2009/10 and 2014/15, leading to a 25% reduction in the number of people receiving publicly funded social care.⁹³³ For STPs seeking to transfer care to the community, there will need to be significant investment in community services and pressures on patients accessing primary care will need to be addressed. It is essential that there is greater input into STPs from clinical staff and support services such as community pharmacies and the voluntary sector. We are concerned that the funding and workforce to do this are not available and instead the focus will remain on clearing the deficits within footprints rather than a transformation of services to improve patient experience and safety.

6.4 Future service delivery will require the involvement of teams working across traditional organisational boundaries to be truly centred on population need. It will be a lengthy process even with coordinated planning and investment, until prevention and effective social care are good enough to relieve some of the strain on acute services. Given the current issues of rising A&E attendance, increasing strain on primary care and delayed transfer, it is important to note that for some patients, hospitals remain the most realistic place of care in the context of the current funding level of adult social care.

6.5 The current discharge system is also failing vulnerable patients too often. Delays in discharge are a problem both for the financial sustainability of the NHS and local government, as well as having a detrimental impact on patients' health, particularly in relation to the mobility of older patients. Official data from the last two years has shown there has been an increase of 270,000 (31%) in the number of days when beds in acute

⁹³² Waiting Times Report: Feeling the Wait. London: The Patients Association, 2016

⁹³³ Lafond, Sarah, Anita Charlesworth, and Adam Roberts. March 2016 Research A Perfect Storm: An Impossible Climate For NHS Providers' Finances?. 1st ed. London: The Health Foundation, 2016. Web. 22 Sept. 2016

hospitals have been occupied by patients who have had their discharge delayed unnecessarily.⁹³⁴ This is an example of inefficiency and waste of resources caused directly by underfunding. Integrating health and social care could help alleviate this problem for the benefit of all patients and staff. This will require integrated budgets, clear communication and responsibilities between hospital and community staff, patients', their careers and families.

6.6 The Patients Association supports the need to integrate physical health, mental health and care budgets to improve the balance between disparate services. This would help to deliver better planning for all patients to improve the integration of care and movement between a system that is currently fragmented streams of hospitals and community care, mental and physical health. Local organisations must be incentivised to work together through a commitment to a shared vision that provides coordinated services and considers the holistic needs of a population. Shared incentives must also work for both providers and commissioners.

6.7 Hospitals, community services, mental and physical health and care services need to better manage the variation in outcomes of long-term conditions and improve patient access to screening and diagnostic services. Localised non-specialised treatment will need to be delivered in community hubs, with hospitals focusing on specialised care this will require a greater integration of patient pathways.

6.8 What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

6.9 The enormity of the changes required should not be underestimated. The degree of change management required to shift to effective and efficient systems of health and social care, will need inspired and inspiring leaders, widespread education and training, much improved communications and adequate funding. Patients and the wider public need to meet their responsibilities as set out in the NHS Constitution to the same extent as healthcare providers. This will require greater patient engagement and knowledge of the NHS Constitution from the current low levels. If patients are to be encouraged to take more preventative health measures, resources should be made available to increase knowledge of the Constitution and methods of improving health and preventing disease. Fundamentally, greater resourcing and priority must be given to comprehensive public health projects in collaboration with local authorities to better inform patients and improve health behaviours.

6.10 Patients must take greater ownership of the care they receive and this must involve patients being seen as expert partners in their own care; where patients are engaged they are more likely to follow a course of treatment. The somewhat secretive approach to the implementation of STPs thus far, with little or no involvement of patients has been a missed opportunity in this regard.

6.11 Sustainability must focus on continuing the development of our response to the threat of antimicrobial resistance. The Patients Association's report on antimicrobial stewardship found that despite improved awareness there remains inconsistency in

⁹³⁴ "Discharging older patients from hospital". Department of Health. National Audit Office. May 2016

embedding recommended antimicrobial stewardship across the country.⁹³⁵

6.12 Healthcare professionals including non-clinical staff will need to be further trained on patient engagement, which may involve an increase in the time patients spend in consultation to develop care plans. This will require patients engaged in self-care and monitoring of their symptoms at home which can only be successful if they are given the tools and knowledge to do so. Patients must have greater confidence in the ability to access diagnostic services. Establishing good health literacy about where to direct questions about their care will be crucial for developing a more preventative system.

6.13 A shift away from direct consultations with patients to remote consultations must seek to address patient concerns about discussing their health in different settings. We are particularly concerned about receptionists recording notes regarding the patient's illness. Not only does this mean that patients may have to disclose information they may not wish to disclose, but there are obvious risks of serious errors or misunderstandings to occur which could result in grave consequences for the patient. The Patients Association believes that it is in the interest of patients to meet directly with their GP as it means they can build up a relationship to help both parties make better informed decisions.

6.14 Patient trust in NHS out-of-hours services is poor. When the Patients Association asked the public "Would you feel safe relying on the NHS out-of-hours service for a potentially urgent medical problem?" Over three quarters of those responding (79.2%) stated that they would not, or that they did not know.⁹³⁶

6.15 While there is strong awareness by providers of the importance of engaging patients as a way of making efficiency savings, it's important to note that radical improvements in population health may not be seen for decades. This means that some of the outcomes anticipated in sustainable transformation plans will not be realised within the next five years.

16.16 What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

16.17 Public health policy must present clear evidence that allows for meaningful consultation with the utmost levels of transparency that makes the intended outcomes clear. Patients and the public

must feel empowered and engaged to make healthy decisions, which will require greater involvement within their community and understanding of where to access information and support. Increasing health literacy to allow patients to access the most appropriate care setting for their needs must be a key element in public health policy as well as a holistic approach to the population's mental, physical and social needs. Public health policy must more effectively communicate the aims and benefits to communities with the adoption of any new policy.

16.18 There is a continuing need to focus on reducing health inequalities and the disparity in outcomes among the population. Public health policy must take a whole system approach and seek to address socially excluded groups, children and young people (particularly in relation to obesity) and a large number of the population over 65

⁹³⁵ Antimicrobial Resistance – A Patient Safety Issue Report. London: The Patients Association, 2016.

⁹³⁶ Primary Care: Access Denied? London: The Patients Association, 2016. Print. Primary Care Review: Vol.II.

who are living alone and face social isolation.

17. What are the best ways to engage the public in talking about what they want from a health service?

17.1 By its very nature, public engagement cannot be a “one size fits all” model and engagement should be embedded in everyday practice. The public must see the value in engaging in what they want from a health service, which will require real change developed from their contributions. The public must also understand the purpose for and their role in any engagement.

17.2 We need to build networks of engagement with patient groups and their local community while sharing their impact and achievements. Community mapping provides an opportunity to list organisations where there are already formal and informal connections.⁹³⁷

17.3 Any engagement of the public must seek to involve groups with protected characteristics and to look beyond the involvement of traditional voices. It is important to note that services users who are repeatedly asked for engagement may develop “involvement fatigue”.⁹³⁸

17.4 At a time when the NHS is undergoing significant financial change and reform, the Patients Association views the strengthening of Patient Participation Groups (PPGs) and local Healthwatch groups as essential to increasing patient engagement. These should be championed as a means of allowing patients and their families to influence commissioning in their local areas. Patient Participation Groups are the key blocks to organising patient feedback in primary care. A strong and effective Patient Participation Group in every practice should play a significant part in the future engagement of patients. Currently, PPGs vary in size and effectiveness. Developed and well run PPGs should seek to support and share knowledge with developing PPGs or with those struggling with patient engagement.

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⁹³⁷ “Working Together: An essential guide for healthcare practitioners, researchers, educators and regulators looking to work with service users, patients, carers and members of the public.” Camera with Plymouth University, The Health Foundation, and The Patients Association. June 2016.

⁹³⁸ “Working Together: An essential guide for healthcare practitioners, researchers, educators and regulators looking to work with service users, patients, carers and members of the public.” Camera with Plymouth University, The Health Foundation, and The Patients Association. June 2016.

Pharmacy voice – Written evidence (NHS0163)

1. Introduction

1.1. Pharmacy Voice is the association of trade bodies which brings together and speaks on behalf of the community pharmacy sector in England. Pharmacy Voice is formed by the three largest community pharmacy owner associations - the Association of Independent Multiple pharmacies, the Company Chemists' Association and the National Pharmacy Association. Collectively, we represent over 11,000 community pharmacies in England, including pharmacy businesses of all sizes. Our members directly and indirectly employ over 30,000 pharmacists and more than 50,000 pharmacy staff members in the community and invest significantly in neighbourhoods, towns, areas of deprivation and rural communities.

1.2. Pharmacy Voice welcomes the Committee's inquiry into the long-term sustainability of the NHS. Community pharmacy has long held the ambition that the accessibility of, and professional expertise within the pharmacy network be better utilised to support the growing and changing needs of the population. Community pharmacy is willing and able to support a high performing, affordable national health service. We have repeatedly called for a strategic partnership approach between the sector, Government and the NHS to plan investment and change to build the future – one that reflects and respects local autonomy and relationships, is closely aligned to the NHS in its goals, but does not leave implementation and delivery to chance. As our focus is on community pharmacy specifically, we have chosen not to answer the broader consultation questions and instead address some of the Committee's key themes, highlighting how we feel community pharmacy can best contribute to the long-term sustainability of the NHS.

2. Resource issues, including funding, productivity, demand management and resource use.

2.1. Community pharmacists and their teams provide easy access to essential healthcare and public health services across the country, and like their colleagues in the NHS and local government are facing similar scenarios and challenges. The intention to reduce funding to the sector by £170 million in 2016/17 was announced on the 17th December 2015 without warning, and was followed by a rushed consultation process. At this time, the sector still faces an uncertain future following the announcement to revise timelines for imposing cuts. While we welcome the Government's decision to restart negotiations with the Pharmaceutical Services Negotiating Committee (PSNC), we are concerned by the unrealistic deadlines the Government has set aside. A decision on funding is expected in mid-October giving effect to changes from December, which would provide contractors with little time to adapt. Government policy in this instance appears to have lacked planning, does not sufficiently account for the long-term and does not support practical solutions to guarantee the sustainability of the community pharmacy sector, a vital amenity within the NHS.

2.2. It is unrealistic and unsustainable to expect system-wide change while simultaneously pursuing a programme of disinvestment. In our initial response to the Government's announcement in December, we called for five commitments in return for the investment of resources, effort, expertise and time that the sector was (and still is) willing to contribute to enable community pharmacy to be fully integrated within a modern, efficient and accessible health and care system. These commitments are to:

- Stop the planned disinvestment in community pharmacy in 2016/17
- Agree a sustainable long-term settlement with the sector
- Invest in service transformation in the same way as for other parts of the NHS
- Put in place a joint, coordinated approach to planning investment and implementing change, in partnership with national community pharmacy bodies
- Deliver the reforms that are required in other parts of the system, and in legislation, to enable community pharmacy to play its full role

2.3. The community pharmacy sector recognises the need to find efficiencies across the health and care system, and sees itself as an underutilised means of achieving this. Community pharmacies contributed a net value of £3 billion to the NHS, public sector, patients and wider society in England in 2015 through just 12 services, according to a recent [Price Waterhouse Coopers report](#). There exists significant potential to increase this value, but community pharmacy will need certainty about its future role, as well as the level of investment required, if it is to realise it. This must also provide a long-term commitment that goes beyond the annual funding process, which encourages short-termism and limits the sector's ability to plan a sustainable future for itself and the wider NHS.

3. Community Pharmacy Forward View

3.1. Many of the themes that are the focus of the Committee are reflected in the [Community Pharmacy Forward View \(CPFV\)](#), which was developed by Pharmacy Voice, in partnership with the PSNC and with the support of the Royal Pharmaceutical Society English Pharmacy Board. This forward view sets out our vision for the future of community pharmacy and, in turn, articulates our contribution to realising the long-term sustainability of the NHS. The CPFV vision is focussed on three core functions of the community pharmacy network:

- As the facilitator of personalised care and support for people with long-term conditions;
- The trusted, convenient first port of call for episodic healthcare advice and treatment; and
- The neighbourhood health and wellbeing hub.

3.2. **Workforce:** Better utilisation of the community pharmacists and their teams will help to reduce pressure and resources in other areas of the health and care system and unlike many other health colleagues, there does not appear to be a

pharmacist workforce shortage on the horizon. These community pharmacists are keen to expand their clinical role by using their skills more fully, which will be required to achieve the ambitions articulated in the CPFV.

- 3.3. **Models of service delivery and integration:** The three core functions set out in the CPFV articulates models of service delivery that will support an efficient and effective health and care system. To achieve this, community pharmacists and their teams will work in partnership with their colleagues across the wider health and care system, systems will enable seamless triage to and referral from community pharmacy in all local urgent care pathways and in the NHS 111 service, and all pharmacies will be connected with other organisations that support health, wellbeing and independence and will be able to refer and sign-post people to them.
- 3.4. **Prevention and public engagement:** As the neighbourhood health and wellbeing hub, pharmacies will be the ‘go-to’ destination for support, advice and resources on staying well and living independently. To ensure these services are effective and valued, pharmacy teams will work closely with community leaders to understand and respond to local needs, to develop appropriate interventions and collect data on impact and outcomes and use this to continually improve their offer.
- 3.5. We attach the Executive Summary of our CPFV, which further expands on these themes and opens a conversation about how we turn this ambition into a reality.

The Community Pharmacy Forward View

Executive Summary

Community pharmacy has a central role to play in delivering high quality, sustainable health and care services and improving population health outcomes.

We want a strategic partnership approach to building the future between the sector, Government and the NHS – one that reflects and respects local autonomy and relationships, is closely aligned to the NHS in its goals, but does not leave implementation and delivery to chance.

The health and care system in England is facing major challenges and undergoing significant change.

The NHS Five Year Forward View (5YFV), published in October 2014, outlined the future on offer and the choices to be made in a world where people are living longer, and with complex health issues; where science and technology are transforming our ability to predict, diagnose and treat disease; where traditional divisions between patients and professionals are being broken down; and where health spending growth remains tightly controlled following global recession.

In short, it sets out a vision for a better NHS, the steps to be taken to get there, and the actions needed from actors across the whole system.

As a core provider of essential healthcare and public health services, community pharmacists and their teams are facing the same scenarios and choices as their colleagues across the wider NHS and in local government, and should play a central role in finding solutions that will secure the best future for the system as a whole.

In this Community Pharmacy Forward View, community pharmacy owners and leaders outline their contribution to this task: how we believe a thriving pharmacy network can best support the high performing, affordable health and care system envisaged in the 5YFV, and the wider economy. As well as describing a vision for the future, we will go on to set out what we believe needs to happen to make the vision a reality.

How will community pharmacy change over the next five years?

Our vision for the future is centred around three core functions of the community pharmacy network:

29. The facilitator of personalised care and support for people with long-term conditions
30. The trusted, convenient first port of call for episodic healthcare advice and treatment
31. The neighbourhood health and wellbeing hub

Much of what is described in this Forward View is already happening across all or part of the community pharmacy network, or could be if we had the right supporting systems, processes and incentives in place. What will make the difference in the future will be consistency of delivery, improving quality and impact across the whole country, enabled by effective planning and commissioning and a rigorous focus on implementation and continual improvement within the sector.

Working together will help take us all forward.

These ambitions and proposals bring together, refresh and develop the thinking of previous work from PSNC, Pharmacy Voice and the Royal Pharmaceutical Society. We know that we need to work with frontline pharmacy teams, with patients and service users, with our professional colleagues, with NHS and local government commissioners and a wide range of other partners as we take this forward. By working in this way, the community pharmacy sector can and will develop better solutions to the challenges we face ourselves, while contributing to the development of a more integrated, efficient and effective health system. This common vision of the national pharmacy bodies is therefore matched by a commitment to engage with, lead and support the community pharmacy sector through change.

The transformation initiatives currently underway as new care models and large-scale prevention programmes are developed across the NHS, and as cities and regions take on new responsibilities for planning and integrating local services, provide opportunities to explore how our ideas might be implemented.

Domain One: The facilitator of personalised care for people with long-term conditions.

Medicines are the most common method of managing long-term conditions (LTCs), so community pharmacy teams should be integral to supporting and empowering people with LTCs and their carers to manage their own health. We want to radically enhance and expand the services that community pharmacy teams currently provide to help people obtain medicines safely and efficiently and use them as effectively as possible. As a result, people will have better health outcomes and the costs of managing LTCs will be better controlled, reducing demand in other areas of the NHS and social care.

An enhanced role for community pharmacy teams in supporting people with LTCs and their carers will be based around the principles of medicines optimisation and personalised care and support planning, and build on the clinical knowledge and procurement skills of community pharmacists to promote evidence-based and cost effective use of medicines.

Community pharmacy integration and new care models:

To achieve this vision, community pharmacists and their teams will need to work in partnership; not just with each other and the people they support, but with their colleagues across the wider health and care system, within the new care models that are emerging across the country.

Community pharmacists and their teams can provide a variety of interventions and support to help people manage their LTCs, dependent on the individual's goals, aspirations and personal care plan. A new approach to community pharmacy funding will be necessary to enable pharmacy teams to work in this way.

Domain Two: the trusted, convenient first port of call for episodic healthcare advice and treatment.

Our vision is that in future the habit of using or signposting to 'pharmacy first' for non-emergency episodic care will be ingrained in patient, public and professional behaviours, because people know they will receive a prompt, helpful and effective response whenever they make a community pharmacy their first port of call.

To facilitate this, systems that enable seamless triage to and referral from community pharmacy will be included in all local urgent care pathways and in the NHS 111 service. With their consent, information about people's health and healthcare will be available to community pharmacists, who will be able to add to an individual's shared care record the advice they have been given or products supplied.

Diagnostics and point-of-care testing will be routinely available in pharmacy settings as will facilities for making appointments with or speaking directly to other professionals and service providers. Pharmacists will be able to prescribe, and to supply products to people as if they had received a prescription from a GP.

As a result, public access to high quality primary care will be maintained and satisfaction improved despite growing demand, and people will find it easier to take responsibility for managing their own health and self-care.

Domain Three: the neighbourhood health and wellbeing hub.

Our vision is that, in future, all pharmacies will operate as neighbourhood health and wellbeing centres, providing the ‘go-to’ location for support, advice and resources on staying well and independent. Building on the Healthy Living Pharmacy model, the safe and efficient supply of medicines managed by pharmacist-led teams will remain at the core of this community pharmacy offer, but will be recognised as one component of a broader set of resources and services available within these health and wellbeing centres.

This is our starter-for-ten.

Our message for community pharmacy colleagues:

We want to work with you in making the case for community pharmacy, setting out this positive vision of the future, and implementing sector-led change. We recognise that doing this means making sure those organisations working to represent and support community pharmacy do so with a common purpose, to help deliver community pharmacy’s unique value to communities.

Our message for policy-makers, commissioners and local system leaders:

Right now, the community pharmacy network provides the vehicle that can deliver much of what the health system needs, in particular to address the workforce and capacity pressures

in other parts of the primary care system. We want to do even more, to help the NHS, national and local government to achieve their future objectives and what is best for patients and the public in the long term. Community pharmacy leaders and representative bodies are committed to working with Government, service users, commissioners, other providers and each other to help achieve these objectives, as partners in outcome delivery. To ignore and undermine this offer would be short-sighted and irresponsible.

To make sure this happens, we want a strategic partnership approach to building the future between the sector, Government and the NHS – one that reflects and respects local autonomy and relationships, is more closely aligned to the NHS at its goals, but does not leave implementation and delivery to chance.

To ensure these services are responsive, effective and valued, pharmacy teams will work closely with community leaders to identify and understand local assets and needs, to develop interventions and services based on this intelligence, to collect data on impact and outcomes and use this to continually improve their offer. Seen as a local community resource and trusted source of information and advice, pharmacy teams will have great connections with other organisations that support health, wellbeing and independence – ranging across local community groups, charities, places of worship, leisure and library facilities, social care, education, employment, housing and welfare services – and will be able to refer and signpost people to them. Some pharmacies will host outreach or dropin facilities for these partner organisations, and pharmacy team

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members will be routinely involved in any community-based health and wellbeing activities they organise.

23 September 2016

PHG Foundation – Written evidence (NHS0080)

Overview

The PHG Foundation is a policy think tank with a mission to make science work for health. **Used properly, biomedical and digital science and technologies have the potential to improve healthcare and underpin more efficient and cost-effective health systems.** We welcome the opportunity for wider engagement with the issue of NHS sustainability through this call for evidence, and are delighted that the committee has already highlighted the need for longer-term thinking by government about the future of our health system. Our response is focused on addressing questions 1, 6 and 8 - those that have an explicitly technological dimension, or where we feel that science and technology might be important in solving the problems highlighted.

Rather than considering how technology can be used to sustain the current model of healthcare delivery (e.g. by reducing demand and increasing efficiency), we believe that what is urgently needed is expert analyses and a public debate that embrace the rapid evolution of both technology and the society in which it is embedded.

We suggest that technological and societal changes should be harnessed to drive a more radical transformation in health care enabled by the new emphasis on personalisation. Underlying this transformation is the principle that individuals would take more responsibility for staying healthy and minimising morbidity through periods of acute and chronic illness by their own personal and self-directed preventive healthcare programmes.

Our detailed responses to individual questions follow below.

The future healthcare system

Question 1: Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

- 1.1 A number of current initiatives, including the NHS Test Bed programme and the 100,000 Genomes Project, seek to harness new biomedical and digital technologies to enable more precise and personalised approaches to healthcare. What is lacking from current health and care policy is, in our view, a coherent, long-term vision of how such initiatives can be connected to one another, and used as the framework around which a truly 'person-centred' health system that effectively prevents and promptly recognises and treats ill health can be re-shaped
- 1.2 The challenge to the NHS is to imagine and plan for a future, 15-20 years or more from now, in which new and emerging technologies such as mobile health apps, implantable biosensors, genome sequencing and the sophisticated use of data are a central part of a transformed health system, having replaced rather than supplemented existing approaches to healthcare and disease prevention.
- 1.3 Furthermore, if the health system is to deliver the radical improvement in disease prevention that will be needed to reduce demand on healthcare services, then it must start now to create and evaluate ways of productively combining these technologies,

enabling more continuous and accurate monitoring of health, more precise targeting of preventive and early and accurate diagnosis with treatment aimed at minimising or reversing impact of disease and reduction of the need for further healthcare interventions.

- 1.4 This may require a degree of creativity and of the allocation of suitable time, space and ‘permission’ to pilot approaches at a level of risk not currently possible within the highly regulated and constrained NHS that exists today.

Prevention and public engagement

Question 6: What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

- 2.1 NHS healthcare and public health (PHE) services have an important role to play in prevention as well as acute care. Currently this is largely mediated through major public health programmes aimed at structural measures in society (*e.g.* smoking bans, food pricing policy, public transport and leisure facilities) and at the population as a whole through major health promotion and screening programmes (*e.g.* Healthcheck) and programmes of secondary prevention (*e.g.* intensive smoking or dietary intervention and rehabilitation following heart attack).
- 2.2 **We believe that the NHS must also recognise and develop a personalised dimension to disease prevention.** This should include the personalised assessment of risk both for common and rare disorders and will often include genetic determinants alongside other biomarkers and more conventional personal and lifestyle risk factors. In particular there will be many subsets of common disease (familial hypercholesterolaemia and coronary heart disease provides a current example) where finding a genetic variant will lead to highly effective preventive action. Health systems of tomorrow must find ways of obtaining and using this information. This will require, among other things, much more priority being given to genetic testing with systematic family cascade testing to identify affected relatives.
- 2.3 The health systems should also reconsider their approach to screening as a means of disease prevention and early detection. It is likely that some relaxation will be required of the current national approach which aims for full-scale national programmes with a one-size fits all attitude to individuals and decided against strict screening criteria. In the future, people will wish to access many different screening tests from diverse sources according to their own judgement of disease risk, seriousness and personal preference and health systems will need to adapt to make best use of this behaviour.
- 2.4 Most people will require support to access and make the best use of new technology-enabled interventions. In order to get the maximum health system and public health benefit from these opportunities we believe that the health system needs to consider at an early stage what support will be required and who should provide it (not necessarily a health professional) as well the nature of the interface with the health system. For example, if an individual accesses screening tests whose results may be indicative of increased risk or early disease, will the health system necessarily pick up the cost of subsequent investigation and treatment?

(g) How could technology play a greater role in enhancing prevention and public health?

- 2.5 One of the key components of a more effective public health service, from a technological perspective, would be the ability to deliver sensitive and specific surveillance of the health states of individuals and the environments in which they are situated. In theory at least, such information could be used to more accurately determine pre-symptomatic risk of disease, allowing risk stratification matched to targeted and tailored preventive interventions, and also for earlier diagnosis of disease, allowing more effective ‘secondary’ prevention through earlier access to healthcare-based interventions to alter the disease process and outcomes.
- 2.6 Advances in both biomedical and digital technologies mean that this ‘personalised prevention’ approach is within our grasp. Wearable and implantable sensors - measuring behaviour, physiology and even biochemistry – are being developed for a wide range of health applications. They enable real-time surveillance of our state of health, which in combination with other sources of environmental, social and health data could be combined to direct us to more appropriate and effective preventive interventions, without the need for expensive ‘upfront’ interactions with healthcare professionals.
- 2.7 An example of this approach as applied to secondary prevention is the ‘artificial pancreas’, a closed-loop system consisting of an implanted glucose sensor, a mobile device for monitoring the data it produces and an implanted insulin pump. Trials of such devices are ongoing in children with Type 1 diabetes, with the aim of improving the control of their diabetes. The impact of such approaches on the health and wellbeing of chronic disease patients could be considerable, and improving their health might, with suitable changes to the way the health system operates, reduce their healthcare service utilisation significantly.
- 2.8 Data from emerging biomedical and digital technologies will serve not only to prevent disease in those from whom it was collected, but should also have a significant impact on population health. This could be achieved through effective capture and integration of data from monitoring devices, health records, environmental and social information. The application of ‘big data analytics’ and in particular machine learning techniques, to such large and heterogeneous data could allow identification of subgroups in the population at higher risk of disease, to whom interventions such as enhanced screening should be targeted, or sub groups of the population for whom particular interventions should not be offered for reasons of safety or lack of effectiveness. Thus ‘big data’ and technologies that generate it could, at least in principle, drive a rationalisation in the allocation of healthcare resources and a consequent decrease in cost, or at least an increase in cost-effectiveness.

Digitisation of services, Big Data and informatics

Question 8: How can new technologies be used to ensure the sustainability of the NHS?

- 3.1 As noted in our introductory remarks and response to question one, the extent to which any new biomedical or digital technologies are able to ‘ensure the sustainability of the NHS’ in 2030 will be a function of the extent to which they drive the radical transformation of the health system and our approach, as individuals, to managing our

own health. It is theoretically possible to model and even predict the impacts of such technologies on demand and cost reduction, but we should not be constrained in our future developments by current NHS practice. Instead, we must first imagine the ways in which cultural and social shifts in our expectations of healthcare and attitudes towards health, our rapidly changing relationship with technology and the knowledge to which it gives us access, will re-shape how we expect to stay healthy in 15-20 years' time. For major system change, need to develop future scenarios including possible changes in these factors in order to develop a different model of care which could fulfil future sustainability requirements.

(a) What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

- 3.2 The role of these technologies is first and foremost to improve the quality and effectiveness of healthcare. In the shorter term, they are being implemented predominantly in areas of currently unmet need, and so are not as yet supplanting existing services to any great extent. As such they will probably increase overall costs to the NHS in the short term.
- 3.3 In the longer term, as the intrinsic costs of these technologies declines further, they have the potential to reduce costs where they supplant existing less effective or more costly approaches to healthcare. However, the reduced cost and increased effectiveness of the technologies themselves is unlikely to be rate-limiting in the process of achieving sustainable services overall. The ability of new technologies to deliver reductions in demand and cost-savings will often depend on changes across the pathways of care in which they are embedded, shifts in the location of 'activity' *e.g.* from hospital to community or GP to patient, and their adoption at a scale and with a degree of integration across organisations that are currently hard to imagine the NHS in its current form achieving.

(b) What is the role of 'big data' in reducing costs and managing demand?

- 3.4 Data (big or small) are useless unless converted into knowledge and information that are acted upon. The health service is already awash with 'big data', but its inability to standardise it, aggregate it, share it, analyse it and then use it intelligently to drive changes in practice means that its impact on reducing cost and managing demand are limited. The example of the National Cancer Registry might be useful to consider as an example where big data, if collected systematically and subject to standardisation and in depth analysis can be used to drive improvements in care. Whether or not use of this data reduces cost and demand overall is less clear, as analysis of such health data may be equally or more likely to reveal gaps in care requiring more investment to close, or highlight opportunities to introduce innovative new interventions for unmet needs *e.g.* targeted cancer therapies that are associated with high costs.

(c) What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

- 3.5 Industrial scale roll-out of a new technology implies a centrally controlled and co-ordinated approach to planning, implementation and change management. There are legitimate questions to be asked about the extent to which such 'top down'

approaches are necessary or desirable for all technologies, but this aside, the barriers include:

- **Fragmentation of the health system** – the financial and organisational independence of hospital trusts (reinforced by the Health and Social Care Act 2012) results in misaligned incentives to compete, not co-operate and to a drive to develop ‘distinctive’ services rather than learn from and adopt best practice developed elsewhere (the ‘not invented here’ problem).
- **Essential sharing of knowledge, data and experience (in particular mistakes and failures) are not encouraged** so each independent laboratory/hospital/clinical service is doomed to ‘reinvent the wheel’, wasting time and money and leading to incoherent and inconsistent implementation of technologies that rely on consistency and scale to achieve patient benefit.
- **Further fragmentation between community, social care and hospital services** adds to the challenge of applying consistent standards during technology implementations, and to the challenge of achieving the economies of scale and interoperability on which their success so often depends. There are some signs that the Vanguard programmes and NHS Test Beds could begin to remove some of these barriers, but it remains to be seen whether they do so in practice.
- **The slow and uneven pace of digitisation** across different parts of the UK, and across different specialities/sectors within the health service inhibits the useful application of ‘Big Data’. Gaps in the data will reduce the utility of analysis that depends upon it, and health inequalities are likely to emerge where areas that have digitised more rapidly are able to provide more effective services, not least through enhanced intelligence about ‘what works’ in their area.
- **Regulatory and technological barriers to sharing all forms of health data**, including but not limited to genomic data, severely impede the utility of ‘big data’ driven analytics. The lack of centralised infrastructure to aggregate, store and share the multitudes of health data required to drive the development and delivery of personalised medicine is a huge barrier to progress.
- **Preference for local solutions** – failures of previous ‘top down’ approaches to technology implementation (*e.g.* Connecting for Health) has led to the development of an organisational culture in which localism and bottom-up ‘bespoke’ approaches to technology implementation are favoured. This may be an appropriate way to meet local needs (*e.g.* to establish a hospital EHR that serves the needs of that particular facility), but fails to meet the needs of the system as a whole in delivering standardised, interoperable and accessible data that can be used to improve patient care nationwide. For specialist services such as those delivering genomic medicine, a closely managed centralised top-down approach such as that taken by NHSE in the designation of the Genomic Medicine Centres has proved successful in driving through changes in IT and laboratory practices to enable the more rapid adoption of whole genome sequencing across the NHS.
- **Risk aversion** – the industrial scale implementation of new technologies will often require a ‘leap of faith’, as the benefits cannot be fully demonstrated prior to full scale implementation. For example, the expected benefits of genomic medicine will only be

fully realised once genome data is available at scale and when genome sequencing costs and turnaround times are lowered significantly through industrial scale use. This evidence can only be produced *after* the enormous capital investment was made by Genomics England to establish the sequencing and IT infrastructure required to deliver the 100, 000 Genomes Project. This investment was a significant risk, without guaranteed returns. However, there is little financial or political scope for the NHS to take similar risks (nationally or locally), given the need to prioritise short term sustenance of existing services.

(d) How can healthcare providers be incentivised to take up new technologies?

- 3.6 Suitable appraisal and evaluation of new technologies will remain important; whilst some risks must be accepted, there should also be sufficient flexibility to allow healthcare providers to decline to take up new technologies without evidence of benefits from use in other systems. With respect to suitable incentivisation measures:
- With increasing recognition of the importance of patient-centred care, a **requirement to demonstrate responsiveness to patient-led demand** for technologies could be a useful element within incentivisation measures. Inevitably, there will remain a need to balance this form of demand against limited resources and other needs (including from less demanding, but no less deserving) patients and citizens.
 - In the same way, **measures to encourage patients and citizens to use new technologies on offer** (especially those such as wearables that may require active compliance) are worth consideration. In some chronic diseases, technologies offer better disease control, fewer side effects resulting from disease or treatment and better long term outcomes. For example, continuous blood glucose monitoring offers many patients (particularly those with unstable diabetes) closer control of their blood sugar resulting in fewer episodes of hyper- or hypoglycaemia and ultimately improved quality of life. Educating patients about the potential clinical utility of such devices via informed healthcare providers is essential.
 - **Financial incentives** for the adoption of new technologies (whether as pilots or permanent services) will remain powerful drivers for providers.
 - **Clinical leaders** are crucial in successful adoption of new technologies and approaches, and so clinical engagement should be incentivised. Measures should include the establishment of networks of ‘clinical champions’ (as pioneers of new technologies) with suitable professional and financial recognition of the value of these roles, including paid time away from clinical duties to develop and implement pilots, share professional learning, and participate in the development of national (and international) guidance for how these technologies can most successfully be used.
- 3.7 This last activity should extend to multidisciplinary and cross-sector collaborative work to ensure that the potential impact of new technologies in the NHS is understood and properly anticipated alongside pilot trials. This, the sort of work in which the PHG Foundation has particular expertise, must include consideration of not only clinical and logistical factors but also economics, law, ethics, and policy drivers, barriers and needs.
- 3.8 Of note, healthcare providers have a responsibility to ensure that the most vulnerable and disadvantaged (*e.g.* the elderly, those lacking capacity, children), especially those who cannot benefit from improved health through their own efforts, still have access

to high quality, safe and timely health care. Health providers therefore need to ensure that these groups are not marginalised or excluded through being less able to benefit from new technologies.

(e) Where is investment in technology and informatics most needed?

3.9 The effectiveness with which technologies, informatics and data can help develop, inform and improve a future (learning) healthcare environment is contingent on not one, but several areas of need. From a very practical perspective the ability to harness ‘big-data’ analytics for health first requires data to be in a digital format. In this respect the drive towards a ‘paperless’ NHS is crucial. However the view of the National Advisory Group on Health Information Technology in England is that the £4.2 billion currently committed to digitising the NHS will not be sufficient to enable digital implementation and optimisation in all NHS trusts. Unless this challenge is addressed there could be longer term disparities in the levels of digital maturity across the country with consequences for health inequalities.

3.10 Besides investment in physical infrastructure it is equally vital to invest in approaches to address the barriers to the use of ‘big data’ and technology listed in 8(c) / paragraph 3.5. These include (but are not limited to):

- fostering a system that is receptive to cultural change
- undertaking public engagement and awareness (*e.g.* around the value and importance of health data sharing)
- ensuring the right skills-mix and capacity to analyse big data.

The success of digitisation, big data and technology in the NHS will rely on a whole-system approach.

23 September 2016

Prederi Ltd – Written evidence (NHS0145)

Introduction

1. This is a submission of evidence from Prederi (www.prederi.com) to the House of Lords Select Committee on the Long-term sustainability of the NHS. Prederi is a small consulting firm, with a combination of clinically qualified and general management consultants who have experience of working with various parts of the health and social care system in England. We have sought to bring out our views of what needs to change based on our direct experience of working to improve healthcare.
2. We have started with some general observations of what needs to be changed at the national political level in order to address the challenges ahead. We go on to make some specific observations under the five themes and have given most emphasis to digitisation, where we feel we have particular expertise and a unique perspective.

The Future Health Care System

3. We believe that the question of how must the health and care systems change to cope by 2030 will only be answered well if there is an injection of honesty into the debate. In particular, this requires politicians and others to:
 - a. move beyond the platitude that the NHS is the envy of the world. While some aspects of the NHS truly are world-class, there are plainly health systems in Europe from which the UK can – and should – learn⁹³⁹.
 - b. move on from dogmatic debates about privatisation. There are areas where resources are best allocated by market-like mechanisms; and there are areas where market failure is unacceptable and simple competition is not appropriate. The issue is efficient resource allocation – not historical accident, ideology or producer interest.
 - c. adopt a grown-up approach to affordability, so that the wider public understand what is feasible; it is plainly unsustainable to provide every treatment whether proven or not at whatever the cost – but in the 2012 British Social Attitudes Survey reported that’s what 30% of respondents said should be provided and a further 40% thought that treatments with proven benefits should be provided regardless of cost⁹⁴⁰.

⁹³⁹ Evidence such as the Health Consumer Powerhouse, *Euro Health Consumer Index 2015* (<http://www.healthpowerhouse.com/en/news/euro-health-consumer-index-2015/>) suggests that the universal ‘Bismarckian’ health systems in Europe are performing better than the universal Beveridge systems. However, the comparisons are sensitive to the measures used and the relative weightings given. Whatever the detail, though, the overall conclusion is that we could learn from the systems in the Netherlands, Scandinavia and Germany, where scores are better on most measures and the culture and societies are similar to the UK so we can apply the lessons. The Institute of Economic Affairs have argued this in the recent paper: “*IEA, What are we afraid of?*”, IEA Current Controversies paper no 50, April 2015 http://www.iea.org.uk/sites/default/files/publications/files/CC_What%20are%20we%20afraid%20of_web_3.pdf. But it is not just the political right who are in favour of learning lessons from abroad. The Socialist Health Association have also published clear arguments in favour of a more open mind to comparisons of what works see the Socialist Health Association, blog, *What do international comparisons say about the NHS?*, 18 January 2015 <http://www.sochealth.co.uk/2015/01/18/international-comparisons-say-nhs/>

⁹⁴⁰ John Appleby, *The public’s view of what treatments should be available on the NHS*, King’s Fund, 17 December 2014

- d. accept that units and hospitals will need to be reorganised and services will be delivered from different centres. Appealing to sentiment and politicising hospital reorganisation may win votes but it costs lives. The reorganisation of stroke services in London is reckoned to save over 90 lives a year⁹⁴¹. It could have been done earlier⁹⁴².

Resource issues, including funding, productivity and demand management

4. Our starting point is that the UK will need to spend more of its GDP on health. International comparisons are difficult to make with confidence, but economically and culturally similar countries such as Germany, Netherlands and the Nordic states spend consistently more on health and social care than the UK. In round terms this is about 10% more than the UK currently spends.
5. This presents a choice for funding and links to our call for honesty in the debate. The extra funding could come from increased taxation (but we note that so far only 42% of people responding to the British Social Attitudes Survey would be willing to pay more through taxation with around a quarter favouring some form of hypothecation for the NHS). In our view, the NHS (in England) should not rule-out in principle alternative approaches such as charging for some other primary care services, with exemptions as there are already for dentistry, ophthalmology and prescriptions, or introducing hospital charges (with similar exemptions) for non-medical services (i.e. the ‘hotel’ element). The tests should be that the increase in revenue raised overall is sufficient; that the administration is efficient and proportionate; and that those with the greatest need are not deterred from seeking the help they require.⁹⁴³ We strongly believe that we must

⁹⁴¹ The UK Stroke Assembly 2016 contrasts the different experiences in London and Manchester after the introduction of hyper-acute stroke units (HASUs). In London over 90 lives a year have been saved compared to the (improving) results in the rest of England.

⁹⁴² Chris Ham, *First do no harm: lessons from service reconfiguration in London*, King’s Fund, 19 October 2012

⁹⁴³ There is a large body of research on the effects that user charges including out of pocket payments, co-payments and insurance, have on demand and use of healthcare.

In general, an increase in user fees leads to a reduction in demand and use of healthcare services (Creese, 1991). A Cochrane review (Lagarde *et al*, 2011) looking at the impact of user fees on access to health services in low- and middle-income countries found a decrease in utilisation with the introduction or increase in fees with reductions being in the range of 5-50%. However, after an initial drop usage rates did begin to increase with time (months to years). Conversely removal of user fees causes an increase in use, in some studies usage rates almost trebled with the reduction of fees, although this was not uniform for all types of healthcare. Use of preventative care and most non-inpatient curative services tended to increase whereas inpatient rates stayed the same. Studies that examined the impact of increasing user fees at the same time as increasing service quality found that utilisation rates increased. Rates were highest for those facilities that improved quality and accepted a mixed method of payment, with some patients paying out of pocket and others through capitation via local taxation. This appeared to improve equity as the proportion of low-income patients accessing care increased.

In the UK a study that examined dental use before and after introducing a more rigorous charging regime found that patients not exempt to charges were 4 times more likely to receive emergency care only. They were 340 times more likely to receive a check-up only and if treatment were received it would be 40% less than that received by patients who did not pay out of pocket (Creese, 1991).

Nolan *et al*. investigated the effects of removing user fees for GP services on GP utilization in Ireland using a cross sectional study design with a large representative sample of the Irish population. They compared GP use amongst 4 groups – those with government provided full medical cover, those with cover for GP visits only, those with private health insurance, those with no cover at all and investigated whether self-reported GP use in past 2 years differed for each group. They found that self-reported GP use declined with decreasing levels of cover. The group with no cover had the lowest proportion of people reporting GP use. This remained after adjusting for socio-economic and health need variables

avoid introducing charges that are inequitable or socially counterproductive (e.g. delaying treatment of infectious diseases).

6. The present way of allocating funds to health, social care and other services is leading to inefficiencies. Cuts in social care are leading to extra costs in the health service; and inadequate funding of mental health services, especially young people's mental health is resulting in extra costs in the criminal justice system. Even with increased funding for health and with improvements in productivity, our experience leads us to conclude that there are four steps required:
 - a. The view of costs and affordability has to be at least as wide as the health and social care system (not just the NHS, let alone secondary care). Ideally costs and benefits in other areas (e.g. criminal justice) need to be taken into account in allocating the health budget. The current culture has not encouraged this approach⁹⁴⁴
 - b. The costs in the health care system should be transparent; costs are not synonymous with prices or tariffs⁹⁴⁵.
 - c. Decisions should not confuse value for money with affordability^{946, 947} Within the affordability envelope, decisions need to be based on value for money (or cost

New Zealand and Ireland are two high-income countries where a substantial amount of healthcare is funded via out-of-pocket charges. In a narrative review of international evidence looking at the impact of different charging models and the implications this may have for NZ on equity of resource distribution and access Cummings and May (1999) describe the different funding mechanisms for primary care that were instigated from the 1960s onwards in NZ with emphasis on healthcare reform from the 1990s onwards. They found that user fees impacted on provider behaviour with GPs less likely to take on more complex cases as these are less cost-effective than short simple consultations (assuming a flat fee for all consultation types). There was evidence that people were unwilling to pay for preventative care e.g. low national rates of immunization uptake (63% in 1998). The system resulted in an uneven distribution of GPs, where areas of high healthcare need were underserved due to limited income factors. Out of pocket charges encourages gaming by providers e.g. choosing high cost services over lower ones, requiring more consultations, shorter consultations. There is evidence from NZ that high-need/morbidity groups have low utilisation of primary care services than would seem appropriate given their poor health status.

Creese A. (1991) *User charges for health care: a review of recent experience*. Health Policy and Planning; 6(4): 309-319

Cumming, J; Mays, N. (1999) *Shifting to capitation in primary care: what might the impact be in New Zealand?* Australian health review: a publication of the Australian Hospital Association; 22(4): 8-24.

Cumming J, Mays N (2011). *New Zealand's primary health care strategy; early effects of the new financing and payment system for general practice and future Challenges*. Health Economics, Policy and Law 6(1), 1-21.

Lagarde M, Palmer N. The impact of user fees on access to health services in low- and middle-income countries. Cochrane Database of Systematic Reviews 2011, Issue 4. Art. No.: CD009094. DOI: 10.1002/14651858.CD009094.

Nolan A, Smith S. (2012) *The effect of differential eligibility for free GP services on GP utilization in Ireland*. Social Science and Medicine 74 1644-1651

⁹⁴⁴ Reablement services provide a good example. Monitor's study on the cost effectiveness of these services looked at them from the perspective of the hospital. This results in the evaluated costs being too high (the estimated reablement costs were higher than they are in practice in local authority services); at the same time the savings to the wider public sector (e.g. lower costs in longer term social care) and social benefits (for patients and carers) are understated.

⁹⁴⁵ An innovative process, developed in the NHS but attracting international attention, for testing for sexually transmitted infections is far quicker than the national standards and is preferred by patients. It also costs far less than the national tariff. Take up across the country is however inhibited by the widespread use of block contracts.

⁹⁴⁶ Palliative care and 'hospice at home' have the double benefit of being what most patients would prefer and also cheaper than services provided in acute hospitals. The current system militates against making this change because the

effectiveness). This should include for example taking account of productivity in the wider economy.

- d. Value should be placed on capacity and the ability to flex and react to changes in demand⁹⁴⁸.

Workforce, especially supply, retention and skills

7. Our experience of reviewing community nursing, health visiting and school nurse services, reablement and social care, leads us to conclude that:
 - a. There is considerable scope to improve productivity through effective mobile working; increasing client facing time from around 35% of total time to 50% or possibly more would address some of the staff shortages⁹⁴⁹
 - b. There is scope to delegate to other less highly paid colleagues – a ‘leaner skill mix’⁹⁵⁰
 - c. Successful delegation requires trust that can only be built by joint working at the most local level; various models could be made to work, so long as trust works at the ground level of the organisations involved
 - d. There should be more power to plan and organise devolved to multi-disciplinary, co-located neighbourhood teams
 - e. Front-line staff should be more empowered and allowed to try – and to fail – with pilot projects
 - f. There should be more apprentice schemes to create career paths that can cross from, say, basic social care assistants to qualified social care assistants and qualified health workers. This would help to make some of the social care positions more attractive career paths. This can be supported by inter-professional learning and multi-professional working.

Models of service delivery and integration

8. In our view models of care need to start with pathways and processes rather than structures. It is only improved processes that will deliver improvements in productivity. This implies that there should not be some top-down reorganisation; and that STPs need to be made to work.

way fixed costs are regarded. All costs are variable in the longer-term, but savings in what are currently fixed costs in hospitals cannot be used to pay for services from hospices.

⁹⁴⁷ The case for increasing the number health visitors is strong given the impact on the trajectories of children through life. Looking at the numbers required at the local level, though, we found that the suggested ratios were unaffordable. Good practice ratios of nurses to children are useful but the realities of budgets and recruitment constraints need to be acknowledged in developing advice on implementing good practice.

⁹⁴⁸ A social care provider was able to offer capacity to create flexibility in the ability to discharge people from hospital. The local commissioners wanted only to pay for services as they were used and could not (or refused to) understand that this would be more expensive than the normal operations. The result was the flexible services were not commissioned and delayed discharges persisted.

⁹⁴⁹ The increase in front-line contact time is based on reviews of timesheets of health visitors. Similar values were found from the records of contact time of care workers providing reablement services.

⁹⁵⁰ The conclusion is based on reviews of the work of health visitors and school nurses and the way in which they were organised.

9. While new models need to start from the processes, it would be helpful to align boundaries. CCG boundaries ideally would follow upper-tier and unitary authority boundaries. We have noticed (in an admittedly small sample) that areas where this is the case (e.g. London boroughs) are more joined up than areas where there are many CCGs to the county. Over time it would be helpful for the building blocks to align; this might be done along with a merger of the smaller CCGs. We do not, however, advocate a top down overhaul; instead this should evolve as the unitary local authorities did.
10. Aligning the boundaries will help to align budgets. Social care budgets need to be integrated with health budgets. There are various plausible ways of doing this, two of which are being introduced in Scotland; there is also the devolution in Greater Manchester. At present, elsewhere there are perverse incentives in making cuts in social care and health that tend to transfer and increase costs in the long term.
11. There needs to be honesty in the system about procurement. Competition – effective and meaningful competition – in this sector needs considerable management attention over a prolonged period (given the EU procurement rules). Not only is it a management distraction, but it is also costly for both commissioners and providers. Commissioners seem to forget that if there is no intention to move from the incumbent, or there is little to be gained from doing so, it is a pointless additional cost for the unsuccessful bidders that has to be recovered elsewhere in the health care system.
12. Unless the commissioners are prepared to allow the provider or the specific service to fail, they should not use competition. Block contracts are little more than lip service to competition and tend to inhibit initiatives to improve efficiencies.⁹⁵¹ Competition can help reduce costs and stimulate innovation, but it needs to be organised so that it can make a difference to services.
13. We also think that there should be clearer thinking about contracting for outcomes. Outcomes are by definition not in the control of the provider. Contracts can be created for inputs, activities or outputs that will hold the contractor to account⁹⁵². Contracts for outcomes will be too risky for a commercial organisation to take on and are likely to socialise risk and privatise profit.
14. The system of Senior Responsible Officers appears to us to be less efficient and effective than it could be. In our view, change should be driven by professional programme directors who can be more focused and accountable with sufficient and protected time to oversee the project or programme.

⁹⁵¹ Local authorities locked into block contracts for sexual health were unable to realise savings and service improvements available from switching to an innovative NHS provider.

⁹⁵² Unlike inputs, process and outputs, the outcomes of a service are in part determined by external factors over which the provider has no control. So, for instance, a local contract to reduce sugar consumption among children will be influenced by, among other things, national policies on taxation and regulation of e.g. advertising. A provider could be accountable for providing advisors to schools (inputs), apps to engage children or delivering campaigns (outputs) but cannot contract for the outcomes while taking full responsibility for the risk. A contract for outcomes is more like a wager or is rendered meaningless by a plethora of assumptions that transfer risk back to the commissioner.

Prevention and public engagement

15. There has to be a major shift to prevention to set the conditions for an affordable NHS. The current arrangements do not support that transition. Expenditure on reducing childhood obesity may not generate savings for decades; and public health expenditure in local authorities results in savings (mostly) in the NHS. With the current downward pressure on local authority spending, this is a model for under-investment.
16. There will always be boundary issues whether local authorities or the NHS host PH, so we do not advocate relocating PH. However, the public health budget needs to be ring-fenced and increased. We also think that the way services are delivered – nationally, regionally and locally needs to be optimised with greater alignment across whole systems.
17. At the local level we think that there is a case for designating neighbourhoods for priority action from PH interventions. Where there overlapping challenges for households through worklessness, poor education, unhealthy environments and risky behaviours, there is a need to tackle the underlying causes in a concerted way.⁹⁵³ Such programmes would be focused on the most deprived wards in the country, combining elements of schemes like the Family Nurse Partnership, Troubled Families and (from the 1970s) Housing Action Areas.⁹⁵⁴
18. We are convinced that digital services will play a major role in this but we note that 25% of over 65s are not on the internet⁹⁵⁵. Digital nudging may be central to helping pre-diabetics in their 40s and 50s, but we must not exclude the people who are most likely to have multiple Long Term Conditions.

Digitisation of services, Big Data and informatics.

19. The recent success of the GB Olympics team demonstrates that well managed systems can produce sustainable improvements. The NHS, and other parts of Government, need to learn the lessons from this success and in particular how to use this learning to exploit for the fast changing opportunities represented by digital technology.
20. On the specific subject of Digital for the NHS, the principal plans and strategies are captured in two key NHS documents: the Five Year Forward View; and Personalised Care 2020.

⁹⁵³ The Family Nurse Partnership has proven successful in the UK and is notable for helping young mothers not just with parenting and improving potential outcomes for children, but also for improving educational attainment and employment. <http://fnp.nhs.uk/evidence/research-england>

⁹⁵⁴ A recent example of the interaction of health and other factors locally is: <https://www.theguardian.com/healthcare-network/2016/sep/21/debt-homelessness-domestic-violence-gp-practice-acting-one-stop-shop?CMP=ema-1700&CMP=>

⁹⁵⁵ ONS, *Internet access – households and individuals: 2016*, August 2016, shows that 99% of households consisting of adults with children have access the internet, only 53% of single adults aged over 65 have access. In 2016, of the 11% of all households in Great Britain with no internet access, 21% reported that this was due to a lack of skills. Further barriers reported included equipment costs being too high and access costs being too high (both 9%), while 59% of households without internet access reported that this was because they didn't need it.

21. Superficially, these take a sound approach to modernising the NHS and the use of digital technology to improve efficiency, effectiveness, safety and patient experience and therefore contribute to a sustainable NHS. However, these plans and strategies are not deliverable because:

- a. *Not formulated with input from the customers* – there is little or no structured input nor analysis of feedback from the public and patients in the formulation of the ambitions for digital and paper free processing at the point of care. Therefore, what we have is a theoretical proposition on the digital services that may reduce administration and increase patient engagement and foster self-care and therefore little certainty about the likely outcome from digital investments.
- b. *Not framed based on an assessment of capability to deliver* – until 2 years after the initial publication of the plans and strategies, there was no formal assessment of the capability of local health systems to deliver the proposed digital capabilities and services. Indeed, even the recent Digital Maturity Assessments do not fully expose the issue of lack of local digital skills and experience within the NHS.
- c. *Not enabled with development of digital leadership* – there is no plan to develop digital leadership and digital skills within the key decision making bodies, that is, CCGs and Trusts. Without an appreciation of the transformative possibilities of digital by key custodians of resources within the NHS, even the basic potential of digital is unlikely to be realised by 2020. This will further impede the effective use of resources and exacerbate the mismatch between demand for care and the ability for the NHS to deliver care.
- d. *Not informed by what the technology can actually do* – the plans and strategies do not account for what the current technology can do. Therefore, there is a risk that local health systems will invent the same but different solutions over and over again to deal with shortfalls in the technology they possess. This is already leading to poor local delivery from lack of local capability and enormous amounts of reinvention across the NHS. The IT suppliers should have been engaged upfront to define what current technology can do and this should have been used to frame realistic short term plans. Then the IT suppliers should have been engaged to develop key features needed for the future digital capabilities. All IT suppliers should be required to develop their products in accordance to Informatics and interoperability standards to enable paper free processing and digital services for the public. This will reduce the burden on local health systems to develop local fixes to “wire-up” disparate IT systems that do not support standards for paper free processing.

23 September 2016

Primary Health Properties – Written evidence (NHS0128)

PRIMARY HEALTH PROPERTIES

Primary Health Properties (PHP) is the largest and longest-standing investor in primary care property in the UK, and has now been involved in the development of nearly 300 first-class facilities. Our new-builds and redevelopments – designed to suit the needs of clinicians that we work with – improve NHS patients’ access to GPs, resulting in enhanced wellbeing, experience and outcomes.

During this period of efficiency savings and challenging financial climate, we have provided much needed external finance for primary care enabling the clinicians we work with to provide a greater breadth of services in the community in modern and appropriate facilities.

PHP is committed to supporting patients and clinicians in the UK, demonstrated by our intention to invest a further £100m this year. I would add that investment is not just a one-off, and our commitment is long-term; we actively manage and invest in our portfolio ensuring our buildings remain fit for the future.

RESOURCING THE HEALTH SERVICE

The inquiry’s focus on this crucial topic is commendable; however, for PHP, the key priority is the quality of the NHS estate, which we firmly believe is closely linked to a number of the issues the Committee is scrutinising. We recognise this is a very challenging period for the NHS, but in attempting to find £22bn of efficiency savings, focusing on the NHS estate will help to make this achievable.

PHP was delighted to learn of the government’s appointment of an ‘estates tsar’ earlier this year, and we are looking forward to Sir Robert Naylor’s forthcoming report on the NHS estate. The report will be particularly important for us as it builds on Lord Carter’s Review of Operational Productivity, which predicted that £1bn could be saved by 2019-20 through more efficient use of estates.

It is concerning to us that too often, the estate is deprioritised in the implementation of initiatives to enhance access to services or develop models of care. For example, we are supportive of NHS England’s Estates and Technology Transformation Fund (formerly the Primary Care Transformation Fund), however, we are concerned that to-date there has been insufficient investment in the estate.

We recognise that capital is tight in the NHS, which will pose a major challenge over the coming months and years to transforming services in a sustainable way; this is where PHP and our sector can make a significant long-term contribution by providing external investment. PHP fully supports Simon Stevens’ recent call for an infrastructure fund. Drawing upon our depth of experience, PHP have outlined the best way we believe such a fund could be disbursed:

MODELS OF SERVICE DELIVERY

Alongside establishing financial balance in the long term, the successful development of new models of care as set out in the NHS Five Year Forward View is vital, and can only become a reality by enabling primary care to fulfil its potential; investment in the estate is critical to the delivery of this agenda and PHP can make an invaluable contribution.

At PHP, we understand that a significant percentage of the primary care estate could be better utilised to deliver greater patient experience and outcomes by drawing in a broader range of services; this would help to boost access and ease the pressure on the wider health service including A&E. Our investment can catalyse the development of new models of care, such as Multispeciality Community Providers and Primary and Acute Care hubs.

Currently, there is significant variation in the primary care estate; this is deeply concerning to us. A BMA survey of GPs found that 70% feel their premises are too small to deliver additional services, whilst 52% responded that their premises had received no investment or refurbishment in the last 10 years. A poor quality estate restricts access to services, resulting in unnecessary attendance to hospitals and risks to patient outcomes. Furthermore, without the necessary infrastructure, shifting care into the community and expanding the role of primary care simply will not be possible.

RECOMMENDATION – PRIMARY CARE INVESTMENT

We still believe there is a need for the Government to commit to introduce a property programme to sanction 1,300 new medical centres. This would serve to address some of the abovementioned difficulties caused by poor primary care estate and infrastructure by kick-starting the property system which has been slow moving in recent years.

There would be an estimated capital cost of c£5bn; the private sector is primed to assist the health service by funding this figure. The programme would require c£300m of rent per annum. Whilst this is a large figure and an increase on current rental spend, when taking a multi-year view, the pay-back/cost benefits from improved, efficient service delivery are significant. Moreover, c50% of this figure is already spent on rent and costs for existing, ageing infrastructure. Crucially, organisations like PHP can support the system by taking on the risk in terms of delivery to time, delivery to budget, securing sites and planning and maintaining buildings.

The benefits of such an approach would be significant:

- Higher quality infrastructure would support the move to better community care, therefore, helping to ease pressure on hospitals, particularly A&E – there is a modal tariff cost of £180 for an A&E visit compared to £45 for an urgent care centre visit (saving of £135 per visit);

Primary Health Properties – Written evidence (NHS0128)

- Facilitates greater access to care for patients 24 hours a day and 7 days a week – appropriate infrastructure will be pivotal in the effective implementation of the Government’s pledges;
- Efficiency savings that would accrue from the use of modern, multi-functional premises are estimated to be more than £270m per annum;
- Moving services into primary care improves access to care and crystallises service delivery savings of c50% of some current costs;
- Organisations like PHP are enablers to delivering a 21st century vision of healthcare, and can help with the development of the new models of care outlined in the Five Year Forward View;
- Ensuring that facilities are high-quality helps GPs to perform their instrumental role and can assist in the recruitment and retention of GPs;
- This approach would generate a wider stimulus to UK economy of c£14.2bn⁹⁵⁶, including a regional impact, from the construction activity it generates.

23 September 2016

⁹⁵⁶ http://www.cbi.org.uk/media/1547179/bridging_the_gap_-_backing_the_construction_sector_to_generate_jobs.pdf

Professional Standards Authority – Written evidence (NHS0168)

Call for evidence for the Committee on the long-term sustainability of the NHS

I am pleased to have this opportunity to submit evidence to the Committee, on behalf of the Professional Standards Authority, on this important topic. Our role is to oversee the regulation of health professionals in the UK, and social workers in England. We also advise the four UK governments on matters relating to the regulation and registration of health and care occupations.

In 2010, we published *Right-touch regulation* (revised in 2015), which sets out our thinking on how regulatory policy should be developed. It stresses that regulation should be agile and risk-based, and that the minimum regulatory force should be used to address identified risks of harm. It argues that regulation should focus on quality control rather than quality improvement, but that it should help to create an environment in which professionalism can flourish. It aims to prevent the introduction of unnecessary regulatory interventions.

Growing demand is putting unprecedented strain on the health and care system, and provision of care struggles to keep pace with technological improvements. The role of regulation is to provide assurance that care remains safe for patients and service users. Professional regulation specifically ensures that professionals are appropriately qualified and maintain their knowledge and skills over the course of their career and that appropriate action is taken if concerns are raised about their fitness to practise. A criticism that is often levelled at regulation is that it stifles change, improvement and innovation – while do we do not believe this criticism is always justified, the current frameworks in place in the UK may in some circumstances have that effect.

In the last twelve months or so, we have put our minds to the question of how to reform professional regulation in health and care so that it meets current and future needs. The comments in our submission on the following pages draw heavily on one existing paper – *Rethinking regulation* – and one that is soon to be published – *Regulation rethought*.⁹⁵⁷ You may wish to refer to these publications for more detail as we have attempted to keep this submission as brief as possible.

I hope you will find our contribution useful. We will forward a copy of *Regulation rethought* to you as soon as it is available. *Rethinking regulation* is attached.

⁹⁵⁷ All our publications are available on our website at www.professionalstandards.org.uk.

Written evidence to the House of Lords Select Committee on the long- term sustainability of the NHS

1. Workforce

- 1.1 As we outlined in *Rethinking regulation*,⁹⁵⁸ quoting the NHS Institute for Innovation and Improvement as was, the NHS currently faces a number of big challenges, including:
- ‘The persistent gap between demand for healthcare and the resources available to meet these
 - The need to move from a ‘sickness’ to a ‘health’ service
 - Disparities in health profiles and outcomes for different geographical and social groups
 - The co-existence of ‘collaboration’ and ‘competition’ in policy prescriptions and institutional arrangements
 - The increasing demands placed on services by patterns of health and ill health, notably resulting from an ageing society
 - The need to increase accountability to the public
 - A workforce that are ‘battle weary’ following successive structural reforms.’⁹⁵⁹
- 1.2 We also evoked the challenges presented by ‘further changes in professional roles and boundaries, the introduction of new technologies and innovative treatments, a shift to more care being delivered at home, and increasingly shared responsibility for the delivery of care from individuals to teams’. The theme of integrating health and social care was of course also central to our thinking.
- 1.3 The prospect of the UK withdrawing from the EU further complicates the picture, as providers face the prospect of a possible reduction in the numbers of staff recruited from other EU/EEA countries. Recent figures show that one in ten doctors and one in twenty nurses working in the UK are EU migrants.⁹⁶⁰
- 1.4 While we may not be able to predict the precise demands on a future workforce in health and social care, we can say with a degree of confidence that the workforce of the future will present the following characteristics:
- Greater reliance on support roles, with the development of new positions, such as the proposed nursing associate role⁹⁶¹ – as a less expensive, more flexible, quicker way of providing care than training, recruiting and employing more senior regulated professionals
 - Increased flexibility and fluidity between roles and across disciplines – to accommodate the new ways in which care will be delivered in terms of both emerging technologies, and evolving care needs
 - More professionals and practitioners providing community-based care, particularly in people’s homes – to ease provision in hospitals, and provide

⁹⁵⁸ Professional Standards Authority (2015), *Rethinking regulation*. <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf>

⁹⁵⁹ NHS (2013) *An introduction to public value*

⁹⁶⁰ See Annex A for a breakdown of numbers of EU/EEA-qualified registrants by regulator.

⁹⁶¹ See: <https://hee.nhs.uk/our-work/developing-our-workforce/nursing/new-support-role-nursing>

a more sustainable way of caring for people with long-term conditions.

- 1.5 We also hope to see an increased use of the practitioners providing alternative or complementary care that are on our accredited registers.⁹⁶² This is a workforce of approximately 71,900 practitioners, covering 54 occupations, from counselling and psychotherapy to foot care and acupuncture. These organisations gain accreditation from us if they meet our standards for how to run a register in the public interest. This workforce has huge, as yet mostly untapped, potential for easing the pressure on NHS services and reducing the demands placed on regulated professionals.

2. Reforming regulation for the future

- 2.1 A number of risks and challenges emerge from the changes described in the previous section. We do not believe that regulation could or should bear sole responsibility for mitigating any increases in risks that arise as the health and care service struggles to adapt to new pressures and circumstances. As we outlined in *Right-touch regulation*,⁹⁶³ the responsibility for providing safe care and mitigating risks of harm to patients and service users lies first and foremost with professionals, providers, commissioners, and employers. Regulatory interventions should be considered a last resort. However, regulators and governments do have a responsibility to respond to new and emerging risks, and to adapt to ensure that regulation is not a hindrance to innovation and change: agility is key.
- 2.2 If in the future, there is greater reliance on support roles, the public, employers, and other health and care professionals will need assurance that the risks presented by these roles have been assessed and are being appropriately addressed. We have developed a methodology for assessing the risks of an occupation or profession, and for identifying appropriate means of assurance to address those risks. The application of this methodology could over time bring some consistency to decisions about how or whether to regulate different groups. It could also encourage the use of alternatives to statutory regulation, such as accredited registers,⁹⁶⁴ credentialing,⁹⁶⁵ or employer-led codes of practice.⁹⁶⁶ These non-statutory options usually have the advantage of being less expensive and quicker to implement, and can be more responsive to change.
- 2.3 In order for there to be some fluidity in the boundaries between roles, regulation will need to adapt so that it is not continuing to set or enforce boundaries that are no longer useful or relevant. In our forthcoming publication *Regulation rethought*,⁹⁶⁷ we propose that greater cost-effectiveness and efficiency might be achieved through the merging of regulators. Larger regulators could in future help

⁹⁶² See: <http://www.professionalstandards.org.uk/what-we-do/accredited-registers/find-a-register>

⁹⁶³ Professional Standards Authority (2015), *Right-touch regulation – Revised*.

⁹⁶⁴ See: <http://www.professionalstandards.org.uk/what-we-do/accredited-registers/find-a-register>

⁹⁶⁵ See for example: <https://www.networks.nhs.uk/nhs-networks/credentialling-for-the-life-sciences-industry/news/june-2015-credentialing-project-update>

⁹⁶⁶ See for example: <http://www.hcswtoolkit.nes.scot.nhs.uk/resources/hcsw-standards-and-codes/>

⁹⁶⁷ This paper will be available at www.professionalstandards.org.uk once published.

to remove some of the barriers between professions, and allow for greater fluidity and overlap in scopes of practice, if the need arose.

- 2.4 We also suggest in *Regulation rethought* that the regulators work towards establishing a shared public register to encompass, in time, not only regulated professionals, but also those on accredited registers and other currently unregistered occupations, subject to proper risk profiling. The aim is to create a more agile framework that is easier for the public, employers, and professionals themselves to navigate. It would facilitate the use of alternatives to statutory regulation that provide greater flexibility to accommodate evolving role boundaries. In addition, the imposition of a shared code of practice for all those on the register would help to instil a shared sense of purpose and belonging across all registered health and care occupations – thereby helping to break down cultural barriers between groups.
- 2.5 Our proposal for a single register could help to address some of the risks presented by an increase in provision of care in people’s homes. Much of this care is likely to be provided by low-paid support workers in a relatively transient workforce. For these groups, the option of statutory regulation may not be viable. However, the domiciliary care setting might suggest a need for a public register through which employers or service users themselves could check an individual’s identity, suitability to practise, and relevant employment history. Our proposals could provide this.
- 2.6 Finally, in writing *Regulation rethought*, we were acutely aware of the cost of running the current regulatory framework – costs that are passed on to health and care professionals themselves.⁹⁶⁸ Several of our proposals, not just the merger of regulators, but also recommendations for example around reform of their complaints functions, could help to reduce the financial impact of regulation on the health and care system as a whole.

3. In conclusion

- 3.1 As we made clear in *Rethinking regulation*, the current regulatory framework is not fit for purpose. It is based largely on the model of self-regulation that was created for doctors 150 years ago, that has now been adopted across the eight other statutory regulators. It is out-dated, inflexible, and expensive. The regulatory functions are enshrined in nine separate pieces of primary legislation – one for each regulator – which makes reforming the system as a whole a complex, highly technical task that so far no Government has tackled.
- 3.2 There was widespread disappointment that the reforms proposed by Law Commissions in 2014⁹⁶⁹ were not taken forward under the Coalition Government. The current Government is however committed to reforming the system as a

⁹⁶⁸ In *Rethinking regulation*, we quoted the figure of £195 million for the combined total annual operating costs of the nine regulators we oversee. This was calculated by the Centre for Health Service Economics and Organisation for the financial year 2010-2011.

⁹⁶⁹ See: <http://www.lawcom.gov.uk/project/regulation-of-health-and-social-care-professionals/>

whole, with a focus on ‘better regulation, autonomy and cost-effectiveness’.⁹⁷⁰ They intend to base their reforms both on the Law Commissions’ work, and on our paper, *Rethinking regulation*. We hope that these necessary reforms will be brought forward and believe that they could help to address some of the issues of sustainability highlighted in this paper.

⁹⁷⁰ See Ben Gummer MP’s written ministerial statement: <https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Lords/2015-12-17/HLWS421/>

Annex A: Percentage of EU/EEA registrants on UK registers

3.3 The table below shows the total number of registrants broken down by UK, EU/EEA and non-EU/EAA graduates (figures for the final quarter of 2015/16).⁹⁷¹

Nursing and Midwifery Council	UK graduates: 589,197 EU/EAA graduate: 34,391 (5%) Non-EU/EAA graduate: 66,876 Total: 690,464
General Dental Council	UK graduate: 96,101 EU/EEA graduate: 6,838 (just over 6%) Non-EU/EAA graduate: 4,891 Total: 107,830
General Medical Council	UK graduate: 173,316 EU/EEA graduate: 30,079 (just over 10%) Non- EU/EAA graduate: 70,408 Total: 273,803
General Chiropractic Council	UK graduate: 2,731 EU/EEA graduate: 20 Non-EU/EAA graduate: 393 Total: 3,144
General Optical Council	UK graduate: 20,877 EU/EAA graduate: 230 Non-EU/EAA graduate: 86 Bodies corporate: 2,526 Total: 23,719 (inc. bodies corp) 21,193 (ex. Bodies corp)
General Osteopathic Council	UK graduate: 5,074 EU/EAA graduate: 24 Non-EU/EAA graduate 15 Total: 5,113
General Pharmaceutical Council	UK graduate: 68,034 EU/EAA graduate: 3,554 Non-EU/EAA graduate: 2,846 Unknown graduate: 523 Premises: 14,393 Total: 89,350
Health and Care Professions Council	341,745 (not broken down on register)

⁹⁷¹ Figures provided to the Authority by the regulators we oversee, as part of the quarterly data collection for our Performance Review

Professional Standards Authority – Written evidence (NHS0168)

Pharmaceutical Society of Northern Ireland	UK graduate: 2,309 EU/EAA graduate: 2 Non-EU/EAA graduate: 0 Premises: 550 Total: 2,861
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27 September 2016

Public Health England – Written evidence (NHS0162)

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

Section 1: The committee's call for evidence

PHE will respond to Question 6 and its subsidiary questions.

What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

The committee has asked that witnesses focus on the long-term and defines this as ten years and more. However, at the hearing there was an interest in hearing about the changes that are being put in place for the next few years as a direct result of the Five Year Forward View, which described the health and wellbeing gap and set out the case for a radical upgrade in prevention. These are set out below and they are also likely to be the foundations the long-term work after the Five Year Forward View.

Clear evidence-based advice and support to the local NHS: the NHS planning guidance and associated publications support local commissioners in identifying the key NHS preventative interventions that have the optimal return on investment. PHE has shared the detailed advice to the 44 sustainability and transformation plan (STP) footprints through the Menu of Interventions.

Continued focus on the national public health programmes funded through the Section 7A agreement – notably the screening and immunisation programmes, need continued commissioner focus to ensure effective local uptake and coverage especially in disadvantaged groups.

Developing incentives for commissioners and providers to invest in prevention – these are being put in place, including the changes in the New Care Models programme (eg the Multispecialty Community Provider model for primary care, with a stronger focus on population health and prevention, which is being tested in 14 vanguard sites across the country, and the use of Commissioning for Quality and Innovation (CQUINs), Quality and Outcomes Framework (QOF) and Quality Premia (with a prevention CQUIN announced).

Full engagement in the ‘place based’ approach with even stronger collaboration between local partners, such as the local government and the local voluntary and social enterprise sector, to deliver an integrated and patient-tailored approach to preventing ill health.

Helping address the wider determinants. As the largest employer in the country and as a central part of civic society, the NHS can play a central part in addressing the wider determinants of health. This includes the work on the healthy NHS workforce and the ways in which the NHS can support improving the food environment and environmental sustainability for example.

Addressing the key threats to the public’s health and its implications on the NHS: there are a range of threats to the public’s health that can have a major impact on the NHS in both the short and long-term. The National Risk Register sets out the largest risks on civic society and important factors for the NHS include issues such as antimicrobial resistance, flu pandemic, air pollution and the global health security issues.

a. What are the key elements of a public health policy that would enhance a population’s health and wellbeing and increase years of good health?

Public health intervention for health improvement can focus on individuals, communities or places, or whole populations. Public health policy is usually established in order to effect change across a range of behaviours and systems for health improvement, at population level – this means that effective public health policy has enormous potential to improve health for large sections of the whole population and to reduce health inequalities.

All public health policy is likely to be aimed at effecting change – in determinants, and therefore in outcomes. And while the detail of an effective policy may vary, there are elements common to effective change-focused policy and health systems that can be employed across public health. These include (National Institute for Health and Care Excellence (NICE), 2007):

- understanding the target group or issue of the policy, through adequate needs assessment
- recognising the context of a public health issue – for example, the impact of maternity, early childhood and socioeconomic factors on adult behaviours and health problems, and tailoring accordingly
- building support for public health improvement into relevant policies beyond health engagement with relevant national and community stakeholders, partners and those engaged in delivering change
- using the policy to establish and support pathways for change – ensuring there are adequate services, support and information to facilitate the type of change required
- basing the policy on evidence about what works

ensuring skilled workforce capacity to deliver relevant services and support monitoring and evaluating the outcomes of policy to inform future programmes and planning

b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

There is a long history of the state playing a key role in protecting the public's health against the key threats – biological, chemical, radiological and environmental. The key risks are captured in the National Risk Register.

Good health is the result of a range of factors and determinants, including individual biology and behaviour through to the environment, the structure of healthcare services, and national policy. This means that efforts to improve health must tackle this wide range of determinants. There is very good evidence to suggest that the state, local and regional bodies, individual services and individuals themselves all need to engage in public health improvement in order for it to be effective (see NICE, 2007; 2014). Increasingly important is the role of the state in working with industry and the voluntary sector to have a wide impact on the public's health.

One particular area for involvement of the state and policy-level intervention is where significant inequalities are experienced by sections of the population in terms of health behaviours, health outcomes and/or access to services, and also where an issue (such as, for example, smoking or car seatbelts) has a universal or near-universal impact.

c. What research is being done on how we influence human behaviours and what developments in prevention are taking place in areas such as dementia and what is the potential for using technologies that predict ill-health such as genomics?

Many of the significant challenges faced in public health, such as encouraging healthy eating, increasing uptake of screening and immunisation programmes, and improving professional's adherence to guidelines, will only be achieved if we are successful at changing behaviours.⁹⁷² More recently, there has been an emergence and prominence of integrative dual process models of behaviour (reflective vs automatic systems)^{973 974}. This model acknowledges that many decisions are made automatically (less consciously), and are often guided by impulses, habits, emotions and our interaction with the environment. This suggests that awareness building, education and information provision alone will not change behaviours.

⁹⁷² King D (2015) Applying behavioural insights to challenges in health policy.

⁹⁷³ Michie, S., Stralen, M., & West, R. (2011). The Behaviour Change Wheel: A new method for characterising and designing behaviour change interventions . *Implementation Science* 2011, 6:42.

<http://www.implementationscience.com/content/pdf/1748-5908-6-42.pdf>

⁹⁷⁴ Kahneman, D. (2011). *Thinking Fast and Slow*. UK: Penguin.

PHE has created a small Behavioural Insights Team, in response to a growing interest in the application of behavioural science to public policy. One of the core functions of the PHE Behavioural Insights Team is to design, test, implement and evaluate interventions using theories and evidence from behavioural science designed to improve population level health and wellbeing. The team also provides advisory services and capacity building in behaviour change techniques across public health. Where possible the team conduct, often in collaboration with local government, NHS and other partners, robust randomised controlled trials, as this is regarded as highest level of research evidence level research design. The team uses low-cost, easily scalable interventions, which often address automatic processes to change human behaviours.

Dementia risk reduction

PHE is taking a number of actions to support dementia risk reduction. In terms of raising public awareness, NHS Health Check Dementia Pilots will test raising awareness about dementia risk reduction amongst people in midlife as part of the health check for the first time. PHE has also jointly published a 'Reducing your risk of dementia' booklet with Alzheimer's Research UK, and a factsheet setting out the links between smoking and dementia with Action on Smoking and Health (ASH). A brain age calculator for public use is under development with University College London (UCL).

In terms of raising professional awareness, PHE is working to strengthen partnerships across the system both nationally and locally. In March 2016 PHE launched the dementia edition of 'Health Matters', a resource for public health professionals, which brings together important facts, figures and evidence of effective interventions to tackle major public health problems.

In order to improve access to evidence and data a suite of healthy lifestyle dementia risk indicators is now available on the Dementia Intelligence Network. An intelligence briefing on dementia risk reduction is due for publication later this year which will include data on dementia and co-morbidities.

In terms of understanding and reducing health inequalities, PHE published a literature review on the 'Prevalence of dementia in population groups by protected characteristics' and will be holding a black and minority ethnic roundtable event in October 2016 to generate action in tackling inequalities across the system. More widely, the UK was recognised for its leadership in driving the global risk reduction agenda at the March 2015 ministerial conference in Geneva. Over 90 countries signed up to a call for action that included dementia risk reduction. PHE continues its global leadership role through influencing the development of risk reduction in the Global Dementia Observatory, working with the World Health Organization.

In terms of dementia research, the Medical Research Council (MRC) Dementias Platform UK (DPUK) is a multi-million pound public-private partnership, developed

and led by the MRC, to accelerate progress in, and open up, dementia research. The DPUK is creating the world's largest population study for use in dementia research, bringing together two million participants aged 50 and over, from 22 existing study groups within the UK.

Potential of genomics in prevention

Genomic technologies analyse all or part of the genes expressed in a cell. Applications include analysis of the genomes of individual people and analysis of the genomes of micro-organisms. The costs of these technologies have decreased significantly in recent years and they are being embedded in routine diagnostic services.

Genomics England Ltd⁹⁷⁵ is delivering the government's vision of sequencing 100,000 human genomes within the NHS. Sequencing is focused on rare inherited disease, cancers and pathogenic micro-organisms and the linkage of these data to patients' health records or other information.

Nonetheless we are at an early stage in optimising the extraction of knowledge from the very significant volumes of information (data) obtainable through genomics. Useful skills and capabilities are developed and deployed routinely by mathematicians and computer scientists in sectors other than health. It is important to create initiatives that secure such expertise to address clinical, biomedical and population health.

A predominant focus to date is to understand how a person's genomic profile influences their response to external agents they come into contact with, for example micro-organisms that may cause diseases or drugs to treat illnesses. Research into potential cancer treatments has led significant progress in genomics; however the ensuing knowledge and technologies are now being applied in areas such as inflammatory diseases, eg rheumatoid arthritis. Essential questions that can be answered by genomics include: Will this person benefit from receiving a particular treatment? Will administration of a specific treatment limit the ability of the bacteria or virus or fungus to cause disease or to spread?

Microbial genomics is also key to understanding the development of the antimicrobial resistance that enables micro-organisms to thrive despite the administration of previously-effective drugs. The tuberculosis (TB) strategy being implemented by PHE and the NHS is an excellent example of how genomics increases the ability to prevent or limit infectious diseases⁹⁷⁶. Genome sequencing improves the timeliness and accuracy of disease diagnosis so that treatment can begin and the spread of the micro-organism within the community can be limited.

The application of genomics to preventing or predicting non-communicable diseases such as cancer, heart disease or dementia is more complex. Current approaches can be improved by integrating genetic, environmental and personally-generated

⁹⁷⁵ <https://www.genomicsengland.co.uk/>

⁹⁷⁶ <https://www.gov.uk/government/publications/collaborative-tuberculosis-strategy-for-england>

lifestyle and medical data. Information about large populations can provide understanding of those at risk, and those who will or will not develop disease. Over time, the accuracy of risk prediction models is improved.

Technological challenges continue to be tackled alongside complex ethical and societal issues as well as human behaviours. For all data that provides information on individuals – whether about their health status, lifestyle, behaviours or other features, issues of confidentiality, data security and ethics are paramount. Very considerable care, attention and resource are dedicated to ensuring that the highest standards are maintained. An ongoing consideration is assurance to the public so they retain confidence that the application of data science to genomic or other health indicators will be beneficial to individuals and populations.

d. Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

Most decisions on the levels of funding for prevention and public health are taken locally and there are many reasons why the investment in public health interventions has historically had different levels of priority. For example, the benefits from preventative activity are largely realised in the future rather than today; public health interventions benefit the population at large rather than individuals; and initiatives require a range of behavioural, organisational and legislative changes that are often difficult to implement comprehensively.

Although the evidence base on the cost-effectiveness of preventative interventions is much stronger than it was a decade ago, the nature of the evidence is such that it is often seen as ‘weaker’ than clinical trial evidence that typifies healthcare interventions (eg drugs, surgery, new technologies). There can be disincentives as the institutions and sectors that can realise the savings from prevention spending are not always the same as those who would fund the prevention interventions.

The funding of interventions to prevent illness come from many different sources – this is not a new issue as many interventions come from a range of national and local government budgets as well from the NHS. Several pieces of work have attempted to address how much is currently spent on prevention within the “health” budget, including the Department of Health’s publication of UK health accounts in 2013 and 2014, a survey of primary care trusts (PCTs) in 2011/12 and the 2009 analysis by Butterfield, Henderson and Scott ‘Public Health and Prevention Expenditure in England’)

These studies have estimated that the proportion of the healthcare and public health budgets spent on prevention is around 3-4%. This is a good starting point, but such studies do not typically include all secondary prevention activity in the NHS and the range of preventative activity undertaken in local government and other

parts of central government. A new project being taken forward by the Health Economics team in PHE will seek to use the systematic methodology of the 2009 Butterfield et al paper to look across the healthcare, public health and social care budgets to map out primary and secondary prevention expenditure. International comparisons of spending on prevention (while needing to be treated with considerable caution) show that the highest spending European Union countries invest around 8% of their health budgets in prevention.

Developing capability on designing and implementing prevention interventions will require collaboration across the public health system, as well as a long-term commitment to effecting change and the alignment of system incentives to bring about that change. PHE is working with local and national partners in many different ways to address these challenges with a focus on the importance of 'place-based leadership'.

e. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

There is evidence that legislation can be an effective tool through which to safeguard or improve health, through changing industry or individual behaviour. Legislation works to effect change through a combination of awareness-raising, compulsion and enforcement, providing legislative or environmental 'structure' to the decisions made by organisations or individuals.

NICE guidance on behaviour change suggests that population-level interventions such as policy and legislation can be effective so long as they are embedded within a supportive delivery framework, where key messages or impacts are consistent with other interventions delivered to communities and individuals, where changes are evidence-based, and where risks, costs and benefits have been assessed for different population groups (NICE, 2007). This last point is particularly important, as there is evidence that intervention at this level can impact differentially on health inequalities – for example, fiscal interventions such as tobacco pricing may help to reduce health inequalities^[1], whereas media campaigns or workplace bans may increase them. Legislation also has the potential to create unintended impacts, such as criminalisation and stigma, displacement or compensatory behaviour.

Government announced plans earlier this year – reiterated in the recently published Childhood Obesity Plan – to introduce a sugar levy. This was welcomed by PHE, which had identified^[2] legislation in this area as one of a range of evidence-based actions that, implemented together, could help reduce the nation's sugar intake. The evidence suggests that increasing the price of high sugar products by 10-20% or

^[1] Lorenc, T et al (2012) what types of interventions generate inequalities? Evidence from systematic reviews. *J Epidemiol Community Health* 2013;67:190-193 doi:10.1136/jech-2012-201257

^[2] Public Health England. Sugar reduction: The evidence for action. October 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf

more through the use of a tax or levy would be likely to have an effect on purchasing behaviour – and therefore sugar consumption – at least in the short term. Although it was difficult to separate changes in purchasing patterns resulting directly from price increases caused by the taxes from the ‘halo’ effect of the tax introduction, such as media articles, activity by campaigners and increased public awareness, these may be important components in enabling whole systems approaches to reducing sugar consumption and levels of obesity as are other measures such as a managed programme of sugar reduction in everyday food.

f. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

There are two main mechanisms to incentivise providers of healthcare services to give a greater focus on prevention and upstream activity to keep people well and out of hospitals. The first option is to incentivise the actions we want to see with targeted payments for the outcomes we want to see, for example ensuring that people with long term conditions are systematically and proactively managed. This would include appropriate quality payments to primary care providers. Currently, a version of this approach is used with general medical practices (GPs) through QOF payments, and multi-spec care providers are exploring other version of this approach as part of the development of new care models. The CQUIN system operates in secondary and community services and there will be a new CQUIN for prevention.

The second option is to move to greater integration between primary and acute care systems, with a long-term, capitated budget (ie a funding allocation per person). This would create incentives for providers to work together to improve health and so reduce costs. Long term budgets remove the barrier to interventions that take a few years to pay back, as is the case with many preventative interventions. This could be supplemented with additional quality measures and incentives. Currently, the integrated primary and acute care systems vanguards are exploring joining up budgets and services, and STPs are bringing organisations together to develop multi-year strategic plans. This could be the catalyst to a move to the development of population health systems focused on improving the health of the local populations.

g. What are the barriers to taking on received knowledge about healthy places to live and work?

Health systems often have difficulties in turning knowledge about what should be done into practical action on the ground. This is sometimes referred to as a ‘know do gap’. Received knowledge in healthcare comes in many forms, from the formal guidance of NICE and professional organisations, to case study examples of good practice.

Common challenges in turning knowledge into action include how to identify and bring together the best knowledge, how to make it easily available and understandable, and how to make it relevant to local decision makers.

PHE works with NICE to support the production of evidence-based guidelines on public health topics, so that the best available evidence is systematically identified, rated and brought together under a structured process to identify the public health actions people should be taking. In addition, where no NICE guidance is available, PHE works to bring together with partners to bring together the best evidence and emerging evidence from practice, to advise local public health teams on what to do.

Particular barriers to the uptake of knowledge include a lack of cost-effectiveness and return on investment evidence (in many areas), a lack of evidence for complex, upstream interventions, differing approaches and cultures around the use of evidence and the absence of a systematic reporting system of public health activity to allow targeting of support.

In addition, in order to be able to translate knowledge and put it into action, people need to be able to access it first. Barriers exist in all parts of the knowledge supply chain – in terms of lack of access to public health evidence across the wider health system, and a lack of strategic co-ordination and inequitable access to specialist expertise and support. PHE is working with partners to create a sector-wide solution to provide better access and value for money in accessing the scientific literature, and promoting open access publication.

Work to address the barriers

On creating healthier places to live, PHE works with many national partners and have developed solely, or with partners, a variety of materials to inform good local planning for healthier places. Our summary of the Healthy Places programme provides more information and links to our variety of products - see attached. PHE gave evidence in 2015 to the House of Lords Select Committee on National Policy on Planning and the findings of the committee in response to this are in the Select Committee report⁹⁷⁷.

For promoting healthier workplaces, there is an evidence base about the nature of what constitute 'good work' which was highlighted in the Marmot Report, which focuses on workplace culture and line management rather than the physical environment of the workplace. The importance of the workplace culture and its impact on health and wellbeing has been highlighted in previous reports by Dame Carol Black and Steve Boorman and others.

PHE has supported the implementation of evidence-based practice in workplace settings through promoting NICE guidelines and supporting local authorities to develop workplace health and wellbeing accreditation schemes such as the Better

⁹⁷⁷ <http://www.publications.parliament.uk/pa/ld201516/ldselect/ldbuilt/100/100.pdf>

Work Award. These accreditation schemes help provide a road map for implementation of NICE guidelines relating to workplace health.

PHE is also working with partners to directly share the best evidence and practice with the business sector through our employer facing toolkits, such as the Business in the Community and PHE toolkit on mental health for employers, which was downloaded over 3,000 times in the first six weeks of publication. PHE is currently commissioning two further tool kits, on musculoskeletal disease and on suicide prevention. PHE is currently working with the strategic Health and Work partnership to develop a National Endowment for Science, Technology and the Arts (NESTA) based call for examples of good practice to assess the evidence-based practice in the field and their impact.

h. How could technology play a greater role in enhancing prevention and public health?

There is substantial potential for technology to provide new and improved preventative approaches and better public health, although in many cases the evidence to support the use of these new approaches is still emerging.

There are new digital health interventions that have the potential to provide behaviour change support at large scale and at low cost – for eg apps on mobile phones to help diet or lose weight, or ‘wearables’ – such as step counters. The number of medical, health and fitness apps is increasing with more than 40,000 on the market⁹⁷⁸. The potential for this is increased by high levels of smartphone ownership in the UK (71% of adults have one⁹⁷⁹).

To support this emerging field, PHE is working closely with NICE and NHS Digital to develop an NHS health app endorsement model, as part of the work of the National Information Board. This work will allow the best apps – both in terms of effectiveness, engagement, safety and security – to be identified, systematically assessed and promoted to the public and with the NHS.

In addition, PHE is pursuing the use of digital technology in the provision of national preventative programmes. For example, the National Diabetes Prevention Programme – which is a three-way collaboration led by NHS England with PHE and Diabetes UK that has commissioned face-to-face diabetes prevention services across England – will also be evaluating new digital approaches to see how well these are used by the public, and how effective they are from 2017 onwards.

⁹⁷⁸ IMS Institute for Healthcare Informatics. Patient Apps for Improved Healthcare: From Novelty to Mainstream. IMS Institute for Healthcare Informatics website. http://www.imshealth.com/deployedfiles/imshealth/Global/Content/Corporate/IMS%20Health%20Institute/Reports/Patient_Apps/IIHI_Patient_Apps_Report.pdf. October 2013. Accessed

⁹⁷⁹ IPSOS MORI TechTracker. Q12016. https://www.ipsos-mori.com/Assets/Docs/Publications/Ipsos_Connect_Tech_Tracker_Q1_2016.pdf

In addition, major PHE marketing campaigns, including the new ONE YOU campaign, offer digital support to help people live healthier lifestyles. More than one million people have completed the online ‘How Are You’ quiz to assess their health and offer suggestions to improve their lifestyle. As a part of this work, PHE is also collaborating with behavioural science experts, to develop evidence based tools to help people change their habits. An app to help people stop smoking is currently in the final stages of development and will be evaluated in late 2016.

Another recent example from PHE is the Sugar App, which allows members of the public to check the amount of sugar in their food by scanning the barcodes with the camera on their mobile phone. This app has been downloaded more than 2 million times, raising awareness in the public about the amount of sugar in their food. However the existing evidence of effect is normally stronger for traditional face to face interventions than for digitally delivered services– for example to stop smoking or reduce drinking. Evidence is emerging for technology driven approaches, but more research is needed to understand how to best deliver these services, and how they compare to conventional approaches. It may be the case that hybrid models that involve both human interaction and technology enabled support are the most effective.

In addition, as with most new technologies, uptake can be skewed towards those who are wealthier, or with higher socioeconomic status – so caution has to be taken to ensure that technological solutions do not act to create or reinforce existing inequalities in access or health status⁹⁸⁰. Also challenges exist around data ownership and privacy for new digital prevention approaches, as well as interoperability of these approaches with NHS data systems.

In the future, there may be opportunities for new technologies, including artificial intelligence and machine learning, to learn to spot disease patterns or provide advice that is highly tailored to the individual or population. For example, Google Deepmind is currently using artificial intelligence techniques to see if it can identify signs of eye disease earlier from eye scans⁹⁸¹ and UCL is developing techniques to use artificial intelligence to rapidly pull together the best evidence on behaviour change⁹⁸². Much of this work is exciting, but still a work in progress.

Section 2: Answering key questions asked at the committee hearing on 19 July 2016

There were a series of questions in the session on 21 July 2016 with the King’s Fund, Nuffield Trust and Health Foundation that were not put to Richard Gleave at the later part of that session on which PHE would like to provide information.

⁹⁸⁰ McAuley A. Digital health interventions: widening access or widening inequalities? Public Health. 2014 Dec;128(12):1118-20.

⁹⁸¹Announcing DeepMind Health research partnership with Moorfields Eye Hospital. Google Deepmind. 2016. <https://deepmind.com/health>

⁹⁸² Human Behaviour Change Project. University College London. 2016. <http://www.ucl.ac.uk/human-behaviour-chang>

The broad areas of questioning were as follows:

a) Who is in charge of public health; is there sufficient priority on public health; is Public Health England putting in enough work into prevention?

The Department of Health has a clear role in leading the public health system – the Shared Delivery Plan on.gov.uk says *'The Department of Health will set the direction and coordinate action across the health and care system, which comprises public health, the NHS and adult social care.'* It also leads on the legislation that government decides to introduce which encourages healthy lifestyles.

Local government leads the local public health systems across the country. It has a statutory duty to improve the public's health and exercises this through both commissioning services that improve the public's health, including specific public health services, and creating opportunities for cross sector and community partners that improve health and wellbeing. The wider determinants of the public's health become more important over the longer term and all academic studies conclude that the wider determinants are significantly more important than healthcare in determining the public's health status. Local government is the right part of government to lead on addressing these wider determinants to improve the health and wellbeing of local communities through the 'health in all policies' approach – and this was recognised by the recent Health Select Committee on the post 2013 public health system.

PHE is an executive agency of the Department of Health. PHE is the expert national public health agency that fulfils the Secretary of State's statutory duty to protect health and address inequalities, and executes his power to promote the health and wellbeing of the nation. It does this through providing specialist public health services across the country, the application of public health science to provide advice, data, knowledge and intelligence working in partnership working across the public health system and directly with the public.

PHE's analysis of the evidence has been widely distributed across the health system and attracted significant media and public attention – notably the 2014 report on e-cigarettes and the PHE evidence to the government on sugar in the nation's diet. There have been three House of Commons inquiries into PHE and the public health system since 2013. The committee's 2013 report noted that transition to the new arrangements did not lead to a dip in delivery. The Public Accounts Committee in 2014 concluded:

'Since it was created in 2013, Public Health England (PHE) has made a good start in its efforts to protect and improve public health. Good public health is vital to tackling health inequalities and reducing burdens on the NHS. We were impressed by the passion shown by PHE's Chief Executive, and his determination to challenge Government to consider public health in wider policymaking.'

NHS England commissions a range of public health services, including the national public health services defined in the Section 7A agreement with the Department of Health (for eg screening and immunisation). Clinical commissioning groups commission many healthcare services that include prevention while NHS primary and secondary care providers deliver services and support patients and the public in improving their own health.

The above answer to Q6 describes the work between PHE and local government with the NHS on addressing the ‘health and wellbeing gap’ in the Five Year Forward View. PHE is at the heart of the collaboration between the health arms-length bodies (ALBs) with local government and other partners, especially the voluntary, community and social enterprise (VCSE) sector. This is the foundation on which a range of effective, evidence-based public health interventions are designed and implemented and it is built into the implementation of the Five Year Forward View at the national and local level – for example there is an NHS Prevention Board, chaired by the chief executive of PHE with NHS, local government, ALB and VCSE representation while PHE centres work with directors of public health and NHS leaders in the 44 STP footprints.

b) Is there published evidence about the return on investment for public health interventions?

There are two complementary sets of publications about the evidence on public health interventions:

(A) The peer reviewed academic evidence

The main method that has been used in the literature to determine whether a public health intervention is worth investing in is through cost-effectiveness analysis (or cost-utility analysis). This methodology uses the ‘quality adjusted life year’ (QALY) to calculate the quality and quantity of a person’s life gained from intervening in a certain way.

The cost-effectiveness evidence around public health interventions is substantial and has been systematically drawn together by Owen et al at NICE (2012⁹⁸³) among others. They analysed all the cost-effectiveness evidence given in 21 of NICE’s public health guidance documents between 2006 and 2010, and found that 30 of the 200 base-case cost-effectiveness estimates given were cost-saving, meaning the intervention was cheaper and found to be more effective than the ‘alternative’ scenario. A total of 141 estimates were found to be cost-effective with a median cost per QALY of £365.

The concept of return on investment is a term more akin to wider cost benefit analysis, where both the costs and the benefits of an intervention are expressed in monetary terms. The World Health Organization (WHO, 2014) defines prevention

⁹⁸³ Owen et al (2012) The Cost-Effectiveness of Public Health Interventions J Public Health <http://jpubhealth.oxfordjournals.org/content/early/2011/09/20/pubmed.fdr075.abstract>

interventions that are giving a return on investment as cost-effective approaches where the financial benefits to health and other sectors outweigh the initial investment.

The report published by WHO (2014⁹⁸⁴) summarised the cost-effectiveness and return on investment evidence available for a wide range of public health approaches. The findings were very similar to those reported in Owen et al (2012).

A number of public health interventions are highly cost-effective and some of these offer a return on investment depending on the timeframe being reviewed. The report found that a number of public health interventions can offer a return on investment in the short-term – including mental health promotion, violence prevention, healthy employment and road traffic injury prevention. On average, individual-level approaches were found to cost five times more than interventions at the population level (WHO, 2011⁹⁸⁵).

Mason et al (in press) have recently undertaken a systematic review of the return on investment of public health interventions, concluding that the majority of local public health interventions offer a good return on investment, with some national programmes delivering even better results.

(B) Practical guides for decision makers and frontline staff

PHE and NICE both publish evidence about the cost-effectiveness and the return on investment of specific public health interventions and on interventions to address particular public health challenges.

As part of the Five Year Forward View, PHE has shared a series of documents called ‘The Menu of Preventable Interventions’ to the 44 teams working on the STPs. These summarise the evidence on a range of interventions that have a clear return on investment and should be considered in developing local plans to address the ‘health and wellbeing gap’.

A recent report published by Public Health Wales (2016⁹⁸⁶) analysed the evidence around public health interventions and found that prevention offered good value for money showing far-reaching benefits above the returns found in health, such as productivity gains and benefits to social care, in both the short and longer term.

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⁹⁸⁴ WHO 2014 The Case for Investing in Public Health *A public health summary report for EPHO 8*
http://www.euro.who.int/_data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf

⁹⁸⁵ WHO (2011). From burden to “best buys”: reducing the economic impact of non-communicable diseases in low- and middle-income countries. Geneva: World Economic Forum
<http://apps.who.int/medicinedocs/en/d/Js18804en/>

⁹⁸⁶ Public Health Wales 2016 Making a Difference: Investing in Sustainable Health and Well-being of the People of Wales
http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20Making%20a%20difference%20ES%28Web_2%29.pdf

Public Health England, Chief Knowledge Officer's Directorate – Written evidence (NHS0137)

Submitted by: Dr J Battersby, Consultant in Public Health Medicine

1. Public Health England's Chief Knowledge Officer Directorate welcomes the opportunity to provide evidence to the House of Lords Select Committee.
2. It is our view that the long-term sustainability of the NHS needs to be considered in the widest sense of the term sustainability.
3. In particular, financial sustainability is closely linked to broader aspects of sustainability such as carbon reduction, sustainable procurement and reducing emissions.
4. In England as a whole and in all the communities the NHS serves, the NHS usually the largest employer, largest procurer of goods and services, one of the largest single causes of road traffic and traffic pollution and by far the largest source of public sector carbon emissions.
5. Reducing the carbon footprint of the NHS is, therefore, important for financial reasons. Money is wasted on historic methods of energy use, unnecessary travel, waste management, models of care and lack of prevention.
6. Reducing the carbon footprint of the NHS is important for health reasons as it leads to direct health improvement (e.g. reduced premature deaths due to air pollution from fossil fuels) and a reduced burden on the health system (less obesity, heart disease, and cancers due to changes in lifestyle linked to reduced carbon use including healthy diets, more active travel and increased physical activity).
7. The sustainability of the NHS depends not just on a greater focus on preventing ill health but on engaging citizens to take responsibility for their health and wellbeing with support from the NHS, Public Health England and other agencies.
8. Reducing the carbon footprint of the NHS is important for exemplar reasons: the NHS employs 1.3 million people (Over 2 million if social care and public health workforces are included).
9. Reducing the carbon footprint of the NHS is also important for social reasons: empowering communities by allowing them to use their own community assets, social and geographical networks, and personal technology to taken more control of their own health and that of the places they live reduces the (financial) burden on the heath service by taking preventative strategies closer to people rather than focusing just treatment strategies in large, unaffordable, depersonalised, unnecessary and unsafe hospitals. Hospitals need to focus on only what they can do

best: hubs in local systems, not the disproportionate consumer of almost every resource on the inaccessible outskirts of every town and city.

10. The long term sustainability of the NHS requires delivering savings now whilst improving health in the communities that the health system supports, reducing demands on the health and social care system later. This can only be achieved by equally valuing social and environmental benefits in all decision making. This will ensure that financial savings and improvements in models of care will drive outcomes such as: improved air quality; local employment; the building of social capital; adaptation to and mitigation of climate change. In addition there are important environmental and health benefits such as reduced air pollution.
11. The cumulative savings from energy measures alone implemented in the NHS in England since 2007 amount to around £1.85bn.⁹⁸⁷
12. The NHS needs to continue realising and increasing these savings at the current expected rate to 2025 – this would return a cumulative saving of £6.2bn against a business as usual case.
13. In summary:
 - Carbon reduction in the NHS can help towards financial sustainability;
 - Some causes of ill health are linked to fossil fuel use through air pollution and transport accidents;
 - Initiatives that promote reduced carbon use may have important health benefits from improved diet and physical activity levels.

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⁹⁸⁷ Securing Healthy Returns. <http://www.sduhealth.org.uk/policy-strategy/engagement-resources/financial-value-of-sustainable-development.aspx> Health returns infographic. www.sduhealth.org.uk/delivery/engage/health-returns-infographic.aspx

Mr Graham Raven – Written evidence (NHS0021)

Submitted by:- Graham Philip Raven, Dental Surgeon (Retired) as an individual member of the public

Observations and suggestions for the consideration of the Lords Select Committee on the Long-term Sustainability of the National Health Service

1. The NHS funding crisis is something which has concerned (and frustrated) me for a long time, and I write to you not only as a member of the public, but also as a retired dentist who has worked both in the NHS and in private practice. During my career, I have seen examples of both good and bad patient care under both systems and I have come to the conclusion that healthcare and business do not make good bedfellows. Whilst I am sure that good, ethical standards of care can be delivered under private arrangements, I am also sure that private medical care can carry too many perverse incentives, meaning that the interests of patients sometimes do not always come first when care providers lack the necessary integrity to make it so. For this reason, I do not wish to see increasing privatisation of healthcare, but wish to see a well-funded, well-staffed, well-regulated, National Health Service which, in terms of quality and availability of service, is not only restored to what was envisioned at its inception, but improved in the future, and in that, I include **not** using its dedicated staff as pawns in a game of “divide and rule” for political purposes, but instead giving them the recognition they deserve (in realistic terms, not just lip-service) and working conditions which encourage them to stay in the United Kingdom (Ref. the Junior Doctors’ dispute and strike action)
2. The old saying, “You can’t get a quart into a pint pot”, also operates in reverse. You can’t get a quart **out** of one, either..... (See next paragraph)
3. Allow me to cite a little history. In 1951, just three years after the inception of the NHS, patients’ charges were introduced for the provision of NHS dentures ... simply because demand was putting resources under pressure. Patients’ charges in the General Dental Services have been a fact of life ever since, and were subsequently introduced for optical services. Prescription charges are also a fact of life.
4. We now have a similar problem threatening the future of the NHS ... a gap between demand and resources, which has been manifesting itself in a number of ways which are causing concern. This refuses to go away, and I would suggest that it is high time that the solution applied to the provision of dentures in 1951 should be seriously considered again now to help resolve the current crisis in the wider NHS.... The introduction of patients’ charges for certain items of healthcare.
5. This suggestion will, of course, be anathema to politicians of every hue, because they are afraid to go against the mantra, “Free at the point of delivery”!! ...that is always

trotted out when the NHS is being discussed, and particularly when there are votes to be won

6. The NHS has never been “free”, because it is paid for through taxation, and I believe it is about time that the “sacred cow” - “free at the point of delivery” should be challenged, because I feel it is now an anachronism holding the NHS back from development into a service fit for the 21st century.
7. My reasoning is as follows:-
 - i. We already have a precedent for this in the existence of charges for dental and optical care and prescriptions, as I have already pointed out.
 - ii. The NHS is in financial crisis and cannot meet the demands made on it at the current level of funding.
 - iii. There are two basic choices about how the dilemma might be resolved.
 - a. Make cuts to the service. The public would find this unacceptable if comprehensive care at anything like existing levels is to be maintained.
 - b. Raise more funding.
8. It is my belief, having talked to friends about this, that the public would far rather see increases in funding than cuts in services, because the NHS is a top priority for most people. Without our health, we have nothing. It’s been said, by the ex-Chancellor of the Exchequer, George Osborne, amongst others, that “a healthy NHS depends on a healthy economy.” A further sentiment, which can be applied in reverse, arises from this:- “A healthy economy depends on a healthy nation”.
9. In my simplistic way, I can think of three basic ways of increasing funding. (There could be other, more sophisticated, less direct ways, of course, but I don’t wish to complicate matters here)
 - a. The state borrows more money to invest in the NHS
 - b. Increase taxes.
 - c. Introduce patient’s charges for certain items of care.
10. It will be said that all three options are likely to be unpopular in one quarter or another, but let us face facts: the extra funding for the NHS is not going to fall out of the sky, and it is up to us to find a solution. When I say “us”, I do mean “us” - Government, medical staff, trust managers, CCGs etc., and the general public, who are also patients.

11. What saddens and frustrates me is that politicians insist on giving us what they think we, the general public, want. They don't take the trouble to consult us about the financial crisis bedevilling the NHS, and seek our thoughts, ideas and suggestions about how the situation might be improved (consumer feedback). At the ballot box, all the political parties just offer us "more of the same", and none have the courage to suggest that there might be a better way of doing things. (I understand that the Private Finance Initiative has left some NHS Trusts with crippling debt). This fear of change (and fear of loss of votes, no doubt) has, in my opinion, prevented successive governments from grasping the nettle over this for decades. A national and public debate might serve to convince government that we might be more amenable to paying a little more to protect the viability of the NHS than they think. But it may depend on how it's done.
12. We are all used to paying an "excess" where insurance policies are concerned. Why should this be a problem where our healthcare is involved? It only becomes a problem if we continue to insist on obsessional adherence to the (now outdated) principle of "free at the point of delivery".

Please bear with me while I develop this point.

13. I do not consider myself wealthy. I have a modest pension income which allows me to live a comfortable existence. Yet I would be perfectly willing to pay, for example, £10 for an appointment with my GP, if it helped protect the NHS and assure me of its continued presence into the future, and to provide me with good quality care, delivered in timely fashion, should I need it. A further example:- I was provided with two NHS hearing aids last year. I would have been perfectly happy to pay, let's say, £50 for that service.... A fraction of the cost of private hearing aids.
14. I do not know how many GP appointments take place in a day, but it must be thousands if not millions. Just think how much money that could raise! And to the objectors, I would say, "You can't buy much for ten quid these days, can you?" And to those who claim that it would deter people from seeking medical care, I would say (with deference to Oscar Wilde) that "there are those cynics who know the price of everything and the value of nothing". If those who could easily afford it let £10 stand in the way of their receiving medical care, then I can conclude nothing other than that they are simply foolish. And to those who object to "paying twice", I would say, "You are not paying twice Your payment is split into two components". But, yes, there would need to be appropriate exemptions from such charges.....That, I accept, but for those who can afford it, it would be a small price to pay. I have suggested £10 as an example (it could be more or less) but it does not even need to be a flat rate. It could be in the form of a sliding scale based, for example, on one's tax code (or something similar).... Payment according to means. I also believe most people would find it preferable to an increase in general taxation, because they would know they would be paying their patient's charge *specifically* for their *own* benefit at the point of delivery..... rather than being paid as general taxation which, they might feel, simply disappears into an unmarked coffer at the Treasury to be used for

goodness-knows-what! (So, in this instance, it's no different from the situation which has existed, and escalated, in dentistry since 1951). It could also be argued that increased general taxation takes payment too far away from the point of delivery, making it appear to be free, and in some cases, less appreciated.... because people often do not value what they don't pay for.... And it's those who don't value it who are often the ones who fail appointments and waste NHS resources! All of this, of course, remains to be seen, but that would be the whole point of having a national debate, with this included as a possible option. A further point is that many people do not realise that only a small proportion of National Insurance contributions goes to pay for patient care. The majority goes to provide pensions and benefits.

15. Earlier this year, I wrote to my MP with this suggestion, and my letter was forwarded to Jeremy Hunt. In his reply Mr. Hunt informed us that the suggestion of patient's charges had been put to the BMA for consideration at its 2014 conference, where the General Practitioners (GPs) voted against it. Reasons were not given, but it may be that they did not want the additional administrative burden this would introduce. If so, I have to ask, who is determining policy, here? Is it the Department of Health and the Treasury, or is it the GPs? Important as they are, they do not represent the whole of the NHS. Furthermore, dentists in 1951 were given no choice in the matter. Patients' charges were introduced as a *fait accompli*. I think it would be unacceptable for any one sector of the NHS to be permitted to attempt to block or veto a change which is deemed, after sufficient consultation, discussion and debate, to be in the best interests of the service as a whole. The NHS exists primarily for the interests of patients, and patients should come first. I realise that this may be delicate matter, but again, let us face facts. We now live in an age where it is possible to purchase virtually any commodity one might care to mention, online, with a payment card, in a matter of minutes, at the click of a computer mouse. Would it be beyond the bounds of possibility for a system to be set up where a GP appointment could be booked and paid for in advance, in the same way? And just think what this could do to reduce the number of failed appointments.

16. What about migrants' entitlement to the NHS ?

I accept that migrants who are working contribute to the NHS through their taxes. However, if large numbers of migrants, new to the country, and making demands on the NHS, mean that accessibility to healthcare is worsened for those who have paid into the system all their lives, in some cases since the inception of the NHS , this is unfair and should not be allowed to happen. This would be a source of great resentment and should be prevented. More funds are going to be needed for this alone. Should a supplementary tax for new migrants be imposed?

17. On a related subject, although compassion has its place, "health tourism" should be stopped.

18. What will happen if we do nothing?

The NHS will stagger from one crisis to the next, demand will continue to grow, dissatisfaction will continue to grow, morbidity and mortality will continue to grow, demoralisation (and likely exodus) of staff will continue to grow, services will be withdrawn, standards will fall, and I fear we will end up with a service which is not worth having, even if it is free at the point of delivery. The alternative could be more people having to take out private medical insurance (and follow the American trend? No, thank you!). What would people rather do? Pay a small charge when they visit their GP once in a while, or pay a three or four-figure sum per annum to an insurance company? Isn't this a "no-brainer"? I paid £1600 this year to renew my BUPA subscription (and that is with an optional £2000 excess!). I would rather not have to do this if I could rely on an acceptable, high standard NHS being there for me in the future, should I need it, and I do not know whether I will be able to continue to afford to do this in years to come.

19. Many people in the UK today have lived their whole lives under the umbrella of the NHS and have no concept of what life was like before it existed, and how it could be so again, if we don't wake up to the dangers and do something urgently.

20. I am sure there are many other issues which need to be addressed to help relieve the NHS financial crisis which are beyond my scope or knowledge. But here I have tried both to set out a principle and to suggest one possible method which I believe would help. I trust this may not fall on deaf ears, and I hope a national debate with public involvement becomes a reality soon.

21. Prior to composing this submission I set up an e-petition on the Government website:-

"Start a public consultation and debate about the future funding of the National Health Service"

[This petition is now live at <https://petition.parliament.uk/petitions/166113>]

I thank the committee for its attention.

Graham Raven BDS (Retired)

13 September 2016

Dr Martyn Read – Written evidence (NHS0008)

Dear members of the “Long-term Sustainability of the NHS” committee,

I write in an individual capacity. I am an NHS consultant with an long-standing interest in protocolization and in computers, and I have published research in these fields. I have worked as a clinical software designer in the NHS Wales Informatics Service, NWIS.

Summary:

- The NHS is struggling with increases in demand that cannot be matched by increases in funding. The only hope is to increase efficiency.
 - Commercial organisations achieve high levels of efficiency and reliability using a systems approach.
 - The NHS is failing to match other industries in this.
 - We need to start changing cultural attitudes to a systems approach (this will take time).
 - We need to commission some technological solutions (these will take time).
1. The NHS is struggling with increases in demand that cannot be matched by increases in funding. The only hope is to increase efficiency and safety (there is a large overlap here: unsafe health care is very expensive). Commercial organisations achieve high levels of efficiency and reliability using a systems approach. The archetype is The Toyota Way.

https://en.wikipedia.org/wiki/The_Toyota_Way
 2. In commercial aviation, airplanes are flown according to “the manual”. The manual is not an abstract idea, it is literally a document that describes the organisation’s systems of what to do in different circumstances.
 3. I will use the term “protocolization” to mean the adoption of a systems approach to health care. Apart from protocols, there are also guidelines, algorithms and others, all very loosely defined.
 4. The NHS is not simply failing to match other industries in protocolization. The situation is much worse. For many NHS staff, it is just not on their radar. We have rudimentary rules about waiting lists and clinic appointments, but in clinical care protocolization is almost completely absent. Furthermore, antipathy toward protocolization is commonplace among consultants and senior medical trainees. They cite half-a-dozen well worn (and unconvincing) arguments against it, but I believe the underlying reason is fear of loss of status.
 5. In his book *The Innovator’s Prescription: A Disruptive Solution for Healthcare*, Clayton Christensen calls protocolized health care “Value-Added” activity. He differentiates this from the traditional model, which he terms “Solution-Shop” activity (known elsewhere as Complex-Adaptive activity).

https://en.wikipedia.org/wiki/Complex_adaptive_systems

6. In short (to return to the aviation analogy) not only do we not have a manual, we haven't even begun to write one, and among senior NHS staff there are those who thwart at every turn any attempt to write one.
7. One reason that health care has been slow to protocolize is its complexity. I have argued that this is not a reason to eschew protocolization, but some clever computer programs will be required. At present no such program exists. (Read M. *Programmes guidelines and protocols: the antithesis of precision medicine* (letter). *Br. J. Anaesth.* (2016) 117 (2) 261, included as appendix 1.)
8. A small fraction of cases will have an unprotocolizable main diagnosis. Even among those patients, aspects of their care will be protocolizable. For instance, a patient with a rare and complicated disease who also happens to be diabetic, could have their diabetes managed by a protocol, even if their main diagnosis is managed by senior doctors using the "Solution Shop" approach.
9. With the right technology in place, the vast majority of care could be delivered reliably by staff with minimal training who would not demand high wages. In this scenario, senior clinical staff would not have become superfluous. Apart from the clinical management of the complex unpredictable cases (the "Solution Shop" health care), they would also be required to write the protocols etc (the manual) and keep it up to date.
10. There are a few successful paper-based protocols within the *Enhanced Recovery After Surgery* (ERAS) initiative that illustrate the usefulness of this approach, but the impact of these has been limited.
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/enhanced_recovery_programme.html
11. Despite the hype, I would say that ERAS has made a tiny inroad into a huge problem. There are a number of reasons for this: many places that claim to do ERAS have only done a partial implementation; the information-handling within it is paper-based, so we don't really know much about how well it has performed; and many management staff see it as something they have successfully introduced, and are now moving funding from ERAS to other things. Overall, ERAS has served mostly to teach us how limited a few protocols can be when they run in an organisation that doesn't believe in protocolization.
12. In order to protocolize most of health care we now need to:
 - make protocolization a high priority in every NHS trust (a board member responsible for it, a hierarchy of staff who report to that board member, repeated publicity about its importance to the organisation, etc).
 - develop electronic information systems that provide a reliable up-to-date diagnosis list for every patient (so that these can trigger the protocols).
 - commission software that will provide the three functions required: (1) giving instructions to staff based on underlying protocols; (2) displaying what the protocols are and where patients are within them: and (3) creating and updating the protocols.

13. Appendix 1. Read M. *Programmes guidelines and protocols: the antithesis of precision medicine* (letter). Columb and Hopkins¹ have confirmed that protocolization is associated with improved outcomes (and that the mechanism of this association is unclear), but economic aspects of protocolization are relatively unexplored. I hypothesize that it will enable the same number of doctors to look after more patients than they can at present, with a corresponding decrease in cost per patient. The suggestion in the editorial that protocolization is necessarily the antithesis of personalized care is a widespread misconception. Complex protocolized care delivered by staff who are not medically qualified and are relatively junior is perfectly possible, but it will require the use of computers to store the protocols and to communicate the steps to the relevant staff at the right time. There is an urgent need for tools for this purpose, but as far as I know none is being developed. (Ref¹: Columb MO, Hopkins PM. *Br J Anaesth* 2015; 115: 485–7.)

15 August 2016

Recruitment Employment Confederation – Written evidence (NHS0052)

Executive Summary

The REC represents over 800 recruitment agencies who supply clinical and non-clinical health and social care professionals to the NHS, as well as to local authorities and the private sector. Our diverse membership includes the NHS's ten biggest staffing suppliers as well as hundreds of SMEs; what unites them is their commitment to robust compliance standards (as required through REC membership), and their dedication to providing 24/7 staffing solutions to the NHS.

The NHS currently helps over 1 million patients every 36 hours, and with an ever-ageing population, often suffering with multiple conditions, the demand for healthcare staff is likely to increase. Together with the government's commitment to delivering a true seven day NHS, and the efficiency savings required by the NHS Five Year Forward View⁹⁸⁸, the recruitment industry will have an essential role to play in supporting the NHS over the next 15-20 years to help deliver safe, effective and cost-efficient care to patients. However, there are many challenges facing healthcare recruiters, not least the introduction of agency price caps, the uncertainty around the availability of EU workers and skills shortages.

In addition to healthcare staff, the NHS of the future is likely to rely heavily upon social care workers. Social care workers are a key part of the UK workforce, providing care to people across the whole span of their life; covering children and teenagers, people with learning disabilities, dementia, mental health issues, long-term conditions and those requiring end-of-life care. With significant advancements in healthcare, people are living longer than ever before. An ageing population brings unique challenges which have to be met by government. However, the combined effect of a lack of investment in training, a workforce approaching retirement, and an absence of clear career paths for the next generation of social care workers is likely to present serious problems for the NHS over the next 15-20 years.

⁹⁸⁸ NHS England (2015) Five Year Forward View. Available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

The REC has only responded to the workforce part of the consultation (question 3), as this is where our area of expertise, knowledge and data lies.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

1. The NHS is likely to face many challenges over the next 15-20 years, such as the budget deficit, patient waiting times, concerns over quality of care, an ageing population (suffering with multiple conditions), increasing demand on services and an ongoing debate about creating (and funding) a *true* seven day NHS. However, the most significant of all these issues likely to impact on the long term sustainability of the NHS is a skills and recruitment crisis.
2. The REC publishes a monthly report (*Report on Jobs*) in conjunction with Markit; and medical, nursing and care professionals have consistently been among the most in-demand category of worker across all sectors. Our data has also revealed a sharp rise in demand for temporary and contract staff in the health sector, primarily to provide the skilled workforce that health and social care employers cannot find any other way.
3. With the predicted increased demand on NHS services in the mid to long term, it is unlikely that this trend will change. In addition, we are consistently finding that broader caring roles such as care workers, nursery nurses, care assistants and home carers are in high demand, but the availability of suitably skilled, qualified and vetted professionals for these roles is in decline. Analysis from the Institute of Employment Studies has found that currently, one in every ten nursing vacancies goes unfilled. This is being exacerbated by an ageing workforce – 29 per cent of the current nursing workforce is aged over 50.
4. Following a Freedom of Information (Fol) request late last year, the BBC showed how there are now 6,207 doctor vacancies – which means the vacancy rate had increased by 60 per cent in the two years from 2013 to 2015. Similarly, the Royal College of Anaesthetists have identified we will have 3,800 fewer anaesthetists than required by 2033. Further Fol requests from the BBC have revealed the extent to which a shortage of consultants has pushed up trust spending in order to cover rota gaps. Spending on high-cost overtime has risen by more than a third in the past two years – a trend which is very likely to continue into the next 15-20 years, unless action is taken.
5. It will be absolutely essential to train as many health and social care staff as are needed for the jobs that will exist in the future. The number of nurses in training in the UK has been declining, rather than increasing. The Royal College of Nursing has long

campaigned for more student nursing places. Their research has identified that cuts since 2010 has resulted in a 15 per cent decrease in available places – at a time when demand has only increased.

6. Given the new government's decision to end bursaries for student nurses, midwives and allied health professionals, we now need a strong, coherent plan to engage and encourage young people from all backgrounds to consider health and social care careers. This means clear careers advice and a guidance strategy that reaches out to children while they are still at primary school, and which prioritises contact with students at the times when they make key decisions about their future. Rightly or wrongly, student loans are part and parcel of university education in the UK today, so the health sector should consider what we have learnt from the rollout of loans, how this has affected student numbers, what we can do to mitigate any impact on enrolments, and the best ways of engaging potential students about the return on investment derived from a university education in healthcare.
7. Along with delivering quality training and encouraging more people to consider a career as a healthcare professional, government needs to prioritise workforce planning for the NHS. In 2013, the Centre for Workforce Intelligence predicted that there would be 47,500 fewer nurses than we need by 2016. The government has acknowledged that while they have put 10,600 more nurses onto wards since the Coalition Government came into power in 2010, there is more to do. Now that the Centre for Workforce Intelligence no longer exists and its responsibilities have been transferred to the Department of Health, Public Health England and Health Education England, government should be leading the way in ensuring that we have robust data to make informed decisions around future training and staffing needs in the NHS.
8. The REC is also concerned about the misrepresentation and misunderstanding of those who work on a locum or temporary basis in the NHS. Pay rates for agency NHS staff are often greatly exaggerated by the media; and the essential contribution that these workers make to the health service is overlooked. On average, a Band 5 agency nurse will earn between £22 and £28 per hour for a day shift, as set out by NHS Improvements' 'Agency Rules' (March 2016). But more important is the reasons why individuals are choosing to work this way. In a YouGov poll of over 4,000 people for the REC, we found that one third of all working adults work on a temporary, contract or freelance basis at some point in their career. The evidence also points to the fact that it is a growing trend among individuals, rather than something being done to people by business.
9. Agency workers have played an increasingly critical role in ensuring NHS services are safely staffed; a fundamental principle of Sir Robert Francis QC's report on the Mid Staffordshire NHS Foundation Trust. Two thirds of our members (67%) are fielding up to 100 staffing requests per trust, per week. 95% have fielded requests to find agency nurses and doctors to fill a shift at less than 24 hours' notice and 64% said they have fielded calls from NHS managers between the hours of midnight and 8am.⁹⁸⁹

⁹⁸⁹ <https://www.rec.uk.com/membership/corporate-blog/new-rec-poll-shows-healthcare-recruiters-working-247-to-guarantee-safe-staffing>

10. Agency spend has wrongly been presented as the sole driver of the current financial crisis affecting trusts, even though it is nowhere near the greatest area of inefficiency or waste in the NHS at present.⁹⁹⁰ In addition, the REC has frequently spoken out about the misrepresentation of spending data – whereby agency and bank staff are grouped together as ‘non-permanent staff’, and a distinction between the two spends is not made (‘Better Procurement, Better Value, Better Care’, NHS England).⁹⁹¹
11. With a projected £22bn funding gap by 2020, our members recognise that year on year increases in agency spend are not sustainable. The current price caps (Agency Rules, NHS Improvement)⁹⁹² imposed on agency staff cannot continue in their current form; they are not safe, not sustainable, and not cost-effective. They will undermine existing framework agreements which currently control agency spend and compliance, and potentially lead to an escalation in rates and off-framework usage in the long term. They will drive many existing agency staff out of the market, further exacerbating staff and skills shortages within the health system. We believe it will be extremely difficult for NHS trusts to adhere to these proposed caps, and the resulting breaches will only cause greater confusion and chaos in the market.
12. When we asked why people work this way, particularly in the healthcare sector, they pointed to the fact that it enabled them to get experience of different disciplines and it supported their lifestyle choices. Agency nurses told us that they had turned to a recruitment agency after decades of working on a permanent, substantive basis in the NHS. They found that as an employer, the NHS could not offer them the flexibility they now wanted and needed in order to restore a work/life balance. Working via an agency meant these individuals could still use their years of experience and put their skills to good use, but in a way that suited them and without putting the care of patients at risk.
13. Rather than scapegoating recruitment agencies for the problems being faced by the NHS and placing ever tighter caps and controls on the workers they supply, a better approach would be to see recruiters as partners in helping to design the NHS workforce of the future. Recruiters often work across multiple trusts so they can see patterns emerging in terms of the skills that are in particularly high demand and low supply. Recruiters also know the reasons behind a candidate’s choice to work or refuse certain shifts in the NHS, and this insight is important to drive improvement. It is worth noting that in the vast majority of cases, individuals are often still working via both routes – direct and through an agency. Recruiters bring intelligence that one NHS trust in isolation may not have the capacity to acquire, especially given the current constraints on their resources.

⁹⁹⁰ Lord Carter of Coles recently found savings of £2bn per annum could be secured by 2019/20 through NHS Trusts improving their substantive workforce management, and a further £3bn from improved hospital pharmacy and medicines optimisation, estates and procurement management.

⁹⁹¹ ‘Better Procurement, Better Value, Better Care’, NHS England, (2013). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226835/procurement_development_programme_for_NHS.pdf

⁹⁹² Agency Rules, NHS Improvement (March 2016). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/510391/agency_rules_23_March_2016.pdf

Furthermore, there must be greater accountability and better management of frameworks by NHS managers; with evidence to show the long-term cost-savings. This insight should inform the wider workforce planning strategy that today's NHS so desperately needs.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

14. Being able to recruit well-qualified and vetted EU nationals has been a lifeline to the NHS, and the decision of the UK to leave the EU is likely to present significant challenges to the NHS's ability to recruit enough staff to meet the predicted demand. It should be noted that the Secretary of State for Health and NHS England's Medical Director have publically acknowledged the value that EU staff bring to the NHS; as have the Medical Royal Colleges.
15. The NHS currently relies upon overseas health and social care staff in order to deliver safe patient care. The latest data from the Health and Social Care Information Centre (June 2016) reports that 57,608 staff employed in NHS Trusts and Clinical Commissioning Groups in England declare their nationality to be from a European Union member state – 71,510 staff are from non-EU member states; collectively accounting for around 11% of all staff. Irish workers account for 12,994 staff, Polish workers 7,297, Spanish workers 7,121, Portuguese workers 6,277, Italian workers 5,228 and Romanian workers 2,961. A similar picture is found in social care – *Skills for Care (2015): The State of the Adult Social Care Sector and Workforce in England* – reports that 5% of adult social care staff are from EU countries and 11% are from non-EU countries.
16. With the huge increased demand expected upon the NHS in the next 15-20 years it is highly likely that the NHS and the wider social care sector is going to require significantly more staff.
17. In a recent poll of our members, 57% believe that limits on EU workers coming to the UK will have a negative impact on their ability to supply staff to the NHS. If further restrictions on EU migration to the UK were introduced, 23% believe that it would impact on their ability to supply highly skilled health and social care staff and 25% said it would affect their ability to supply mid-level staff to the NHS.
18. The Migration Advisory Committee has made a recommendation to keep nurses on the Shortage Occupation List, making it easier for the NHS to bring them in when they have exhausted all avenues for domestic recruitment. The REC believes that this is a step in the right direction and one that must be considered for other NHS professions when the evidence shows there is a need.
19. Whilst there is a short-term need for the government to clarify the status of existing EU health care staff working in the NHS, it is particularly important that the government ensures that it has plans in place over the long-term to ensure that Brexit negotiations include provisions for managing supply and demand. We need to make it clear to

anyone with the skills and capabilities to contribute to the NHS that Britain is open to them.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

EU and non-EU staff

20. Following the UK's decision to leave the EU, the REC has been particularly concerned about the future ability of the NHS to recruit overseas health and social care professionals, and about the perceived *attractiveness* of the UK as a place to work for EU and non-EU health staff.

21. The latest data from the Health and Social Care Information Centre (June 2016) reports that there are 1.16 million staff employed in NHS Trusts and Clinical Commissioning Groups in England; of which 57,608 declare their nationality to be from a European Union member state and 71,510 to be from non-EU member states. There are around 19,000 doctors from the EEA working in the UK, around 8% of doctors licensed to practise here. The NHS is clearly heavily dependent upon overseas workers in order to provide safe and effective care. With the anticipated ongoing demands on the NHS, it will be essential that the UK is still able to continue to recruit qualified professionals from overseas. It will be essential that government takes into account the necessity of overseas workers when formulating its plans on the status of existing and future EU nationals. In our latest webinar on 17th August we surveyed 55 members, the majority of whom told us that any limits on EU workers coming to the UK would have a negative impact on the NHS. Interestingly, members flagged that restrictions would impact not just highly-skilled jobs, but could have even more impact on mid-level and low/no skilled roles.

22. We have also received feedback indicating that overseas nurses no longer see the UK as their 'first choice' place to work; with Australia and Canada being seen as more attractive options. In order for the NHS to provide the quality of care that patients need in the next 15-20 years, the UK must position itself as an attractive option in order to recruit both the quantity and quality of staff.

Junior doctors

23. While the current junior doctor's contracts dispute could be seen as a potentially short-term issue, the long-term effects on NHS staffing could be serious. The junior doctors of today will be the consultants of the future – positions which are already under-filled. The Department of Health must seek to bring an end to the current dispute, and ensure that there are adequate safeguards to ensure that there is no repeat in the future. It will be vitally important that the NHS trains up as many doctors as possible today, in order to meet expected demand in the long-term. Anecdotal data from our members suggests that many junior doctors are already seeking work in the private sector and some have left the profession altogether in favour of other careers.

Social Care

24. Whilst social care does not come under the direct remit of this consultation, the importance of social care in partnering with the NHS cannot be underestimated. Approximately 1.45 million people work in adult social care in England, but it is already struggling to recruit and retain staff. Nearly 1 in 20 (4.8%) of positions in England are currently vacant – nearly twice the vacancy rate in the UK’s labour force as a whole (2.6%).⁹⁹³ Even in the short-term the adult social care sector in England faces a gap of 200,000 care workers by the end of this Parliament because of restrictions on immigration and a failure to attract British workers. Longer term, the sector could face a shortfall of 1 million workers in the next twenty years.⁹⁹⁴
25. Despite the vital role of social care in the health and well-being of the nation, the sector has often been under-resourced, under-valued and has lacked clear training and defined career pathways.⁹⁹⁵ The social care sector is dominated by older workers, and is heading for a crisis if it fails to attract younger people. The marked reduction of temporary assignments offered to the under 34s⁹⁹⁶ means those who have just entered the profession and are in the early stages of their careers, are finding it harder to adequately develop their skills in the workplace.
26. Local authorities are focusing their efforts on addressing crisis situations, rather than on long-term planning for the future of the sector. It will be essential for local authorities to do more to offer appropriate assignments and training to those with less experience or who have just entered the profession; equipping both them and the sector for the future. Extra investment in training, apprenticeships and career development will be necessary to make social care an attractive career choice. Adding highly skilled roles within the adult social care sector to the Shortage Occupation List, will be required to make it easier for employers to recruit from overseas when they have exhausted UK sources. The REC also believes that allowing low-skilled migrant workers to enter the social care workforce can be improved by opening up the Tier 3 visa route. Without adequate planning for the future – particularly with the uncertainty surrounding the implication of UK’s decision to leave the EU – social care provision over the next 15-20 years is not likely to meet demand.

Background information on the REC

The REC represents 3,350 recruitment businesses – 80 per cent of the UK’s £31.5 billion industry by turnover – and 8,400 individual recruiters through its Institute of Recruitment Professionals. REC member agencies supply workers into every sector of the UK economy. All members must abide by a code of professional practice and must take a compliance test to enter and stay in membership. The REC is committed to raising standards and highlighting excellence throughout the recruitment industry.

⁹⁹³ International Longevity Centre-UK (2015) Moved to Care. Available at:

http://www.ilcuk.org.uk/index.php/publications/publication_details/moved_to_care

⁹⁹⁴ Independent Age (2015) Available at: <https://www.independentage.org/news-media/press-releases/care-sector-faces-crisis-as-huge-new-care-workforce-gap-revealed-0>

⁹⁹⁵ REC (2015) Getting on: what progression looks like for low-paid workers today. Available at:

https://www.rec.uk.com/__data/assets/pdf_file/0020/260255/Getting-On-2015-progression-for-low-paid-workers.pdf

⁹⁹⁶ Comensura (December 2015) Social Care Index. Available at: <http://www2.comensura.com/socialcareindex/issue3>

23 September 2016

Rethink Mental Illness – Written evidence (NHS0156)

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

The introduction of access and waiting time standards in mental health is an opportunity to review how access to evidence-based treatment is supported by a well-equipped workforce. Our members raise particular concerns about mental health awareness among GPs, often the gatekeepers to secondary care and specialist treatment, and health professionals in A&E and general hospitals. More psychological expertise across the mental health workforce would be beneficial, for example mental health professionals being trained to deliver brief psychological interventions.

We are particularly keen on improving carer involvement. Even when a person has given their consent, confidentiality concerns often act as a barrier to health professionals sharing information with a person's family or carer. Even where consent is not given, carers are still entitled to support and basic information to help them in their caring role but in practice this does not occur. The National Audit of Schizophrenia found that 24% of carers said they hadn't been given enough information about how the illness of the person they are caring would progress in the long term.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

We welcome the Mental Health Taskforce's recognition of the need for high-quality community services and alternatives to admission. Care in the least restrictive setting is critical as delayed discharges from secure and other inpatient settings can have a detrimental impact on people's recovery.

Alternatives to admissions can also be cost-effective - inpatient care costs £350 per day on average compared to £13 per day in a community setting.

The poor physical health of people living with mental illness is a longstanding concern for Rethink Mental Illness. We are pleased that the Taskforce has recommended action across primary and secondary care to address the health inequalities faced by this group. Rethink Mental Illness is trialling a smoking cessation intervention, both in its own services and in partnership with services across the country, as part of the Innovation Network. The pilot trains mental health professionals in smoking cessation so they are better equipped to offer advice and support to people wishing to quit.

7. What are the best ways to engage the public in talking about what they want from a health service?

Rethink Mental Illness has long promoted involving people living with mental illness and their carers in the commissioning process. We have supported local commissioners to embed a model of co-production that supports involvement in the earliest stages of planning, designing and reviewing services. This is especially important for younger people, as we often hear stories of the damaging impact of moving from services for adolescents into adult services. One of the pilot programmes we have developed in London to address this gap has now been extended to reach 25% of the Greater London area, and we hope to extend this further as the programme becomes established.

23 September 2016

Kevin Riley – Written evidence (NHS0124)

THE FALSE PERCEIVED NEED TO MAKE "SAVINGS"

I would draw your attention to the fact that, legally, there is no need to achieve any so called "savings" in the NHS, as each year the government can choose how much of taxpayers' money it is willing to allocate to the NHS -- ***it is merely a matter of determining priorities.***

Currently the amount the UK spends on the NHS ranks it 13th out of 15 of the original members of the EU -- a ranking that is quite frankly appalling. See below for details. In addition, each year the legitimate demands on the NHS for medical; services is increasing due to inescapable demographic changes -- not least the ever growing aging population who present with multiple medical problems.

Given the reality of the above, it is therefore patently unrealistic (and indeed "unlawful" see below) for any Government to insist on "savings" on a budget that in legal terms is "historic".

It is also needs to be pointed out to Jeremy Hunt (and the anonymous tax payer funded so called "spokesman" at the DOH) that it is a nonsense for the Government and the DOH to behave as if it is largesse on their behalf in the amount of tax payers money that goes to the NHS.

The money comes from the taxes of people who for most of their lives have paid both through their taxes and through their National Insurance contributions for care from the NHS.

THE RELEVANCE OF THE CRIMINAL LAW.

What has also not be recognised is the reality that everyone connected with the NHS (including Jeremy Hunt) owe an *overriding* "duty of care" to all users of the NHS. If, because of decisions made either by Jeremy Hunt or anyone else, patients die, that is prima facie evidence of the commission of a serious criminal offence.

POOR RANKING OF THE UK SO FAR AS EXPENDITURE ON THE NHS IS CONCERNED.

Given the differences in the way countries fund their health care it is usual to compare total spending (public plus private) expressed as a proportion of countries' GDP.

On this basis, data from the OECD shows that in 2013 (the latest year for which figures have been published) the UK spent 8.5 per cent of its GDP on public and private health care. (This excludes capital spending equivalent to 0.3 per cent of GDP to make figures comparable with other countries'.)

This places the UK 13th out of the original 15 countries of the EU on the amount it spends on the NHS -- yet the present Government requires the NHS in the UK to make significant further "savings.

The findings of the Public Accounts Committee (and the DOH) were that there are not enough front line staff (Doctors and Nurses) to safely operate a five day service let alone a seven day one - which Hunt(in my opinion as an experienced Solicitor, "unlawfully") wants to impose.

The fact that Hunt intends to do the above without providing additional resources makes his legal position even more unsustainable, ***as it is happening at a time when the NHS has not enough Doctors and Nurses .to provide a five day service let alone a seven day one.***

THE ONGOING INCIDENCE OF PREVENTABLE DEATHS PRIMARILY THE RESULT OF INSUFFICIENT RESOURCE ALLOCATION BY SENIOR MANAGEMENT IN THE NHS.

Thousands of patients who are still suffering "preventable/avoidable deaths" due to the failure of the now "free from democratic control" 165 + NHS Foundation Trust Chief Executives to employ enough Nurses and Doctors - a failure that was identified by Robert Francis QC three years ago as the primary cause of the 1200 "preventable deaths"" that had occurred at the two Hospitals run by the Mid Staffs NHS Foundation Trusts.

As a result Robert Francis recommended that the Government itself set a minimum "safe" number of Nurses and doctors that should be employed at all front line service areas in all Hospitals with which all 165+ Chief Executives would have to comply.

Jeremy Hunt refused to accept this recommendation and, contrary to all reason, stated that this decision was best left to the "free from democratic control" NHS Foundation Trusts to determine - a freedom which was the very reason for the 1200 "preventable" deaths that Robert Francis QC had identified.

The other factor that should be mentioned is the reality that, since the Health And Social care Act 2012 we no longer have a truly "national" Health Service ,as the Chief Executives of each of the "free from Democratic control" NHS Foundation Trusts can make his or her own decisions about how many nurses and doctors are employed and how health services are provided in the Hospitals under his or her control - and crucially ,in so doing, can ignore completely any advice or recommendation that Simon Stevens, Jeremy Hunt or the DOH give in this respect.

The only role that the above now have is in determining how much of tax payers s money is given to these now legally independent bodies - once this money is allocated - none of the above can control how this money is actually spent.

The above reality was made perfectly clear in the White Paper issued by the DOH prior to the Health And Social Care Act 2012 becoming law.

The NHS five year plan was drawn up by NHS England **who have no power to force any of the independent NHS bodies to take on board any of it's contents** - .is respect it is merely the unenforceable aspirations of civil servants who routinely over state the powers they possess..

EXTRACT FROM WHITE PAPER.

1.3 NHS Trusts will be established in law as new legally independent organisations called Public Benefit Corporations, with a duty to provide NHS services to NHS patients.

1.7 NHS Trusts will be set free from central Government control, manage their own budgets and be able to shape the healthcare services they provide to better reflect local needs and priorities.

23 September 2016

Kevin Riley – Supplementary written evidence (NHS0165)

AN EASY WAY TO MAKE SUBSTANTIAL SAVINGS WHILE NOT AFFECTING FRONT LINE CARE.

1 - "Managers and senior managers accounted for only 2.35 per cent of the 1.318 million staff employed by HCHS and GP services across the NHS in 2015"

(Source <http://www.nhsconfed.org/resou...> * HCHS = Hospital and Community Healthcare Services .

Therefore 50% of the total amount spent by the NHS on staff is being spent on only 2.35% of the individuals employed..

The 2.35% being the 165+ Chief Executives and the numerous Directors and other Senior Managers employed by the now "free from democratic control" NHS Foundation Trusts.

A gross disparity between operational and non-operational "service delivery" staff, that would never be tolerated in any other "service" industry - let alone one dealing with (literally) life or death situations on a daily basis.

In one relatively small regional "rural" NHS Foundation Trust, ten of the senior managers are paid substantially more than the Prime Minister and the Chief Executive twice as much.

In London, an investigation carried out by the by the London Evening Standard with the results published in in August 2015 (in an article which is still available on the internet) , .revealed that at that date more than 60 London hospital senior managers were receiving salaries far in excess of that being received by the managers in this rural NHS Foundation Trust.

Note - It is very unlikely that the information in this published article over states the salaries being paid twelve months later - in reality the opposite is more likely to be the position - with the salaries now being paid being greater than those quoted in this article - although the individuals occupying the senior positions mentioned may have "moved on" .

The article (which is still available on the internet) includes the information set out below.

The published article stated that high earners included a chief executive lured from Australia with a £50,000 "golden hello" and an agency finance chief who cost £275,000 for less than a year's work.

The article goes on to include the following information - again the information set out below can be verified by accessing the original article..

The article states as follows:

Barts Health chief financial officer Mark Ogden was allowed to claim up to £36,000-a-year expenses for his accommodation — while the trust ran up the biggest debt in NHS history.

Kevin Riley – Supplementary written evidence (NHS0165)

Mr Ogden,, earned so much at Barts Health in one year that his pay package topped £280,000 — outstripping his boss, chief executive Peter Morris.

His departure in January 2015 came as the trust was about to declare an £80 million deficit — a figure predicted to rise next year to £135 million.

He came to Barts in July 2012 from an NHS job in the North-West. In two and a half years there he earned £545,000 in pay on top of £92,657 to cover rent.

In a similar deal, fellow Barts executive Len Richards was paid £58,700 accommodation costs in less than two years.

Barts, Britain’s biggest NHS trust, was embroiled in similar controversy in June 2015 when it emerged interim finance chief Ian Miller was paid, via his private company, £46,800 a month — more than most Barts staff earned in a year

Imperial College Healthcare chief executive Tracey Batten was London’s best-paid NHS boss, with £342,500 in 2014/15 — including a one-off £49,860 to aid her move from Australia -Ms Batten, earned £90,000 more than her predecessor.

Trusts with numerous executives who earn more than David Cameron’s £142,500 included University College London Hospitals with seven, Barts and Guy’s and St Thomas’ with six, and the Royal Free, King’s College Hospital and Chelsea and Westminster with five. All figures exclude pension contributions.

The Standard found 64 executives earning more than the Prime Minister.

End of Article.

THE FALSE PERCEIVED NEED TO MAKE "SAVINGS"

Legally, there is no need to achieve any so called "savings" in the NHS, as each year the government can choose how much of taxpayers' money it is willing to allocate to the NHS -- it is merely a matter of determining priorities.

Currently the amount the UK spends on the NHS ranks it 13th out of 15 of the original members of the EU -- a ranking that is quite frankly appalling. See below for details.

In addition, each year the legitimate demands on the NHS for medical; services is increasing due to inescapable demographic changes -- not least the ever growing aging population who present with multiple medical problems.

Given the reality of the above, it is therefore patently unrealistic (and indeed “unlawful” see below) for any Government to insist on “savings” on a budget that in legal terms is “historic”.

It is also needs to be pointed out to Jeremy Hunt (and the anonymous tax payer funded so called “spokesman” at the DOH) that it is a nonsense for the Government and the DOH to

behave as if it is largesse on their behalf in the amount of tax payers money that goes to the NHS.

The money comes from the taxes of people who for most of their lives have paid both through their taxes and through their National Insurance contributions for care from the NHS.

THE RELEVANCE OF THE CRIMINAL LAW.

What has also not been recognised is the reality that everyone connected with the NHS (including Jeremy Hunt) owe an overriding “duty of care” to all users of the NHS.

If, because of decisions made either by Jeremy Hunt or anyone else, patients die, that is prima facie evidence of the commission of a serious criminal offence.

POOR RANKING OF THE UK SO FAR AS EXPENDITURE ON THE NHS IS CONCERNED.

Given the differences in the way countries fund their health care it is usual to compare total spending (public plus private) expressed as a proportion of countries’ GDP.

On this basis, data from the OECD shows that in 2013 (the latest year for which figures have been published) the UK spent 8.5 per cent of its GDP on public and private health care. (This excludes capital spending equivalent to 0.3 per cent of GDP to make figures comparable with other countries’.)

This places the UK 13th out of the original 15 countries of the EU on the amount it spends on the NHS -- yet the present Government requires the NHS in the UK to make significant further “savings.

THE EXISTING DANGEROUS SHORTAGE OF FRONT LINE "SERVICE DELIVERY" STAFF IN THE NHS

The findings of the Public Accounts Committee (and the DOH) were that there are not enough front line staff (Doctors and Nurses) to safely operate a five day service let alone a seven day one - which Hunt (in my opinion as an experienced Solicitor, “unlawfully”) wants to impose.

The fact that Hunt intends to do the above without providing additional resources makes his legal position even more unsustainable, as it is happening at a time when the NHS has not enough Doctors and Nurses .to provide a five day service let alone a seven day one.

24 September 2016

Professor Martin Roland CBE – Written evidence (NHS0009)

In 2015 I chaired a report commissioned by the Secretary of State on the Future Primary Care Workforce. The report made a series of recommendations about the future shape of primary care that would be needed to meet the future needs of the NHS in our report '*The Future of Primary Care: Creating Teams for Tomorrow*' <https://www.hee.nhs.uk/our-work/hospitals-primary-community-care/primary-community-care/primary-care-workforce-commission>

In this report we pointed to a two decade year-on-year decline in investment in primary care relative to specialist care, despite the rhetoric from successive governments that more care needed to move into primary care. Indeed, in the last 10 years, general practice's share of the NHS budget has fallen progressively from 11% in 2006 to under 8.5% in 2015.

The recommendations of our report were endorsed by the House of Commons Health Committee in a report on primary care published in April 2016 (www.publications.parliament.uk/pa/cm201516/cmselect/cmhealth/408/408.pdf) and were largely been taken up by NHS England in the *General Practice Forward View* published the same month (<https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>). This included a commitment for £2.4bn additional funding for general practice by 2020. In his foreword to the *General Practice Forward View*, Simon Stevens wrote: "If anyone ten years ago had said: 'Here's what the NHS should now do - cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs', they'd have been laughed out of court. But looking back over a decade, that's exactly what's happened".

The point I wish to make in this submission is the very simple one that the long term sustainability of the NHS depends crucially on a strong and vibrant primary care sector. As I expressed it in a BMJ editorial in February this year (www.bmj.com/content/352/bmj.i942) 'If general practice fails, the whole NHS fails'. Put simply, GPs are the gatekeepers to hospital care, and if the gate is left open, costs will spiral out of control.

23 August 2016

Helen Ross – Written evidence (NHS0086)

Issue	Problems	Solutions	Guidance / Evidence
Resource issues, including funding, productivity and demand management;	<ul style="list-style-type: none"> • Lack of resources to meet needs and demands • Money wasted on historic methods of energy use, unnecessary travel, poor waste management, models of care, lack of prevention • liability for fines, prosecution and damage to reputation as a health sector 	<ul style="list-style-type: none"> • Financial sustainability is more likely to be achieved when we consider environmental and social sustainability as highly supporting (not competing) approaches. • de-carbonise the health system asap even just for purely financial savings and reduced burden on the NHS 	<ul style="list-style-type: none"> • East Midlands NHS Carbon Reduction Project http://www.sduhealth.org.uk/ • 40,000 premature deaths due to air pollution from fossil fuels • decarbonising, waste reduction, valuing finite resources leads to direct health improvement and less burden on the health system: less obesity, heart disease, and cancers from healthy diets and more active travel and physical activity • cumulative savings from energy measures alone implemented in the NHS in England since 2007 amounts to c. £1.85bn, in addition to environmental and health benefits such as reduced air pollution • Securing Healthy Returns. http://www.sduhealth.org.uk/policy-strategy/engagement-resources/financial-value-of-sustainable-development.aspx • ...we don't always have to choose between saving financial resources or protecting the environment – indeed, the most effective investments can often save money, improve health now, and safeguard the environment on which all future health depends. What's good for the environment, and good for the patient's health, can be good for the nation's finances too." John Holden, Director of Policy Partnership & Innovation, NHS England
Workforce, especially supply, retention and skills;	Any consideration about the financial sustainability of the NHS is incomplete without considering the huge part the	To be an excellent employer (between 7-10% of the local population) - a progressive an ethical procurer of goods and	<ul style="list-style-type: none"> • Public Services - Social Value Act 2012 and Climate Change Act 2008 • the NHS employs 1.3 million people (Over 2 million social care and public health workforces included) • The direct low carbon economy generated £26.2bn in this country, two and a half times the size of the pharmaceuticals sector [BIS, march 2015])

	<p>NHS has to play adding social value to the communities it serves.</p>	<p>services - an exemplary partner anchor institution in creating highly efficient local low carbon economies for all (where much of the economic development in this country is already happening).</p>	<ul style="list-style-type: none"> • The Public Services (Social Enterprise and Social Value) Bill 2010, became law in January 2012. It requires all commissioners of public services (e.g. CCGs, NHS England) to explicitly consider the economic, social and environmental value, not just price, when buying goods and services.
<p>Models of service delivery and integration</p>	<p>Treatment strategies in large, unaffordable, depersonalised, unnecessary and unsafe hospitals. Disproportionate consumption of resources on inaccessible outskirts of towns and cities.</p>	<p>Empowering communities by allowing them to use their own community assets, social and geographical networks, and personal technology to taken more control of their own health and the places they live reduces the (financial) burden on the heath service by taking preventative strategies closer to people Hospitals need to focus on only what they can do best: hubs in local systems NHS needs to continue realising and increasing</p>	<ul style="list-style-type: none"> • benefits reinforce each other (they offer significant benefits in different areas (co-benefits) for health, for the NHS and for the health and care system, and all that makes living possible and desirable • An integrated National Health and Care Service? Incentivisation for health and social care integration; Incentivisation is key: for OUTCOMES and PREVENTION – NOT simply ACTIVITY.... http://www.sduhealth.org.uk/areas-of-focus/clinical-and-care-models.aspx <p>– this would return a cumulative saving of £6.2bn against a business as usual case</p>

		these savings at the current expected rate to 2025;	
Prevention and public engagement	<ul style="list-style-type: none"> the NHS is very good at incentivising activity, often at unknown cost effectiveness or acceptability to patients Even the STP process is not prioritising prevention in practice. Public Health services in Local Authorities are being drastically cut due partly due to Local Authority efficiency savings 	<ul style="list-style-type: none"> Incentivise prevention and outcomes by embedding principles of prevention and outcome into the NHS. Address preventable conditions by a sustainable and low carbon approach Increase resources for healthy sustainable policy, strategy and practice. Allocate a ring fenced budget for sustainable health and care services. 	<p>Faculty of Public Health: -</p> <ul style="list-style-type: none"> Active Travel Fuel Poverty and Excess winter deaths Food for Life partnership <p>http://sustainablefoodcities.org/keyissues</p> <p>http://www.sduhealth.org.uk/</p>

23 September 2016

Dr Emma Rowland – Written evidence (NHS0091)

Emotional Geographies of care work in the NHS

Summary

The implications for policy and practice provided here are taken from pages 353-357 of a PhD thesis which focused on the emotion management of health professionals in both NHS hospital and ambulance service settings. The full thesis, abstract and conclusions can be found [https://kclpure.kcl.ac.uk/portal/en/publications/emotional-geographies-of-care-work-in-the-nhs\(e8d893c2-9a35-42e9-ac62-9e550f0a21c0\).html](https://kclpure.kcl.ac.uk/portal/en/publications/emotional-geographies-of-care-work-in-the-nhs(e8d893c2-9a35-42e9-ac62-9e550f0a21c0).html)

The thesis provides evidence to support the long-term sustainability for the NHS, focusing specifically on the NHS' workforce, especially in relation to retention and (emotion management) skills. This research has value, due to its exploration of the workforce of a range of health professionals and managers working in the hospital setting but also the health professionals of the ambulance service, who are under-researched.

The Francis Report (2013), sought to enhance overall care performance through the delivery of compassionate care. In addition it recognised that better support should be provided to enhance the emotional and psychological well-being of health professionals and managers so that they have a sense of pride in their care delivery and facilitate and engender a culture of emotional care work.

The research shows benefits to the retention of the workforce as a direct result of supporting health professional's emotional well-being at work:

- Emotion management training will provide effective coping strategies to support health professionals care work. Currently health professionals do not receive any training in emotional labour and this is essential not only for the delivery of compassionate care but for health professional's emotional well-being. Effective emotion management reduces fatigue, ill-health and burn-out which often leads to absenteeism.
- Provision of new care directives that provide guidance and support to health professionals in how to build emotional relationships with their patients is required. Balancing care against time directives often leads to a focus on physical care. Health professionals often feel guilt and anxiety in not sufficiently addressing their patient's emotional well-being. New guidance will demonstrate that policy makers take patients emotional and social care as seriously as their physical health (Francis Report 2013) and will demonstrate to health professionals that their emotion work is valued. This will lead to less stress, frustration and burn out, enhancing staff retention.
- Cathartic spaces are needed in the hospital and ambulance service to allow health professionals to de-brief with their peers following stressful, upsetting and traumatic jobs. "Emotion talk" will increase staff retention as emotional talk fosters resilience.

The implications for policy and practice emanating from the thesis are attached below:

The findings and conclusions presented here demonstrate the relevance and timely nature of this thesis. The recent publication of the Francis report (Francis report 2013a,b,c) and other health professional guidelines such as the Nursing and Midwifery (NMC) code of conduct and “Compassion in our practice: Nursing, Midwifery and care staff” (Nursing and Midwifery Council 2013) emphasises the importance for health professionals to enhance overall care performance through their delivery of compassionate care to increase patient satisfaction. In addition, the Francis report seeks to instil a sense of pride in care delivery and to recognise that better support should be provided to enhance the emotional and psychological well-being of health professionals and managers so that they are able facilitate and engender a culture of emotional care work. Data were collected prior to the publication of the report thus highlighting that emotional (compassionate) care has long been an important part of care delivery and management for those practicing at ward level. The renewed significance and attention that policy makers are giving to emotion in care work is encouraging.

There are several ways in which an emotional geographies perspective to care work may influence policy and practice. First, in focusing on the temporal and spatial characteristics of carescapes, the establishment of emotional care relationships between health professionals and their patients is accentuated. In understanding and recognising that different carescapes impose different emotional challenges to the health professionals working within them, policy makers may be able to implement tailored emotional labour training that specifically addresses the emotional demands and challenges within each carescape. Currently, limited formal emotional labour training is provided for health professionals (Smith 1992; Smith 2012). Specific training may extend and support the repertoire of emotion management skills and tools already possessed by health professionals, providing effective coping strategies to support their emotional care work. Greater proficiency in emotional labour techniques may assist health professionals in protecting their own and their colleagues’ emotional and psychological well-being, reducing emotional fatigue and burn-out, which in turn may reduce absenteeism (Hochschild 2003b; Allan and Barber 2005).

Furthermore, understanding and recognising that different carescapes pose different emotional challenges for health professionals can also lead to the establishment of new care directives that could provide guidance and support to health professionals in delivering care at ward level. New directives could allocate time within practice for building emotional and social relationships with patients in relevant spaces of care. This would not only demonstrate that policy makers are taking the role of emotion in care work seriously and showing that emotional care is equally as important as the physical care provided, but will also convey a clear message to those already forming emotional connections with their patients (and their relatives) that their work is valued and the organisation supports them in this endeavour. Time for relationship building may reduce feelings of guilt and anxiety, especially for those health professionals working within contested spaces of care, and will also enhance consistency of care across the organisation.

Third, in exploring the spatialities of emotional care work, an emotional geographies lens demonstrated that emotions can become contained or circulate within different carescapes. Health professionals may use this knowledge as an effective emotion management tool to change the emotional climate or affective ambiance of the carescape in which they are

working to ease their emotional labour. This knowledge may also be pertinent to hospital designers and policy makers. Recent research has shown that the nightingale ward is increasingly being replaced by single occupancy rooms to reduce the spread of infection and enhance patient satisfaction (Penfold and Maben 2013). Single occupancy rooms however are not favoured by all patients or health professionals. It has been demonstrated that some patients, especially elderly patients, do not like single occupancy rooms as they incite feelings of isolation. In addition, single occupancy rooms may increase health professionals' anxieties due to fears about patient safety. The emotional and psychological consequences for both patients and health professionals' well-being as a result of hospital design should be explored further.

Fourth, in recognising that logistical spaces are highly complex emotional terrains, this thesis suggests that health professionals and managers could be better supported in these spaces. Currently there is limited recognition of the emotional demands of those managing care, with limited formal training to support decision making surrounding the managing and scheduling of care. Training would enhance the emotional and psychological well-being of health professionals, especially for those working at the boundaries of private and public care where the shifting politics of care create additional emotional challenges.

Policy makers may also benefit from an awareness of the emotional burden placed on both recipients and providers of care at the edge of care boundaries when creating care guidelines. A more considered approach could have implications for service use in the longer term. Better support for health professionals in managing patients' and relatives' emotions at the boundaries of private and public care may result in less anxiety and emotional strain. In addition, health professionals may be in a better position to empathise, support and encourage relatives in caring for their elderly and / or vulnerable relatives in the home. This may reduce the burden on NHS resources in caring for elderly / vulnerable patients but may also prevent relatives from accessing additional NHS resources as a result of their own stresses caused by the care burden.

The thesis also highlighted implications for the ambulance service's policy and practice. The importance of emotionally connected workplace relationships in supporting coping strategies following challenging jobs was emphasised. However, due to their mobility, ambulance crews rarely have the opportunity to spend time at the station outside of meal breaks to build relationships with a wider network of crew. Policy makers should recognise the value of the ambulance station as a cathartic and therapeutic space and allow crews to return to base, especially following bad jobs, to assist coping. Being isolated at standby causes negative thoughts, feelings and affects to manifest leading to a haunted mind which may be detrimental to crews' emotional and psychological well-being if unmanaged.

23 September 2016

The Royal College of Anaesthetists – Written evidence (NHS0073)

Response to House of Lords Select Committee inquiry on the Long-Term Sustainability of the NHS.

The Royal College of Anaesthetists (RCoA) is the professional body responsible for the specialty throughout the UK, and represents a combined membership of 21,000 doctors who work in the NHS. The RCoA is committed to improving patients' safety, wellbeing and outcomes through the maintenance and advancement of standards in anaesthesia, critical care and pain medicine. Through our services, anaesthetists will be well trained and supported, and we continue to uphold a central role in the development and delivery of high quality healthcare.

Anaesthesia is the UK's largest secondary care specialty; 16% of all hospital consultants are anaesthetists and over two-thirds of in-patients will see an anaesthetist during their stay in hospital. Moreover anaesthetists play a vital role in the delivery of pre-hospital emergency medicine and the ambulance services.

We therefore welcome the opportunity to give evidence to the House of Lords Select Committee inquiry on the long-term sustainability of the NHS. We would be happy to supplement this written evidence with oral evidence, or answer any further questions, comments or queries in writing.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

The NHS is facing increasing pressures from a multitude of sources. Medical innovation brings with it increased costs of new treatments and therapies as well as the exciting potential of individualised treatment plans as genetic phenotyping continues to improve. An ageing population, multimorbidity and increasing patient expectations contribute to an increased burden on primary care and hospital services as well as increasing social care requirements and pressure on the health and social care budgets. The RCoA believes it is likely that multiple changes will be required to cope:

- Increasing NHS funding from the UK Government.
- Consideration of reorganisation of healthcare supported by greater investment in public health and public education which can support improved decision making between clinicians and carers.
- An increased focus on the importance of the role of Perioperative Medicine and the importance of anaesthetists within this. Perioperative medicine describes the practice of patient-centred, multidisciplinary, and integrated medical care of

- patients from the moment of contemplation of surgery until full recovery.
- Greater research and focus into the outcomes of patients who choose more conservative and less invasive treatment approaches. The development of perioperative medicine, which traverses the boundaries between primary and secondary care, and health and social care, provides an opportunity to address this through, for example:
 - Improved public health through support for primary care in optimisation of patients who are considering surgery (e.g. smoking cessation, interventions to reduce harmful alcohol consumption, weight loss, earlier identification of pernicious co-morbidities such as hypertension and diabetes mellitus). Optimisation leads to fewer complications and shorter length of hospital stays with better utilization of financial resources.
 - Improved resource utilisation through use of clinical decision aids and shared decision making which support patients in choosing less invasive treatment options which may lead to better patient-centred outcomes.
 - Better supported follow-up to reduce the risk of prolonged (unnecessary) treatments which are both costly and potentially harmful (e.g. antibiotics and opioid analgesics).
 - New drug treatments and new surgical procedures are generally evaluated using a patient group that excludes older patients or patients with multiple medical conditions. We need to learn how to study the patient population that we have in the NHS.
 - We need to know what happens to patients who decide not to undergo surgical procedures. There is a publication bias in surgical research in that few studies look at the outcome to patients who do not have surgery. This bias also exists in the national surgical audits such for procedures such as Abdominal Aortic Aneurysm, Emergency Laparotomy, Hip Fracture and the Cancer Registries.
 - Better patient reported or patient derived outcome measures need to be developed to evaluate the outcome from health care interventions. These outcomes need to be available in a timely manner to health care organisations at a local level to help priorities spending.
 - We need to know what patients want or value by improving shared decision making by all healthcare professionals. This may both reduce demand and develop rational allocation of spending without the unpopular need for rationing.
 - The outcome measures and often tariffs we focus on in surgery are based on outcome measures determined by doctors many years ago and now accepted as a standard. For example this leads us to focus on how long a hip replacement lasts or 5-year cancer survival instead of quality and length of life.
 - There is an overlap between health care and social care in keeping people healthy and well. Currently, there is a potential conflict between funding social care and funding health care, which needs to be addressed.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

The current funding envelope for the NHS is not realistic. NHS activity is expected to increase by 3% a year.⁹⁹⁷ However in real terms, NHS funding will increase by only 0.2% a year to 2020.⁹⁹⁸ This will cause a budget shortfall. Although the health system is looking at ways to implement the Five Year Forward View within the current cost envelope, and Sustainable Transformation Plans are looking at how to bridge the funding shortfall, a subsequent shortfall in care is highly probable. Modelling suggests that an annual increase in funding of 3–6% in real terms would enable the NHS to meet increased demand.⁹⁹⁹

Along with workforce issues and spiralling service pressures, the consequences of reduced health spending at this time could not be more severe. At the current trajectory, we are heading for a perfect storm with implications for the welfare of both patients and clinicians.

We have known for a number of years that the squeeze on public spending has hit the health sector particularly hard. The UK is committing a smaller proportion of its GDP to healthcare provision than many of its peer group of G20 nations, and the significant majority of NHS trusts are in deficit. Anaesthesia and intensive care medicine are specialties that have felt the impact of these cuts.

The RCoA 2015 Medical Workforce Census revealed a significant shortfall in the anaesthetic workforce required to meet the need identified by the 2015 Centre for Workforce Intelligence (CfWI) review, with challenges including increases in staff rota gaps, high vacancy rates and an ageing anaesthetic workforce.¹⁰⁰⁰ The Census shows that numbers of consultants will need to double by 2033 to maintain the levels required to deliver safe healthcare as identified by the 2015 CfWI review.¹⁰⁰¹

As doctors, anaesthetists possess a unique skillset essential to maintaining core hospital services including surgery and intensive care. The potential impact of reduced health spending would exacerbate existing issues and have serious implications for the anaesthetic workforce and therefore patient safety across the NHS.

Results from the RCoA's 2016 membership survey shows the impact of the current lack of financial resource on the ability to deliver safe and effective patient care.¹⁰⁰² Over a

⁹⁹⁷ Buchan J, Seccombe J, Charlesworth A. Staffing matters; funding counts. London: The Health Foundation, 2016. www.health.org.uk/publication/staffing-matters-funding-counts

⁹⁹⁸ Appleby J. New NHS inflation figures underline funding pressures facing the NHS. London: BMJ, 2016. <http://blogs.bmj.com/bmj/2016/05/20/new-nhs-inflation-figures-underline-funding-pressure-facing-the-nhs/>

⁹⁹⁹ Appleby J, Galea A, Murray R. The NHS productivity challenge: experience from the front line. London: The King's Fund, 2014. www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/the-nhs-productivity-challenge-kingsfund-may14.pdf

¹⁰⁰⁰ Royal College of Anaesthetists 2015 Medical Workforce Census. <http://www.rcoa.ac.uk/census2015>

¹⁰⁰¹ In depth review of the anaesthetic and intensive care medicine workforce. CfWI, London 2015 <http://bit.ly/1WlyPgy>

¹⁰⁰² Royal College of Anaesthetists 2016 Membership Survey. Results to be published in October 2016 www.rcoa.ac.uk

third of all anaesthetists in the RCoA survey indicated that a chronic lack of resources is impacting on their ability to deliver safe and affective patient care, citing a lack of qualified staff, inadequate facilities, disengagement and lack of co-operation by management and a demoralised workforce

- a. Does the wider societal value of the healthcare system exceed its monetary cost?

Yes - the basic founding principles of the NHS should be maintained: healthcare free at the point of delivery to all citizens irrespective of wealth or ability to pay and based on need.

- b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

Commitment from the government to increase NHS funding as a proportion of GDP. Modelling suggests that an annual increase in funding of 3–6% in real terms would enable the NHS to meet increased demand.

- d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

Charging any fee for GP and hospital attendances or rationing of healthcare services are not recommended and could increase healthcare imbalances for vulnerable adults and children.

Some interventions, such as non-scientific medicine, e.g. homeopathy and some plastic surgery procedures should be removed from the list of NHS treatments offered at no cost.

Access to ambulance services to drive patients home could be more tightly regulated to prioritise transporting those patients who need it most.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

- a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

The 2015 report by the Centre for Workforce Intelligence, which is part of Health Education England, showed that demand for anaesthetic services would grow by 25% by 2033 because of the ageing and growing population. That would require the number of anaesthetists to grow by 300 a year to keep up. However, findings

from the RCoA's 2015 Medical Workforce Census show that only 130 more a year were added between 2007 and 2015, leading to a significant gap that on current trends is set to continue widening. The RCoA's Census also showed that by 2033 every hospital trust will have 10-20 fewer consultant anaesthetists than they will need to meet rising patient demand. The research estimates that, while the NHS has agreed that its total of anaesthetists should expand to 11,800 by that date, on current trends it is likely to reach only 8,000 – a shortfall of 3,800, or about 33%.

The recent publication of recruitment data by Health Education England reflects the difficult financial climate in which we are operating, with anaesthesia among other specialties continuing to experience problems in filling posts in parts of the UK. With entry at ST3 level dropping to 90 percent for anaesthesia and fill rates for intensive care medicine lower still, at 89 percent, the RCoA believes that one of the fundamental causes of the failure to fully recruit at these levels is an inadequate supply of suitably qualified trainees, which could be attributed to insufficient funding of new trainee posts. Coupled with the data from our 2015 medical workforce census, the RCoA believes there is a strong case for an increase in Core/Acute Care Common Stem (ACCS) trainee posts, in order to secure a sustainable anaesthesia and intensive care workforce.

Equipping the existing non-medical workforce – nursing, community and support staff – with additional skills may be one way to develop the capacity of the health service workforce, but this sort of reshaping is not without challenges. New or extended roles could lead to an increase in demand, more rather than less cost, fragment care and compromise quality.

For our own specialty, Physicians' Assistants (Anaesthesia) - PA(A)s - are an established group of healthcare professionals, currently numbering about 150 across the UK. The current lack of statutory regulation of PA(A)s is a major obstacle to new ways of working. Development of PA(A) enhanced roles is taking place and this remains a controversial issue. The RCoA and The Association of Anaesthetists of Great Britain and Ireland (AAGBI) would only consider supporting role enhancement when statutory regulation is in place. Responsibility for such role enhancement, where it exists, currently remains a local governance issue. Patient safety remains the priority of the RCoA and we will continue to press for statutory regulation of PA(A)s.

- b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

The UK is currently heavily dependent on the invaluable contribution EU migrants make to staffing the NHS and social care sectors. 130,000 people from the EU work for the NHS or in social care, including 10% of doctors, 5% of nurses and 5% of the social care workforce.

The RCoA's 2016 membership survey of our 21,000 members showed that of the current workforce, 70% received their Primary Medical Qualification in the UK, 7%

from a European Economic Area (EEA) country and 23% from a non-EEA country. The NHS could not deliver a safe and sustainable anaesthetic, pain medicine and intensive care service without the pivotal contribution of EEA colleagues.

What is unknown at the moment are the implications of the EU referendum outcome on key policy areas affecting our specialty, including free movement of the workforce, which is a cornerstone of EU membership, and the European Working Time Directive (EWTD). The EWTD has been a controversial issue in healthcare, and for the medical profession for many years. EWTD has been welcomed for the protection it brings for doctors and their patients from working excessively long hours. However others express concern that doctors in training are denied the opportunity to gain valuable clinical experience and to maintain continuity of patient care.

- c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

The impact of cumulative issues for doctors on retention of the workforce cannot be underestimated. Results from the RCoA's 2016 membership survey show that a third of anaesthetists indicated that a chronic lack of resources was causing a lack of qualified staff, inadequate facilities, disengagement and lack of co-operation by management and a demoralised workforce.

Some of these issues could be addressed by:

- An increased recognition by senior managers within hospitals of the importance of anaesthetists in service delivery and the need to involve them in decision making at an executive senior level.
- An increase in the number of Core Anaesthesia and Acute Care Common Stem (ACCS) trainee posts in order to secure a sustainable anaesthesia and intensive care workforce.
- Offering flexible working patterns to increase access to training in medicine.
- Supporting the physical health of the workforce by giving doctors rapid access to healthcare for personal use if needed, such as fast-tracking of referrals and procedures to minimise time spent off work. This would reduce the amount of time spent on sick leave awaiting procedures and investigations. It would also reduce strain on remaining healthcare workers as staffing levels would be better.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

- a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

Ways to encourage lifelong learning should be explored where different professional groups learn in partnership.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

- a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

Targeting at risk populations with strategically developed policies. This could include incentivisation for healthier behaviours, rather than just financial penalties for unhealthy behaviours (such as tobacco tax).

Targeting children and young adults to enhance healthy behaviours which may be sustained into adulthood.

Incentivisation for employers to promote healthier lifestyles – e.g. tax breaks, opportunities to use pre-tax income of employees to fund contribution to workplace fitness programmes etc.

- d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

The RCoA is a member of the Obesity Health Alliance (OHA) - a coalition of organisations committed to share expertise and support Government to tackle the issue of overweight and obesity in the UK.¹⁰⁰³ We call for:

- Government to take action to reduce the consumption of sugar-sweetened beverages (SSBs) by introducing a 20% tax on SSBs.
- Targets for retailers to improve in-store architecture to reduce the display of unhealthy foods in areas such as checkouts and end of aisle displays and increase price promotions of healthier alternative products.
- Government to develop an independent set of incremental reformulation targets for industry, backed by regulation and which are measured and time bound. These targets should address salt, sugar and saturated fat levels. Compliance with these targets should be monitored and non-compliance should be backed by meaningful sanctions.

22 September 2016

¹⁰⁰³ Obesity Health Alliance. <http://obesityhealthalliance.org.uk/policy/>

The Royal College of Emergency Medicine – Written evidence (NHS0029)

The Royal College of Emergency Medicine is the single authoritative body for Emergency Medicine in the UK. The Royal College works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

Question One: Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

The background to demand and demand management.

1. As was highlighted by the Committee in the background of to its call for evidence¹⁰⁰⁴ the NHS in England faces a significant challenge to meet the health needs of an aging population with increasingly complex needs. The number of people over 85 years of age will grow by almost 90k per year for the next 20 years.¹⁰⁰⁵ Moreover, compared to 2010 there are already an additional 130,000 people aged over 85 alive today.¹⁰⁰⁶ In addition, the drive to care for people with mental health problems and older people in their own homes has already led to increased demand for A&E services.
2. While these changes are significant when considered on their own, they are compounded by elderly populations changing attitude to their own health. Analysis of both Disability Free Life Expectancy¹⁰⁰⁷ and Healthy Life Expectancy¹⁰⁰⁸ data released by the Office for National Statistics has shown that while life expectancies are increasing those same people's assessments of their remaining life expectancy in good health are decreasing.
3. This in turn is reflected in an increasing propensity to access health services. As the King's Fund has recently shown, demand from this age group has grown and continues to grow considerably beyond mere demographic change. This has resulted in rising numbers of GP appointments both in person and over the phone.¹⁰⁰⁹
4. Emergency medicine is not isolated from these pressures and a similar pattern of demographic pressures and cultural change¹⁰¹⁰ has seen the pressures on emergency departments rise consistently over the last ten years.¹⁰¹¹

¹⁰⁰⁴ <http://www.parliament.uk/documents/lords-committees/NHS-Sustainability/call-for-evidence.pdf>

¹⁰⁰⁵ NHS Confederation [Key Statistics on the NHS](#)

¹⁰⁰⁶ ONS [Mid-Year Population Estimates 2015](#)

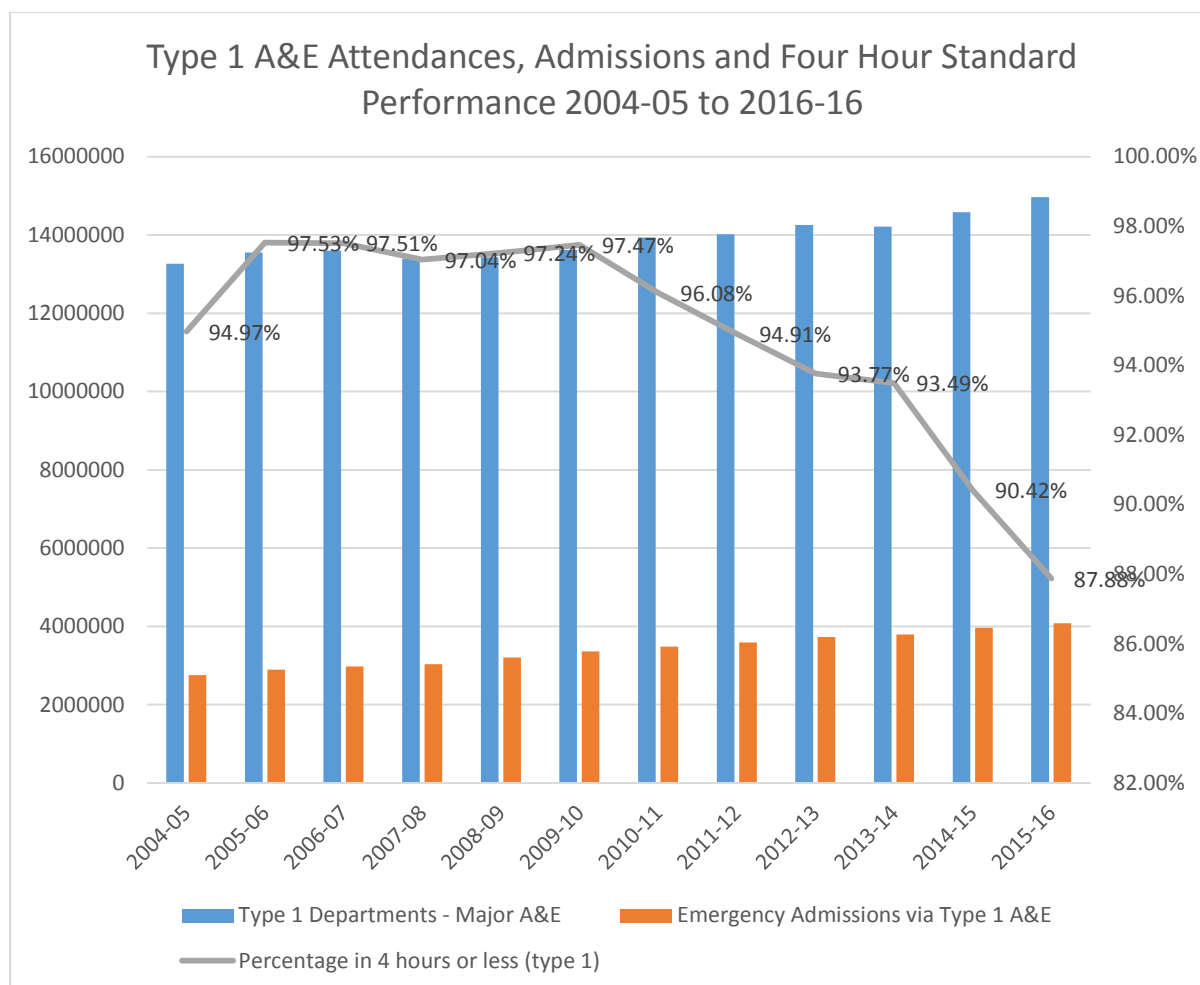
¹⁰⁰⁷ ONS [Changes in Disability Free Life Expectancy](#)

¹⁰⁰⁸ ONS [Health Life Expectancy](#)

¹⁰⁰⁹ King's Fund [Understanding Pressures in General Practice](#)

¹⁰¹⁰ Royal College of Emergency Medicine [Time to Act - Urgent Care and A&E: The Patient Perspective](#)

"Patients were asked if they had sought primary care treatment for this particular episode of illness. Almost a quarter (23%) of patients reported contacting their GP surgery to make an appointment prior to presenting to A&E. Of these people, the greatest proportion (45%) had been informed that they could be seen the same day with an average appointment time within three hours of their telephone call."



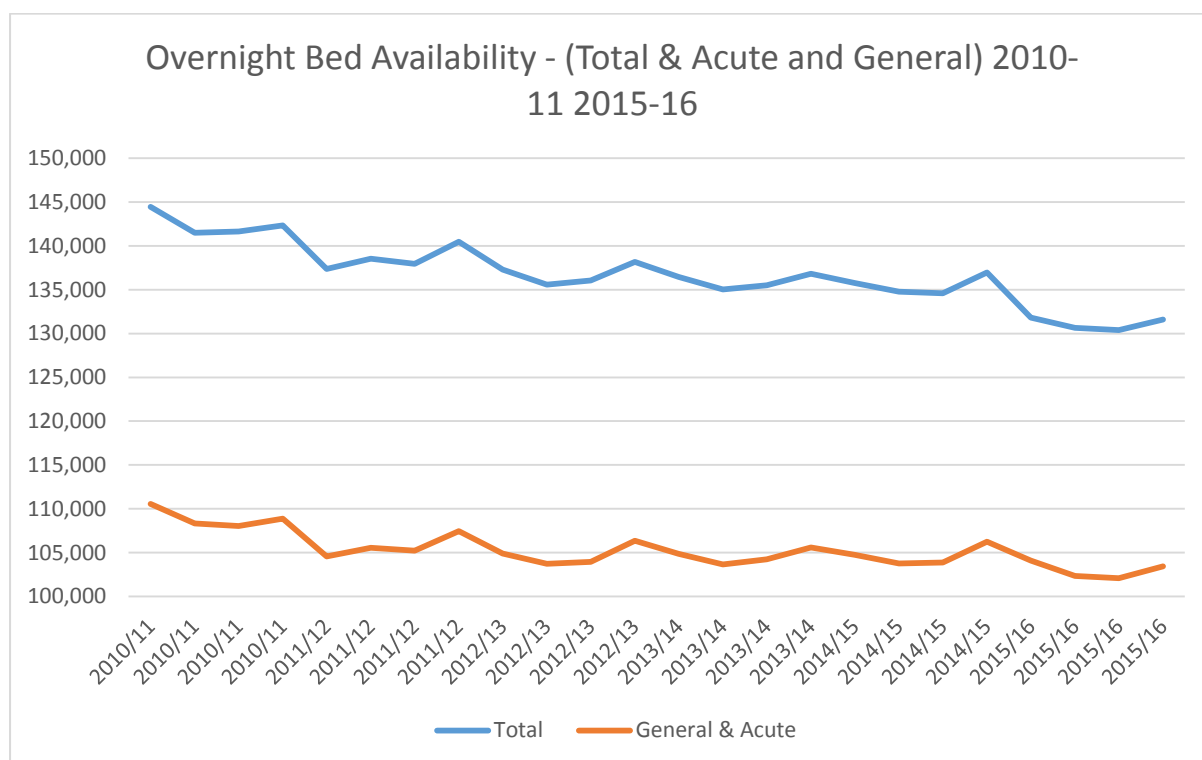
5. Since 2010-11 attendances have increased by 1,031,164 (7.4%) but admissions have increased by 603,063 (17.34%). Not only does this demonstrate that redirection strategies have largely failed, it also indicates that they are seeking to address the wrong problem. The growth in admissions is more than double the growth in attendances. We are not dealing with ‘more of the same’. The casemix has shown a significant rise in the proportion of patients whose care cannot be delivered outside of the acute hospital setting.
6. The increase in attendances in the last 5 years is equivalent to the workload of 10 medium sized departments in England alone – none of which have been built. Moreover, during the last 5 years the number of beds available for admission of acutely ill and injured patients has continued to fall and we now have the lowest number of beds per capita in Europe and England has the lowest number within the UK.¹⁰¹²
7. The rise in admissions coupled with a reduced bed stock creates a phenomenon of ‘Exit Block’. This occurs when a patient requiring admission cannot be moved to an

¹⁰¹¹ NHS England [Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England](#)

¹⁰¹² NHS England [Average Daily Available and Occupied Beds Timeseries](#)

appropriate ward in a timely fashion. Since 2013-14 the number of patients waiting over 4 hours has increased by 131% and the number of patients waiting over 12 hours has increased by 323%¹⁰¹³.

8. These trends provide both cause and effect with respect to Emergency Department (ED) capacity. Reduced flow through the emergency department impedes the accommodation of new attendances. In turn all aspects of A&E performance deteriorate including ambulance off-load times.
9. Exit block is proven to be associated with both significant morbidity and mortality. The latter has been estimated at 3000 patients per year in the UK.¹⁰¹⁴ Problems associated with exit block are both dangerous and demoralising for patients and staff.
10. Paradoxically exit block is associated with a greater number of patients admitted to ‘any bed’ rather than an ‘appropriate bed’. In turn this leads to greater lengths of stay, reducing the available bed stock and perniciously increasing the frequency and severity of exit block.
- 11.



12. It is within this context that the Royal College of Emergency Medicine takes the view that EDs have struggled in the face of rising demand, not because success is impossible,

¹⁰¹³ NHS England [Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England](#)

¹⁰¹⁴ Royal College of Emergency Medicine [Exit Block in Emergency Departments 6 month review](#) .This estimated 13 deaths per 50,000 patients.

but because we continue to systematically under-resource emergency departments in the forlorn hope that the next redirection strategy will succeed where all others have demonstrably failed.

13. For example, ‘The Keogh Urgent and Emergency Care Review’ has been progressing since 2013. Much of its attention has been directed at reducing patient demand on A&E departments.
14. This is commendable, though the College is of the opinion that the gains realisable from such a strategy are limited. The UK already has a relatively low usage of emergency departments when measured as visits per annum per capita.¹⁰¹⁵
15. In 2015, the Royal College of Emergency Medicine endorsed ‘Safer, Faster, Better’ published by NHS England. This offered ‘good practice in delivering urgent and emergency care’ and was, in our view, a constructive step forward.
16. This document put forward a number of principles, ‘to improve safety and flow, and help reduce unwarranted variation and manage demand’. The first of those principles states:

“Emergency departments (EDs) should be resourced to practice an advanced model of care where the focus is on safe and effective assessment, treatment and onward care. While it is essential to manage demand on EDs, this should not detract from building capacity to deal with the demand faced, rather than the demand that is hoped-for.”¹⁰¹⁶

¹⁰¹⁵ Royal College of Emergency Medicine [Why Does Winter in A&E Get Worse Every Year?](#)

¹⁰¹⁶ NHS England [Safer Faster Better](#)

How must the health care systems change to cope by 2030?

17. Given these trends, and the demonstrable inability of redirection or re-education strategies to alleviate these pressures, it is more logical to respond positively to the needs and demands of patients rather than seek to resist them. It is our opinion that the way to do this is to put in place the co-location of key out of hours urgent care services. This alignment of services can be achieved both physically and through the greater use of technology such as virtual consultations and telemedicine. This would improve the flow and quality of care for patients seeking urgent and emergency care. It would also improve the sustainability of emergency medicine in the English NHS by decongesting emergency departments.
18. A co-located model – in which key components of urgent health care are physically and functionally co-located and integrated would allow the alignment of behaviours with resources. In turn this would promote collaborative working and better focus service provision according to patient need. Such a model has been implemented in a range of systems over the past decade with over 45% of EDs reporting some form of co-location in the RCEM Drive for Quality Report in 2012.¹⁰¹⁷ . Proper alignment of services can produce the most cost effective and efficient models.¹⁰¹⁸
19. The College's own data is even more compelling¹⁰¹⁹. Our Sentinel Sites study published in 2014 shows that more than a fifth of attendances could be managed without input from an EM doctor¹⁰²⁰. As such, it is quite certain that a proportion of low acuity patients with primary care needs attending an Emergency Department could be managed at least as well by other services/ staff.
20. Accurate data recording also has a role to play. The Health Select Committee¹⁰²¹ recognised this in 2013 when they stated 'the system cannot accurately analyse the cause of the problem, still less resolve it, if it continues to 'fly blind'. More accurate information about the causes of rising service pressures is not simply a management convenience; it is fundamental to the delivery of high quality care'. The College has been leading a project to develop a new data standard to address this, the Emergency Care Data Set, and would appreciate the Health Select Committee's ongoing support regarding its implementation.
21. It should also be added that the College recognises that the increasing availability and sophistication of technology has a role to play in helping us to treat our patients more efficiently and more effectively.
22. A&E has become 'Anything and Everything' in the out of hours period especially, a function it is not resourced to deliver. The lack of other services for urgent care needs leads to clinically improbable spikes in attendances at weekends and bank holidays.

¹⁰¹⁷ NHS Pathways Reception Point <http://systems.hscic.gov.uk/pathways/blackpool>

¹⁰¹⁸ NHS Pathways Reception Point <http://systems.hscic.gov.uk/pathways/blackpool>

¹⁰¹⁹ Royal College of Emergency Medicine [The Drive for Quality](#)

¹⁰²⁰ Royal College of Emergency Medicine [Sentinel Sites: Better Data Better Planning](#)

¹⁰²¹ Health Select Committee [Urgent and Emergency Services](#)

Establishing an aligned hub model of service provision would ensure that up to a fifth of patients were seen by more appropriate providers/ services thereby decongesting the emergency department and improving the care delivered to those most in need of clinicians in the Emergency Department.

23. This model is endorsed by the following key stakeholders; the Royal College of General Practitioners, the Royal College of Psychiatrists, the Patients Association, the Royal Pharmaceutical Society and the British Geriatric Society.
24. The Nuffield Trust has shown that 84% of Emergency Department attendances are by people who live within 7.5 miles of a major Emergency Department.¹⁰²² That is why the College believes that providing such a hub of services within easy travelling distance of most of the population is both effective and efficient. For those not within easy travelling distances non-urban urgent care centres could provide all but hospital based services.
25. Under shared locally agreed governance, the co-location of the Out of Hours Primary Care Team, Community Pharmacy, Out of Hours Mental Health Team, Frailty Team and the Emergency Department would provide patient services more appropriate to case-mix and skill mix than the current arrangements. This is not to argue for new services but for the co-location of existing services around the point that patients attend: the A&E department.
26. In-reach frailty services based upon a Comprehensive Geriatric Assessment are proven to reduce admissions and length of stay and must be regarded as an essential component of 21st century acute services. The care of this section of our population more than any other will determine the success or otherwise of the acute care system. Currently the probability of admission is directly correlated with age. It is imperative that this default option is challenged.
27. However it is vital to recognise that meeting this challenge will require a multi-disciplinary approach with skilled and expert teams working together, as the burden of illness carried by this elderly cohort is substantial.

Question Two: To what extent is the current funding envelope for the NHS realistic?

28. Since the NHS was founded in 1948 health expenditure has increased by an average of 3.7% per annum in real terms.¹⁰²³ However, in more recent years – while there has been a real terms increase – that increase has been at the much lower rate of 0.7% per annum.¹⁰²⁴

¹⁰²² Nuffield Trust: [Focus On: Distance from home to emergency care](#)

¹⁰²³ The Health Foundation [Hospital finances and productivity: In critical condition?](#)

¹⁰²⁴ The Health Foundation [Hospital finances and productivity: In critical condition?](#)

29. At the same time, in order to bridge the gap, *The Five Year Forward View* demands £22 billion of efficiency savings by the end of this Parliament.¹⁰²⁵ According to NHS England’s own estimate this translated to efficiency gains of the following magnitude:

“A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.

“Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time.”¹⁰²⁶

30. Given that the Office for Budget Responsibility estimated that the historic rate of efficiency growth within the NHS was no more than 0.8%, even at the time NHS England were forced to admit that gains of 2 to 3 percent *“would represent a strong performance – compared with the NHS’ own past, compared with the wider UK economy, and with other countries’ health systems.”¹⁰²⁷*

31. Perhaps at this stage NHS England might be tempted to reach for strong adjectives because thus far, efficiencies on the scale required have stubbornly refused to appear.¹⁰²⁸ Instead of which, despite the best efforts of bodies like NHS Improvement and others we now see widespread evidence of acute and unsustainable financial distress.¹⁰²⁹

32. These wider points matter for a number of reasons. Firstly because – as is in part demonstrated by the focus of this enquiry – this prompts questions about what services the NHS can or should be expected to deliver. While changes to demographics and casemix can be expected to drive developments in the range and scope of NHS services, there is no appetite for change as a pseudonym for rationing, deterioration, or withdrawal of services to patients.

33. While there is widespread acceptance that the country continues to face challenging financial circumstances, this is a matter of deciding national priorities. As such, we would echo views which have been expressed across the sector. Namely, what needs to be addressed is whether it is still appropriate to spend just 8% of our national income¹⁰³⁰ on healthcare – a figure which is predicted to fall to just over 6% by 2021?¹⁰³¹ To place this in context, the OECD average (excluding the United States) is 9.1%.¹⁰³²

¹⁰²⁵ NHS England [NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios](#)

¹⁰²⁶ NHS England [Five Year Forward View](#)

¹⁰²⁷ NHS England [Five Year Forward View](#)

¹⁰²⁸ The Health Foundation [Hospital finances and productivity: In critical condition?](#)

¹⁰²⁹ NHS Improvement [Monitor: Annual Report and Accounts 2015/16](#)

¹⁰³⁰ ONS [Expenditure on Healthcare in the UK: 2013](#)

¹⁰³¹ King’s Fund [The NHS Productivity Challenge](#)

¹⁰³² King’s Fund [How does NHS spending compare with health spending internationally?](#)

34. This is important because emergency medicine within the NHS is currently operated on a tariff which depends of cross subsidy; income from elective operations is used in part to subsidise the provision of urgent and emergency care. Yet it is clear that it is near impossible to continue to offer an effective level of cross subsidy within a system on the edge of bankruptcy.
35. As this indicates, improving the system that is currently used to fund emergency care systems in England has an important role to play in longer term sustainability. Tariffs have led to chronic underfunding of acute care in general and emergency care in particular.
36. The current system has also created perverse activity incentives. As referred to above, the 30% marginal tariff for acute admissions guaranteed acute services in hospitals were dependent upon cross subsidies from elective care. This meant that any arguments for increasing acute care capacity were subordinated to the delivery of more elective services.
37. This failure to align incomes with activity only changed with the uplift of the tariff to 70% when it became clear that bed occupancy rates in England were so high that elective activity and hence income had become compromised. Regrettably this revision was too little too late.
38. Within the Emergency Department itself tariffs are also ill conceived. Those patients requiring least intervention, investigation or treatment are remunerated at a rate that enables services to be maintained. However the maximum tariff for the most seriously ill or injured is less than £250. This ensures that treating the very patients emergency departments are established to treat is a loss-making endeavour for a hospital.
39. Poor systems of reimbursement for acute care have led to almost two decades of underfunding. We are currently reaping both the capital and revenue consequences with Emergency Departments designed and built for far fewer attendances and woefully understaffed much of the time.
40. In 2014 Hughes, Higginson and Mann published *Tariffs in Emergency Care* in the British Journal of Hospital Medicine, and sought to describe the situation, to which these arrangements inevitably lead.¹⁰³³ They write:

*'The result has been chronically under-resourced emergency departments running on large numbers of expensive temporary staff and requiring repeated financial 'bail-outs'.*¹⁰³⁴
41. This summing up was prescient at the time, but reads like a parable of recent events at Pennine Acute Trust¹⁰³⁵ and United Lincolnshire Hospitals NHS Trust¹⁰³⁶ and cannot be

¹⁰³³ T. Hughes, I. Higginson, C. Mann Tariffs in Emergency Care 2014.

¹⁰³⁴ T. Hughes, I. Higginson, C. Mann Tariffs in Emergency Care 2014.

¹⁰³⁵ Care Quality Commission [North Manchester General Hospital Quality Report](#) & Royal College of Emergency Medicine [Press Statement: Pennine Acute CQC report](#)

allowed to continue. As Trusts up and down the country are well aware, the costs of employing locum cover to support this overstretched system are considerable. Over 2015-16 the NHS in England spent £3.7 billion on locum staff¹⁰³⁷ of which 19% was spent on emergency medicine.¹⁰³⁸

42. This indicates that the cost of employing ED clinical staff on a locum basis is £13.5 million per week.¹⁰³⁹ The average annual running cost of a medium sized emergency department is between £10.5 million and £13.2 million per annum.¹⁰⁴⁰ It is therefore a matter of simple arithmetic that if that money was invested in training a sufficient number of permanent staff, you could run at least 25 more Emergency Departments and still save something in the order of £370 million pounds per annum.
43. While, as this indicates, the current financial situation is clearly a cause for concern, we take the view that a possible route to resolve these problems is the establishment of a dedicated Emergency Care Transformation Fund which would support the reforms necessary in our Emergency Departments to meet demand and ensure quality of service delivery. The sums involved in this fund might well be regarded as substantial but we believe this could yield equal if not greater efficiency savings in the longer term over a 3-5 year period. The College is currently working on the details of such a strategy and will report in 2017.

¹⁰³⁶ Royal College of Emergency Medicine [Press Statement: Potential Closure of Grantham A&E](#)

¹⁰³⁷ NHS Improvement [Agency controls significantly reduce NHS spend on agency staff](#)

¹⁰³⁸ Liaison [Taking the Temperature](#)

¹⁰³⁹ Actual figure £13,519,230.

¹⁰⁴⁰ This calculation is based on NHS Reference costs for 2014-15 of £132 per A&E attendance. See [Department of Health: Reference Costs 2014-15](#) It should be noted that the Royal College of Emergency Medicine has stated in the past that Reference Costs are problematic. To quote from our response to the 2014 Monitor consultation on tariffs "It will tend to overestimate the costs of treating low acuity (VB11) patients, and underestimate the costs of treating high acuity (VB01) patients, and this is exactly what we see. Reference costs give only the historic cost of care, not of what the cost of providing high quality care *should* be."

Question Three: What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare worker such as doctors, nurses and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

44. The first step to optimising the supply of staff for the long term needs of the NHS, is to recognise that the number of clinical staff – in the Emergency Department and elsewhere – must reflect the numbers of patients the NHS is actually called upon to treat.
45. To provide some context, the table below illustrates some of emergency medicine physicians (FTE) working in the NHS in England, as recorded by the Health and Social Care Information Centre¹⁰⁴¹ (HSCIC)

Staff Grade	FTE							Change	Percentage Change
	2010	2011	2012	2013	2014	2015	2016		
Emergency Medicine Consultants (FTE)	1,013	1,100	1,230	1,320	1,425	1,483	3470	46.40	
Higher Specialist trainees EM	2064	2166	2185	2256	2376	2359	295	14.29	
Foundation Year 2	1104	1086	1086	1088	1144	1156	52	4.71	
Foundation Year 1	200	206	192	205	209	223	23	11.50	

46. These figures indicate a growth in the workforce but the ratio of patients to ED medical staff is stark. Currently there is 1 EM consultant for every 11,000 attendances. No other developed country operating modern day Emergency Departments has so few senior decision makers.
47. There are 176 type 1 Emergency Departments in England. Currently there are insufficient consultants in post to provide even one on duty in every department for even 16 hours per day.
48. Had staffing levels been adequate¹⁰⁴² and kept pace with admissions¹⁰⁴³ by 2015-16 there would have been 2516 EM consultants in the NHS in England c.f. 1483. Had the workforce as a whole grown at a similar rate there would now be 8,074 doctors working in our emergency departments rather than, as now, 6,087. The College has carried out further work to support the breadth and depth of staffing required to cover the range of departments across the NHS in *The Drive for Quality* in 2013¹⁰⁴⁴ It is clear that the strategic thinking that has led to chronic understaffing of Emergency Departments over the last decade combined with increasing demand has led to the on going staffing crisis.

¹⁰⁴¹ Health and Social Care Information Centre NHS Workforce Statistics

¹⁰⁴² Royal College of Emergency Medicine [The Way Ahead](#).

¹⁰⁴³ See above 17.34% growth in admissions.

¹⁰⁴⁴ Royal College of Emergency Medicine [Drive for Quality](#)

49. In the wake of the Francis Report, Trusts have frequently complained about the difficulty of recruiting sufficient numbers of consultants, a situation which can only have been made worse by the significant number of NHS trained professionals who have chosen to work in other countries¹⁰⁴⁵. Over 600 senior emergency medicine doctors trained in the UK now work in Australia. All of this contributes to an increased risk of attrition and burnout for those EM staff who remain in the UK¹⁰⁴⁶
50. Having shown the number of clinicians who would be required to ensure adequate staffing levels in current conditions, we must now ask how many staff will be required in the future. Given that future service models and economies of scale are uncertain, such predictions are problematic. Nonetheless, if we are clear about our assumptions, estimates can be made.
51. For example, in October 2015 the Office for National Statistics estimated that the population in England would reach 60.2 million by 2029.¹⁰⁴⁷ Whereas in 2015 the population in England was 54,786,000.¹⁰⁴⁸ In the same year (2015) there were 14,584,736 Type 1 Emergency Department (ED) attendances.¹⁰⁴⁹ This translates as 1 ED attendance for every 3.76 members of the population.
52. If we use the same assumption (without making any upward adjustment to account for the aging of the population) this means there will be 16,010,638 Type 1 ED attendances in 2029. This would mean an increase in Type 1 A&E demand of 9.78% between 2015 and 2029. This – based on the staffing estimates stated above – would necessitate an ED consultant body of 2,762 and overall emergency clinical workforce of 8,863.
53. Moreover, these figures are likely to be a significant under estimate, for several reasons. Firstly, as already mentioned, this makes no allowance for the demographics of our aging population which are already having, and will continue to have, a serious impact on the casemix of patients arriving the ED.
54. Secondly, as we have seen, since 2010 Type 1 ED attendances have grown at a rate of 1.224%¹⁰⁵⁰ per year. If this rate of growth continues until 2029 then instead of their being 16,010,638 attendances there will be the even higher number of 17,526,718. This, logically, would require still higher staffing numbers to provide safe adequate care.
55. Thirdly, the College takes the view that as we are increasingly being asked to deliver care within fewer and larger specialised centres this will require greater breadth and depth of senior decision makers.

¹⁰⁴⁵ Royal College of Emergency Medicine [Why Does Winter in A&E get Worse Every Year](#)

¹⁰⁴⁶ Royal College of Emergency Medicine [Stretched to the Limit](#)

¹⁰⁴⁷ ONS [National Population Projections: 2014-based Statistical Bulletin](#)

¹⁰⁴⁸ ONS [Population Estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2015](#)

¹⁰⁴⁹ NHS England [Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England](#)

¹⁰⁵⁰ NHS England [Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England](#)

56. Finally, we welcome the fact that the gender balance of the clinical workforce is becoming more equal. As this is set to continue, it makes sense to support further action to aid necessary workforce flexibility by increasing the number of consultant posts.
57. However, as the numbers of clinical staff choosing to move to Australia does something to indicate, it is not enough simply to train more doctors and nurses. It is also necessary to recruit and retain them.
58. As part of our STEP campaign, we have been arguing that to do this the following steps should be taken:¹⁰⁵¹
- Annualised Rota systems: The College strongly recommends that Trusts should adopt annualised rota systems. These are proven to allow greater flexibility of working for clinicians and to improve work life balance whilst enhancing service provision.
 - Remuneration for out of hours work: Clinical duties during the day differ in intensity to clinical duties in the evening, which in turn differ to those at night. The College believes that PAs should reflect the actual time of day during which the clinician is working and the intensity of this work. A sliding scale of remuneration should be adopted where hours per PA reflect the resource consequences. Appropriate compensatory rest periods must be factored in to such calculations to allow recovery from evening and night time working.
 - Annual leave proportional to out of hours work: This is the key proposal of the Royal College of Emergency Medicine. Clinicians whose job plans require regular work in out-of-hours periods should be recompensed through enhanced annual leave entitlements. This enables work life balance deficits accrued each week or month to be offset by pro-rata increases in annual leave entitlement. Hybrid arrangement would increase the flexibility of the system for both employers and employees.
 - Age related work patterns: Career longevity would be significantly enhanced if there was flexibility to opt out of work in the late evening / overnight for practitioners over the age of 55.
 - Sabbaticals: To help retain, support and motivate EM consultants the College proposes the introduction of career sabbaticals. These are currently in place in NHS Wales, in Scandinavia and as Long Service Leave in Australasia. These schemes allow consultants to enrich and refresh their careers and benefit the departments in which they work by the introduction of new knowledge, skills and techniques.
 - Retirement: Most existing EM consultants intend to retire well before the statutory pension age. This loss of senior workforce will exacerbate the current difficulties. It

¹⁰⁵¹ Royal College of Emergency Medicine [DDRBR Special remit letter of 30 October 2014 from Department of Health](#)

also acts as a deterrent to trainees who will be expected to work until they are 68. Unsurprisingly they (as do their peers) view current working patterns in emergency medicine as untenable in the 7th decade of life. More flexible retirement ages and an acknowledgement of the age related implications for shift patterns would diminish these losses and the consequent loss of expertise and capacity.

- The College believes that failure to address the terms and conditions of emergency medicine doctors will result in continued workforce shortages.
- Further details can be found by consulting the College’s sustainability strategy, *Creating successful, satisfying and sustainable careers in Emergency Medicine*. [Link](#)

Conclusion

59. As stated above, in 2015 we welcomed the publication NHS England’s ‘Safer, Faster, Better’, and endorsed all of the conclusions:

- Emergency departments (EDs) should be fully resourced to practice an advanced model of care where the focus is on safe & effective assessment, treatment and onward care.
- Whilst it is essential to manage demand on EDs, this should not detract from building capacity to deal with the demand faced, rather than the demand that is hoped-for.
- ED crowding adversely affects every measure of quality and safety for patients & staff.
- The main causes of ED crowding include surges in demand and lack of access to beds in the hospital system due to poor patient flow and high hospital occupancy rates.
- EDs should be staffed so that capacity meets variation in demand NOT average demand.
- Performance against the 4-hour standard is a useful proxy measure of crowding.

60. Admissions via Type 1 EDs have risen annually by an average of 110,000 since 2005. This rise is set to continue.¹⁰⁵²

61. There are too few senior medical staff in Emergency Departments to deliver effective and efficient care. The attrition rate from UK training programmes has wasted our most valuable resource. We must ensure the work environment and shift patterns promote rather than discourage staff retention.

62. Planning must especially address the need to cope with rising numbers of attendances by the frail elderly – with complex interactions between health and social care and long term co-morbidities.

¹⁰⁵² NHS England [Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England](#)

63. Provision of co-located services within a hub to decongest Emergency Departments will deliver a successful strategy that is patient centred, affordable, efficient and effective.
64. Correct funding of emergency care is essential as the cross subsidy model has failed. The College will publish a strategy in 2017 for an Emergency Care Transformation (ECT) Fund. If implemented this has the potential deliver a cost effective and efficient transformation of services. The transformed emergency care system will serve the country well over the next decade and produce high quality care for our patients in every part of England.

24 August 2016

The Royal College of General Practitioners – Written evidence (NHS078)

House of Lords Select Committee on the Long-term Sustainability of the NHS

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to the House of Lords Select Committee on the Long-term Sustainability of the NHS.
2. The RCGP is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 50,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with expertise in patient-centred generalist clinical care.
3. Our response focuses on the importance of general practice, as the gatekeeper of the wider healthcare system, to the long-term sustainability of the NHS.

Summary

4. General practice is the foundation of the NHS and the site of 90% of all patient contacts with the NHS. As a result, the sustainability of general practice is essential to the sustainability of the wider NHS.
5. Increased investment in general practice must be delivered to ensure its sustainability in the face of rising demand and an ageing and growing population, and to reverse a trend of disinvestment that has been taking place over the last decade.
6. The movement towards the increased provision of care in the community will help to reduce demand for secondary care services as more patients are treated closer to home. General practice must be supported to be at the centre of this movement, exploring new models of care allowing patients to see a wider variety of clinicians and receive more specialised care within general practice.
7. The provision of more GPs as well as other clinicians in general practice such as practice-based pharmacists will be crucial to this effort, as will the development of existing clerical staff and the provision of new roles such as medical assistants.
8. The delivery of the *GP Forward View* is essential to allow general practice to continue to deliver sustainable high quality care and to empower general practice to be at the heart of the movement towards more care in the community.

9. The Sustainability and Transformation Plan process offers an opportunity for local health systems to redress the balance between hospital care and community care but they must properly reflect the need to invest in general practice and avoid being dominated by the acute care sector.

The future healthcare system

Question 1 – Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

10. General practice accounts for 90% of all initial patient contact with the NHS, and GPs themselves carry out a number of roles, such as co-ordination of care, care navigation, diagnosis, and management of existing conditions, which are essential to patients' overall care and to the management of demand for secondary care¹⁰⁵³. General practice is the bedrock of the NHS, and the long-term sustainability of the healthcare system is dependent on its survival.
11. The underfunding of general practice is correlated with increased hospital use¹⁰⁵⁴, while studies in England have found not only that each additional GP per 10,000 patients is associated with a 6% decrease in mortality, but moreover that an increase in the number of GPs per head of the population has a greater positive impact on hospital death rates than the number of hospital staff. As general practice receives more investment, and more GPs are recruited, quality and patient safety improve – not just in general practice, but in the wider health service as well.
12. Analysis undertaken by Deloitte on behalf of the RCGP has found that not only does investment in general practice have a positive impact on health outcomes, but also that investment in general practice would result in significant savings in health spending across the UK. These findings are detailed in the appendix.
13. Analysis by The King's Fund in May found that the overall number of GP consultations has increased by 15% over the past five years, which is three times the rate of increase in the number of GPs¹⁰⁵⁵. A major study by The Lancet in June also found that the GP consultation rate per person per year rose by 13.67% from 2007-

¹⁰⁵³ Deloitte (2014) 'Spend to save: The economic case for improving access to general practice, a report for the RCGP'. Available at: http://www.rcgp.org.uk/campaign-home/~/_media/Files/PPF/2014-RCGP-Spend-to-Save-Deloittereport.ashx

¹⁰⁵⁴ Irvine, H. and Gomez, J. (2015), 'Using routinely collected data to figure out where the NHS is going wrong'. Available at: http://www.gla.ac.uk/media/media_443697_en.pdf

¹⁰⁵⁵ The King's Fund (2016), 'Understanding pressures in general practice'. Available at: <http://www.kingsfund.org.uk/publications/pressures-in-general-practice>

08 to 2013-14, while the average length of face-to-face GP consultations increased by 6.7% over the same period¹⁰⁵⁶.

14. These statistics demonstrate the significant growth in demand for general practice services that has already taken place. This is a trend that is set to continue, which will render general practice ever more important to the sustainability of the wider NHS. As the volume of GP consultations increases, the importance of general practice as a gatekeeper to the wider health service increases. Moreover, both The King's Fund and The Lancet showed that the largest increases in demand came from the over-85 age group – where the number consultations rose by 28%¹⁰⁵⁷ and the average length of face-to-face consultations increased by 10.1%¹⁰⁵⁸.
15. General practice will become even more critical to the sustainability of the wider NHS in the future as the population continues to grow and age. As well as the analysis by The King's Fund and The Lancet, analysis conducted by the RCGP has shown that by 2025, the number of people living with one or more serious long-term condition in the UK will rise by nearly one million, from 8.2 million to 9.1 million¹⁰⁵⁹. Patients with long-term conditions currently account for 55% of all GP appointments: as the number of patients with one or more long-term condition grows, the role of general practice in providing care to these patients will become ever more important¹⁰⁶⁰.
16. There is broad consensus that the way to ensure high quality care for patients with multimorbidity is to move away from a system of care which focuses on the treatment of single diseases to one which focuses on providing holistic care that recognises patients' priorities and empowers them to take control of their own health. General practice, as the holder of the registered list of patients, and due to its generalist approach to care, is well placed to be able to deliver this kind of care¹⁰⁶¹.
17. The *Five Year Forward View* makes it clear that list-based general practice and primary care will remain the foundation of NHS care and that the stabilisation of general practice and the role of GPs as commissioners will enable the necessary shift in investment from acute to primary and community services. The new deal for general practice, offered by the *GP Forward View*, is therefore essential to the

¹⁰⁵⁶ Hobbs, F D Richard et al. (2016), 'Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007-14' *The Lancet*, 387 (10035), pp.2323-2330

¹⁰⁵⁷ The King's Fund (2016)

¹⁰⁵⁸ Hobbs, F D Richard et al. (2016)

¹⁰⁵⁹ RCGP (2016), 'Continuity of Care in modern day general practice'. Available at: <http://www.rcgp.org.uk/policy/rcgp-policy-areas/continuity-of-care.aspx>

¹⁰⁶⁰ House of Commons Health Committee (2014), 'Managing the care of people with long-term conditions'. Available at: <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/401/401.pdf>

¹⁰⁶¹ RCGP (2014), 'An Inquiry into Patient Centred Care in the 21st Century'. Available at: <http://www.rcgp.org.uk/policy/rcgp-policy-areas/inquiry-into-patient-centred-care-in-the-21st-century.aspx>

delivery of the *Five Year Forward View* and the movement towards the increased provision of care in the community.

18. There are a number of actions that should be taken in order to support general practice to becoming the core of a future health service that is more community-based, and delivers holistic, person-centred care to patients. For example, GP practices should be supported to adopt new forms of working at scale such as in federations; the £30 million national investment pledged in the *GP Forward View* to support the growth of general practice at scale is therefore welcome, but further support is required. In particular, the new Multispeciality Community Partnership voluntary contract must offer sufficient support both to practices who wish to form MCPs and those that do not. MCPs are an important model for providing integrated care in the community and their introduction cannot be done in a one size fits all manner.
19. Despite the increase in demand for GP services over recent years, and the future importance of general practice in delivering holistic, patient-centred care, the level of investment has declined and the number of GPs being recruited has been insufficient. Since 2005/06 the level of investment in general practice as a proportion of the NHS budget has declined from 10.7% to a record low of 8.4% in 2011/12, while the College estimates that the failure of GP recruitment to keep pace with demand is set to leave a shortfall of 9,940 GPs across the UK by 2020¹⁰⁶²¹⁰⁶³.
20. The long-term sustainability of the NHS therefore depends on general practice receiving sufficient investment to be able to cope with growing demand and to be able to deliver more care in the community. As 90% of patient contact with the NHS occurs within general practice, even a small diminution of the number of patients able to access general practice would mean a significant additional burden on secondary care, particularly A&E. It is therefore essential that the recently published *GP Forward View* is delivered in full. In particular, the delivery of £2.4bn additional yearly investment in general practice by 2020, and the delivery of 5,000 additional doctors and 5,000 other members of staff working in general practice by 2020 will be essential to ensuring the sustainability of both general practice and the NHS.
21. After 2020 the Government must continue to ensure that general practice receives the investment it requires to continue to deliver more services within the community and to cope with demand as it grows until 2025 and beyond. The consensus that the way to care for a growing and ageing population is to deliver more care in the community is welcome – but must be matched by increased investment in general practice and wider primary care.

¹⁰⁶² NHS England (2015), 'Annual Report and Accounts 2014/15'. Available at: <https://www.england.nhs.uk/wp-content/uploads/2015/07/nhse-annual-report-2014-15.pdf>

¹⁰⁶³ RCGP (2016), 'Patient safety in general practice could be 'at risk' – unless chronic shortage of GPs is turned around'. Available at: <http://www.rcgp.org.uk/news/2016/september/patient-safety-in-general-practice-could-be-at-risk-unless-chronic-shortage-of-gps-is-turned-around.aspx>

Question 3 – What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

22. GPs will be very important in the provision of patient-centred holistic care in the future NHS due to their expert medical generalism. GPs are well equipped with a view of the whole person and are the natural leaders of a team including a variety of different specialist clinicians. The first requirement of the future NHS workforce is therefore the provision of more GPs¹⁰⁶⁴.
23. In order to provide a sustainable general practice that is able to cope with increasing demand, increasing complexity, and deliver more care in the community, it is essential that the number of GPs is increased. The *GP Forward View* commits to creating an extra 5,000 additional doctors working in general practice by 2020 – this is a positive commitment welcomed by the RCGP but it is essential that these numbers are delivered as the very minimum.
24. There are a number of measures that the Government, NHS England and Health Education England should take to ensure that there are sufficient numbers of GPs in the workforce. In the first instance, the recruitment of GPs must be increased – the *GP Forward View* includes a number of positive pledges in this regard such as a major recruitment campaign to attract doctors to become GPs and 250 new post-certificate of completion training (CCT) fellowships in areas of poor GP recruitment. Schemes that have already been rolled out and proved successful, such as the Targeted Enhanced Recruitment scheme awarding £20,000 bursaries in hard to recruit areas, should be expanded.
25. Action should also be taken to make it easier for doctors to return to general practice in England and the UK. Some work has already been carried out in this area, such as in the introduction of the new portfolio route to the Induction and Refresher scheme, which helps GPs working abroad to prepare a portfolio of their work while abroad. The *GP Forward View* includes other pledges such as the launch of targeted financial incentives to return to work in areas of greatest need: NHS England and Health Education England should develop their plans in this regard as a matter of priority.
26. Finally, action must be taken to improve the retention of GPs across the UK. In many areas the workforce is ageing considerably, leaving many practices at risk of closure. Recent analysis by the College has identified 594 practices across the UK where 75%

¹⁰⁶⁴ RCGP (2012), 'Medical Generalism: Why expertise in whole person medicine matters'. Available at: <http://www.rcgp.org.uk/policy/rcgp-policy-areas/medical-generalism.aspx>

of the GPs are aged 55 and over – with the retirement of so many GPs a present danger for these practices, the College has identified them as being at risk of closure by 2020¹⁰⁶⁵.

27. Nationwide, the proportion of GPs aged 55 or over in 2015 was 20.8% in England, 19.9% in Scotland, 23% in Wales and 25.2% in Northern Ireland¹⁰⁶⁶. At the same time, GPs are reporting increasing workloads and fatigue as well as decreasing morale, potentially leading to early retirement. Clearly, the GP workforce cannot afford to lose one-fifth of GPs while recruitment rates are failing to keep pace. NHS England and Health Education England must therefore set out and deliver a comprehensive plan to retain doctors in the workforce, especially older GPs and GPs who wish to take up flexible working.
28. More widely, the general practice workforce must be diversified in order to enable patients to receive more care within general practice. the *GP Forward View* contains a number of important pledges in this regard. For example, the roll out of 3,000 mental health therapists in general practice is a highly welcome commitment which will help to support the movement of mental health treatment into general practice. It is essential that the pledges number of mental health therapists is delivered by 2020 and that they receive sufficient training in order to deliver mental health services within general practice.
29. Similarly, the expansion of the recent pilot to introduce practice-based pharmacists is a positive step. With the new £112 million investment to extend the programme, a further 1,500 pharmacists have been pledged by 2020. As the proportion of the population with one or more long term condition grows, the role of the practice-based pharmacist will become ever more important in streamlining prescribing practices, medicines optimisation, and helping people with long term conditions to manage their health and their medicines effectively.
30. Practice nurses are an extremely important part of the general practice team and will only become more important as care is moved into the community and a wider variety of skills is introduced into general practice. Despite this, the ratio of nurses to patients is also failing to keep pace with increased demand and complexity, with 2.7 FTE nurses for every 10,000 patients in England in 2014/15, the same ratio as in 2010/11. As well as this, the practice nurse workforce is ageing, with 31% of practice nurses aged 55 or over in 2014/15¹⁰⁶⁷.
31. The commitment to invest £15 million nationally in general practice nurse development pledged in the *GP Forward View* is therefore essential to developing

¹⁰⁶⁵ RCGP (2016), 'Patient safety in general practice could be 'at risk' – unless chronic shortage of GPs is turned around'.

¹⁰⁶⁶ NHS Digital (2016), 'General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics'. Available at: <http://www.hscic.gov.uk/catalogue/PUB20503>

¹⁰⁶⁷ Ibid.

the general practice workforce and allowing it to support the wider health service as effectively as possible. However, there is little clarity about many aspects of the programme, including what the shortfall of practice nurses is, what targets there are for increasing practice nurse numbers, and indeed from whom the required investment will actually come. As a matter of priority NHS England, Health Education England and others should clarify where responsibility lies for rolling out the practice nurse development programme and begin research to establish what the shortfall of practice nurses is and what number of practice nurses will be the target for the programme.

32. As well as the provision of additional clinical staff members, the development of clerical staff in general practice is important to the future of general practice at the heart of a person-centred NHS. A number of pledges in the *GP Forward View* are welcome in this regard, such as £6 million investment in a development programme for practice managers, as well as £45 million over the next five years to help reception and clerical staff play a greater role in care navigation, signposting and handling clinical admin. This will be supported by the piloting of new roles such as that of the medical assistant, who could be trained to carry out both clinical and administrative work to free up GPs' time.

Question 5c – How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

33. The proportion of the NHS budget spent on specialised services compared to that spent on general practice is illustrative of a fundamental imbalance between hospital and community services that must be redressed. Despite general practice accounting for 90% of all patient contact with the NHS, the budget allocated for specialised services is double that of general practice. While the College recognises the importance of care provided by specialised services, greater investment in general practice and primary care will reduce demand for specialised services by offering greater care in the community.
34. Sustainability and Transformation Plans offer local health systems the opportunity to collaboratively design whole care systems, based on the requirements of their local population. This process is an important one to the balance between hospital and community services and mental and physical health care services.
35. In order to stimulate the growth of community-based integrated care in their footprints, local health leaders producing Sustainability and Transformation Plans must ensure that their STPs are sufficiently reflective of the need to invest significantly in general practice. NHS England's planning guidance for 2016/17 – 2020/21 identifies the implementation of local plans to address the sustainability

and quality of general practice, including workforce and workload issues, as one of the nine ‘must dos’ for 2016/17 for every local system.

36. Similarly, the *GP Forward View* states that the proportion of investment in general practice will rise to over 10% by 2020/21, rising further as CCG investment also rises. This includes specific investment such as a £171 million fund for CCGs to provide practice transformation fund. The *GP Forward View* and NHS England’s planning guidance therefore constitute a clear mandate for CCGs and STPs to ensure that they are committing to increased investment in general practice to ensure that their local health systems are based on a robust and effective general practice.
37. In particular, the College is clear that the STP process must not become dominated by large acute trusts and that funds intended for investment in general practice and primary care must not be used to service deficits in the acute sector. The College’s Regional Ambassador programme has shown that a significant proportion of STPs are secondary care focused, with propping up acute services and reducing deficits being seen as the key priority in many footprints. Many STP leaders are unaware of the *GP Forward View* and the mandate it gives for increased local investment in general practice, and many STPs do not identify general practice as a priority area, despite general practice being a ‘must do’ in NHS England’s planning guidance.
38. The Government and NHS England must therefore ensure that STPs are properly reflective of the need to invest in general practice by:
 - a) Ensuring that they take sufficient steps to consult and engage front-line GPs, and are not overly dominated by hospital acute trusts
 - b) Ensuring that they give investment in general practice sufficient priority in their plans
 - c) Ensuring that the total investment in general practice in their plans is enough to put the total combined level of investment in general practice over 11%, the College’s target in the *Put patients first: Back general practice* campaign
 - d) Ensuring that during the further development and implementation of STPs, investment in general practice is maintained and delivered
39. It is essential to the future sustainability of the wider NHS that general practice investment is delivered at both the national and the local level – the STP process must therefore reflect this need.
40. As stated above, the balance between hospital and community services and mental and physical health and care services can be improved by improving the skill mix in general practice and allowing more care to take place within general practice and primary care, especially in new models such as GP federations. This will reduce the

need for hospital admissions and make it easier for patients with to access treatment outside of hospital.

Annex: potential savings from increased investment in general practice¹⁰⁶⁸

1. Analysis carried out by Deloitte for the RCGP found that increased investment in general practice could generate savings of £580m - £960m per year in short, medium and long term savings.
2. In the short term, increased investment in general practice has the potential to reduce the demand for secondary care, particularly A&E, generating savings that could amount to £315m-£447m per year across the UK.
3. In the medium term, the movement to a care system in which general practice empowers patients to manage their own conditions could lead to an 8-11% reduction in avoidable admissions, generating savings of £148m-£333m.
4. In the long term, the potential of general practice to carry out proactive population health management using their registered lists could help to reduce certain harmful lifestyle factors such as smoking and alcohol consumption, or increase beneficial ones such as exercise. General practice therefore is estimated to have the potential to generate savings of £68m-£110m per year through increased smoking cessation and £47m-70m through reduced alcohol consumption.

23 September 2016

¹⁰⁶⁸ Deloitte (2014)

The Royal College of Midwives – Written evidence (NHS0067)

Summary

1. The RCM supports a comprehensive national health service free at the point of need, paid for out of general taxation. We support in principle the merging of health and social care, but it is essential that all sectors of care remain adequately funded. We support the expansion of 'sin taxes' which encourage behaviour change and will also pay long-term dividends alongside the creation of new income streams.
2. We call on the Government to be ambitious in improving the health of the public, if long-term sustainability of the NHS is to be achieved, and for a centralising of workforce planning decisions to end the current fragmentation which will not deliver the workforce we need in 25 years time.
3. A modern maternity service should be flexible and adaptive. New technologies, new challenges and new populations will all demand the provision of maternity services that are open to learning and open to change. The National Maternity Review has laid out radical policy ambitions for maternity which will help in our sustainability challenge. As midwives refocus their role in relation to women's expectations and policy drivers there will be an inevitable shift in professional boundaries and practices (not to mention locations of care) but it is essential that as this takes place the body of knowledge that defines midwifery and the activities of the midwife are retained and enhanced. Quality maternal and newborn care has a lasting impact on mothers' and infants' physical and psychosocial health and well-being, on their need to pay for ongoing health care costs, and on the ability of their families to escape poverty. It also has an economic impact on communities and countries and boosts efforts to tackle intergenerational inequalities in health.¹⁰⁶⁹ Investment in the start of life is key to making the NHS sustainable.

NHS resource

4. Since 1951, NHS spending in England has increased on average by 3.7% per year in real terms.¹⁰⁷⁰ Between 2009/10 and 2020/21 however, planned expenditure on the NHS in England will rise by an average annual rate of just 0.9%.¹⁰⁷¹ As a result the NHS currently faces enormous financial challenges, with 67 per cent of providers finishing 2015/16 in deficit. This restraint will leave the NHS in England needing an estimated additional £30 billion by the end of the decade, according to the NHS's *Five Year Forward View*. Of that, it is assumed – but by no means guaranteed – that £22 billion could be saved through more efficient use of resources, leaving the Government to make up the additional £8 billion shortfall.¹⁰⁷²

¹⁰⁶⁹ Mary J Renfrew et.al, [Midwifery: an executive summary for the Lancet's Series](#), Jun 2014.

¹⁰⁷⁰ The Health Foundation, [Health and care funding in a nutshell](#) [no date]

¹⁰⁷¹ The King's Fund, [The NHS budget and how it has changed](#), Jan 2016

¹⁰⁷² Full Fact, [NHS 'black hole' - the size of the funding gap to 2020](#), Apr 2015

5. The resource situation has particular implications for any plans to merge health and social care. As the Barker Commission made clear, there is a strong case for the merger of health and social care.¹⁰⁷³ But the challenge to make it work is not structural but funding. Any merger should not be attempted until we face up to that reality and have found the money.
6. Whilst many would argue that more needs to be spent on providing NHS care, the unmet demands for social care are arguably far greater. Take, for example, just the most recent years. Whilst spending on the NHS in England has at least kept pace with inflation, spending on social care has not. Public expenditure on social care in England between 2009/10 and 2013/14 fell by 1.8% per year on average in real terms.¹⁰⁷⁴
7. However, if health and social care were to be merged and paid for out of the same pot, it seems inevitable that social care spending would rise at the expense of healthcare. This could have a deleterious effect on services such as maternity care, which is entirely funded out of the healthcare budget. As things stand the RCM's assessment is that maternity services in England are underfunded. While the proportion of funding that goes to maternity services has remained largely consistent, at around 3% of the NHS budget, the amount that providers report spending on maternity services has exceeded the income they have received via the tariff as demand increases.¹⁰⁷⁵ The draining away of NHS resources into social care in a merged system could only make this worse.
8. When the Committee heard oral evidence from the Nuffield Trust, The King's Fund, and the Health Foundation, there was consensus that switching to another funding model is not the answer for the funding challenge.¹⁰⁷⁶ The position of the RCM is that the fairest system we can have is for care to be free at the point of need. Co-payments and increased user contributions in healthcare can only increase inequality of access, so the fairest system is for it to be funded out of general taxation.
9. The question is how that taxation is raised. The RCM would support taxes that simultaneously raise revenue and change behaviour. This helps to reduce demand for treatment (by improving public health) whilst raising money to pay for the care that is needed.
10. In 2015/16, tobacco duties raised over £9bn and alcohol duties almost £11bn.¹⁰⁷⁷ We would like to see these kinds of duties expanded. We support the proposed soft drink levy¹⁰⁷⁸ and urge Government to investigate similar measures, e.g. a tax on saturated fat in food.

Public Health

¹⁰⁷³ The King's Fund, [Commission on the Future of Health and Social Care in England](#), Sep 2014

¹⁰⁷⁴ The Health Foundation, *ibid.*

¹⁰⁷⁵ RCM, [Postnatal care funding: the case for better resourced maternity care](#), 2014

¹⁰⁷⁶ [Unrevised transcript of evidence](#) taken before the Select Committee on the Long-Term Sustainability of the NHS inquiry on the Long-Term Sustainability of the NHS, 19 July 2016

¹⁰⁷⁷ HM Revenue & Customs, [HMRC Tax Receipts and National Insurance Contributions for the UK](#), Jul 2016

¹⁰⁷⁸ HM Treasury, [Budget 2016: some of the things we've announced](#), Mar 2016

11. We also need to see much bolder action from the Government on behaviour change and public health. Supporting people to keep well and make good choices in relation to behaviours such as diet, exercise and lifestyle choices is fundamental to ensuring the long-term sustainability of the NHS. Investing in effective public health programmes can change lifestyle behaviours with the potential to realise up to £30 billion a year savings for the NHS.¹⁰⁷⁹ Securing savings of this magnitude will only be possible with a clear strategy and sustained action across Government departments and arms length bodies.
12. The Government's new plans to tackle childhood obesity are weak and will do little to limit the rise in obesity in the coming years.¹⁰⁸⁰ Our concern is that without stronger action and a more robust strategy, obesity will continue to represent a significant drain on NHS resources for decades to come. We need to see more action on improving health right at the start of life, and we would highlight the role of maternity services in helping to deliver long-term health benefits, for example through breastfeeding support, healthy diet and smoke-free support. There are undoubtedly resource implications that come with all of these measures, particularly relating to the midwifery workforce, but an investment in the short to medium term will yield improvements in outcomes, in the health and wellbeing of the population and accordingly in the long-term sustainability of the NHS. It is at this point in life - in the first year, rather than the last - that real, transformative savings will be made long term, but with dividends not payable for 20 years or more. For example, improving England's poor breastfeeding rates by investing in postnatal care will help counter childhood obesity and help prevent cardiovascular disease and some cancers within women.¹⁰⁸¹

The workforce

13. We urge the Committee to take a serious look at how the NHS workforce is planned. Since 2012, numerous organisations within the NHS have taken control elements of workforce planning, but there has been no single strategic oversight. There needs to be an overarching accountability in the Department of Health for systems and workforce strategy. We cannot look at these issues in isolation if we are to staff the NHS with the right people in the right places. The NHS workforce is *the* key to sustainability - staff costs account for just under half of total NHS spending and approximately 70 per cent of a typical hospital's total costs.¹⁰⁸²
14. As Richard Murray of the King's Fund recently testified to the Committee, one of the present challenges is with the difference in workforce planning between models that build up from population need and models that build up from what NHS employers can afford to pay for.¹⁰⁸³ For maternity services we are fortunate that there is a workforce planning tool – Birthrate Plus – which is based on the needs of women and babies and which is robust, credible, supported by the RCM and widely used in maternity units

¹⁰⁷⁹ Local Government Association. [Money well spent? Assessing the cost effectiveness and return on investment of public health interventions](#). Nov 2013.

¹⁰⁸⁰ BBC News, [Childhood obesity: Plan attacked as 'weak' and 'watered down'](#), Aug 2016

¹⁰⁸¹ NHS Choices. [Benefits of Breastfeeding.](#) 29 Jan 2016.

¹⁰⁸² Appleby et.al. [The NHS productivity challenge: Experience from the front line](#). The King's Fund, 2014.

¹⁰⁸³ [Unrevised transcript of evidence](#) taken before the Select Committee on the Long-Term Sustainability of the NHS inquiry on the Long-Term Sustainability of the NHS, 19 Jul 2016

across England. It has a long track record in enabling managers to measure the work and time involved in providing high quality maternity services and translating this into staffing numbers. It has now been endorsed by NICE as a workforce planning tool that can assist with implementing the recommendations in the NICE guideline for safe midwifery staffing.¹⁰⁸⁴

15. The RCM has used the Birthrate Plus methodology to assess the adequacy of the size of the midwifery workforce; our current assessment is that midwifery services in England are 3,500 wte midwives short of what would be needed to ensure that every woman could receive 1:1 midwifery care in labour, as clinically recommended.¹⁰⁸⁵ The impact of these shortages is demonstrated by Heads of Midwifery Services who report routinely reducing services, temporarily suspending services as well as reducing access to midwives' training and development opportunities. The impact is also evident in the amount of unpaid additional hours midwives are routinely working, their failure to take required breaks and the stress that they are under.
16. There is insufficient capacity to meet demand. The major driver of demand for midwives is the number of babies being born. In England there were 664,399 babies born 2015, 2,903 more than in 2014 and over 100,000 more than the equivalent figure in 2001. Births in England remain at a historically high level and this is set to continue, with the ONS projections indicating that, for the UK as a whole, births will remain between 800,000 and 815,000 a year for the next 20 years.¹⁰⁸⁶
17. The impact of a rising birth rate on maternity services is compounded by the growing complexity of many births. For example, births to older women have risen significantly since 2001 with a 33 per cent increase in births to women in their late thirties and a 78 per cent increase in the number of births to women aged 40 and older.¹⁰⁸⁷ Midwives are also caring for a growing proportion of pregnant women who are obese¹⁰⁸⁸ or who have gestational diabetes. Without a significant change in the prevalence of diseases of 'lifestyle', it is likely that the demands on maternity services from high birth rates over the next 20 years will continue to be exacerbated by an increasing proportion of complex pregnancies and births.
18. The main source of recruitment to maternity services in England is via pre-registration midwifery degree programmes. Since 2010, training commissions for student midwives have been maintained at around 2,500 places a year, even in years when commissions have been reduced for other healthcare degree programmes. This has contributed to a modest reduction in the shortage of midwives in England, but without an increase in training places there will continue to be an under supply of midwives into the next decade and beyond. This is because the overall contribution that pre-registration training makes to the midwifery workforce is diluted by a number of factors, like part

¹⁰⁸⁴ NICE. [Safe midwifery staffing for maternity settings](#). Feb 2015

¹⁰⁸⁵ RCM. [Midwife shortage soars, as birth rate figure continues to rise steadily in England](#), Jul 2016.

¹⁰⁸⁶ Office of National Statistics, [2012-based National Population Projections](#). Nov 2013.

¹⁰⁸⁷ RCM. [State of Maternity Services Report](#), 2015.

¹⁰⁸⁸ In March 2016, 20 per cent of women attending an antenatal booking appointment with a recorded BMI were obese.

time working,¹⁰⁸⁹ an aging workforce,¹⁰⁹⁰ falling numbers of clinical leaders and attrition rates of students on midwifery courses. Any sustainability plan for the NHS must be responsive to the changing needs of the workforce for work/life balance and caring responsibilities (both for older and younger relatives), for example.

19. In recent years an increasing number of midwifery services have sought to manage shortages by recruiting midwives from the European Union. According to the HSCIC, there are 1,192 wte midwives from other EU countries working in the NHS in England. Given our estimate of a shortage of 3,500 midwives in England, these are midwives that the NHS can ill afford to lose. The RCM has called on the Government to give a commitment to EU nationals working in the NHS that they can remain living and working in the UK.
20. If one consequence of Brexit is to choke off the supply of midwives from the EU, then the answer has to be to increase the supply of domestic student midwives. In this context, the RCM is extremely concerned about the impact of the Government's reforms of healthcare education funding, with the bursary for student midwives replaced by loans and student midwives liable for tuition fees from September 2017. In our view, the prospect of accumulating significant debt, including for many student midwives who already have a degree, will deter many aspiring students, thereby threatening the stability and supply of the future midwifery workforce.¹⁰⁹¹
21. Fundamentally, this shortage is a problem of provider finances constraining the ability of maternity services to employ sufficient midwives, leading to excessive workloads, burn out and stress.¹⁰⁹² It means a long hours culture, where there is little support for continuing professional development and high anxiety caused by continually feeling unable to give of your best. For women it means that antenatal care is often disjointed and the quality of postnatal care poor. The real challenge for the maternity workforce therefore is that there are not enough midwives and the real solution lies in the NHS increasing the number of midwives it employs.
22. Furthermore, the shortage of midwives has been exasperated by the ongoing pay restraint in the NHS. Since 2010 the Government has constrained the NHS Pay Review Body (NHSPRB) from making an independent recommendation for a pay uplift for Agenda for Change staff and imposed a pay freeze or 1% pay cap. It has been announced that this will continue until 2020. The RCM estimates that the average midwife at the top of band six will have seen a decrease in the value of pay from 2010-2016 of over £6,000 (if increases had kept pace with RPI inflation). Additionally, in 2014 the Government rejected the 1% pay uplift as recommended by the NHSPRB (after capping the award at 1%) which led to the RCM taking industrial action for the first time in our 134 year history. Not only is long term pay restraint and a decrease in the value of pay impacting on morale and motivation of staff and thus impacting on quality of

¹⁰⁸⁹ According to the NHS Staff Survey 2014, only 73 per cent of midwives were contracted to work more than 30 hours a week.

¹⁰⁹⁰ 47 per cent of the midwifery workforce is aged 45 and older.

¹⁰⁹¹ Public Accounts Committee, [Managing NHS clinical staff numbers: Written evidence from the Royal College of Midwives](#), Feb 2016

¹⁰⁹² RCM, [Caring for you: Survey Results](#), May 2016.

care and outcomes it is also impacting on NHS organisations' abilities to recruit and retain staff. In order to address the shortage of midwives the NHSPRB needs to be allowed to make unfettered recommendations for pay for permanent staff. In the long term this will save money because currently the NHS is making up the shortfall of staff by using costly agency staff. The RCM conducted a freedom of information (FOI) request that showed that NHS organisations were paying, on average, £49.01 per hour for an agency midwife compared to £17.84 for a permanent midwife with ten years' experience.

23. In terms of aligning skills with future needs, the RCM welcomes any development of the midwife's role which enhances standards of care and which makes care more accessible and responsive to women's needs. This will require having midwives who are competent to work in different settings, work in new ways, learn new skills and address particular needs which impact on maternal and infant wellbeing. However, there is much work currently undertaken by midwives that could be better and more appropriately carried out by administrative and clerical staff, by house keeping staff and most obviously through a support role that allows units to flex their skill mix. Matching staffing levels, skill mix and staff deployment to the model of care, taking staff health and wellbeing into account, is complex – and even more challenging and essential when resources are restricted.
24. The RCM does not endorse the extension of the midwife's role into obstetric, nursing or other spheres of practice where this does not demonstrably improve the quality of, or access to, midwifery expertise. It is not acceptable to permanently alter midwifery roles to compensate for staffing shortages or changes in doctors' roles. Therefore, proposals for advanced practitioner roles are not necessary for maternity care. What maternity services need instead is more consultant midwives, whose focus is improving quality of care. Further, the MSW role has become increasingly important since its widespread introduction twenty years ago and their contribution to maternity care should be further encouraged. It is unfortunate that the development of the MSW role has been given insufficient attention in England. In England there is no standard job description, no portability of qualifications and nor is there any clear route for career progression. This is a missed opportunity as MSWs allow for a more flexible deployment of the workforce and they enable midwives to spend more time with women.

New models of care

25. There is a recognition throughout the NHS that models of care have to change, both in the short term through the STP process and the *Five Year Forward View* but also long-term, to improve quality and meet the challenges of 21st century healthcare. In the context of maternity services, the NHS must develop new models of care to improve outcomes for women and babies, tackle socially-graded disease, reduce inequalities and set our population on the right path to long-term health and wellbeing . It is these objectives that will help the NHS remain sustainable beyond 25 years.

26. The National Maternity Review in England (*Better Births*)¹⁰⁹³ has laid out a vision for maternity services which correctly views a woman's contact with a maternity service as one of the most, if not the most, critical times in her child's life. The RCM fully supports the Review's recommendations and urges this committee to look carefully at the vision it sets out. In particular, the proposals for Local Maternity Systems, in which providers and commissioners collaborate on co-designing services, offers the possibility of driving up quality, and allowing new kinds of providers to enhance women's choice of maternity care. Fostering collaboration will allow those services which run at a 'loss' – but which otherwise provide essential care with exceptional clinical outcomes – to remain sustainable as part of the wider network. Picking up the themes in the *Five Year Forward View*, The Review's call to bring care closer to where women and their families live, via community hubs, will enable women to access elements of their care from multi-agency teams working together to offer midwifery, obstetrics and other services, including public health (e.g. smoking cessation, weight reduction).
27. The Review also urges the NHS to develop systems to facilitate continuity of carer, whereby a woman's care from pregnancy through to the postnatal period is provided by midwives working in small teams. Care delivered in this way is more highly rated by women than care that is delivered in a more fragmented fashion by professionals working out of different teams. Having a midwife to know and understand women also facilitates public health messaging. Positive clinical outcomes associated with this model of care include less likelihood of pre-term birth, baby loss and episiotomy. Robust economic analysis of continuity of care is limited at this stage, but the hypothesis is that allowing midwives to work more closely with women will lead to more positive maternity outcomes and that this will result in a net benefit to the NHS. This example of a new way of thinking about how best professionals can care for women is precisely the kind of innovation that is needed for sustainable midwifery services and the NHS as a whole.

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¹⁰⁹³ National Maternity Review. [Better Births, Improving outcomes of maternity services in England, A Five Year Forward View for Maternity](#). Feb 2016.

The Royal College of Nursing – Written evidence (NHS0149)

Summary

Ensuring the NHS in England is sustainable for the future needs to be addressed in the lifetime of this Parliament. The NHS has been a great success story, but for the NHS to be sustainable for the future, up to and well beyond 2030, significant decisions and changes must be made. As part of this, it is critical that the NHS is understood as a core component of an eco-system which encompasses the entirety of health and care provision. This includes activity and outcomes that span the prevention of disease and injury, public health promotion and improvement, treatment, rehabilitation and recovery, condition management and support for independent living.

We firmly believe that given the socio-economic context, profile of our population and current health outcomes and inequalities mean that a future health and care system must be funded, designed and delivered in ways that meet the needs of the population. We continue to make somewhat arbitrary distinctions about what should be funded by the NHS or by local authorities, for example. The reality is that the failure to fund either effectively, or address people's needs through design and delivery of integrated services, is negatively impacting both funding and outcomes. We must consider these aspects of care and support as fundamentally connected and interdependent, rather than seeing them in isolation from one another.

We are particularly concerned that efforts to ensure the sustainability of a future health and care system should prioritise preventative aspects, as well as ensuring that we are able to effectively and meaningfully support people to live independently, for as long as possible, where appropriate. There is much that can be said about how the NHS can be improved and supported to be sustainable, but for brevity we have focused on those issues that relate directly to nursing and its contribution.

Our headline recommendations to ensure the sustainability of the NHS are that we need to determine and address the funding gap within health and social care and impact on whole population health; develop a workforce which addresses current gaps and is fit for our future needs; and design and deliver safe, effective services which meet need and generate positive outcomes for patients.

Key recommendations

1) Determine and address the funding gap within health and social care and impact on whole population health

The fundamental interdependencies between health, care and what is public health is already well understood, and we want to be clear that continuing to see the funding, design and delivery of these systems in isolation is unhelpful in trying to address the sustainability of the NHS, and in addressing the needs of the population as a whole. There is a well understood requirement for health and care support to make a fundamental shift towards

more preventative action, and also to provide support which enables individuals, where appropriate, to live independently for as long as possible. What is currently known as public health activity is a core part of this, such as school nursing and health visitors.

While it is fundamentally clear that the NHS in England must be given more funding, to accommodate inflation and the increase in demand predicted for the next decade, the function and impact of what is currently NHS-funded cannot be seen in isolation. Continuing to do so negatively impacts on NHS-funded activity, as, for example, people unable to access social care find their health deteriorating and in consequence end up needing NHS care. Once in NHS care the lack, or denial, of social care can leave individuals inappropriately 'stuck' in the NHS. On the public health front continuing cuts have recently been described as a 'false economy' by the Health of Commons Health Select Committee, in its inquiry on public health post 2013¹⁰⁹⁴.

Instead, we need to consider, in the round, what population needs are, what the current funding gap is with regards to known evidence-based interventions in health (equally valuing people's physical and mental health), social care and public health, and what the impact of this funding gap is in terms of efficiency, productivity, inequalities and outcomes. It is only by understanding this gap, and its impact in the round, that the Government can then explore what can be considered in order to address the needs of the population - equally valuing our physical and mental health - including what can be funded and delivered by the NHS. We are clear that any potential for a further gap developing (and increasingly inequalities in health outcomes) which might occur as a consequence of the decision to leave the European Union must be mitigated and addressed as part of discussions which prepare us for impending change.

It is also clear that while exploring how best to fund, distribute funds and design effective delivery mechanisms which address health, public health and social care needs, to enable both current and future iterations of health and care services, we must see an appropriate and equitable balance of focus between supporting and improving services, and building a workforce for the future.

2) Develop a workforce which addresses current gaps and is fit for future needs

There is a vast range of evidence which makes clear that we have significant gaps in the existing health and care workforce, and that these need to be plugged in more substantive and sustainable ways other than continuing to over-rely on agency staff, bank staff and immigration policy as temporary measures to alleviate pressure at great cost. The urgent requirement to figure out how we might meaningfully build a workforce fit for the future also comes at a time when we are experiencing a substantial reduction in the funding of education and professional development. Yet it is only by equipping those working in health and care environments with professional development, training and support that our existing workforce can help to transform the way we work so that we are also able to creatively envision, strategic, plan and deliver a future workforce in ways that meet the population's health and care needs in a sustainable way.

¹⁰⁹⁴ Public Health Post 2013 House of Commons Health Select Committee 1 September 2016 [Available Here](#)

Resolving these issues, and creating a workforce that is fit for the future needs to grow our domestic workforce, and also inform effective migration policy (continuing to ensure that a pipeline of international talent contributes to our health and care system). This fundamentally requires the Government to drive the creation of a comprehensive workforce strategy that equips us for a future health and care system in a systematic and coherent way, while also alleviating pressures in our current system. This can really only be delivered through robust co-ordination between the departments that play a key role in public services employment, including HM Treasury, Home Office, Department of Communities & Local Government and the Department of Health.

In terms of the equipping the NHS, to aid recruitment and on-going retention pay increases which reflect the cost of living must be awarded to all staff on Agenda for Change (AfC) grades. In particular, ongoing pay restraint is contributing to a growing nurse shortage, so we are clear that nurses must be awarded a fair increase in pay which starts to bridge a gap of 15% between pay and their cost of living.

Sufficiently funded pre-registration nursing training places must be made available to support both current and predicted future demand, and ensure continuity of supply. This is an important issue in-light of the uncertainty following the UK's vote to leave the EU.

Changes to nurse education funding must not result in an inability to strategically plan to create the workforce of the future. It is not yet clear how the move to a market-led approach will lead to right numbers of nursing students in the right places, especially as HEE funding for clinical placements will still be capped. The Government have committed to monitoring and evaluating the impact of plans but they remain an untested gamble, and a risk to the future supply of nurses that we would like to see effectively mitigated by

These changes sit alongside a raft of other changes to nurse education and training, including a move towards apprenticeships in nursing, and the new Nursing Associate role. While these are distinct and separate programmes they are all pieces of the same jigsaw, with real implications for the development of the future nursing workforce. We would like to see Government proposals responding to the reality that modern nursing is complex and requires high levels of skills and knowledge.

Another aspect of doing this requires doing more to ensure that the future nursing workforce is 'tech enabled' and 'tech literate'. At the level of the individual the aim of the work is to enable practitioners to articulate their professional development needs and support the process of revalidation. At a system level the aim is to build digital capability. We believe it is important to emphasize the capability approach. We understand that as one that takes into account emergent contexts and evolving practices and innovative ways of working. They are inherently predictive and key to building a resilient health and care system.

Investment is needed to ensure growth in the overall supply of registered nurses through education and training. Changes to nurse education funding should be enabling the Government to strategically plan for the workforce of the future, and we are not confident that this is happening. In the least, current reforms must be carefully monitored and evaluated. For existing nursing staff who wish to increase their skills and competencies in clearly defined areas, for instance as 'Clinical Nurse Specialists' or 'Advanced Nurses Practitioners', funded and structured pathways must be established. To aid and accelerate this, the RCN is actively developing a credentialing programme, but its realisation

necessitates support from the Department of Health, Health Education England and NHS England. Ideally, the RCN's work should neatly contribute to the creation of a workforce strategy by these system partners.

3) Design and deliver safe, effective services which meet need and generate positive outcomes

We believe there are two areas where the nature of health and care services must fundamentally change in order to help design and deliver safe, effective services which meet need and generate positive outcomes in a sustainable way within a future health and care system. These are, broadly speaking, how the NHS can use advances in technology to deliver a health and care service that is sustainable; and to have open and honest discourse between the political establishment and the public about what the NHS can and should do. This second aspect needs to be part of wider discussions about creating a sustainable health and care system.

Exploring what a 21st century health and care system can and should do will necessitate a mature political conversation about what the 'NHS offer' should be, as part of designing a health and care system which is sustainable and fit for our future needs. This will also require discussion of citizens' rights and responsibilities. Lastly, the success of this approach will also require consistent co-production and partnership work between citizens and health and care services, to design and deliver interventions which meet population need, are high quality, are effective and enable people to live and be supported independently within their communities for as long as possible, where appropriate.

ADDITIONAL COMMENTARY ON WORKFORCE

Recruitment and retention

The NHS needs a workforce strategy, which connects to other parts of the health and care system and ensures that we have sufficient properly trained health and care staff. Staff terms and conditions need to be improved to make a career in health and care rewarding and a fairly remunerated option. Nursing education needs to be affordable, and not discourage anyone because of their socio-economic status or background. Nursing education needs to be refreshed to ensure trainee nurses are equipped to manage the demands of a 21st population and a very complex healthcare system. Specialist areas of practice, such as mental health, learning disability, children and young people, and those working with people with long-term conditions such as asthma, dementia, diabetes, and multiple sclerosis, need to be resourced sufficiently to ensure they are attractive to new entrants.

Nursing shortage

The current nursing shortage is having a detrimental impact on the delivery of care in the NHS but also has significant implications for NHS finances. The increase in the agency bill over the past two years and the cost of repeated overseas recruitment drives shows that additional resources are needed to fill the gaps created by not training enough nurses domestically. The significant rise in the use of agency nurse and medical locums has been flagged as contributing to the size of the current NHS deficit. This is a symptom of the previous 'boom and bust' approach to workforce planning. Any sustainable health and care

system needs to break the cyclical pattern of large undersupply, which is then plugged with overseas recruitment. Brexit and immigration controls will all impact on our ability to recruit from overseas.

Pay

The starting salary for a newly qualified nurse is £21,909, and the average salary for a staff nurse is £24K per year. In addition to these low salary levels, and in line with all other staff subject to NHS Agenda for Change pay scales, nurses have also been subject to public sector pay restraint since 2010.

The lack of pay increase over a sustained period, combined with the impacts from reductions in nursing numbers, means that across the NHS many nursing staff nearing retirement are considering it as an option. Without a commensurate increase in new recruits, and without that increase being aligned with the flow of retiring nurses, the NHS risks losing both absolute numbers and the opportunity for a transference of knowledge, skills, and experience that are vital to providing truly patient-centred care.

NHS pay bill

NHS Improvement has recently flagged 63 trusts for significant increases to their pay bill over the last few years and reported comments made by Jim Mackey, Chief Executive of NHS Improvement claimed that Trusts had been over-recruiting. Drives to make savings and reduce the deficit should not be taken by reducing an already over-stretched workforce. Some of the Trusts named by NHS Improvement are high performing Trusts with good and outstanding CQC ratings. Trusts should not be penalised for ensuring they have enough staff to meet demand and delivering high quality care. Likewise, we agree that the agency bill does need to be brought down, but in a sustainable way which does not prevent trusts from providing safe care.

23 September 2016

The Royal College of Obstetricians and Gynaecologists – Written evidence (NHS0093)

The Royal College of Obstetricians and Gynaecologists (RCOG) is the professional membership body for women's health. We welcome the opportunity to submit our views to this inquiry.

General points

In its current form, the NHS is not sustainable over the medium term. We have a population living longer with higher demands and expectations; widening health inequalities, long-term multi-morbidities and the burden of obesity; and long-term reduction in public funding. Services are now deteriorating, waiting times and rationing are increasing, and many service providers are reducing provision to avoid mounting debt. It is likely that the quality and safety of care will be affected. Under increasing pressure and stress, the NHS workforce may feel increasingly demoralised, workplace illness and burn-out will lead to sickness absence and early retirement. Too busy fighting service crises, health commissioners and providers may fail to find the transformation plans demanded by NHS England. This will fail to win over the public.

- The NHS is the most democratic modern institution in the UK and the public must be engaged in finding a secure future. The Commission should begin a national conversation to find what the public wants for the NHS. Should we ration services and reduce to a core of acute services? Should it become a safety net service for those unable to afford care? Should the NHS remain universal and comprehensive, as now, but find different funding, e.g., item of service fees, means-tested private or employer health insurance, or hypothecated tax, or higher taxation to pay for quality care?
- The division of NHS and social care funding must end. The Commission should encourage NHS England to fully embrace the Barker Commission Report and ensure that by 2020 budgets are controlled by integrated commissioning agencies, completely separate of provider interests.
- Doctors and other clinical professionals need to change the way they train and practice. The Commission should review 'Shape of Training' Report and encourage Royal Colleges to work together to offer generic training programmes and also to prepare clinical teams to work in many different settings. Thousands of new community settings for NHS services should be trialled, combining GP and specialist clinics, in supermarkets, leisure centres, shopping centres, cinemas and community centres. This could break down the old barriers of primary/secondary, hospital/community with a new pattern of provision emerging.
- Tackling health inequalities and lifestyle diseases must be made independent of Government in a similar way that the Bank of England was made independent of the Treasury. Public Health England could have a new compact with Government in return for a significant increase in funding (5% of NHS budget?) to tackle entrenched health inequalities and individual health behaviour.
- The Commission needs to find how the public can reimagine hospitals. One hospital in each English region could become a digital centre of excellence: the 'future

hospital today' programme. These will be showcase centres using epigenetics and the best in modern clinical care to allow the public to visualise the future of hospitals (fewer, larger, specialist referral centres).

1. Workforce

- 1.1 One of the consequences of the move to Foundation Trust, CCG and local authority funding is that responsibility for training has suffered through service fragmentation. In some cases, independent sector providers are not providing training. Furthermore, in times of financial difficulty, these disparate commissioning entities may become insular and make unilateral plans that impact on training. HEE must have a greater role in this process and be transparent in the way training is commissioned.
- 1.2 Within maternity care, there is a close interaction between an increased demand for services with the increasing numbers of complex pregnancies because of the lifestyle factors mentioned in the paragraph above. At times, this demand has led to the temporary closure of NHS maternity units on safety grounds as a result of the lack of specialised skills and/or equipment to care of women.
- 1.3 The implementation of the [Shape of Training](#) review and the [Five Year Forward View](#) mean that resources are now concentrated in primary care and while there is logic in these developments, as a consequence, the pool of talent is smaller for the medical specialties to draw from.
- 1.4 The RCOG has long argued for a consultant-delivered service in obstetrics and gynaecology. This requires multidisciplinary team working and an expansion of the consultant workforce as outlined in the report [Safer Childbirth](#). This was also the main thrust of the joint RCOG/Royal College of Paediatrics and Child Health [report](#) on compliance with the European Working Time Directive. The benefits include enhanced patient safety, increased training opportunities and trainee supervision and a better work/life balance for both consultants and trainees. These recommendations were not widely put into place.
- 1.5 The RCOG is also concerned by the [calculations](#) on the O&G workforce by the Centre for Workforce Intelligence (CfWI) in 2015 which underestimated the workforce numbers needed by the specialty in response to population trends. The CfWI assessment that the specialty was in danger of overproducing trainees by 2028 does not take into account the demographic changes in specialty training which includes vacancies caused by less than full time working, maternity and out of programme leave. These workforce developments have resulted in a middle grade rota gap of about between 20-30% in obstetrics and gynaecology at any time of the year. A knock-on effect is that in some instances, consultants have had to act down in order to meet service needs.
- 1.6 Similarly, the RCPCH's recent [report](#) on rota gaps and vacancies have shown a 10-20% rota gap rate in that specialty. Given the role of neonatal care in maternity

services, a broader view needs to be taken in workforce planning. The Department of Health and Health Education England must accept that with the shift towards multidisciplinary team working in the NHS, no one specialty should be viewed in isolation since changes in one will have an impact on the overall care of mothers and their babies.

1.7 The RCOG is due to publish its complementary reports from the Providing Quality Patient Care Working Party, a section of which will make recommendations on service provision and consultant working. The RCOG commends these report findings to the Lords Select Committee to address the current shortfall in trainees and senior staff.

1.8 The system needs to optimise on training opportunities and retain the consultant workforce. It must be flexible to accommodate the needs of trainees and be sensitive to the role and capacity of consultants at the later stages of their careers. To deliver safe and high quality obstetric and gynaecological care, the RCOG suggests the following actions:

- In most units, hybrid rotas encompassing out of hours resident working (to include evenings and weekend day-time) are needed for the majority of consultants
- The expectation that only newly qualified consultants should provide this service is unfair and untenable. Units must modify job descriptions and job plans of existing consultants so that there is greater equity.

1.9 There will be some resistance to these proposals to remodel the O&G workforce. There are currently pockets of good practice in England which the Lords Select Committee should note, as detailed in the appendices of this report. Key to the success of this is a cultural change in the mindset of the specialty.

1.10 The RCOG will also work its colleagues from other craft specialties to develop collaborative training proposals.

2. Models of service delivery and integration

2.1 Political interference coupled with high profile media campaigns have resulted in failed reorganisations, in some cases to the detriment of the local health economy. The rationale to centralise care is to enable greater efficiencies and a better deployment of resources across a geographical area. It must be noted that the key principle for reconfiguration is to offer a safe service. However, in some circumstances, local services should be maintained to meet the needs of communities.

2.2 The primary issue is an inability to staff all the obstetric units in the UK safely all of the time. Some close regularly. [Better Births](#) and the [Birthplace](#) study advocate choice and flexibility for women to deliver outside the hospital environment. The RCOG does not support this for all pregnancies but can accept the argument for

parous patients with a previous uncomplicated delivery and care. The transfer rate of > 40% for primigravida will place an unnecessary burden on emergency services. If one assumes that a third will need a doctor to deliver, a third a midwife and the others a combination the model of site provision suggests that reconfiguration is feasible and could be resourced. The present model of doctors in 95% of the units is unsustainable. Either more trainees, more trained staff or a reduction in medically provided care, ie a reduction in unit numbers is suggested. In England this might dictate closing or rebadging 20-40 maternity units across the country depending upon access/proximity and population growth.

- 2.3 The RCOG's [Good Practice paper](#) offers guidance on the reconfiguration of women's health services and these principles should be read alongside the RCOG's [guide on its invited service reviews](#) which sets out the process to investigate clinical governance and standards in each unit. The RCOG will publish a report on the location and delivery of women's healthcare by its Providing Quality Patient Care Working Party later this year. It will set out the options that need to be considered for the reorganisation of services based on its learning from previous service reviews.
- 2.4 The RCOG's [Clinical Indicators Project](#) analyses data from Hospital Episode Statistics and shows wide variation in outcomes and practice. The reasons why this should be the case is complicated and the RCOG has, through [High Quality Women's Health Care](#), proposed that women's health services function within strategic clinical networks. This has been accepted in the *Better Births* report and should be implemented through the Maternity Transformation Board which is likely to recommend that the denominator is the Sustainable and Transformation Plan (STP) for maternity and neonatal care but linked across the larger geographical footprint of a network.
- 2.5 This clinical network approach with clear referral pathways linking primary with secondary and tertiary care is supported by the evidence which shows improved patient outcomes and experience through the concentration of skills, expertise and facilities alongside better training opportunities at centres of excellence.
- 2.6 Within a network, there should be at least one unit providing enhanced acute care that caters to the low volume, high cost complex cases. Partnership working should enable smaller units to have clear transfer arrangements with the bigger units. Similarly, where appropriate, some small and isolated units could see an expansion of services through staff rotations between units.
- 2.7 Smaller units can be maintained provided they belong to a network with specialist support in fetal and maternal medicine and in gynaecological and neonatal care. This pooling together and sharing of knowledge and resources crosses geographical boundaries, assists in quality improvement and audit and allows for joint training between maternity professionals.

- 2.8 Because of the way in which maternity care interdigitates with gynaecology, there are immediate knock-on effects to gynaecology provision when the pressures in maternity result in a shift of staff to provide cover. Early pregnancy complications are nearly always dealt with by gynaecology teams of nurses and doctors and do not reach inpatient antenatal care until around mid-gestation. This push-and-pull effect of emergency maternity care, when a pregnancy can move from low to high risk rapidly throughout pregnancy but especially during the intrapartum period, has an adverse impact on cover for gynaecology and must be addressed to ensure medium to long term service stability. Emergency and post-operative high dependency gynaecology patients must have the same responsive, high quality care that women in maternity care get and services that are reconfigured should have clear plans to protect emergency gynaecological services within care networks.
- 2.9 The community hub model of care, as recommended in the National Maternity Review report [Better Births](#) fulfils many of the RCOG's requirements in offering personalised care and continuity of carer. Community hubs will help reduce health inequalities in a geographic region by linking the various care models and agencies within a series of linked services. Information, protocols, resources and facilities are shared within a network of care. However, the development of this infrastructure (which includes other disciplines such as paediatrics and anaesthesia and auxiliary support such as ultrasound scanning and ambulance services) requires investment and potentially new build at a time when NHS funding is stretched.
- 2.10 In its [response to the Kirkup Report](#), the RCOG recommended that these networks are underpinned by risk assessment protocols, clear pathways of care and the use of tools such as the [maternity dashboard](#) and an obstetric staffing equivalent of [Birthrate Plus](#). The RCOG understands that this work is currently being undertaken by NHS England as part of the Maternity Transformation Programme and looks forward to their wide use across the NHS to enable safer care and better planning.
- 2.11 It is clear that medical innovation and new technologies, better collaboration between the NHS and independent sector providers, an NHS-wide procurement system and robust and unified data collection can all assist in the reconfiguration process but other considerations such as clinical negligence claims alongside unrealistic NHS targets (eg. waiting times, referrals rates) and undefined patient choice all have an impact on whether services should be reorganised.
- 2.12 It is also widely recognised that the maternity tariff is currently unrealistic and does not take into account the overheads of a maternity unit. Funding for and the commissioning of services in O&G must accurately reflect levels of complexity.
- 2.13 The RCOG will be making recommendations on the core everyday essentials needed to provide a seven-day service in O&G, through a report by its Providing Quality Patient Care Working Party and welcomes a further discussion on the practical application of these care principles with the Lords Select Committee following publication in 2016.

3. Prevention and public engagement

- 3.1 The NHS should help the public to understand the cost of treatment/missed appointments so that they take some responsibility for their health and wellbeing. The concept that the NHS is *free at the point of delivery* can too easily be perceived as *a free service* with no cost to society.
- 3.2 The NHS should proactively engage with marginalised, vulnerable and elderly individuals before known healthcare problems can develop using a range of tools including traditional and social media. High risk groups (eg. the homeless, refugees/asylum seekers/undocumented migrants, victims of violence etc) should be targeted for greater engagement with the health service.
- 3.3 The RCOG has already made the case for embedding the life course approach into medical practice in paragraph one above. Based on the emerging evidence from epigenetics, the NHS must use the opportunities it has to better control pre-pregnancy health and intrapartum disease (eg. blood pressure/gestational diabetes/prematurity) as these have a medium to long term effect on the mother's health (eg. risk of Type II diabetes/subsequent cardiovascular disease) and impact on the future health of infants.
- 3.4 Obesity is the public health time bomb that needs to be tackled urgently. Apart from the obvious dangers during pregnancy and evidence of its impact on fertility, there will be effects in the ageing population result in increasing levels of hormone sensitive cancers. The NHS must have an Obesity Task Force that prioritises this work.
- 3.5 Public health policy should encourage and incentivise individuals to be physically active according to international guidelines. The costs of gym/sport clubs membership and weight management support can be restrictive. Policy should also focus on helping individuals to maintain a healthy diet and nutrition levels. There should funding for training for those delivering pre-conception counselling and the roll-out of Sex and Relationships Education in the national curriculum. Early intervention is key and these initiatives should target schools so that children are aware of the importance of adopting healthy lifestyle choices from an early age. In particular, the RCOG feels strongly that there should be an emphasis specifically on women's role in society as it has significant bearing on her future family's health and wellbeing. The NHS should also engage with employers (starting with public sector employees and using public sector procurement with private contractors) to provide a healthy workplace environment eg. standing desks, availability of healthy food in canteens etc.
- 3.6 Within the community hub model described in the paragraph above, the Committee should consider the co-location of health services beyond conventional healthcare settings, eg. GP surgeries or pharmacies in post offices, libraries, schools, children's centres, local leisure/fitness centres and museums.

3.7 Finally, it must be noted that public health policies must examine measures that manage the circumstances linked to poor health. Messages that individualise lifestyle factors as a matter of personal ‘choice’ do not recognise how some of the most of the most serious threats to health and wellbeing are related to factors beyond individual control, ie external/environmental influences (eg. poor quality air in cities, the wide availability of high-fat and high-sugar processed foods, poverty and low social mobility etc).

23 September 2016

The Royal College of Ophthalmologists – Written evidence (NHS0032)

The Royal College of Ophthalmologists (RCOphth), the professional body for ophthalmologists, is responsible for developing and maintaining standards in ophthalmic training and practice to provide safe and effective treatment and management of eye diseases and conditions.

We welcome the Select Committee's inquiry into the 'Long-term Sustainability of the NHS' over the next 15 – 20 years; this is a time of great change and we wish to play our part in improving eye care for patients. We understand the need for brevity in this submission but more detailed information can be provided. We refer to the "Way Forward" project in some of our answers and this is due to be published later in 2016. Commissioned by the RCOphth, it identifies ophthalmology departments which have developed efficient ways of working in order to meet the increasing demand for eye care.

The future health care system

1. Taking into account medical innovation, demographic changes and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

The UK is facing a triple challenge of an aging population, effective but expensive, long-term treatments and stretched resources. It is clear that the situation cannot continue if access to NHS services is still to be free at point of access, based on clinical need, not an individual's ability to pay.

Resource issues including funding, productivity and demand management

2. To what extent is the current funding envelope for the NHS realistic?
 - a) Does the wider societal value of the healthcare system exceed its monetary cost?

The wider societal value is encapsulated in the NHS Constitution: it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. While it remains a loved institution, "the **closest thing** Britain has to a national **religion**", **the current funding envelope is not realistic.**

- b) What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

We believe that NHS services should continue to be free at the point of use, except where charges are expressly provided for in legislation. This is partly to retain the support of all socio-economic groups and partly because those in the lower socio-economic groups have the greatest need given their increased incidence of many eye conditions.

Capitation would decrease the bureaucracy that has grown with the payment by results system and put the control back in the hands of those who know where it is best to spend the budget – the health care professionals (HCPs). Please also see the answer to 5 b).

- c) What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

Improve the partnership the NHS has with clinical research companies; greater collaboration regarding costs and profit shares as opposed to one-off payments to units or individuals for research collaboration.

Learn from countries that have better integration of private practice streams – e.g. India.

Optimise returns on insurance schemes – motor insurance, travel insurance, high risk activity insurance.

Developing partnership with sport – e.g. professional football, to promote individual activity and work with communities to encourage healthy living and reduce injuries. This could be a positive, national initiative that would benefit the sport and the population and gain access to partnership funding for preventative strategies.

- d) Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a (Dilnotstyle) cap?

There is not enough funding to meet demand and there needs to be an honest, national debate as to whether funding is increased or access to service and treatments restricted. In a national health service there must be an end to post-code lottery provision of care. Means testing would be expensive to administer and only realistically possible for elective activities.

Workforce

3. What are the requirements of the future workforce going to be and how can the supply of key groups of healthcare workers such as doctors, nurses, sub-professional, care staff and leaders and managers be optimised for the long term needs of the NHS?
- a) What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

The UK does not train enough doctors. The nation needs a coherent plan to increase medical student and doctors in training numbers and recognise that doctors in training are a valuable workforce.

Make it easier to enter and work in the UK if the individual from certain countries where we know the training is good and English is the first language spoken. Encourage Colleges to define equivalence of training criteria for workers from these countries and abandon an English test for those whose first language is English.

- b) What are the implications for the supply of healthcare workers following the Outcome of the recent EU referendum?

The Department of Health, which has its own capacity issues, has the enormous task of reviewing EU regulations to decide which should be replaced with UK-drafted alternatives. In the meantime the government should clarify its intentions regarding EU nationals who currently work in UK health roles.

Thereafter much depends on the new migration rules. Legislation to permit trained healthcare workers who are proficient in English to apply for posts in open competition would counteract a negative EU referendum effect. To be the best you need to recruit the best – open competition is the way forward and the previous system of limiting applicants to EU citizens was detrimental to this philosophy. However, it is necessary to take into account the potential for depleting other country's workers – some form of quota per year from each country should help to alleviate this problem.

- c) What are the retention issues for key groups of healthcare workers and how should these be addressed?

Value staff by Improving their working conditions and they will stay. Create a good working environment with flexible working opportunities, consistent with the needs of patients acknowledging current lifestyle choices. Staff that are treated with respect and compassion are likely to reflect those values as they treat NHS patients. T

Provide staff with more control over their working lives – with responsibility and accountability.

The RCOphth has, with other professional bodies, drafted a Common Competencies framework designed to standardise care across the sector and promote the importance of continuing professional development to maintain and update competences and knowledge. Its adoption will encourage non-medical healthcare professionals to take on expanded roles due to better recognition of competences and improved training.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

- a) What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

Utilisation of high quality activity data per individual and department to maximize the efficiency of the workforce – as per the National ophthalmology database (NOD).

Value continued education of workforce with meaningful rewards for additional competencies/ qualifications. Utilise and encourage internet learning of valuable, targeted skills not just repeated “compulsory training” which is of little proven value for many staff.

- b) What are the cost implications of moving towards a workforce that is equipped with a more adaptable skills mix being deployed in the right place at the right time to better meet the needs of patients?

There is much in ophthalmology, particularly in glaucoma management – see the ‘Way Forward’ documents. Cost effectiveness is not clear, the methods of evaluation reflect a managed market with pre-determined tariffs, and even so, the less qualified staff option is commonly more expensive due to less efficiency. Such activity must be audited and managed to ensure it is effective. However, less well trained staff have important roles in caring for selected groups of patients and in performing specific assessments and therapies as part of a well-functioning team.

Too many adaptable skills can mean fewer specialised skills and a less stable workforce – which has proved difficult in ophthalmology. Training staff to a certain level to find that they move on, once they become proficient, to another role but needing to be trained again.

- c) What investment model would most speedily enhance and stabilise the workforce?

Create Clear models of career progression with the opportunity to maintain active clinical care whilst progressing up the ladder.

Encourage and Incentivise senior and experienced staff to stay in the NHS by being proactive in discussing their future.

Older staff should be encouraged to consider changing their work patterns to create a new challenge that would increase the likelihood of remaining after financially they could leave.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

- a) How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

In ophthalmology, efficiency savings can be made by utilising those best suited to certain activities for a greater proportion of their working week. For example traditional consultant job plans have only two or perhaps three operating lists per week. Increasing the allocation to the most efficient surgeons will improve output and probably lower complication rates. In a capitation funding system other procedures would not be undervalued as they are now in the Payment by Results system.

- b) How can local organisations be incentivised to work together?

A single capitated budget, joining health and social care resources to cover all care for a local population, moves away from looking at specific diseases and puts the patient at the centre of provision of care. It does require the cooperation of all interested parties (primary and secondary care, local authorities and third sector) and Commissioners to develop new ways of contracting with providers to align incentives with a local plan.

A provider who meets the specified needs of the target population for less than the

capitated payment will generate a financial gain to the local health system and may receive an incentive for keeping patients in their target population healthy. Such providers are more likely to identify risks, intervene early and arrange the appropriate treatment for patients.

- c) How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

Please see our forthcoming Way Forward documents

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

- a) What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

Move towards a total ban of smoking – the next step would be a ban in all public areas effectively limiting smoking to private premises. Introduce incentives for keeping within BMI “zones”. Make cycle helmets compulsory for any journey on or off road.

- b) What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

Legislation works in certain areas (e.g. the seat belt law) - governments should not shrink from legislating when there is a clear benefit for public health.

- c) Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

Public health initiatives need to be properly evaluated for efficacy and understood to have a long payback time. The public health budget should be ring-fenced as it is often a soft target for re-allocation to resolve acute problems.

- d) Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

If some processed foods were relatively more expensive and fresh foods cheaper, low income families might be more likely to eat better but the impact of upbringing and education cannot be discounted. A sugar tax might be achieved by a packaging tax or similar.

- e) By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

Patients who miss their review appointments have a higher risk of losing vision from a chronic disease (glaucoma, diabetic retinopathy, wet Age related Macular Degeneration). Give providers financial incentives to ensure patients attend their follow up visits (this can be done by percentages attending). One method would be to target those most likely to 'did not attend' with automated reminders.

The corollary is that patients should be empowered to take responsibility for their health and encouraged to challenge delays to their follow up appointments.

- f) What are the barriers to taking on received knowledge about healthy places to live and work?
- g) How could technology play a greater role in enhancing prevention and public health?
See e) above.

Campaigns such as Movember, which raises men's health issues have successfully used social media to raise awareness.

Broadcasting (BBC best as could be cost neutral) has been used to increase public awareness of important public health issues involving prevention. Clunk/click every trip worked in the 1970s/80s when backed up with legislation.

- 7. What are the best ways to engage the public in talking about what they want from a health service?

Engage lay members of Community and Hospital Trusts in a national organisation of lay advisers.

Digitisation of data and services

- 8. How can new technologies such as data sharing, Big Data including the use of genomics and so on be used to ensure the sustainability of the NHS?
 - a) What is the role of technology such as telecare and telehealth, wearable technologies and genetic medicine in reducing costs and managing demand?

The role of technology is potentially massive in ophthalmology. Efficient virtual clinics such as those for common eye diseases are rendered most effective by the correct usage of imaging technology. Linking community clinics with secondary care centres via secure internet links and using new imaging technology would reduce the carbon footprint of review care considerably. Pilots of schemes utilising the technology we have now vs traditional care should be funded to test this hypothesis. Genomics will revolutionise the way we treat patients. To achieve improvements and efficiencies research should concentrate on common conditions collecting genetic data to determine genetic factors that determine response to treatments.

- b) What is the role of "Big Data" in reducing costs and managing demand?

The long-term strategy is to put patients at the heart of data collection, to monitor current outcomes of care and project future health needs.

A successful example is the National Ophthalmic Database (NOD) which holds data for cataract surgery with feasibility studies in train for three other conditions. This powerful quality improvement tool is used to update benchmark standards of care and identify outliers of poor performance.

- c) What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

The main barrier is the absence of a coherent, long-term strategy. A specific issue is that data is not routinely gathered on appointments that are delayed or postponed for patients under review, putting patients at risk of not receiving care within a safe timescale.

Collection of such data must become mandatory in order to identify unsafe delays, to highlight service inadequacies and inform future service development. All hospitals should collect and share adequate, mandatory data about hospital delayed appointments with clinicians, managers and commissioners to inform and develop services to meet local needs.

- d) How can healthcare providers be incentivised to take up new technologies?

Set realistic dates for implementation of minimal technology advancement with fines if dates are not achieved.

- e) Where is investment in technology and informatics most needed?

Getting electronic records in secondary care right. There are too many examples of a cheaper option being used which is not fit for purpose.

19 September 2016

The Royal College of Paediatrics and Child Health – Written evidence (NHS0133)

The Royal College of Paediatrics and Child Health (RCPCH) is pleased to contribute written evidence to the House of Lords Select Committee on the Long-Term Sustainability of the NHS and would welcome the opportunity to give further oral evidence.

The RCPCH has over 17,000 members in the UK and internationally and sets standards for professional and postgraduate education. The RCPCH aims to transform child health through research, knowledge, innovation, expertise and advocacy, and achieve a healthier future for all infants, children and young people (ICYP).

Summary of RCPCH Response

Challenges

- 1) **The poor health of UK children:** The UK lags behind much of Western Europe on key measures of child health and wellbeing and continues to have one of the highest mortality rates for under-fives^{1095 1096}. UNICEF places the UK 16th out of 29 rich countries in measures of child wellbeing¹⁰⁹⁷. One in three 10 year olds are overweight or obese¹⁰⁹⁸; almost one in three five-year-olds have tooth decay¹⁰⁹⁹; and one in 10 children and young people aged between five and 16 years old have a mental health disorder¹¹⁰⁰. Many of these serious conditions are entirely preventable.
- 2) **Inadequate investment in health:** ICYP make up over 20% of the population, are high users of healthcare services, and hospital attendances and admissions continue to increase; yet preventive health services for ICYP are bearing the brunt of cuts to public health spending in England. The public health budget has had a £200 million cut in 2015-16 and is set to fall by at least £600 million in 2020/21; of the £50.5 million reductions planned for 2016-17 by local authorities, the biggest single cut was a £7 million reduction to services directly aimed at ICYP, such as health visiting, school nursing and childhood obesity programmes¹¹⁰¹. Concurrently the net deficit of all NHS providers now at £2.45 billion¹¹⁰².
- 3) **An inadequate child health workforce:** Rota gaps are increasing and currently average 20% at senior trainee level; in the second quarter of 2016, four out of five paediatric clinical directors expressed concern about how their service would cope in the next six

¹⁰⁹⁵ Viner et al. Deaths in young people aged 0–24 years in the UK compared with the EU15+ countries, 1970–2008: analysis of the WHO Mortality Database. *The Lancet* 2014; 384: 880-92.

¹⁰⁹⁶ RCPCH, National Children's Bureau and British Association for Child and Adolescent Public Health. *Why Children Die: death in infants, children and young people in the UK*. 2014

¹⁰⁹⁷ UNICEF Report Card 11.2013

¹⁰⁹⁸ HSCIC. *Statistics on Obesity, Physical Activity and Diet: England*. 2014

¹⁰⁹⁹ HSCIC. *Child Dental Health Survey*. 2013

¹¹⁰⁰ Green, MGinnity, Melzer, Ford and Goodman. *Mental Health of Children and Young People in Great Britain, 2004*. 2005.

¹¹⁰¹ HSJ. '[Children's services hardest hit by public health cuts](#),' 4 July 2016

¹¹⁰² NHS Improvement <https://improvement.nhs.uk/news-alerts/nhs-providers-working-hard-still-under-pressure>

months¹¹⁰³. Summer 2016 has seen withdrawal of children's Accident and Emergency services in Stafford, and around 1000 sick newborn babies are transferred between hospitals each year because of insufficient cot capacity.

- 4) **The low priority afforded ICYP:** Key forums established to champion the needs of ICYP have been closed (Chief Medical Officer's Children and Young People's Health Outcomes Board; Children and Young People's Health Outcomes Forum); and the removal of ICYP would as a national priority for Clinical Networks in England. The focus on the ageing population and drastic cuts to the public health budget in England fail to acknowledge that better care in early life will enhance healthy longevity and reduce the long-term burden on health and social care.

Solutions

- 1) **Redesign of services around patient needs:** Key components include hospitals organised in managed clinical networks; breaking down the current divide between acute and primary care services; integration with strengthened public (preventive) health services, and crucially for ICYP, education services.
- 2) **Urgent investment in health services, including public health:** The growth in demand and the necessity of modernising and thus sustaining UK health services as a global model of cost-efficiency, without redress of the current funding shortfall is unrealistic.
- 3) **Better workforce planning:** An increase in the children's healthcare workforce (paediatricians, children's nurses and general practitioners trained in paediatrics); we note that Health Education England is tasked with training a sufficient number of consultants, but not with ensuring adequacy of the total healthcare workforce; this serious discrepancy in remit is illustrative of difficulties posed by the current fragmentation of healthcare.
- 4) **A national child health strategy:** ICYP must be considered equitably with adults in all aspects of healthcare; health research and development, prevention and intervention in infancy and childhood offer substantial value for money by reducing health burdens later in life.

RCPCH Response

The future healthcare system

Question 1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

1. Since the founding of the NHS, there has been a shift in the burden of disease in childhood away from infectious diseases to more chronic, long term conditions. One in seven 11 to 15 year olds now has a long term condition or disability¹¹⁰⁴. Investing in prevention and early intervention (including smoking, obesity, mental health, and safe

¹¹⁰³ RCPCH. *Rota Vacancies and Compliance Survey*. 2016

¹¹⁰⁴ Association for Young People's Health. *Key Data on Adolescence*. 2013

behaviours) will ensure that ICYP grow up to be healthy, resilient adults. Better care, including preventive care, in infancy (including fetal life), childhood and young adult life would reduce the population burden of chronic ill-health in adult life and hence be a sound national investment.

2. Over the last decade there has been a 28% increase in emergency admissions for ICYP, with a particularly sharp increase for under five year olds¹¹⁰⁵. Hospital admissions of less than 24 hours ('zero-day') have also doubled during the last decade. The reasons behind this rise are complex, and likely include lack of public confidence in care being provided quickly and safely in the community. GPs are the main healthcare providers for ICYP. As parents' preference for initial advice is their GP¹¹⁰⁶ a primary care led model of service delivery should remain the focus but this is hindered by only a third of GP having had an opportunity to undertake paediatric training. The current fragmentation of health services is exacerbating these difficulties. Strong central coordination, oversight and vision, with the active engagement of children, young people and their families, is required to achieve better connectivity between primary and secondary care, and an increase in more care delivered outside hospital.
3. Medical research and innovation has been disproportionately focussed upon adult needs. Child health research is not accorded the same appreciation as adult research; funding for child health research represents 5% of the annual UK public and charitable research expenditure of approximately £2.2 billion, equivalent to less than £10 per child each year¹¹⁰⁷ compared to £50 per year for each adult. ICYP are not small adults, and need biomedical and health services research that takes account of their changing physiology and addresses their problems directly. Research targeting the needs of ICYP is essential to improve the evidence-base for disease treatment and prevention, public health interventions, and health services configuration. Incentivising industry, including the nutritional, and electronic technology industries, as has been done for the pharmaceutical industry, to focus upon ICYP would reap dividends for population health.

Resource issues, including funding, productivity, demand management and resource use

Question 2. To what extent is the current funding envelope for the NHS realistic?

a. Does the wider societal value of the healthcare system exceed its monetary cost?

4. There is a disproportionate emphasis on treatment over prevention, a failure to recognise the positive impact of investment in early years health upon healthy old-age, and hence upon reducing the burden of chronic non-communicable diseases that have many of their determinants in early development. The Chief Medical Officer's annual

¹¹⁰⁵ Gill et al. Increase in emergency admissions to hospital for children aged under 15 in England, 1999–2010: national database analysis. *Archives of Disease in Childhood* 2013; 98: 328–334

¹¹⁰⁶ RCPCH, Royal College of General Practitioners, College of Emergency Medicine, NHS Direct, Joint Royal Colleges Ambulance Liaison Committee, University of Leicester and University of Nottingham. *To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature)*. 2010

¹¹⁰⁷ RCPCH. *Turning the Tide*. 2012.

report in 2012 (Our Children Deserve Better)¹¹⁰⁸ highlighted an expected annual rate of return on investment of 6-10% through interventions in early life.

b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

5. The Commonwealth Fund has consistently ranked the UK first in both quality of care and efficiency¹¹⁰⁹. The current funding envelope for the NHS is unrealistic; equally unrealistic is the £20 billion “efficiency savings” target. What is needed is consistent striving for efficiency, coupled with investment to strengthen and modernise a globally envied healthcare system. The experience of the UK prior to the birth of the NHS, and around the world, shows clearly that ICYP and other vulnerable groups would be most disadvantaged by the loss of a publicly funded, managed, and delivered healthcare system.
6. Existing payment mechanisms do not encourage proactive new ways of working, for example, between primary and secondary care, and in some situations have led to perverse incentives to see or keep ICYP in hospital. Contracting is not currently done for pathways of care and as a consequence many ICYP are falling between contracting gaps, for example, there is now very poor provision of effective continence care for the one in ten ICYP with bladder and bowel problems. We question the cost-effectiveness of the internal market in healthcare.
7. We are concerned about the use of private providers to deliver NHS services for ICYP, following concerns raised by RCPCH members; for example in relation to bids by Virgin Healthcare to provide community child health services in the South of England; RCPCH members who met with Virgin Healthcare during the tendering process highlighted that Virgin did not understand the service that was currently provided and thus offered an inadequate budget which is resulting in cuts to services. This also applies to safeguarding where local authorities are outsourcing the care of vulnerable ICYP to ‘voluntary children’s trusts’ where it is unclear who carries the risk.
8. Many children’s services lie at the interface between services commissioned by clinical commissioning groups, NHS England (specialised commissioning) and local authorities. This is causing fragmentation of services and a lack of accountability for the overall provision of children’s services; due to the complexity and number of different agencies in the current health care system. We need a more patient-focussed approach and clear leadership to address these boundary problems ensuring accountability and transparency in decision making with better information on spend, quality, outcomes and patient experience.

¹¹⁰⁸ Chief Medical Officer’s Annual Report 2012. *Our Children Deserve Better*.

¹¹⁰⁹ 2014 Commonwealth Fund report on 11 wealthy countries

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

9. The UK spends less of its GDP on healthcare than most other developed countries and so it is entirely sensible to conclude that there is scope to increase overall spending. To provide this additional initial investment, there needs to be a wide and honest debate on how the NHS is funded, including the public's view on increased taxation (which have been positive on each occasion when consulted previously).
10. A hypothecated tax would have the disadvantage of removing the ability of ministers to deploy public funds flexibly in response to the national need.

d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

11. Under Article 24 of the UNCRC, governments must ensure that no child is deprived of the right of access to health services. ICYP should be not deprived of health care as a result of actions taken by their parents/carer. Health messages for families, regardless of social or economic background, must be clear and must be consistent, i.e. if you are concerned about the health of your child, you should take them to see a health care professional without delay and in doing so there should be no financial risk to you or your family.
12. The NHS must remain free at the point of care. Means testing while unsupported by evidence as an effective mechanism for controlling cost, would inevitably result in increased administrative expenditure. The UK has pioneered the allocation of resources on predefined objective assessments by the National Institute of Health and Care Excellence (NICE). This mechanism should be strengthened.

Workforce

Question 3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

13. We propose three mechanisms to increase supply:
 - i) the Medical Training Initiative scheme and other options to increase the supply of doctors from overseas is currently limited to 40-60 paediatricians per year; this could be increased and the process made more efficient. RCPCH does not wish to contribute to a "brain drain" on health systems overseas, but does believe that short-term opportunities to receive experience in the UK would be mutually beneficial;

- ii) strengthening the career pathway for staff and associate specialists (doctors who do not wish to choose a consultant career pathway);
- iii) raising the number of medical places and raising the numbers of Foundation Doctors who go on to specialty training (this fell from 71.3% in 2011 to 52% in 2015¹¹¹⁰).

14. The RCPCH agrees with the issues raised by the National Audit Office in 2016¹¹¹¹. There are a lack of both good data and an effective model of supply and demand.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

15. 5.6% of paediatric consultants in the UK in 2013 were graduates from the European Economic Area (EEA); and 5.1% of paediatric trainees are EEA graduates compared to 3.6% of trainees across all medical specialties¹¹¹². However, 18.7% of paediatric trainees are international graduates compared to 11.7% of all trainees; hence any restrictions on immigration from outside the EU would have a larger impact on paediatrics.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

16. Current workforce shortages increase the demands placed on existing staff both in terms of service delivery, and in ability to provide a good training environment. The RCPCH annual *'Rota Vacancies and Compliance Survey'* of neonatal and paediatric units, found that there is now a 10% tier 1, and 20% tier 2 rota vacancy rate and averaged across both tiers there has been an increase in the rate from 12% in 2015 to 15% in 2016. In order to meet current service standards, the RCPCH estimate that an additional 1000 WTE consultants are needed and to meet government demands for 24/7 services the figure will be higher still.

17. The RCPCH cohort study of trainees who began training in 2007 has shown an attrition rate of between 3.6% and 5% per annum¹¹¹³. Approximately half of leavers go into other medical training especially general practice and those who leave tend to cite work-life balance and concern about working resident shifts on a long term basis. Attrition must be anticipated when modelling requirements.

18. Around half of paediatric consultants and over 75% of those recruited to training in recent years are women. As these proportions have grown, so inevitably has time out of programme due to parental leave for both men and women. These trends do not appear to have been taken fully into account by workforce planning bodies nationally, and by local commissioners and providers when determining training numbers.

¹¹¹⁰ The UK Foundation programme. *F2 Career Destination Report*. 2015

¹¹¹¹ <https://www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/>

¹¹¹² GMC State of Training 2015 <http://www.gmc-uk.org/publications/somep2015.asp>

¹¹¹³ www.rcpch.ac.uk/mmc

19. Since the imposition of the junior doctor contract in England, we have evidence from RCPCH recruitment data that morale is at an all-time low. In a reversal of previous years' figures, junior doctors are moving out of England; 100% of posts at junior trainee level were filled in Wales, Scotland and Northern Ireland compared to 93% in England.

Question 4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

20. Technology may be better used to enable ICYP to self-manage their own health and to provide quick access to advice, rather than having to wait for a face-to-face appointment. Specialist centres may be some distance from general hospitals, but communications technology offer opportunities to facilitate outreach clinics and remote diagnosis. Local commissioners/planners should be encouraged to explore telemedicine with providers as has been successfully piloted in the North of Scotland through their Paediatric Unscheduled Care pilot¹¹¹⁴.

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

21. More integration between paediatric, primary care and mental health training, in particular, opportunity for doctors entering general practice to receive paediatric training and flexibility in training to take into account changes in career intentions is needed.
22. The 2015 RCPCH survey into paediatricians' involvement in research found that many carry out research in their own time; 81.6% did not have Programmed Activities for research in their job plans. It is important that capacity is made available for research.
23. Children and young people have reported feeling that conversations are focused on the adult with them, language is inaccessible and positive, empowering behaviour is not consistent across all healthcare professionals¹¹¹⁵. Training should be mandatory and regularly refreshed for all healthcare professionals on how to communicate with ICYP to enable them to be heard and listened to in individual care discussions and strategic decision making.

c. What investment model would most speedily enhance and stabilise the workforce?

¹¹¹⁴ <http://www.sctt.scot.nhs.uk/programmes/health/paediatrics/puc-service/>

¹¹¹⁵ & Us Roadshow Review, RCPCH, 2016

24. Further detail on our model for training in paediatrics is set out in the RCPCH response to the Shape of Training review¹¹¹⁶.

Models of service delivery and integration

Question 5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

a. How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

25. Compared to adults, ICYP have a greater reliance on the family and education sector and less reliance on social care¹¹¹⁷. Therefore, integrated health services for ICYP must connect to education and youth justice systems as well as to social care. Parents and children are frustrated by fragmentation and poor coordination between services and this leads to duplication and omission where families are forced into repeating the same information to different practitioners. Children and young people have told us that healthcare professionals should ‘know about all the issues relevant in a young person’s life like school work/university, physical and mental health, friends and family’ and ‘don’t just treat what hurts, treat me’(RCPCH & Us[®] Voice Bank 2016). For integration to work there needs to be good communication, shared records and, if professionals need to meet, recognition of the additional time needed both for travel and the meeting itself.

b. How can local organisations be incentivised to work together?

26. From the perspective of families, they often mind much less about which agency professionals come from i.e. health, education or social care or who funds what. What matters most is that they receive coordinated care based on the assessed needs of the individual and their family, that meet those needs and is acceptable to the individual and their family. It should be standard practice that ICYP and their families should be fully included in all decision-making discussions, recognising that resources are not unlimited.
27. Existing payment mechanisms do not encourage proactive new ways of working, for example, between primary and secondary care, and in some situations have led to perverse incentives to see or keep ICYP in hospital. Contracting is not currently done for pathways of care and as a consequence many ICYP are falling between contracting gaps, for example, there is now very poor provision of effective continence care for the one in ten ICYP with bladder and bowel problems. We question the cost-effectiveness of the internal market in healthcare.

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

¹¹¹⁶ <http://www.rcpch.ac.uk/system/files/protected/news/2016-02-26-RCPCH-position-paper-in-response-to-SoT-v1.0-final.pdf>.

¹¹¹⁷ Wolfe et al. Integrated care: a solution for improving children's health? *Archives of Disease of Childhood* 2016

28. Attendances and admissions to hospital continue to increase¹¹¹⁸ and estimates of the proportion of emergency department attendances which are unnecessary and potentially avoidable vary from 15 percent¹¹¹⁹ to 40 percent¹¹²⁰. Within these estimates the largest subgroup is ICYP presenting with symptoms of minor illness^{1121 1122}. Unnecessary attendances are distressing and disruptive to ICYP and also a wasteful high-cost intervention in a resource-limited health service, putting additional pressure on the hospital. Parents' preference for initial advice is their GP¹¹²³ and primary care services must be better equipped to identify ICYP with early signs of serious illness, enabling them to be appropriately managed at first point of contact.
29. The RCPCH is clear that closer working between primary and secondary care services is required to ensure that ICYP are getting the right care, in the right place and at the right time. Providing high quality paediatric care in a community setting will also reduce pressure on acute services. We need to help ICYP and their families navigate the options available to them, including self-care at home, with better signposting and safety netting.
30. The RCPCH's *Facing the Future: Standards for Acute General Paediatric Services*¹¹²⁴ and *Facing the Future: Together for Child Health*¹¹²⁵ make the case for whole system change in acute care paediatrics to meet the needs of ICYP. The model recommends fewer, larger inpatient units which provide consultant delivered care and are therefore better equipped to provide safe and sustainable care. These units need to be connected by managed clinical networks of services across defined geographical areas. More care should also be delivered through community children's nursing teams who can support early discharges so that more children are managed at home and with better paediatric provision in primary care.
31. Services also need to better support ICYP (up to age 25) with long-term conditions to be as independent and healthy as possible, preventing complications and the need to go into hospital. Health plans are important tools for managing a range of long term conditions^{1126 1127} and the RCPCH is calling for, just as is being proposed for the frail elderly, all ICYP with long-term conditions to have a named health professional who

¹¹¹⁸ Gill et al. Increase in emergency admissions to hospital for children aged under 15 in England, 1999–2010: national database analysis. *Archives of Disease in Childhood* 2013; 98: 328–334

¹¹¹⁹ Mann and Tempest. Beyond the official data: a different picture of attendances. *Health Services Journal* 22 May 2014

¹¹²⁰ NHS England. *Transforming urgent and emergency care services in England: Urgent and Emergency Care Review End of Phase 1 Report*. 2013

¹¹²¹ Mann and Tempest. Beyond the official data: a different picture of attendances. *Health Services Journal*. 22 May 2014

¹¹²² McHale et al. Who uses emergency departments inappropriately and when - a national cross-sectional study using a monitoring data system. *BMC Medicine* 2013; 11: 258

¹¹²³ RCPCH, Royal College of General Practitioners, College of Emergency Medicine, NHS Direct, Joint Royal Colleges Ambulance Liaison Committee, University of Leicester and University of Nottingham. *To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature)*. 2010

¹¹²⁴ RCPCH. *Facing the Future: Standards for Acute General Paediatric Services*. 2015

¹¹²⁵ RCPCH, RCN, RCGP. *Facing the Future: Together for Child Health*. 2015

¹¹²⁶ RCPCH. *Coordinating epilepsy care: a UK-wide review of healthcare in cases of mortality and prolonged seizures in children and young people with epilepsies*. 2013.

¹¹²⁷ Royal College of Physicians. *Why asthma still kills: the National Review of Asthma Deaths (NRAD)*. Confidential enquiry report. 2014.

coordinates their care. These ICYP are vulnerable, often have complex needs and are frequently being seen by a plethora of healthcare professionals. For example, 85% of children with epilepsy have developmental impairments, meaning they see a range of specialists, including paediatricians, health visitors, school nurses, geneticists and neurosurgeons. 'It would be great to have a key worker which helps with the coordination of different things. My child was under 17 different healthcare professionals and although this gradually decreased to seeing around 5 different consultants, it's good to stick to see only a few rather than so many. It's so overwhelming especially when the child is first diagnosed and we (the family) literally had no support at all' (RCPCH & Us[®] Voice Bank 2016).

32. Despite recognition of the high mental health needs of ICYP and investment in the NHS in this area, services remain under staffed with a lack of resources leading to long term mental health problems continuing into adulthood and repeated hospital attendances and admissions. RCPCH members have raised concerns that, despite the welcome additional funding to NHS services for child and adolescent mental health, ongoing reductions to local authority and voluntary sector mental health services could negate the benefits of additional NHS spending. Integrated commissioning is essential and services should be structured around a local offer for mental health, supported by a family centred approach to care planning and information sharing and recognising the key role for schools to foster an improvement in mental health and wellbeing.
33. Transition from paediatric to adult services is a particularly difficult time with inconsistencies in age of transfer, decisions made about transfer of clinical or care responsibility not related to need or in some cases no adult service available to transfer to. We want to highlight transition as a key area where there is a particular need for improved services.

Prevention and public engagement

Question 6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

34. Prevention and early intervention, particularly in childhood, offer substantial value for money in reducing health burdens later in life. For example, parenting programmes to prevent conduct disorders pay back £8 over six years for every £1 invested with savings to the NHS, education and criminal justice systems¹¹²⁸. Despite public statements from senior officials recognising that there must be a shift from intervention to prevention, this is not been accompanied by resources. The UK spends about £6 billion a year on the medical costs of conditions related to being overweight or obese and a further £10 billion on diabetes and yet the UK spends less than £638m a year on obesity prevention programmes¹¹²⁹. Similarly treating mothers and their babies with problems caused by

¹¹²⁸ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf

¹¹²⁹ McKinsey Global Institute (2014) *Overcoming obesity: An initial economic analysis* McKinsey and Company

smoking during pregnancy is estimated to cost the NHS between £20 million and £87.5 million each year¹¹³⁰. Effective identification of, and early, targeted intervention for, parents at risk for abusing their children, through increasing parenting capacity, enhancing individual and community resilience, and provision of material support for the family will have a huge long-term gain for ICYP and for the nation's social and economic well-being.

b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

35. ICYP are usually dependent on care givers (primarily their parents). This dependence makes child protection an important and distinctive part of children's healthcare. Children's health and wellbeing relies on multiple actors and agencies, including the Government, education, social services and local government.

36. Investment should be made in both universal and targeted services as recommended by the Healthy Child Programme, which should be commissioned in full. There is a need to reinforce the importance of intervening early in life on determinants of child health. This includes: healthy behaviour and lifestyle of the child and the parents (for example nutrition, smoking); the families' ability to care for the child; education; the broader socio-economic conditions (i.e. social protection, poverty and inequity); and the environment. Child health (both physical and mental) is largely influenced by these broader determinants rather than the health care system, so there is a need to work with a range of professionals across the different sectors and organisations with a focus on children's health and wellbeing.

c. Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

37. We have previously stated our concerns about the cuts to the public health budget in England. We believe that public health functions related to NHS service delivery are experiencing increased vulnerability following the Health and Social Care reforms; resulting in fragmentation of service delivery between NHS and local authorities. For example, feedback from our members suggests that health visitors now have less contact with GPs, reducing capacity for ICYP to receive coordinated care, and in some circumstances, being alerted to safeguarding concerns, and resulting in many referrals to secondary care for minor behavioural concerns.

d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

¹¹³⁰ ASH report

38. While we welcome the Government's levy to help ICYP (and adults) cut down on their sugar from sugar-sweetened beverages, we are very disappointed at the long-awaited Government's Child Obesity Plan which provides no bold action, and instead relies on physical activity, personal responsibility, and voluntary product reformulation. The RCPCH has long called for a combination of measures that include restrictions on fast food outlets near schools and banning advertising of junk foods. If we do not tackle childhood obesity now, the NHS will face an ever increasing crisis.

e. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

f. What are the barriers to taking on received knowledge about healthy places to live and work?

39. Within the NHS, there needs to be more of an emphasis on making every contact count. There are over 2.5 million outpatient and 2.2 million inpatient visits by ICYP in the NHS every year. Each of these is an opportunity for assessment, basic lifestyle advice and referral if needed. *Royal Colleges, Faculties and other professional clinical bodies should promote targeted education and training programmes for healthcare professionals so that 'making every contact count' becomes a reality, particularly for those who have most influence on patient behaviour. This must include a focus on communication with ICYP and families.*

Question 7. What are the best ways to engage the public in talking about what they want from a health service?

40. Public consultation must include children, young people and families, and vulnerable groups, seldom seen and heard groups, and children and young people with complex needs and disabilities. RCPCH has an experienced patient network to support such dialogue; ' & Us' is the RCPCH platform for children, young people, parents, carers and families.

Digitisation of services, Big Data and informatics

Question 8. How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

41. Technology may be better used to enable ICYP to self-manage their own health and to provide quick access to advice, rather than having to wait for a face-to-face appointment. Specialist centres may be some distance from general hospitals, but communications technology offers opportunities to facilitate outreach clinics and remote diagnosis. Barriers include a rigid tariff system. Local commissioners/planners should be encouraged to explore telemedicine with providers as has been successfully piloted in the North of Scotland through their Paediatric Unscheduled Care pilot¹¹³¹.

¹¹³¹ <http://www.sctt.scot.nhs.uk/programmes/health/paediatrics/puc-service/>

These technologies offer potential but require investment and rigorous evaluation that hitherto has been lacking in UK healthcare.

b. What is the role of 'Big Data' in reducing costs and managing demand?

42. Potentially enormous, but this has suffered major set-back through poor oversight, poor procurement, and inadequacy of public consultation (e.g. care.data). Existing datasets are not being fully utilised, for example, the National Neonatal Research Database that contains detailed information on every infant admitted to a NHS neonatal unit.

c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

43. The continuing emphasis on establishing new databases that impose substantial data entry burdens on healthcare staff instead of investing in the development of repositories of healthcare information using extracts from Electronic Patient Records is a major barrier.
44. There is a failure to invest in strengthening healthcare data quality and completeness. Issues around clinical governance and data sharing at the individual and population level also need to be addressed. The RCPCH neonatal audit has proved that this is possible with clear communication and engagement and has achieved 100% participation.

d. How can healthcare providers be incentivised to take up new technologies?

45. By getting the basics right first; investment and addressing workforce issues.

e. Where is investment in technology and informatics most needed?

46. Investment is needed in improving data quality and completeness, and in evaluating health services and patient outcomes rigorously. Currently far too many healthcare evaluations are methodologically poor and lack rigour. Devolving analyses to local providers is ineffective and wasteful; differences in methodological approaches result in inability to compare results from different providers; small numbers result in insufficient statistical power to detect unusual variation or performance (i.e. to distinguish significant from chance variation).
47. The majority of evaluation, research, audit and quality improvement in the NHS relies on data from coders who extract information from unstructured notes and code using ICD10 for diagnosis and OPCS for procedures. These data are widely acknowledged to be insufficiently detailed or quality assured. The RCPCH strongly supports the adoption of SNOMED-CT to improve the ability to conduct high quality NHS audits, other health services evaluations, and research utilising clinician-entered data without imposing additional burden. To be successful this needs to be adopted across the healthcare system.

48. Investment is needed to develop standard datasets, map these to electronic terminologies such as SNOMED-CT, and support staff undertaking data entry. Clinical, social and educational data requires linkage and should be made rapidly available for all authorised purposes.
49. No matter where ICYP are being cared for, their health information should be available to those looking after them. Information should be recorded once and should flow between systems while keeping confidential information safe and secure using the ICYP unique patient identifier number (NHS number in England and Wales, Community Health Index number in Scotland or Health and Care number in Northern Ireland).

23 September 2016

The Royal College of Pathologists – Written evidence (NHS0061)

1 About the Royal College of Pathologists

1.1 The Royal College of Pathologists (RCPATH) is a professional membership organisation with charitable status. It is committed to setting and maintaining professional standards and to promoting excellence in the teaching and practice of pathology. Pathology is the science at the heart of modern medicine and is involved in 70 per cent of all diagnoses made within the National Health Service. The College aims to advance the science and practice of pathology, to provide public education, to promote research in pathology and to disseminate the results. We have over 10,000 members across 19 specialties working in hospital laboratories, universities and industry worldwide to diagnose, treat and prevent illness.

1.2 The Royal College of Pathologists comments on the House of Lords Select Committee on the long-term sustainability of the NHS - Call for Evidence . The following comments were made by Fellows of the College during the consultation which ran from 25th July until 9th September 2016 and collated by Dr Rachael Liebmann, Registrar.

2 Consultation responses

2.1 The future health care system

2.1.1 The NHS has changed considerably since its inception in 1948, and if anything the pace of change is increasing. There is a requirement to build flexibility into the NHS to meet those changes which are predictable, but more importantly those that are not.

2.1.2 Pathology is the study of disease and this scientific understanding underpins modern medicine. Pathology is fundamental to the diagnostic process and for monitoring ongoing disease. The modernisation of pathology services over the last 10 years has been a prelude to the current round of service transformation. As pathology diagnostic services cut across the traditional boundaries of primary, secondary and tertiary care, we therefore have unique experience of the challenges and possible solutions to achieving a sustainable NHS. Through understanding the mechanisms and manifestations of disease and ensuring the quality of investigations, pathology can contribute significantly to an NHS that could be the first healthcare system in the world to implement a cost-effective integrated approach to disease prevention, early detection, diagnosis and treatment that would benefit its population and its economy.

2.1.3 The implementation of whole genome sequencing soon after birth has the potential to replace the current limited metabolic heel-prick screen, and at the same time provide knowledge of genetic predisposition to disease and pharmacogenomic data to ensure optimal use of drugs and avoidance of side-effects. Such a programme would be likely to be cost-effective since as more data is gathered, machine learning could allow greater predictive capacity.

2.1.4 Genetic screening is insufficient to guide healthcare provision for individuals in isolation, as disease is usually the result of a combination of predisposition and environmental factors, including lifestyle choices such as smoking. We therefore need to put in place a system of health checks based on evidence of benefit. It is already commonplace for GPs to check blood pressure, cholesterol level and weight. The ability to screen for early disease potentially allows early intervention, and often better outcomes for patients. The health economics of screening programmes are rigorously examined by the national screening committee, and it is important that this work continues to avoid inappropriate testing and expense.

2.1.5 The importance of monitoring the health of those with chronic disorders is well known. The use of point of care devices providing diagnostic information to the patient and their doctors is increasingly important.

2.1.6 The need for hospital admission will always be appropriate for acute disease, trauma and more invasive investigation of illness. Technological advances in laboratory investigations and in imaging methods provide more accurate diagnosis and treatment planning. These advances will continue with a risk of increasing costs. Drug costs are likely to continue to increase, and the importance of companion diagnostics to limit the use of such drugs to those who can most benefit from them is an important area for investment.

2.1.7 The different ways in which primary care, secondary care and nationally commissioned services are incentivised within the NHS and the market-driven fragmentation within the English NHS has led to financial compartmentalisation rather than clinical pathways and the needs of the service. This leads to the preservation of financial vested interests and confusion between clinical effectiveness and cost improvement. Streamlining and clarifying the financial relationships between sectors of the services might begin to release the investment necessary to improve the success rate of laboratory consolidation. Such investment should be in improved local connectivity, and nationally via the National Laboratory Medicine Catalogue to help deliver the 2020 vision. Scottish Fellows pointed out that in Scotland there is close working between the professions, Colleges and Scottish Government. As a result the realistic medicine programme focuses on driving priorities while offloading waste or excess.

2.1.8 College Fellows expressed the opinion that a health service free at the point of delivery was crucial and most respondents considered the NHS to be entirely sustainable provided the population have a clear idea what the NHS is for. At the moment, it is a massive organisation which treats everything from cheap and relatively trivial complaints through to hugely expensive cancer drugs which provide a couple of extra weeks of life. This is not sustainable because the NHS can always find bigger and better ways to spend money. If there is a political will to ensure that we can afford the NHS, the cash limits must be clear. And most importantly it must be politicians who set the cash limits. Handing the responsibility for rationing healthcare to the National Institute of Health and Care Excellence (NICE) was considered to represent a failure of political leadership. So the view of the profession is that politicians should stop inferring that with ever increasing efficiencies the public purse will supply all the healthcare that anyone could possibly want. It is time for explicit admissions from the elected government that rationing in some form has always

existed and will have to get tighter as an inevitable consequence of scientific developments, healthcare economics and population demographics. The view was expressed that it should be for politicians to decide what the nation can afford and to say how much will be spent. Then if the population disagrees the cost of increasing standards will have to be part of a manifesto or a referendum. It was considered that the current system allows politicians to abdicate their responsibility for healthcare rationing.

2.1.9 Finally, the expectations of patients, carers, families and primary and secondary care need to be managed so that decisions on the most appropriate type and place of treatment can be made rationally. The decision about whether to refer someone to hospital or indeed to undertake a diagnostic test should be predicated on the benefit expected. The Choosing Wisely programme aims to ensure that patients are appropriately informed about the benefits and positive and negative consequences of investigations and interventions.

2.2 Resource issues, including funding, productivity, demand management, and resource use

2.2.1 The current tax-based system has the advantage that there are no extra costs associated with collection of fees. It is arguable that charging for prescriptions costs more than it saves, and it is likely that any similar such initiatives will detract rather than add to the total funding available. The College does not believe that charging for diagnostic services would be in the best interests of the NHS or patients. As a profession we have serious concerns around the commercialisation of pathology diagnostic services, as this can have an adverse impact on the availability of interpretive advice, training the future workforce, standards and quality and the long term sustainability of services and research.

2.2.2 The Royal College of Pathologists has considerable experience of the difficulties of demand management, as the number of diagnostic tests requested has increased continuously over the last 30 years, and the pace of increase shows no signs of reducing. This may reflect the added value of diagnostics to the scientific practice of medicine. However, there is no point in doing a diagnostic test unless it is going to alter a patient's management. One can perhaps take this further and suggest that there is no advantage in admitting a patient to hospital for tests unless they are fit to receive treatment.

2.2.3 We have found that electronic requesting of tests and acknowledgement of reports ensures that tests are not requested unless they are truly needed by the requesting physician. We welcome the optimisation of diagnostic pathways implied by the 28 day cancer diagnostics project. Pathology needs to impact on patient pathways in ways that deliver the greatest benefit.

2.2.4 The main concern Fellows have is that any proposed changes in healthcare provision must maintain the protection patients have to be free from the twin abuses of over investigation and over treatment. Perhaps the most important principle of the NHS is that all our patients can rely on receiving the most efficient assessment, investigation and management of their illness; not because UK health care is free at the point of access but because the clinicians do not have any direct pecuniary interest in the investigation and

management of individual patients. This is what makes the NHS so efficient and such good value for money.

2.3 Workforce

2.3.1 As the need for pathology diagnostic services increases, there is a corresponding need to train the workforce to operate laboratory equipment, interpret the results, and report them appropriately in an environment that promotes quality. The College has responsibility for the training and examination of both medical and scientific staff engaged in pathology across 19 specialties, the majority of which are essential to the safe operation of the NHS. In our view it is essential that pathology is included in the training of doctors, nurses and other allied health professionals across the NHS. The understanding of disease diagnosis and monitoring underpins the safe practice of health care at every level, and this is the business of pathologists. Through laboratory accreditation we have many years experience of quality management and continuous quality improvement. Unreliable investigations and advice are ultimately more costly to the service.

2.3.2 The College views the impact of Brexit with concern, as the UK is fortunate to attract many scientists and doctors from Europe into pathology. As a College we also participate in a large number of European initiatives, and have published joint guidance with Europe in a number of areas, including molecular pathology. The College Fellows have grave concerns about research funding as much pathology research is collaborative across Europe.

2.3.3 The reduction in medical academic staff, and particularly academic pathologists, is a major concern as it limits the number of pathologists who can be trained for future requirements. Pathology is an integral part of almost all health research so is at the forefront of innovation. Most clinical trials will involve the assessment of tissues (for cancer) or blood samples; the quality of the clinical trial and the interpretation of the outcome is critically dependent on accurate pathology diagnostics.

2.3.4 We should not rely on other countries to train pathologists for us, just as we would find it unacceptable to train large numbers of pathologists who then benefited other countries.

2.3.5 Retention of pathologists is an issue, and is likely to become a greater problem in the next 20 years as many of those currently in post are due to retire during this time. Working conditions, reimbursement, and demand management of workload are all important factors which can be used to mitigate the problem. Recent pension changes and the reduction and potential future loss of Clinical Excellence Awards are resulting in many doctors retiring earlier than they had originally intended, resulting in loss of the most experienced part of the workforce.

2.3.6 Workforce re-profiling allows for increasing diversification of service delivery by scientific and medical staff with the most appropriate skill mix and supports evolving services. The NHS needs to support staff – its most valuable resource – and help them to develop their potential.

2.3.7 In molecular pathology and genetics, we are encouraging a range of training options for new pathologists and those already in post. This range of opportunities includes postgraduate and undergraduate courses, conferences, internet modules, and the concept of just-in-time learning allowing need to dictate the acquisition of knowledge. Just-in-time learning is important as it is an expensive option to train people in skills and knowledge that they do not then use.

2.4. Models of service delivery and integration

2.4.1 The current disconnection between primary and secondary care in England is counter-productive and integrated models, supported by pathology services should be able to help. This includes increased point of care monitoring of chronic disease, using diagnostic devices linked to central laboratories. Hospital-based blood sciences laboratories already provide a large proportion of their work within the community through GP phlebotomy services. Pathology already crosses these boundaries and is able to facilitate the wide debate around service transformation.

2.4.2 There seems to be an increasing reliance on emergency departments to provide care which could be provided within the community. This includes access to diagnostic tests, such as simple blood tests, which are rarely available out of hours and not accessible to patients who are housebound. Community phlebotomy services are urgently needed, and reliance on district nurses who may not be experts in obtaining blood, or indeed trained to do so, is not ideal. In some areas, community phlebotomy is available, and we believe that this is making a difference. Increasingly there is a plethora of medical ‘apps’ allowing mobile diagnostic assistance. Self-testing will enhance these technological tools.

2.5. Prevention and public engagement

2.5.1 Prevention is usually better than cure for people and the country, but may be more expensive in the short term, requiring up-front investment for long term benefit. This includes screening for disease, but there is now an opportunity to intervene early using coordinated diagnostic technologies based on risk and lifestyle. It may also be possible to complete the circle, by using the results of diagnostic technologies to influence behaviour.

2.5.2 We need better public engagement. Not lecturing but informing and engaging patients. Patients having access to their own medical records, including pathology diagnostic test results, may increase their engagement but will vastly increase the need for information and people to interpret and explain results. Pathologists are ideally placed to do this but it will require a significant increase in workforce.

2.6 Digitisation of services, Big data, and Informatics

2.6.1 Pathologists have continuously embraced new technologies to improve their practice over many decades, if not centuries. The combination of changes in the molecular understanding of disease and advances in digital technology, including artificial intelligence, and improvements and diagnostic devices could be integrated to provide monitoring of

health for the population. This would allow early intervention during the pathogenesis of disease which is likely to be both cost-effective and result in better patient outcomes.

22 September 2016

The Royal College of Physicians – Written evidence (NHS0065)

1. Introduction

The Royal College of Physicians welcomes this opportunity to respond to the Lords Select Committee inquiry on the long-term sustainability of the NHS. This response is based on the experiences of our members and fellows (primarily hospital-based doctors).

2. About the RCP

The RCP plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing almost 33,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high quality care for patients.

3. Summary

In order to ensure the long-term sustainability of the NHS, the Royal College of Physicians (RCP) has long argued that we need to rethink the way we deliver healthcare: breaking down barriers between hospitals and the community, and working in partnership with patients to deliver joined-up care. To achieve this, we need a national health service that is funded to meet the needs of our ageing population. Yet the NHS in 2016 is underfunded, underdoctored and overstretched.

4. The long-term sustainability of the NHS is not predicated purely on finances. Government must strike the right balance between oversight of financial discipline and consequences for poor performance with equally vociferous protection for safe, high quality patient care. Meeting staffing requirements is one such fundamental. We are aware that many trusts are failing to fulfil existing medical staffing establishments – highlighted by the RCP’s data on [unfilled consultant vacancies and frequent gaps in rotas](#) for trainee doctors – and that consultants are already struggling to find workarounds and ways to fill the gaps to protect patients. If this crisis is not resolved, patient care will be compromised.

- The NHS will struggle to meet the requirement, set out in the Five Year Forward View, to save £22bn by 2020
- Moving to innovative new ways of delivering care across traditional boundaries – such as the RCP’s Future Hospital model is essential. However, redesigning services does not always lead to cost savings in the long-term
- The delivery of high quality patient care is vital to the long term sustainability of the NHS
- The UK does not train enough doctors to meet demand
- The use of other groups of healthcare professionals should be considered to fill the gap

- The expansion of the medical workforce will necessitate increases in medical school numbers, foundation training places, core medical training places and speciality medical training numbers now.
- Ensuring adequate funding, staffing levels and resources are key to making services more integrated, responsive and patient-centred
- Preventing ill health and improving health are amongst the most effective and cost effective ways to ensure our health service is fit for future generations.
- Cuts to spending on public health will have serious and lasting implications for both the health of communities across England and the long term sustainability of the NHS.
- Providers should use an agreed standardised structure and content for electronic records

Evidence

Resource issues, including funding, productivity, demand management and resource use

5. Numerous analyses of the current funding envelope for the NHS have come to the conclusion that the health service will struggle to meet the requirement, set out by the Five Year Forward View, to save £22 billion by 2020¹¹³². Recent analysis by the Nuffield Trust concludes that even if hospitals and other NHS providers made cost savings of 2 per cent a year, the funding gap would still stand at around £6 billion by 2020–21¹¹³³. The Five Year Forward View proposes that much of this funding gap will need to be closed through efficiency savings by providers. However, there is scepticism that trusts can eliminate deficits through effective planning, good management and ‘belt tightening’, and increasing consensus that **the long-term sustainability of the NHS is predicated on fundamental change in the structure and delivery of health and social care services**. With eight in ten trusts operating in deficit, the current financial crisis clearly goes beyond individual organisations’ financial discipline.
6. The approach must go beyond enforcing financial discipline on individual organisations through cost savings, to encompass holistic redesign of health and social care delivery in local health economies. **Moving to innovative new ways of delivering care across traditional boundaries – such as the RCP’s Future Hospital (FH) model is essential**¹¹³⁴. The Future Hospital Programme (FHP), developed from the [Future Hospital Commission](#), aims to implement the vision of improving care for patients by bringing medical specialist care closer to the patient wherever they are, in hospital or in the community.
7. Transformation requires upfront investment, and relies on healthcare teams having the capacity to explore, implement, lead and share new ways of designing and delivering services. However, it is important to note that redesigning services does not always lead to cost savings in the long term. It therefore continues to be a concern that the allocations

¹¹³² NHS Five Year Forward View. <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [accessed August 2016]

¹¹³³ Gainsbury S (2016) Feeling the crunch: NHS finances to 2020. Nuffield Trust

¹¹³⁴ [Future Hospital Programme](#). [accessed August 2016]

from the Sustainability and Transformation Fund to support innovative new models of care are far outweighed by the sums assigned to reduce the deficit.

8. In a recent survey of members and fellows, 85% of physicians believe that current health service funding is not sufficient to meet demand¹¹³⁵. Respondents identified several areas where efficiency savings have had an impact:
 - Reduction in staff: patient ratios (83%)
 - Reduction in the amount of time that physicians are able to spend with patients (71%)
 - Increase in waiting times (67%)
9. There are also concerns for the future: 82% of respondents believe that it will not be possible for their hospital to make further efficiency savings in 2015-2020 without this having a negative impact on patient care.
10. Many NHS trusts are struggling to deliver safe, effective patient care that meet quality standards and national targets, while simultaneously undertaking the required service transformation. Open and public debate about the limits of what the NHS can provide within the allotted cost envelope has also lagged behind what is needed.
11. It is also important to note that health spending in England has a direct impact on the devolved nations through the Barnett formula, which means that increased spend on the NHS in England has a direct effect on the sustainability of services in the devolved nations.
12. The financial challenge facing the NHS is having a real impact on the delivery of patient care. Although demand for services increases by 4% every year¹¹³⁶, NHS funding will increase in real terms by only 0.2% per year to 2020¹¹³⁷. Cuts to the budgets of social care and public health services and recorded hospital deficits of £2.45 billion¹¹³⁸ are already impacting on patient care: growing waiting lists, patients stuck in hospital because of discharge delays, emergency departments closing their doors, and the threat of 'rationing' treatment.
13. These conditions put patient safety and recovery at risk. A truly 7-day health and care system will only be possible when we address the underlying and immediate threats to patient safety caused by insufficient investment in NHS finance and staffing.

Funding for social care

¹¹³⁵ Royal College of Physicians (2015) *The NHS: the doctors' view*.

¹¹³⁶ NHS Confederation. *Key facts and trends in acute care*. London: NHS Confederation, 2015. www.nhsconfed.org/resources/2015/11/key-facts-and-trends-in-acute-care [Accessed 7 September 2016].

¹¹³⁷ Appleby J. New NHS inflation figures underline funding pressures facing the NHS. London: BMJ, 2016. <http://blogs.bmj.com/bmj/2016/05/20/new-nhs-inflation-figures-underline-funding-pressure-facing-the-nhs/> [Accessed 7 September 2016].

¹¹³⁸ National Audit Office. Reports on Department of Health, NHS England and NHS Foundation Trusts' consolidated accounts 2015–16. London: National Audit Office, 2016. www.nao.org.uk/report/reports-on-department-of-health-nhs-england-and-nhs-foundation-trusts-consolidated-accounts-2015-16/ [Accessed 7 September 2016].

14. Investing in social care is vital to the long term sustainability of the NHS. Across the country, patients fit for discharge are waiting to leave hospital, in many cases because social care support is unavailable. The proportion of delayed discharges attributable to social care has risen recently (from 26 per cent at the end of 2014/15 to 31 per cent in the third quarter of 2015/16)¹¹³⁹. This reflects pressures faced by local councils, which have seen significant cuts to their budgets in recent years. Spending on social care began to fall in real terms from 2009, though it has fallen much more steeply since 2010¹¹⁴⁰. The Local Government Association estimates that social care faces a funding gap of £4.3 billion by 2020¹¹⁴¹. **The RCP believes that it is unrealistic for the NHS and social care system to absorb these pressures.** The RCP has repeatedly called for both social care and the NHS to receive sufficient funding to ensure that care is focused around the needs of patients¹¹⁴².

Workforce

15. The RCP's members and fellows are working in an, **under-funded, under-doctored and overstretched health service**, with rising demands of treating older comorbid patients and limited financial and workforce resources. Research conducted by the RCP between 2014-2015 shows that 40% of advertised consultant vacancies remain unfilled; the most common reason is due to a lack of suitable candidates¹¹⁴³. This proportion of unfilled vacancies increased in 2015 to 43%. **This is significantly impacting on the ability of doctors to deliver high quality care for patients.** 28% of consultants have reported 'significant gaps in the trainees rotas such that patient care is compromised'. More consultants are now covering gaps in trainee rotas: 13% regularly do so, and almost a third of consultants cover gaps in trainee rotas as a one-off. Together with a shortage of nurses, this has left our hospitals chronically understaffed¹¹⁴⁴. This increases pressure on NHS staff, impeding morale and putting patient care at risk.
16. The RCP's report *Underfunded, Underdoctored, Overstretched* outlines a range of options for increasing the supply of doctors to fill this gap and ensure the workforce is sufficiently and appropriately trained to meet the changing needs of patients¹¹⁴⁵.

Increasing the supply of doctors

17. **The reason there are such a high number of unfilled consultant posts is because the UK does not train enough doctors.** There are fewer medical students now than in 2010¹¹⁴⁶, despite an increasing number of patients. The number of qualified doctors training to be

¹¹³⁹ [What's going on in A&E? The key questions answered](#). The King's Fund [accessed July 2016]

¹¹⁴⁰ [How serious are the pressures in social care?](#) The King's Fund [accessed July 2016]

¹¹⁴¹ [Adult social care funding: 2014 state of the nation report](#). Local Government Association. 2014

¹¹⁴² [Doctors urge chancellor to increase social care funding](#). BBC News [accessed July 2016]

¹¹⁴³ [Federation](#) of the Royal College of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK 2014-15*. London: Royal College of Physicians, 2016

¹¹⁴⁴ Institute for Employment Studies. *One in three nurses to reach retirement age within ten years*. Brighton: IES, 2016. www.employment-studies.co.uk/news/one-three-nurses-reach-retirement-

¹¹⁴⁵ Royal College of Physicians of London. 2016. *Underfunded, Underdoctored, Overstretched. The NHS in 2016*.

¹¹⁴⁶ UCAS. *End of cycle 2015 data resources: DR3_015_01 acceptances by detailed subject group*. Cheltenham: UCAS, 2016. www.ucas.com/sites/default/files/eoc_data_resource_2015-dr3_015_01.pdf [Accessed 8 September 2016].

medical specialists has also fallen¹¹⁴⁷ and in recent years there have been difficulties in filling significant numbers of specialty training posts¹¹⁴⁸. This in part due to the relatively high number of doctors in core medical training (CMT) who choose not to progress to specialty training and become medical registrars. Another major factor is a mismatch between the number of doctors at CMT level and the number of specialty training posts: current CMT numbers would fill only around three-quarters of medical registrar posts. This leaves the NHS reliant on importing doctors from other countries and doctors returning from time out of training. The shortage of medical registrars increases the pressure on existing doctors-in-training and discourages core medical trainees from moving into these roles, and compromises patient care¹¹⁴⁹.

18. It also has a knock-on effect on more senior roles: **hospitals are unable to recruit two out of five consultant physician posts that they advertise, owing to a lack of suitable candidates**. This failure to appoint is even higher for in-demand roles focused on caring for the acutely ill and older people¹¹⁵⁰. Despite the continuing increase in demand for experts in geriatric medicine, the number of training places for this specialty fell in 2015¹¹⁵¹.
19. Training a physician is a long and expensive process that takes an average of 10 years from graduation. The expansion of the medical workforce will take time to achieve and will necessitate increases in medical school numbers, foundation training places, core medical training places and speciality medical training numbers now.
20. Given we are not training enough doctors in the UK, **recruiting from overseas** is another option. As immigration rules have proven to be a major barrier to doctors working in the NHS, the government must consider relaxing Migration Advisory Committee (MAC) rules for doctors. The RCP's **Medical Training Initiative (MTI)** provides another avenue through which to recruit doctors from overseas¹¹⁵². The MTI is a mutually beneficial scheme that provides junior doctors from all over the world with the opportunity to work and train in the UK, while giving trusts a high quality, longer-term alternative to using locums to fill rota gaps.
21. The **use of other groups of healthcare professionals** is another option but will take time to achieve. The success of physician associates (non-medical allied health professionals specifically trained to support medical teams and deliver defined medical care) makes them a potential solution with many new training programmes starting up around the UK. Physician associates work alongside doctors, GPs and surgeons providing medical care as

¹¹⁴⁷ Federation of the Royal Colleges of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary*. London: RCP, 2016. www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees [Accessed 7 September 2016].

¹¹⁴⁸ Joint Royal Colleges of Physicians Training Board. *2015 Annual Specialty Report*. London: JRCPTB, 2016. www.jrcptb.org.uk/documents/2015-annual-specialty-report [Accessed 8 September 2016].

¹¹⁴⁹ Royal College of Physicians. *Under-funded, Under-doctored, Overstretched*. 2016

¹¹⁵⁰ Federation of the Royal Colleges of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary*. London: RCP, 2016. www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees [Accessed 7 September 2016].

¹¹⁵¹ Federation of the Royal Colleges of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary*. London: RCP, 2016. www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees [Accessed 7 September 2016].

¹¹⁵² <https://www.rcplondon.ac.uk/education-practice/advice/medical-training-initiative>

an integral part of the multidisciplinary team¹¹⁵³. Duties include taking patient histories, carrying out physical examinations, and developing and delivering treatment plans. The current output from physician associate programmes in the UK is 80 per year, which is set to increase to 700 in 2017–18. Despite this expansion, it seems unlikely that a sufficient workforce will be in place before 2025¹¹⁵⁴.

Issues with recruitment, retention and morale

22. Although physicians are in demand more than ever before, recruitment and retention in hospital medicine is challenging. **In 2014-15 the NHS was unable to fill 40% of the consultant physician posts it advertised and there are vacancies in trainee rotas¹¹⁵⁵.** Alongside this increase in demand, there is also a decreasing interest in pursuing hospital medicine as a career and poor satisfaction rates in General Internal Medicine (GIM) training. In addition, negotiations over the proposed junior doctor contract have left many doctors in training feeling beleaguered and demotivated. This dispute highlights the many financial and workforce challenges facing the NHS. A combination of falling morale, leading to falling productivity and difficulties in recruitment ultimately compromises patient care.
23. **Falling morale:** one-quarter of doctors in-training report that their working pattern leaves them feeling short of sleep on a daily or weekly basis. Yet, despite compelling evidence showing the benefits to patient safety¹¹⁵⁶, many doctors are actively discouraged from taking naps during night shifts¹¹⁵⁷. Three-quarters (74%) of doctors-in-training go through at least one shift per month with insufficient hydration, and over one-third (37%) do not drink enough water on seven shifts per month¹¹⁵⁸. Poor working conditions lead to doctors feeling undervalued and disengaged. Four out of five doctors-in-training report that their job often or sometimes causes them excessive stress¹¹⁵⁹, and half of consultants report working under excessive pressure¹¹⁶⁰.
24. **Falling productivity:** Given the fall in levels of morale it is not surprising that sickness rates among physicians has increased. The NHS lost 15.7 million days to sickness absence in 2015¹¹⁶¹. Two out of every five doctors have considered taking leave owing to work pressures, while one third (36%) have seriously considered reducing their hours. Seeing

¹¹⁵³ [Who are physician associates?](#) Faculty of Physicians Associates

¹¹⁵⁴ Goddard, A. 2016. Ensuring a general medicine workforce for the future. *Future Hospital Journal* 2016 Vol 3, No 1: 40–4

¹¹⁵⁵ Federation of the Royal College of Physicians of the UK. Census of consultant physicians and higher specialty trainees in the UK 2014–15. London: Royal College of Physicians, 2016

¹¹⁵⁶ Horrocks N, Pounder R. Working the night shift: preparation, survival and recovery – a guide for junior doctors. London: RCP, 2006. <http://shop.rcplondon.ac.uk/products/working-the-night-shift-preparation-survival-and-recovery> [Accessed 8 September 2016].

¹¹⁵⁷ Lintern S. Exclusive: patients at risk as doctors forced to work without rest at night. London: HSJ, 2016. www.hsj.co.uk/topics/workforce/exclusive-patients-at-risk-as-doctors-forced-to-work-without-rest-at-night/7006252.article [Accessed 8 September 2016].

¹¹⁵⁸ Royal College of Physicians. Survey of medical trainees 2016 (unpublished data).

¹¹⁵⁹ Royal College of Physicians. Survey of medical trainees 2016 (unpublished data).

¹¹⁶⁰ Federation of the Royal Colleges of Physicians of the UK. Census of consultant physicians and higher specialty trainees in the UK, 2014–15: data and commentary. London: RCP, 2016. www.rcplondon.ac.uk/projects/outputs/2014-15-census-uk-consultants-and-higher-specialty-trainees [Accessed 7 September 2016].

¹¹⁶¹ Royal College of Physicians. Work and wellbeing in the NHS: why staff health matters to patient care. London: RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-

more senior colleagues under pressure discourages the next generation of consultants: for eight out of ten doctors-in-training, the lack of work–life balance for medical registrars is a deterrent to pursuing a career in medicine¹¹⁶².

25. **Falling recruitment figures:** Hospitals are finding it increasingly difficult to recruit to jobs at the front line of hospitals resulting in significant shortages for ‘generalist’ posts¹¹⁶³. Fewer doctors choosing to work in general medicine increases the workload for those who do, leading to a poorer trainee experience and more challenging working conditions¹¹⁶⁴.
26. **Falling patient safety and experience:** Poor staff wellbeing and morale threaten patient care: 95% of doctors-in-training report that poor morale is having a negative impact on patient safety in their hospital, with half reporting a serious or extremely serious impact¹¹⁶⁵. Engaged doctors make fewer mistakes, and better staff wellbeing is associated with lower death and MRSA infection rates. When staff wellbeing suffers, patient satisfaction and experience suffer too: NHS organisations with ‘poor’ staff health and wellbeing are, on average, among the 25% worst performers in patient satisfaction reviews¹¹⁶⁶. **We need to start prioritising staff wellbeing and engagement as red flags for patient safety, taking urgent, preventative action when they are threatened**¹¹⁶⁷.
27. Evidence shows that when staff feel healthy, valued and engaged they deliver better care, with improvements in patient safety and experience, and reduced costs^{1168 1169}. **We need national and local action to make all doctors feel valued and empowered, and to retain their experience and expertise in the NHS.** In its guidance to CEOs and Medical Directors, the RCP outlined some of the key steps that can be taken by NHS trusts to improve the working lives of doctors in training¹¹⁷⁰. These include:
- **Create a positive working environment:** establish a robust induction programme for all trainees; monitor workloads and support flexible working
 - **Ensure strong teams and effective rotas:** establish a regular on-call team; develop team rotas that reflect role and career stage; prioritise time for handover; plan rotas that allow time for training
 - **Protect time for training and teaching**
 - **Build capacity:** explore opportunities to employ international medical graduates

¹¹⁶² Royal College of Physicians. The medical registrar: empowering the unsung heroes of patient care. London: RCP, 2013.

¹¹⁶³ Doctors in general internal medicine (GIM) diagnose, treat and manage the care of inpatients and outpatients with acute and long term medical conditions

¹¹⁶⁴ Royal College of Physicians. Under-funded, Under-doctored, Overstretched. 2016

¹¹⁶⁵ Royal College of Physicians. Survey of medical trainees 2016 (unpublished data).

¹¹⁶⁶ Royal College of Physicians. Work and wellbeing in the NHS: why staff health matters to patient care. London: RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-staff-health-matters-patient-care [Accessed 8 September 2016].

¹¹⁶⁷ Royal College of Physicians. Survey of medical trainees 2016 (unpublished data).

¹¹⁶⁸ Royal College of Physicians. Work and wellbeing in the NHS: why staff health matters to patient care. London: RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-

¹¹⁶⁹ Royal College of Physicians. *Work and wellbeing in the NHS: why staff health matters to patient care*. RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-staff-health-matters-patient-care [accessed August 2016].

¹¹⁷⁰ [Valuing trainees resource for CEOs and MDs](#). Royal College of Physicians. 2016. [accessed August 2016]

28. **Geographical location** also affects recruitment and retention. In a recent study, location was identified as the single biggest factor affecting where foundation applicants applied to, followed by perceived reputation of the hospital trust and job track¹¹⁷¹. Participants identified free/heavily subsidised accommodation or the offer of additional qualifications in leadership or teaching as the main incentives that would have a positive effect on applications to geographically undesirable trusts. The study found that overall; these efforts should lead to savings in recruitment costs, a reduction in vacant training posts and thus a decreased reliance on locum doctors, culminating in improved patient care.
29. The workforce we need is ageing like the population that it serves, and issues related to the **time of potential retirement** also need to be considered. As doctors near the end of their careers, pension provision, workload and health affect decisions about whether to continue working and in what way. Recent changes to the NHS pension have moved the retirement age from 60 to 67–8 for those younger than 50 in 2015, which will result in younger consultants working longer in the NHS but could also lead to an early loss of many older consultants if working conditions worsen. Already, there are predictions of substantial losses from the primary care workforce, which could be mirrored in the hospital workforce. **If we plan to increase the workforce, we need to ensure that we keep pace with losses and changes in participation.**

Ensuring the workforce receives appropriate training

30. An increase in the workforce trained in and delivering general medical services seven days per week has been proposed as a solution to the crisis facing acute hospital system in the NHS¹¹⁷². The inpatient population is becoming older with more comorbidities. The skills of the physician workforce therefore must be appropriate to meet the needs of these patients and general medicine is seen as a solution. For example, a patient on the respiratory ward could also have diabetes, Parkinson's and heart failure. Therefore we need to ensure that our specialists are also generalists.
31. **It is very unlikely that a generalist workforce can be achieved in less than 10 years** without a clear strategy from government and increased staffing levels. In a consultant survey about general medicine, 64% of respondents stated that they 'practised general medicine', which also varied substantially between specialties¹¹⁷³.

Models of service delivery and integration

¹¹⁷¹ Curran, J & Baker, P. Future Hospital Journal. 2016 vol 3, no.1, 17-20

¹¹⁷² Doctors in general internal medicine (GIM) diagnose, treat and manage the care of inpatients and outpatients with acute and long term medical conditions.

¹¹⁷³ Moore A , Newbery N , Goddard AF . Consultant perception of general internal medicine – a survey of consultant physicians . *Clin Med* 2015 ; 15 : 511 – 9 .

32. Integration can take many forms, whether it is between health and social care providers or between different elements of healthcare provision such as primary, secondary and community care. **Ensuring adequate funding, staffing levels and resources are key to making services more integrated, responsive and patient centred.**

What are the practical changes required to provide the population with an integrated National Health and Care Service?

33. The case studies in a recent RCP and Royal College of GPs report give examples of how integration can be achieved and developed, and provide learning about how physicians and GPs in particular can work more closely together¹¹⁷⁴.
34. **The ability to work across geographical boundaries and locations is a vital aspect of integrated working.** In Tower Hamlets, to provide multidisciplinary diabetes support, 35 GP practices are grouped geographically into eight networks of four or five practices. Six times per year, a consultant attends each network to undertake a 2-hour multidisciplinary team (MDT) meeting with GPs, practice nurses, dieticians, diabetes specialist nurses and a diabetes psychologist. This has resulted in more improvements in blood pressure and cholesterol control in Tower Hamlets than in any other clinical commissioning group (CCG) in England over a 2-year period¹¹⁷⁵.
35. **More than just physical integration is required;** many of the case studies demonstrate success using virtual platforms. Highly rated services feature innovative ways of connecting GPs and physicians for advice, and virtual clinics can help to build relationships and make subsequent collaboration more straightforward. An example is the Whittington Health Integrated Community Ageing Team (ICAT), which established a telephone advice line for GPs to discuss the health needs of care home residents and a community geriatric service for the wider population¹¹⁷⁶.
36. Patient needs are complex and do not neatly sit within one part of care delivery. The Rapid Elderly Assessment Care Team (REACT) at Mid Yorkshire Hospitals is a multi-disciplinary team (MDT) made up of geriatric consultants, specialist nurses and therapists who work together to assess patients aged 80 and over, or those aged 65 and older who are care home residents, within 24 hours of their arrival at hospital. The MDT meets daily to coordinate the care and treatment of patients to help them to be fit to leave hospital and prevent unnecessary admission. The MDT is able to care for patients in a person-centred way as they can offer people access to both the health and therapeutic services they need.
37. The REACT team has also established joint partnerships with third sector professionals, namely Age UK, to ensure that patients are receiving safe transfers of care into the community¹¹⁷⁷. Age UK regularly come into the acute assessment unit at the hospital and physically help patients return home; they offer transport and a grocery shopping service so that vulnerable older people are not discharged without adequate support. Working collaboratively with health and social care professionals outside of the hospital building has

¹¹⁷⁴ Royal College of Physicians and Royal College of General Practitioners. *Patient care: a unified approach*. 2016

¹¹⁷⁵ Royal College of Physicians and Royal College of General Practitioners. *Patient care: a unified approach*. 2016. P.18

¹¹⁷⁶ Royal College of Physicians and Royal College of General Practitioners. *Patient care: a unified approach*. 2016. P.10

¹¹⁷⁷<http://www.ageuk.org.uk/brandpartner/global/wakefielddistrictvpp/documents/frailty%20conference/frailty%20in%20secondary%20care.pdf>

enabled frail older patients to receive personalised care in the community and has helped them to maintain their independence which in turn prevents readmission.

How can local organisations be incentivised to work together?

38. An often-cited barrier to new ways of working is the current commissioning, contracting and payment system. Where barriers to joined-up care exist, they should be dismantled, and commissioning should be based on whole pathways of care¹¹⁷⁸. Long-term planning is also essential so that initiatives can operate in a secure environment. A move away from commissioning for activity to a payment system that rewards added value and shared, desirable patient outcomes is likely to drive the process of professional integration. Involving both commissioners and healthcare professionals in the early stages of planning and development is a way of overcoming any potential barriers. Oxfordshire CCG's new Musculoskeletal service has been developed with a costed business plan, followed by joint commissioning with local providers to refine the details. A delivery plan is currently being developed, which will then be implemented¹¹⁷⁹. By integrating care, pressure on the whole system will be relieved; however, funding must be provided to support services, irrespective of the setting in which they are provided.

Prevention and public engagement

Delivery of public health and commissioning arrangements

39. Following the Health and Social Care Act, fragmented commissioning arrangements have had an impact on the delivery of public health interventions and on patient care. In many areas of England, patients are experiencing the adverse consequences of fragmented care, particularly with regard to sexual health services. The different services that make up sexual healthcare are now commissioned respectively by Clinical Commissioning Groups (CCGs), NHS England and local authorities. Some local areas such as North West London and Leicester are leading the way, with integrated sexual healthcare that brings together the whole patient pathway¹¹⁸⁰. These exemplars enable patients to access seamless care at every stage of their journey. Unfortunately, this patient-centred approach is not available everywhere, despite national guidance. In many areas of England patients are facing the serious consequences of fragmented care¹¹⁸¹.
40. **The RCP believes that 'place-based' commissioning, where organisations work together to commission health and care for an entire local population, must become the norm¹¹⁸².** Furthermore, clear lines of accountability must define which commissioner is responsible for each area of patient care. No services should fall through gaps between commissioning organisations. Patients must be able to access the same high-quality standard of care wherever they live.

Funding of public health and prevention

¹¹⁷⁸ Royal College of Physicians. Putting the pieces together: Removing the barriers to excellent patient care. London: RCP, 2015.

¹¹⁷⁹ Royal College of Physicians and Royal College of General Practitioners. *Patient care: a unified approach*. 2016. P.14

¹¹⁸⁰ Making it work A guide to whole system commissioning for sexual health, reproductive health and HIV

¹¹⁸¹ Putting the pieces together: Removing the barriers to excellent patient care. London: RCP, 2015

¹¹⁸² Putting the pieces together: Removing the barriers to excellent patient care. London: RCP, 2015

41. Additional funding is just one element needed to build a sustainable NHS. We must also reduce the number of patients requiring care. This can only be done through investment in prevention. The RCP is gravely concerned that cuts to local authority public health allocations will cause serious and lasting adverse implications to both the NHS and the health of the people it serves. The cuts announced in the 2016 Spending Review will have a major impact on the many prevention and early intervention services carried out by local authorities. These include tackling the nation's obesity problem, helping people to stop smoking and tackling alcohol and drug abuse. **The RCP strongly opposes the introduction of these cuts and we urge against any further cuts to public health funding.** Investing in prevention ultimately saves lives and improves long term patient outcomes. This is in addition to saving money for other parts of the NHS by reducing demand for hospital, health and social care services.
42. Data collected from local authorities shows that a substantial proportion of public health funding is spent on services delivered by NHS providers. In some councils this is as much as 80% of the total public health budget¹¹⁸³. This means the planned £200 million funding reduction will have an immediate impact on the NHS. The explicit function of local public health services is to prevent ill health and improve health. Funding reductions will impede local authorities' ability to achieve these goals, thereby increasing the burden of ill health on the NHS. **The NHS faces unprecedented financial pressures, continued growth in demand, and an increasingly complex range of patient need. It is therefore a false economy to impose funding reductions that will directly and adversely impact on the health service and the health of the people who rely on it.**

Promoting public health through government intervention

43. The RCP believes that the food and drinks industry must do more to safeguard the nation's health and that government must take a balanced approach to promote this, particularly given the failure of voluntary agreements such as the Responsibility Deal^{1184 1185 1186}.

Tackling obesity

44. Despite a commitment to introduce a levy on sugar sweetened beverages, the RCP is extremely disappointed that after such a long wait for the childhood obesity strategy, the government has published a downgraded plan that fails to address key issues such as marketing and promotion of sugar-filled and unhealthy foods to children¹¹⁸⁷. The estimated cost of obesity to the UK economy is approximately £27bn¹¹⁸⁸. A consequence of failing to

¹¹⁸³Taken from a survey of directors of public health conducted by the Association of Directors of Public Health.

¹¹⁸⁴ [Responsibility Deal pledges](#) [Accessed August 2016]

¹¹⁸⁵ Dead on Arrival? Evaluating the Public Health Responsibility Deal for Alcohol. Institute for Alcohol Studies. November 2015.

¹¹⁸⁶ [Food industry 'responsibility deal' has little effect on health, study finds](#). Guardian 12 May 2015. [accessed August 2016]

¹¹⁸⁷ <https://www.rcplondon.ac.uk/news/rcp-president-jane-dacre-disappointed-government-childhood-obesity-plan>

¹¹⁸⁸ 'The Economic burden of Obesity', National Obesity Observatory, PHE, October 2010.

act now is to commit the NHS to greater expense in the future as it struggles to fund care and treatment for obesity-related medical conditions. A strong package of measures and concerted action across all government departments is required to turn the tide on obesity. As a member of the Obesity Health Alliance, the RCP will continue to campaign to ensure the health harms related to obesity are tackled effectively¹¹⁸⁹.

Tobacco control

45. The RCP hopes that the government's upcoming tobacco control strategy will be ambitious and go further to ensure that the burden of ill health caused by tobacco is reduced. The total cost of smoking to society, including healthcare, social care, lost productivity, litter and fires, was conservatively estimated in 2015 to be around £14 billion per year¹¹⁹⁰. The RCP therefore welcomed the planned increases in tobacco duty of 2% above the rate of inflation for manufactured cigarettes and 5% for hand-rolled tobacco at the 2016 Budget. These measures will provide a significant boost in the campaign to reduce smoking and reduce the burden of ill health in the long term. However, cuts to local authorities' public health budgets are having a damaging impact on services that help people to stop smoking¹¹⁹¹. We hope that the government's upcoming tobacco control strategy will set out ways to support these vital services. **There is evidence which demonstrates that expenditure on tobacco control provides good value for money: reduced smoking results in a net annual benefit of £1.7bn, in addition to tobacco tax revenue¹¹⁹².**
46. The government must also look at the application of harm-reduction strategies to tackle tobacco dependence. A recent report published by the RCP recommends that it is **in the interests of public health to promote the use of e-cigarettes, nicotine replacement therapy and other non-tobacco nicotine products as widely as possible as a substitute for smoking¹¹⁹³**. The report found that e-cigarettes are not a gateway to smoking. In the UK, use of e-cigarettes is limited almost entirely to those who are already using, or have used, tobacco¹¹⁹⁴. Furthermore, e-cigarette use is likely to lead to quit attempts that would not otherwise have happened¹¹⁹⁵.

Alcohol

47. The RCP supports the introduction of a minimum unit price for alcohol (MUP). Alcohol misuse places a huge burden on the NHS, police, criminal justice system as well as the wider community. The simplest way to reduce demand for alcohol is to raise the price. The RCP is committed to MUP because it is an evidence-based intervention which has been shown to

¹¹⁸⁹ [New alliance on obesity outlines priorities for action](#). [accessed August 2016]

¹¹⁹⁰ Action on Smoking and Health. Smoking still kills. Protecting children, reducing inequalities. London: ASH, 2015. www.ash.org.uk/files/documents/ASH_962.pdf [Accessed 10 June 2015].

¹¹⁹¹ *Results of a survey of tobacco control leads in local authorities in England*. Action on Smoking and Health.

¹¹⁹² <http://www.ash.org.uk/information/facts-and-stats/fact-sheets>

¹¹⁹³ Royal College of Physicians. *Nicotine without smoke: Tobacco harm reduction*. London: RCP, 2016

¹¹⁹⁴ Royal College of Physicians. *Nicotine without smoke: Tobacco harm reduction*. London: RCP, 2016

¹¹⁹⁵ Royal College of Physicians. *Nicotine without smoke: Tobacco harm reduction*. London: RCP, 2016 p129

be effective in tackling health inequalities and reducing consumption¹¹⁹⁶. Of all alcohol sold, it is the very cheap products such as large bottles of strong cider, that play the biggest part in alcohol-related harm. **A minimum unit price of 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price.** The impact of a 50p minimum unit price has been modelled by Sheffield University, who found that if implemented, there would be 35,100 fewer hospital admissions per year by the tenth year following introduction of the 50p MUP¹¹⁹⁷.

Air pollution

48. A recent report from the RCP and Royal College of Paediatrics and Child Health (RCPCH)¹¹⁹⁸ found that each year in the UK, around 40,000 deaths are attributable to exposure to outdoor air pollution, which plays a role in many of the major health challenges of our day. It has been linked to cancer, asthma, stroke, heart disease, diabetes, obesity and changes linked to dementia. The health problems resulting from exposure to air pollution have a high cost for people who suffer from illness and premature death, for our health services and for businesses. In the UK, these costs add up to more than £20 billion every year.
49. As a member of the UK Health Alliance on Climate Change (UKHACC)¹¹⁹⁹, the RCP will be campaigning with colleagues across health and social care to highlight better approaches to tackling climate change that protect and promote public health, whilst also reducing the burden on health services. An upcoming report from the UKHACC considers the ways in which integrated strategies to address air pollution and climate change will simultaneously lead to greater health benefits, tackling issues such as obesity, and cost-savings, rather than strategies which address them separately.

Digitisation of services, Big Data and informatics

The use of information technology across the health system

50. Information technology should be used to share data and improve communication between acute and community settings. In particular, **health service providers should use an agreed standardised structure and content for electronic records.** The RCP has produced a standardised structure for electronic records, which includes a uniformed format for discharge and transfer of care notes¹²⁰⁰. **One of the main barriers that our members and fellows face when trying to achieve a smooth transition within hospital services and between community and hospital settings for their patients, is fragmented and complex IT infrastructures and patient records.** There is often little standardisation of clinical data in source systems, either in the headings under which data are recorded or in the definition of individual clinical terms. This has led to huge variations in record structures and clinical language, and major problems with the coding of clinical concepts.

¹¹⁹⁶ Wagenaar, A.C., Salois, M.J., Komro, K.A. (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction* 104(2): pp 179-90.

¹¹⁹⁷[Income group-specific impacts of alcohol minimum unit pricing in England 2014/15](#). University of Sheffield. 2013. [accessed August 2016]

¹¹⁹⁸ Royal College of Physicians. *Every breath we take: the lifelong impact of air pollution*. Report of a working party. London: RCP, 2016.

¹¹⁹⁹ <http://www.ukhealthalliance.org/>

¹²⁰⁰ <http://theprsb.org/publications/bible-sets-out-the-latest-agreed-standards> [accessed 19 September 2016]

What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

51. The most important aspect of digital technology that has the potential to reduce NHS costs is the electronic health record. A good electronic health record system will capture data faithfully and contemporaneously in usual clinical practice, it will ensure that the data are structured and organised (so that they can be easily retrieved, interpreted or transferred), and will make the data available in appropriate formats for patients (to help them understand their condition), clinicians (to enable them to make appropriate decisions), health service planners (to ensure that services are able to cope with demand) and researchers (to find out ways of improving the quality or reducing the cost of healthcare). This will reduce costs by avoiding duplicate investigations, improving patient safety and enabling better decision support systems which can inform clinicians of the cost-effectiveness of potential investigation or therapy plans. Better electronic communication can avoid the need for paper-based administrative and secretarial tasks. For example, dictation of clinic letters may be replaced by voice recognition and direct data entry into the patient record.
52. The use of telemedicine for supporting effective and timely discharge of frail older patients should be explored and implemented if there is local infrastructure able to support its introduction. The FHP development site at Betsi Cadwaladr University Health Board in rural Wales is using telemedicine to offer people who live far away from specialist care follow-up appointments with their consultants via video conferencing which is hosted at their local community hospital¹²⁰¹.

What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

53. The main barrier is the lack of structure, standardisation and usability of electronic health record systems in current use. These systems often depend on proprietary operating systems requiring expensive hardware. Interfaces between the different systems are expensive to maintain because they are not standardised. Vendor lock-in creates a monopoly situation where the cost of modifications or additional software is unconstrained. Development of new electronic health record systems is prohibitively expensive so only large companies are able to do it, which stifles innovation.
54. The key change required is for systems to become modular and to use standardised, open interfaces. The openEHR standard will ensure that data has the same meaning in different systems regardless how it is physically stored¹²⁰². Modularity will allow individual components of the information system (e.g. the user interface, the openEHR server) to be independently developed and exchanged. This will accelerate innovation and lower the bar to entry, allowing clinicians and small-medium size companies to develop software that can actually be used (e.g. assisted by the HANDI-HOPD project¹²⁰³). Standardisation across the NHS will reduce the development costs of multiple software systems. Use of a fast, open-source operating system will avoid premature hardware obsolescence.

¹²⁰¹ https://www.youtube.com/watch?v=GRIan_4oDtw

¹²⁰² <http://www.openehr.org/>

¹²⁰³ <http://handihealth.org/introducing-handi-open-platform-demonstrator-handi-hopd/>

23 September 2016

The Royal College of Physicians of Edinburgh – Written evidence (NHS0064)

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

There undoubtedly will need to be significant changes to ensure a sustainable healthcare system by 2030. A partial solution is significantly greater financial investment into healthcare. However this may be unrealistic; and even if it were forthcoming, without greater system changes it would probably still not be enough.

The frequency of almost all chronic or long term illnesses increase with advancing age, and many co-exist in older people. The latter makes the course of the illnesses more complex, and increases sharply the demands and costs of both the investigations and management in those patients. Given the ageing population, increasing training and experience in all aspects of the care of the complex frail older population will be vital.

We have witnessed a welcome and unprecedented revolution in medical knowledge and technologies allowing for the better diagnosis and treatment of illnesses. These treatments have grown in complexity and understandably in cost. Not only are we able to cure many intercurrent illnesses, but we are able to sustain longevity despite the presence of treatable, but not curable, illnesses which constitute the bulk of long term conditions. We are able to post-pone death and prolong the period of ill health that requires sustainable expenditure - which is expanding in parallel with the expansion of the vulnerable population.

The NHS spends a huge amount of money on treatment of patients in the last few months of life when often high quality care would be more appropriate and kind. We need to recognise impending death much better.

There should be realism about what the NHS can offer, and further discussion around the roles played by both family and the state in providing care. There is currently a lack of balance between the demands on social services and their ability to deliver, which is one of the major reasons for the high pressures on hospital beds in the UK.

Many attempts to reform the NHS, particularly in the community, have resulted in excessive efforts to re-group, re-package and re-design services which consume time, effort and funds only for a new cycle of reform to begin a few years later. There is an over-emphasis on appearing to reform rather than sustaining and improving existing services.

Finally, improving the morale of the healthcare workforce which has decreased massively over the last 10 years is a vital part of the future healthcare system. The efficiency of having a well-motivated, well rewarded workforce is important, as huge pressures exist in hospital settings.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

It is clear that financial resources are not sustainable and are not realistic. The Committee may wish to consider which measures might be introduced to prevent possible misuse of a system that is deemed to be 'free'. Cross party solutions should be considered with each new Health Minister not obliged to re-organise for political purposes.

It is likely that there will be a greater push towards centralisation of specialist services to preserve resource in staffing, backed up by local hospitals with more outreach into the community using virtual wards, telemedicine, e-consultations etc. Ideally there would be a switch to enhanced community care – however, there is currently no evidence that switching resources from secondary to primary care has reduced demand for hospital services. Bed numbers in the UK are already low compared to EU averages.

Social care is also key to resource issues and the focus should be on highlighting its successes in supporting vulnerable people rather than concentrating on fraudulent practices. Failures in providing social care impact on the healthcare budget when patients are not able to be discharged from hospital because they lack a care package.

a. Does the wider societal value of the healthcare system exceed its monetary cost?

This is difficult to quantify. It is clear that the public hugely value the NHS as a concept, and with the correct funding, management and support it can still deliver care in the way that it has previously rather than some of the drives towards complex provision of costly fragmented care.

b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

By considering the NHS as an organisation itself rather than multiple competing providers moving funding around a system. This could still leave the greater organisation free to innovate and generate profit; but the service overall should be funded by general taxation at an appropriate level.

A cross-party or independent social and healthcare taxation commission could be considered to advise Government on this issue.

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

Unhealthy food should be made more expensive with healthier lifestyles encouraged and rewarded through making healthy foods affordable and improving opportunities for active and public transport.

- d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?**

There are huge ethical arguments about some aspects of this but there are some procedures (eg some aspects of cosmetic surgery) provided by the NHS that could be handled differently. There is already some variation across the UK that could be regarded as unfair (eg prescription charges).

Workforce

- 3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?**

It seems likely there will be a relatively small number of highly trained professionals in the future, supported by healthcare assistants. There are also roles for hospital apprentices and hospital volunteers who can perform many and varied support tasks.

- a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?**

Our current entry systems have proved to be effective at recruiting the best candidates for the health professions, and have allowed us to maintain high standards of individuals admitted to the Universities and Colleges. More places could also be made available across the healthcare and allied professions.

Rigorous selection programmes of certification examinations and assessments of linguistic and professional standards of overseas graduates should remain in place to ensure standards are not compromised.

Consideration should be given to developing and further recruiting into the newly created option of physician assistants who would provide a stable subsidiary work-force that can work to supplement the doctors and not replace them within prescribed specialties and roles.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

The UK imports more healthcare professionals from the EU than it exports so there is a potential risk here. Should a points based system be introduced for immigration there would be the opportunity to prioritise healthcare workers.

In applying rules of worker selection the UK will be able to ensure professionals have an adequate command of the English language, and meet the same high standards applied to UK graduates and workers.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

Retention issues are caused by the downward spiral of shortages and low morale. This can only be broken by getting staff numbers up to standard quotas. There is also a role for better hospital management with the correct interpersonal and leadership skills.

There could be a national drive to attract young people into the Health Service, for example as is done with campaigns to join the armed services. Family friendly working patterns need to be supported, along with recognition of professionalism rather than a production line approach.

Some issues are national and others more localised and there is no comprehensive joined up plan of deployment of personnel, rather this is tackled at local or specialty level.

Where positions are not filled, there is a resulting increase in pressure on those in post in these areas to deliver what would have been expected from full complement of teams. These increased pressures can cause a decline in both the quality of work provided and in the morale of the workforce. This is driving senior GP's to early retirements and younger doctors in both the hospitals and the community to emigrate mainly to Australia/New Zealand and to Canada. When the current medical trainee workforce reach their consultant posts this is likely to be even worse given the recent contract dispute.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

Through better strategic planning, closer ties to Universities, and agility in introducing new roles such as the Physician Assistant and Advanced Nurse Practitioner - many universities now offer such courses.

There is a role for enhanced simulation and fast tracking in view of the present crisis.

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

Training programmes are already making good use where appropriate of the new technologies and simulation training.

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

There have been a number of discussions recently regarding the potential to shorten medical training, although there is also a case for extending training given the increased burden on the workforce. Adaptable skill mix is all very well, but this should not be at the expense of expert specialism.

There will be costs at two levels:

1. the cost of the extra-training of the existing work force to do other previously not done tasks;
2. the cost of recruiting more of those to back fill the tasks that they will not be doing because of their extended roles. No one can do extra without having to drop some of what they are currently doing.

Workers who take on more and new tasks and who receive extra-training will view themselves as more qualified and would inevitably expect a rise in their remuneration.

Multi-tasking is a potentially fulfilling extension of the roles for those who are being asked to do them, but it cannot be regarded as the 'cheap method' of avoiding the reality of the need to spend more.

c. What investment model would most speedily enhance and stabilise the workforce?

Long term steady investment is needed to train new workers and meet the demand appropriately; this can also help boost workforce morale. Short term, immigration will potentially have to be part of considerations.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

a. How could truly integrated budgets for the NHS and social care work and what

changes would be required at national and local levels to make this work smoothly?

By removing boundaries and having joint organisations covering both aspects as already being tried in parts of the UK. This may involve ensuring some ring fencing or protection of social care budgets due to the increasing demands they are under.

b. How can local organisations be incentivised to work together?

Local organisations could be penalized for delays in providing services for patients who need them, that significantly delay the patients' discharge from hospital. Provision of cheaper, viable alternatives to hospital beds when hospitalization is no longer required is a potential method of avoiding penalties invoked against the social services when the provision of care package is delayed for patients who need to be discharged from hospital.

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

- (a) Could consider an integrated model where single health boards are responsible for community and hospital care which could remove local protectionism and increase understanding. Having roles which work across both settings may also help.
- (b) These could be improved through combined work between the Liaison Psychiatrists and the doctors and nurses providing physical health services. This requires funding of further posts for the Liaison Psychiatry services (doctors and nurses) and close working relationships with those working on physical health (through multi-disciplinary team working) which helps with smoothing any difficulties in the provision of care in either direction.

Prevention and public engagement

5. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

Public health policies that enhance a population's health and wellbeing and increase years of good health are based on measures that are simple to implement, characterized by lower cost, and have profound impact on people's health that is sustained in the long term. One example of such a policy is the smoking ban in public places.

There are many potential preventative interventions that could be designed to maximize the impact on health and reduce spending, for example the prevention of osteoporosis in the population that is ageing.

b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

The State's responsibility lies mainly in enacting laws and enabling their implementation through funding or budgeting and enforcing penalties. Local and regional bodies have responsibility for implementing policies and encouraging those individuals who are in positions of power to educate the public and encourage their adherence to these policies.

It is important to highlight the importance of supporting research that investigates the role of interventions at societal level and to investigate the cost-effectiveness of these interventions.

c. Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

With the demonstration of the cost effectiveness of the interventions in public health, one could then expect the government and the funding bodies to honour the funding commitments to public policy.

d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

Potentially, and expanding the role of bodies such as NICE could help the UK Government in choosing the interventions that need to be enacted in law because of their public health impact.

The Government should be prepared to legislate whether it be on sugar, alcohol or smoking, in order to protect public health.

e. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

This could be through establishing quality standards parameters that need to be implemented for these providers to be given good assessment status compared to their peers, or to link achieving those good quality standards to income of the provider.

f. What are the barriers to taking on received knowledge about healthy places to live and work?

There is a good argument for centralisation of public health and ensuring education of the nation, including within schools.

g. How could technology play a greater role in enhancing prevention and public health?

Technology and improved technology can be used to detect pollution, purify water supplies from bacteria, and detect illnesses prior to symptoms developing. Examples of the latter include plans to detect impaired left ventricles prior to demonstration of heart failure symptoms, detecting hypercholesterolaemia and treatment thereof prior to the establishment of coronary artery disease, and treatment of patients with positive calcium coronary score in the absence of symptoms of angina.

7. What are the best ways to engage the public in talking about what they want from a health service?

There is a place for honest public debate and conversation about what the NHS can offer, with educational and publicity programmes encouraged through various channels including digital.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

There is no doubt that some new technologies are helpful in some aspects of healthcare. However, the wholesale adoption of these because of their being trendy is to be discouraged. Like all interventions technologies need to be subjected to the same levels of evidence as those for pharmacological ones. We need to encourage studies demonstrating cost effectiveness and health benefits of these technologies before they are adopted.

b. What is the role of 'Big Data' in reducing costs and managing demand?

The main role is to minimize duplication and provide health workers with access to all the information available on the patient and thus avoiding un-necessary expenditure.

c. What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

The cost of these remains prohibitive and previous attempts to automate have previously failed to attain the projected aims and escalated in their costs beyond the budget. In addition, these need to be restricted to technologies proved to be effective, helpful and cost-efficient.

d. How can healthcare providers be incentivised to take up new technologies?

By demonstrating the benefits of such provision to the health of the patients and the efficiency of the services provided (including cutting costs).

e. Where is investment in technology and informatics most needed?

In the acute hospital sector, to access test results and the link between primary and secondary care.

23 September 2016

The Royal College of Psychiatrists – Written evidence (NHS0123)

Introduction

The Royal College of Psychiatrists (RCPsych) is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

The RCPsych strongly supports the continuation of a National Health Service that is free at the point of use.

Sustainability and Public Mental Health issues are a priority for the RCPsych, which has appointed two senior positions to lead these related areas of the College's work: our Associate Registrar for Sustainability, Dr Daniel Maughan, and our Associate Registrar for Public Mental Health, Dr Peter Byrne. Both have contributed to this submission.

We have focused in our submission on the broad principles and approaches we consider necessary for achieving this in a financially and demographically challenging environment, which have particular relevance to the Committee's focus on: resource issues, models of service delivery, prevention and public engagement.

Summary: Guiding principles of the NHS

To optimise the sustainability of the NHS, the established principles of sustainability should be employed: prevention (at all levels: primary, secondary and tertiary), empowerment, and improving the value of services. Following these principles will reduce the economic burden on the NHS, which is the foremost threat to its sustainability.

First, we must ensure priority is given to preventing the onset of illness, to reduce the future burden on services.

Second, we must empower and enable patients, carers and communities to manage illnesses independently, therefore reducing the burden on services.

Third, if people need services then we must ensure that everything is done to improve the value of the health care they receive. Essentially, this means delivering the right intervention to the right person at the right time. This includes stopping high-cost and low-benefit interventions, overtreatment and poor use of staff time, while reducing waste in the system.

1. Prevention and Public Mental Health approaches

It is vital that the well-founded and accepted arguments for mental health have parity with physical health, and the fact that there is ‘no health without mental health’ should become a reality. This requires a coherent strategic approach that places mental health and public mental health at the centre of all health considerations, and also of policies led by other government departments, which have a major impact on the determinants of mental health. This includes in particular, but not exclusively, the Department for Work and Pensions, the Department for Education, the Department of Communities and Local Government, the Home Office and the Ministry of Justice.

An important step for realising this aim is sustained and appropriately funded activity to implement and fully deliver the recommendations of the report of the independent Mental Health Taskforce, *The Five Year Forward View for Mental Health*¹²⁰⁴.

A key sustainability challenge is tackling obesity. The incidence of obesity is rising in men and women, increases the risk of cardiovascular disease, diabetes and some cancers, and is estimated to cost the NHS £5.1 billion each year¹²⁰⁵. It is a good example of an issue that crosses the lifespan, engages both mental and physical health, and requires cross-government action to prevent its continuing rise. This should include supporting overweight, bullied children at the earliest opportunity, and, more broadly, supporting people to eat a better diet, promoting responsible practices in food provision and waste, and enabling more walking and cycling, which will also reduce the pollution caused by motorised forms of transport.

Effective Public Mental Health should start very early, and should include a range of evidence-based perinatal services for mothers affected by moderate and severe mental health problems, as an important foundation for building resilience, and helping to give every child a mentally healthy start in life. Measures to tackle child poverty are important, as are programmes such as Sure Start, designed to meet the needs of the most disadvantaged children and families, and targeted mental health interventions in schools. There is substantial evidence of the benefits of commissioning public mental health programmes throughout the life course, much of which is set out in the Joint Commissioning Panel for Mental Health Guidance on Commissioning Public Mental Health services (<http://jcpmh.info/wp-content/uploads/jcpmh-publicmentalhealth-guide.pdf>).

2. Empowerment

Action must be taken to use all available resources to help patients and communities self-manage their health, including through the use of online resources, existing community structures and peer support. Further, all steps must be taken to empower people to live independently, including helping them to return to education, employment and stable housing. The following steps all reduce use of health care services:

¹²⁰⁴ The Mental Health Taskforce (February, 2016), *The Five Year Forward View for Mental Health*, available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

¹²⁰⁵ NICE (May 2013), ‘Preventing obesity and helping people to manage their weight’, Local Government Briefing 9 [LGB 9], available at: <https://www.nice.org.uk/advice/lgb9/chapter/Economic-impact>

- i. Peer support groups can reduce hospitalisation and save costs¹²⁰⁶
- ii. Integration of peer-provided services can empower people with mental illness to self-care and reduce burden on services¹²⁰⁷:
- iii. Guided Internet Interventions for managing mental health conditions should be provided. These are cost-effective for depression, anxiety, smoking cessation and alcohol consumption, and more cost-effective when compared to existing interventions such as group cognitive behavioural therapy, attention control, telephone counselling or unguided Internet Cognitive Behavioural Therapy (CBT)¹²⁰⁸
¹²⁰⁹.
- iv. Individual Placement and Support (IPS) can reduce service use and improve outcomes¹²¹⁰.
- v. Providing housing, with appropriate community support, improves outcomes and reduces the use of services¹²¹¹.

3. Improving value of healthcare

In 2014, the Academy of Medical Royal Colleges published *Protecting Resources, Promoting Value: A Doctor's Guide to Cutting Waste in Clinical Care*¹²¹². In a powerful Foreword to this report, the then Chair of the Academy of Medical Royal Colleges, Professor Terence Stephenson, set out the importance of protecting resources in clinical care and using them wisely:

“As this report spells out, avoiding waste and promoting value are about the quality of care provided to patients – which is a doctor’s central concern. One doctor’s waste is another patient’s delay. Potentially, it could be that other patient’s lack of treatment. Protecting resources and promoting value is therefore important at any time. When resources are increasingly constrained - and likely to become more so in the future – this becomes a necessity. ... [T]his is not simply about costs. It is about supporting doctors and other clinicians to ensure that the resources of the NHS are used in the most effective way possible to provide the best possible quality and quantity of care for patients”.

The Academy has continued its work in this area through its work on “Choosing Wisely”. This work, to which the RCPsych has contributed, promotes the identification of tests or

¹²⁰⁶ Chinman, M., George, P., Dougherty, R.H., Daniels, A.S., Ghose, S.S., Swift, A. and Delphin-Rittmon, M.E., 2014. Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatric Services*.

¹²⁰⁷ Resnick, S.G. and Rosenheck, R.A., 2015. Integrating peer-provided services: a quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services*.

¹²⁰⁸ Donker, T., Blankers, M., Hedman, E., Ljotsson, B., Petrie, K. and Christensen, H., 2015. Economic evaluations of Internet interventions for mental health: a systematic review. *Psychological medicine*, 45(16), pp.3357-3376.

¹²⁰⁹ McCrone, P., Knapp, M., Proudfoot, J., Ryden, C., Cavanagh, K., Shapiro, D.A., Ilson, S., Gray, J.A., Goldberg, D., Mann, A. and Marks, I., 2004. Cost-effectiveness of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial. *The British Journal of Psychiatry*, 185(1), pp.55-62.

¹²¹⁰ Burns, T., Catty, J., Becker, T., Drake, R.E., Fioritti, A., Knapp, M., Lauber, C., Rössler, W., Tomov, T., Van Busschbach, J. and White, S., 2007. The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial. *The Lancet*, 370(9593), pp.1146-1152.

¹²¹¹ Nelson, G., Aubry, T. and Lafrance, A., 2007. A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry*, 77(3), pp.350-361.

¹²¹² Academy of Medical Royal Colleges (2014), *Protecting Resources, Promoting Value: A Doctor's Guide to Cutting Waste in Clinical Care*, available at: http://www.aomrc.org.uk/wp-content/uploads/2016/05/Protecting_Resources_Promoting_Value_1114.pdf

procedures whose necessity should be questioned and be the subject of discussion between individual clinicians and patients. It is important that the issue of overtreatment, in all medical specialties, should become a prominent national concern. This will involve informed and sensitive debating of the issues, with the aim of achieving public and professional consensus on the need for this approach to healthcare.

23 September 2016

The Royal College of Radiologists – Written evidence (NHS0049)

1. The Royal College of Radiologists (RCR) works with its membership to improve the standards of practice in the specialities of clinical radiology and clinical oncology.
2. We have focused this response on those issues particularly relevant to our specialties, including models of service delivery and integration, informatics and public health and, most specifically, workforce. There is a severe and chronic shortage of clinical radiologists and a looming workforce crisis in clinical oncology. We outline the problems here and suggest ways of amelioration.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

3. There should be integration of services between primary, secondary and social care. The IT infrastructure and connectivity to support care must be fully operational, and seamlessly integrated, to enable teleconsultations, and regional NHS teleradiology.
4. We are seeing an increasing incidence of most cancers, mainly due to an ageing population, improved efficacy and greater availability of cancer treatments. Many more patients are living longer with their cancers. The workforce and imaging and radiotherapy equipment will need to be markedly expanded to be able to deal with this shift (see response to 2 d).

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

5. The current funding envelope is insufficient to meet the demands of technological advances, changing demographics and patient (and political) expectations.
6. The UK spends substantially less per head of population than other developed countries on healthcare. The percentage of GDP spent on healthcare needs to increase to match the mean spent by other developed nations in order to have comparable standards of healthcare.

a. Does the wider societal value of the healthcare system exceed its monetary cost?

7. In our view, the NHS has become a key element in our national identity.

b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

8. Substantial extra revenue could be found for the NHS and social care by increasing tax on alcohol, tobacco, sugary and high salt foods.

9. The itemised cost of NHS healthcare should be transparent and publically promoted. All providers of NHS healthcare should be required to display posters of approximate costs relevant to activity (for example the cost of imaging investigations and procedures) to help educate the public, patients, doctors and other healthcare workers. This should help to introduce a more realistic awareness of what the NHS can and cannot afford to provide. These costs could be automatically displayed electronically (on electronic patient record systems in hospital and general practice) to requesters of imaging tests and procedures, chemotherapy drug prescriptions and radiotherapy treatment.

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

10. See 2 b. We feel there is a need for a national debate on these issues.

d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

11. If the scope of the resources that are free at the point of use is to be restricted, there is an urgent need for a mature discussion with the population about what can be afforded across all areas of health care.

12. Consideration could be given to delaying elective surgical procedures on obese patients for one year, to allow these patients the opportunity to lose weight (whilst receiving education and support to help them do so). This would also potentially reduce the risk to their health of undergoing a surgery more likely to fail in obese patients, developing infections (wound, respiratory) and suffering other serious complications such as deep venous thrombosis and pulmonary emboli.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

13. The training of sufficient doctors is a paramount requirement to maintain standards of healthcare. Doctors are the only members of the workforce who are trained in the totality of medical care. Aspects of work traditionally performed by doctors can be safely undertaken by other appropriately trained non-medical personnel only when adequate numbers of doctors are available to provide leadership, training and support. It is essential that such training of non-doctors is regulated and standardised at national level.

14. It is counter-productive to lower standards of healthcare by having non-doctors attempt to perform complex work which requires full medical training to be performed properly to a high standard. For example it is inappropriate for diagnostic radiographers (who are not doctors) to be reporting complex radiological CT or MR scans, or chest x-rays, instead of radiologists (who are doctors). Radiologists are able to use the full depth and breadth of their medical knowledge to provide actionable, diagnostic reports, rather than producing descriptive reports on the appearance of the images, (as is the case for radiographers).

15. There are extant serious shortages of all allied healthcare workers (nurses, radiographers), and the valuable work performed by these non-medical people should not be further compromised by changing the nature of the work to the detriment of the quality of patient care.

16. The development of functional networks providing services to a larger population than that traditionally served by a single hospital will allow safe and high quality services for patients with rare conditions to be provided by a smaller number of sub-specialists.

Radiology workforce issues

17. The UK has a severe and chronic shortage of clinical radiologists. There are around seven radiologists (consultants, trainees, academic and staff grade radiologists) per 100,000 people in the UK.¹ Data from the European Commission places the UK third bottom of 31 countries and we are far short of the European average of 12 radiologists per 100,000 people.² This has been brought into focus by the tremendous growth in workload in recent years. In England, the consultant radiologist headcount increased by 5% between 2012 and 2015, yet the number of computed tomography (CT) scans increased by 29% and magnetic resonance (MR) scans by 26%.¹

18. In Scotland the discrepancy between the number of consultant radiologists and the increasing workload is almost double these figures (3% increase consultants with 55% increase in CT and MR scans¹. The exponentially increasing workload shows no sign of abating.

19. 9% (324) consultant radiology posts were vacant in the UK in 2015. 41% were unfilled for over a year due to insufficient applicants of acceptable standard.

- a. The Royal College of Radiologists. *Clinical radiology UK workforce census 2014 report*. London: The Royal College of Radiologists, 2015.
- b. <http://ec.europa.eu/eurostat/web/health/health-care/data/database>

Oncology workforce issues

20. As the number of people diagnosed with cancer continues to increase, and early diagnosis through screening initiatives and enhanced public awareness becomes more significant, this will place increasing strain on the oncology workforce. This will need to be addressed to:

- See and treat increasing numbers of patients, many with multiple conditions.
- Follow up an increasing number of patients who are living longer with their cancers.
- Develop and roll out newer treatment techniques for radiotherapy treatment for the different mix of patients that will present when the impact of earlier diagnosis is felt.
- Upskill the clinical oncologist workforce to define and deliver those treatment regimens.
- Ensure that modern specialised techniques for the radical (curative) treatment of cancer are no longer regarded as innovative treatments, but become the accepted norm.

- Provide a rolling programme of radiotherapy equipment renewal to allow clinical oncologists to continue to practise state-of-the-art modern radiotherapy techniques irrespective of their UK location.

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

Clinical Radiology

21. The only credible short term source for the necessary urgent large number of doctors in radiology is through substantial recruitment of International Medical Graduate (IMG) doctors.

22. Brexit has reduced the likelihood of significant numbers of EU IMGs emigrating to the UK. Many are hampered by English not being their first language.

23. Australian, New Zealand, South African, Canadian and American radiologists would be a very valuable stop gap to help fill the deficit of consultant radiologists in the UK. Many are keen to come and work in the UK for a period of several years. We know that they undergo rigorous high quality radiology training in their own countries, and that the higher radiology exams they have to pass to practice in all these countries are of a very high standard (equivalent to, or more difficult than, the British FRCR examination). The GMC should accept their higher radiology qualifications and exempt them from the administratively cumbersome and costly (in time as well as expense) process of “equivalence”. They should be accepted as eligible to apply for substantive consultant radiology posts in the UK. Immigration regulations should be waived for these radiologists.

24. Efforts by the RCR and other medical Royal Colleges to encourage IMGs to work in the UK have been well intentioned but not resourced or co-ordinated. NHS Employers should promote careers in the NHS to IMGs, especially in India, and particularly for Indian (and other overseas) radiologists who have already passed the British FRCR examination. NHS Employers should run courses and provide online resources to upskill local HR departments on facilitating IMG entry into NHS posts, as recruitment is only the first part of the process before NHS patients can fully benefit from IMGs. NHS Employers should fund medical Royal Colleges to develop better website resources to help IMGs to adapt to the NHS and help local consultants to mentor them effectively.

25. Currently such Medical Training Initiative IMGs have a Tier 5 visa which requires them to return to their country of origin after only two years. This makes such schemes profoundly unattractive. However, if the Home Office would change the visas for such schemes to a Tier 2 type, IMG doctors could apply for an extension of two to three years after their first two years (total five years) if their UK employer supported them. That would give them more time to work for the NHS, and the NHS would be likely to recruit more IMGs. These visa changes for doctors recruited through Medical Training Initiative schemes need priority action by the Home Office.

26. Radiology regional networks (“teleradiology platforms”):

The RCR has been promoting and supporting the concept of using regional NHS informatics networks to assist on site NHS radiologists deliver their imaging services more comprehensively and safely.

[https://www.rcr.ac.uk/sites/default/files/RCR Clinical Radiology response to Dalton Review.pdf](https://www.rcr.ac.uk/sites/default/files/RCR_Clinical_Radiology_response_to_Dalton_Review.pdf)

Clinical Oncology

27. A comprehensive overhaul of role definitions/competencies is needed to encourage appropriate skill mix, enabling Allied Health Professionals (AHPs) to undertake enhanced roles. A current example with some benefit would be a four tier radiographer workforce but instituted across the whole patient pathway.

28. Overseas recruitment is less appropriate in clinical oncology due to different types of practice as the UK's highly cost-effective integrated model of training and practice (in which clinical oncologists deliver all forms of non-surgical cancer treatment) differs from that in most other countries. Shifting the workload delivery by employing overseas doctors with restricted skills changes the service specification of the home-grown workforce, potentially leading to unintended consequences including deskilling.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

29. NHS radiology and oncology services depend to a large extent on the contribution of doctors and other health professionals who have trained and qualified overseas. Uncertainty since the referendum result was announced has led many to consider their long term futures in this country. At the same time, it will inevitably become more difficult to attract staff from other EU countries to work in the UK. This effect could potentially be offset if Brexit makes immigration easier for doctors and other staff from non-EU countries. For example, many doctors from the Indian sub-continent already have appropriate knowledge assessment in terms of College exams and good English language skills.

30. The potential impact of leaving the EU on cancer research is of major concern however as cancer research relies heavily on European collaboration and EU funding. It is likely that even with "replacement" UK government funding, establishing research collaborations will be more difficult because potential European collaborators will be more hesitant to work with those from the UK.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

- Fatigue and demoralisation due to chronic over-work and relentless increase in demand.
- The administrative burden of appraisals and five yearly revalidation (without any current published evidence that these processes enhance healthcare) are a disincentive to older radiologists and clinical oncologists to continue working. There needs to be a significant reduction in the appraisal/revalidation requirements for more senior radiologists and clinical oncologists. These requirements should be tailored specifically to the (often restricted) clinical work these older doctors now perform at this stage of their career.
- Unfavourable changes to the NHS pension scheme have acted as a driver for early retirement
- Availability (for radiologists) of lucrative employment in the independent sector

working for teleradiology outsourcing companies with much improved work-life balance

- Poor NHS working environments in many hospitals
- Inadequate support for less-than-full-time working. There are many oncologists approaching retirement age who would like to continue working, but not on a full time basis but NHS employing organisations are often reluctant, or unwilling, to take a flexible approach to this issue.

Also see answer to 3 a.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

- Provide appropriate support for trainers (i.e. time and training)
- Provide appropriate leadership
- Sharing of training resources when appropriate
- More on-line resources as part of a training programme of blended learning well supported by trainers (can be networked)

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

31. The IT infrastructure is critical to facilitate communication between primary, secondary and social care. Multiple IT systems with poor inter-connectivity across organisations reduce efficiency.

32. Mandating the imaging informatics industry to implement a few simple vendor-neutral IT standards would greatly facilitate interconnectivity between different medical informatics and imaging systems in the UK. One example is mandating that the patients' NHS number is automatically assigned to the same specified DICOM field (DICOM is an internationally implemented imaging informatics standard).

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

33. It is inevitable that there will be cost implications as a result of ensuring an efficient, adaptable and multi-professional workforce.

34. Match the competency and knowledge base of the staff to the tasks they are being asked to perform is essential if standards of healthcare delivery are to be upheld.

c. What investment model would most speedily enhance and stabilise the workforce?

- If the expansion of the medical workforce is not supported, we will have a disparate workforce with different areas of extended practice. This will cause difficulties in training and be very hard to replace and is therefore not sustainable. More generic skills for all professions are needed. Support is required for staff to maintain the skills they have when they qualify.

- Investment in supporting the workforce in terms of equipment, ergonomic working environments, respect, appropriate workflow and team-working will enhance and stabilise the workforce.

Models of Service Delivery and Integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

- Integrated primary, secondary, social and preventative care funding, with particular emphasis on support for social care to facilitate discharges from hospital or interventions to prevent admissions.
- Remove operational aspects of the NHS as far as possible from political control and allow decisions on service reconfiguration to be made without political interference.

a. How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

35. No comment (outside our expertise)

b. How can local organisations be incentivised to work together?

36. If there is a single funding “pot” they will have to work together to make it work. Despite moves towards population-based health and social care, the underpinning ethos (and supporting legislative framework) of current structures remains one of competition rather than collaboration.

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

37. No comment (outside our expertise)

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a. What are the key elements of a public health policy that would enhance a population’s health and wellbeing and increase years of good health?

38. There needs to be a greater recognition of the social determinants of health and treatment outcomes. In the case of cancer, survival rates are worse for patients from deprived areas. This is a societal issue and cannot be resolved by the NHS or social care alone.

39. The public needs to be empowered to take responsibility for its own health by education on issues such as: avoiding obesity by correct diet and sufficient exercise; dental hygiene and avoiding sugary drinks and foods.

40. Investment in public health environmental measures to reduce air and land pollution (including toxic farm fertilisers and weed-killers), reduce carbon footprint, and prevent further climate change will help population health. This will reduce respiratory diseases, and psychological and physical damage from floods, heat waves etc.

b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

41. In order to reduce the risk of cancer and other diseases, there must be continued action on the well recognised lifestyle issues, for example, smoking cessation, avoidance of excessive sunlight, obesity, exercise etc. There is a limit to what health education can achieve and historically the most effective initiatives have been legislation and pricing initiatives.

c. Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

42. Public health measures do not necessarily involve additional costs. For example, not marketing high sugar content drinks should not involve more cost. Regular exercise is “free”, although could be facilitated by measures such as safe cycle lanes.

d. Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

43. Yes. There is good evidence that legislation and pricing policy can drive improvements.

e. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

44. This is a complex issue but inevitably people will need to take a shared responsibility for their own health and well being, via a combination of education and incentivisation.

f. What are the barriers to taking on received knowledge about healthy places to live and work?

45. Regarding health at work, a lot could be done to promote healthy eating and measures to help ensure an appropriately healthy work life balance, and encouraging and facilitating workers to take more exercise.

g. How could technology play a greater role in enhancing prevention and public health?

46. Modern digital technologies and use of social media could play a much greater part.

7. What are the best ways to engage the public in talking about what they want from a health service?

47. A mature conversation is required between the public and politicians about what the NHS can provide and how it is to be funded in the future. This will require a highly sophisticated approach to ensure engagement with all groups of the population and across the breadth of issues. No one medium or technique will suffice.

48. Much more explanation is required about the massive costs of healthcare and likely health care cost inflation.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

- Telecare and telehealth should reduce requirement to attend a GP surgery and many OPD appointments.
- Advances in genomics/genetics need to be realised before personalised medicine can be implemented so not easy to estimate.

b. What is the role of 'Big Data' in reducing costs and managing demand?

49. No comment

c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

- Poor IT infrastructure.
- Lack of funding.
- Lack of seamless informatics interconnectivity

d. How can healthcare providers be incentivised to take up new technologies?

50. We do not perceive a reluctance from healthcare providers to take up new technologies. The barriers are usually time, cost and maintenance.

51. Healthcare providers should be supported by advice on writing specifications and contracts when tendering for new informatics equipment to help them avoid various pitfalls. For example: the contract should specify free updates and upgrades, and it should include robust realistic penalty clauses for unplanned downtime, or for the equipment not being fit for purpose.

e. Where is investment in technology and informatics most needed?

52. Connectivity and rapid, seamless sharing of data – imaging and clinical - between all relevant parts of health and social care.

22 September 2016

The Royal College of Radiologists – Supplementary written evidence (NHS0192)

Brief opening statement

Consultant radiologists are doctors who interpret x-rays, scans and other types of medical images to detect and diagnose disease and injury. They also use advanced, minimally invasive techniques to treat disease such as cancer and stop internal bleeding thereby saving lives. Timely, accurate diagnosis using imaging techniques can speed up access to treatment, prevent or reduce hospital stays and offer major cost savings.

Clinical oncologists are doctors skilled in non-surgical cancer treatment, using radiotherapy, chemotherapy, hormone therapy, radioactive isotopes and other special techniques to treat people with cancer. The clinical oncologist is often the only doctor, together with the GP, to manage the patient through the whole course of their cancer.

Both are consultant led and delivered specialties. Clinical radiology underpins the vast majority of medical diagnoses and is essential to all major surgery; and clinical oncology provides an holistic approach to non-surgical cancer treatment utilising curative and therapeutic radiotherapy and chemotherapy.

The Royal College of Radiologists leads, educates and supports both medical specialties to help deliver better care for patients and ensure the standards of training and education are maintained and improved.

The overwhelming concern of the College for the future of the NHS is workforce in both our specialties, most critically in clinical radiology: put simply we have a workforce that is under-funded, under-doctored and overstretched. The NHS will collapse without radiology, and the cancer pathway will fail without clinical oncology.

1. What impact do you expect changing patterns of disease, demography and medical advances to have on the model of care in 2030? What does this mean for the roles of the healthcare workforce that you represent?

- By 2030 advances in technology, allied to spiralling healthcare requirements, will make radiology even more pivotal to the whole of healthcare. Radiological diagnosis and interventional radiology procedures will be even more key than they are now.
- There is an increasing incidence of most cancers, mainly due to an ageing population and unhealthy lifestyles. Many more patients are living longer with their cancers due to improved efficacy and greater availability of cancer treatments. The clinical oncology and clinical radiology workforces and imaging and radiotherapy equipment will need to be markedly expanded to be able to deal with this shift.
- Earlier diagnosis through screening initiatives using imaging, enhanced public awareness and the ambitions of the English and Scottish cancer strategies. These will place an increasing strain on the workforce.

- Clinical oncologists will need to develop and roll out different radiotherapy treatment for the different mix of patients from earlier diagnosis and upskill to do that. The more complex radiotherapy planning needed occupies more time with an impact on the workforce numbers needed.
- Stroke – urgent imaging and interpretation of brain imaging, and many more interventional neuroradiologists are needed to allow optimal diagnosis and treatment of stroke and for the new treatment of mechanical thrombectomy (clot removal from brain arteries) to be effective.
- Molecular imaging using new radioisotope tracers more accurately to diagnose and monitor specific types of cancer, and to determine whether they are responding to treatment are expensive and technically demanding, but have great patient benefit. Molecular cancer treatments targeted on specific cancer cell types, and delivered directly into the tumour tissue will require more interventional oncology radiologists.
- Increased patient expectations as to rapid diagnosis and targeted effective treatment. Such expectations are routine in the modern world where most services and commodities can be acquired almost instantaneously over the internet.
- NICE guidelines which are increasingly advocating imaging, and more complex imaging techniques as the optimal investigation in many diseases (examples from 2016 include: (1) the use of cardiac CT – a complex examination requiring heart rate monitoring and accurately timed intravenous contrast administration - as the first investigation for acute stable chest pain, (2) the use of the technically and professionally demanding investigation of whole body magnetic resonance scanning of patients with the haematological disease of multiple myeloma instead of the simpler, much less sensitive imaging test of a skeletal survey using several plain x-rays).
- The impacts of obesity, diabetes and dementia on population health and therefore on imaging and oncology.

2. What are the most significant workforce issues for the members you represent?

Radiology workforce issues

The UK has a severe and chronic shortage of clinical radiologists. There are around seven radiologists (consultants, trainees, academic and staff grade radiologists) per 100,000 people in the UK (1). Data from the European Commission places the UK third bottom of 31 countries and we are far short of the European average of 12 radiologists per 100,000 people (2). This has been brought into focus by the tremendous growth in workload in recent years. In England, the number of computed tomography (CT) scans increased by 29% and magnetic resonance (MR) scans by 26%,¹ yet the consultant radiologist headcount increased by 5% between 2012 and 2015.

In Scotland, the discrepancy between the increasing workload and the number of consultant radiologists is almost double these figures (55% increase in both CT and MR scans¹ with only a 3% increase consultants). The exponentially increasing workload shows no sign of abating.

Between 2015 and 2020, depending on retirement date, census data suggests that between 15% and 20% of the clinical oncologist workforce could retire.

Between 2015 and 2020, depending on retirement date, census data suggests that between 15% and 18% of the clinical radiologist workforce could retire.

9% (324) consultant radiology posts were vacant in the UK in 2015. 41% of these were unfilled for over a year due to insufficient applicants of acceptable standard. Feasible options for increasing supply of radiologists:

The urgent immediate shortfall could be addressed by stop gap measures:

- European radiologists are currently accepted as equivalent to those trained in the UK, and they are allowed unrestricted entry to the UK and recognition by the GMC. This policy must be continued post Brexit, since we need these European radiologists and clinical oncologists. (They currently constitute x% of our consultant radiology workforce).
- Substantial recruitment of International Medical Graduate (IMG) doctors and amended visa/equivalence requirements to enable the process to be carried out quickly and smoothly.
- Use of regional networked teleradiology informatics platforms(3) to assist on site NHS radiologists to deliver their imaging services more comprehensively and safely. These teleradiology platforms would allow the provision of second opinion services in acute shortage subspecialties such as paediatric radiology. They would also allow radiation planning between regional sites.

In the longer term, many more radiologists must be trained (260 extra trainee radiologist places are required every year for the next 5 years merely to catch up with the mean in Europe). This can be achieved by:

- using the very considerable surplus training capacity already identified in numerous district general hospitals around the UK
 - opening new radiology training academies in the UK (in Wales, the East Midlands, the West Midlands, Kent and Scotland) in addition to the radiology training academies in the UK which already exist
 - These academies could train many more radiologists per year than they already do. They could also be used for parallel training for non-doctor radiographers since there is currently a 13%(4) national shortage of radiographers to work the X-ray and scanning machines and produce the radiology images)
- c. The Royal College of Radiologists. *Clinical radiology UK workforce census 2015 report*. London: The Royal College of Radiologists, 2016
- d. <http://ec.europa.eu/eurostat/web/health/health-care/data/database>
- e. Who shares wins: efficient collaborative radiology solutions https://www.rcr.ac.uk/system/files/publication/field_publication_files/rcr164_who-shares-wins.pdf
- f. <http://www.sor.org/learning/document-library/diagnostic-radiography-uk-workforce-report-2016>

Oncology workforce issues

The College's latest CO census findings (2015) (5) show that:

- **28%** of unfilled Consultant posts have been vacant for 12 months or longer. Many cancer centres are experiencing difficulties in recruiting new members of staff
- Nearly **1 in 5** of the oncology workforce could retire in the next five years. In some UK regions the figure is as high as **26%**

- **67** additional full-time Consultants are required to cover the excess workload undertaken by the current workforce.

With a median retirement age of 60, it is expected that 55% of the current consultant workforce in clinical oncology are due to retire by 2025. As it takes a clinical oncologist seven years of specialty training before becoming a consultant this could impact on the care of cancer patients; especially as one-in-two people will be diagnosed with cancer in their lifetime, while four out of every 10 cancers cured include radiotherapy as part of their treatment which can only be prescribed by clinical oncologists.

The feminisation of the workforce, the complexity of therapies to be delivered, the constant adaptation arising from the availability of new therapies and the different side effects they each have and the increased support needed for patient populations that are multiply comorbid all contribute to increased demands on an already stretched workforce.

- g. The Royal College of Radiologists. Clinical oncology UK workforce census 2015 report. London: The Royal College of Radiologists, 2016.

3. What changes to the skills mix of the workforce do you think need to happen over the longer-term? To what extent will this mean developing or extending the scope of existing roles within the health workforce?

Clinical radiology

In radiology services, the highly skilled work done by radiologists and radiographers means that skills mix is not the best term to apply to team working. The more appropriate concept is role extension: for radiologists this means the constantly evolving skillset needed to adapt to ever advancing technology and the demand for ever more accurate diagnosis. For radiographers, this is ensuring they have careers that develop and grow to use their skills effectively.

However, both workforces are under immense pressure. Just last week a report from the Society and College of Radiographers revealed a nationwide shortage of diagnostic radiographers with a 13% vacancy rate(4). This must not be exacerbated by taking radiographers away from performing their core skills by role extension. Coupled with the workforce problems for clinical radiologists, the prospects for further role extension are very limited. Those huge shortfalls must be plugged simply to keep current services going. Further role extension is not a sustainable solution for the NHS in radiology services.

The training of sufficient doctors is paramount to maintaining standards of healthcare. Doctors are the only members of the workforce who are trained in the totality of medical care. Aspects of work traditionally performed by doctors can be safely undertaken by other appropriately trained non-medical personnel only when adequate numbers of doctors are available to provide leadership, training and support. It is essential that such training of non-doctors is regulated and standardised at national level. This is currently not the case for non-doctor radiographer reporting, or for non-doctor ultrasound.

It is counter-productive to lower standards of healthcare by having non-doctors attempt to perform complex work which requires full medical training to be performed properly to a high standard. For example it is inappropriate for diagnostic radiographers (who are not doctors) to be reporting complex radiological CT or MR scans, or chest x-rays, instead of radiologists (who are doctors). It is vital to understand that reports on radiological examinations often do not provide clear cut “yes/no type” answers, like a blood test revealing whether or not the haemoglobin is normal. A radiological report is a medical opinion, often a differential diagnosis, based upon the appearance of the chest X-ray or scan, in the context of the patient’s clinical condition and the results of other clinical investigations. Radiologists are able to use the full depth and breadth of their medical knowledge to provide actionable, diagnostic reports, rather than producing merely descriptive reports on the appearance of the images, (as is the case for radiographers, who are working at a disadvantage because they lack medical training).

Such role extension is not clinically contributory if a high quality service is to be maintained, and is not fair to patients.

Clinical oncology

In Clinical oncology the needs are not the same as patterns of working have evolved differently. The NHS England consultation on radiotherapy service delivery to be issued early next year and the Cancer Research UK research project into the non-surgical oncology workforce offer opportunities to review future skillsmix and the College will be taking a leading role in both.

4. In order for the NHS to be sustainable over the next 15 to 20 years, will the healthcare (and social care) systems need to be organised differently? If so, how?

- Early diagnosis helps prevent admission to hospital. Integrated primary, secondary, social and preventative care, with particular emphasis on support for social care to facilitate discharges from hospital or interventions to prevent admissions.
- The development of functional radiology networks (^{ref}Who shares wins: efficient collaborativeradiologysolutionshttps://www.rcr.ac.uk/system/files/publication/field_publication_files/rcr164_who-shares-wins.pdf) providing timely and robust medical diagnosis services to a larger population than that traditionally served by a single hospital are probably the only way for such services to survive in the current economic and workforce climate. Such networks are the way also to provide safe services for paediatric patients and those with rare conditions.
- Mandating the imaging informatics industry to implement a few simple vendor-neutral IT standards would greatly facilitate interconnectivity between NHS medical informatics and imaging systems in the UK. This would make it easier to link different imaging IT systems and search for a patient’s imaging studies across the region (e.g. putting the patient NHS number in the same DICOM field regardless of the make of the system)
- Interventional radiology is a large part of the speciality of radiology. Interventional radiologists provide effective internal treatment without the need for surgery, and generally without the patient undergoing a general anaesthetic. Interventional radiologists treat acute bleeding from the gut, the womb and after trauma by

blocking (embolising) the bleeding artery without surgery. Interventional radiologists also kill cancer by a variety of minimally invasive techniques such as directly freezing or burning the tumour, or by treating the tumour with locally internally delivered radioactive particles or drugs. Interventional neuroradiologists can stop bleeding from brain arteries (subarachnoid haemorrhage) and can remove blood clot from acutely blocked brain arteries thereby curing/treating strokes and preventing long term paralysis and dependent care.

- The NHS referral and care system needs to be changed to become more efficient, so that interventional radiologists are sent patients directly, can see them in outpatient clinics (if not emergency presentations) and can admit patients to beds directly if necessary.

5. How far is over burdensome regulation in healthcare a barrier to driving the improvements in the delivery of healthcare that are needed to ensure the system is sustainable in the long-term?

- Medical revalidation has proved to be a considerable administrative and time consuming burden, most of which has to be performed in a doctor's spare time. It is a huge barrier with no proven benefit. As yet we have not had any evaluation as to its effectiveness and whether it has made any positive impact on the safety and standards of patient care in the UK. The GMC is conducting that work now and we understand that it is due to conclude in 2018. We have growing evidence that revalidation is a major deterrent to keeping in practice many doctors later in their careers. This is denying the NHS valuable and highly experienced members of the workforce.
- NHS hospitals are imposing a blanket requirement on all doctors to undergo unnecessary mandatory training to "pass" their yearly appraisals. For example, those radiologists who simply want to continue to teach and report plain X-rays and scans, at the ends of their careers, and have no patient contact do not need to undergo patient safety, resuscitation or patient lifting courses and tests. The imposition of these time-consuming and, in these cases, futile, requirements is driving more senior doctors to take early retirement rather than carry on working. The profession and the NHS – and thereby patients - lose a hugely valuable and experienced resource which we so desperately need to report imaging examinations and to help train the future generations of radiologists. Doctors should undergo mandatory training only pertinent to the clinical work they are currently performing.
- Bodies such as CQC and NHS Improvement, are imposing over-burdensome regulation on hospitals. There are inconsistencies and inaccuracies in inspection reports. Again there is no proof that they actually make a difference.

6. What is your key suggestion for a change this Committee could recommend which would support the long-term sustainability of the NHS?

Overall the UK must increase the percentage of its GDP spent on the NHS so that it is comparable with that in other western countries (The UK spends 9.9% GDP on health and social care. France and Germany spend approx 11%, USA spends approx 16.5%)

In clinical radiology and clinical oncology there have to be short term and long term solutions to the workforce crisis.

Short term:

- Structured, funded, concentrated efforts to bring in radiologists from overseas

Long term:

- Sustained investment over the next decade in additional training places for both specialities, using available district general hospital training capacity and more training Academies with greater through-put.

December 2016

The Royal College of Speech and Language Therapists – Written evidence (NHS0113)

1. Executive summary

1.1 To support the long-term sustainability of the NHS it is important to maximise and utilise the skills of the whole health workforce. We encourage the Committee to recognise the contribution that speech and language therapists (SLT) can make to efficiency savings within the NHS and their role in supporting the delivery of new models of care, self-management of long-term conditions and promoting public health.

1.2 The Royal College of Speech and Language Therapists is committed to supporting workforce transformation within the speech and language therapy profession. There is an urgent need to reshape the NHS workforce and the way in which NHS services are delivered to meet the needs of service users both now and in the future.

2. About the Royal College of Speech and Language Therapists

2.1 The Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists (SLTs), SLT students and support workers working in the UK. We have just under 17,000 members. We promote excellence in practice and influence health, education, employment, social care and justice policies.

3. About speech and language therapists

3.1 SLTs provide life-improving treatment, support and care for people who have difficulties with speech, language or communication or eating, drinking or swallowing problems. SLTs are central to the provision of safe, value for money healthcare and supporting the delivery of NHS priorities. From helping babies with cleft lip and palate, to supporting people recovering from a stroke or older people living with dementia, speech and language therapy transforms lives.

4. Utilising the talents of allied health professionals

4.1 In response to reductions to national healthcare budgets and a rising population with complex needs it is vital that the skills of allied health professionals (AHPs) are used more fully. As highlighted by the Nuffield Trust, there is a need to reshape the health workforce to deliver the care that patients need and alleviate pressures on the health system (such as challenges affecting primary care and high levels of spending on agency staff).¹²¹³

¹²¹³ Nuffield Trust (2016) Reshaping the workforce to deliver the care patients need:
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/reshaping_the_workforce_web_0.pdf

4.2 It is important that workforce planners and policy makers recognise the potential of AHPs, such as SLTs, and the contribution that they make towards NHS efficiency savings and improvements in patient care. The following paragraphs outline further information regarding the work of SLTs and how they can support the sustainability of the NHS.

5. Supporting the delivery of new models of care

5.1 As highlighted by the Chair of NHS England, AHPs have a vital role to play in the delivery of new models of care and shifting care from hospitals to community settings.¹²¹⁴ SLTs already provide preventative health care in local communities and are skilled in multidisciplinary team working and the delivery of integrated care. As noted as part of the House of Commons Health Committee inquiry on primary care, incorporating allied health professionals into general practice can help to alleviate pressures on GPs and improve services for patients.¹²¹⁵

5.2 In many parts of the country SLTs are already employing innovative approaches to deliver enhanced patient care. For example, SLTs in Blackpool have used teleswallowing technology to conduct remote speech and language therapy assessments of older people in care homes.¹²¹⁶ The use of this new way of working has helped to reduce travel costs and increase staff capacity so that their time is 'freed up' and can be used to treat more patients.

6. A focus on prevention and public health

6.1 As highlighted in the Five Year Forward View, the sustainability of the NHS requires a radical focus upon public health and prevention.¹²¹⁷ SLTs work across the four domains of public health:

- **Health protection:** SLTs support screening and early identification of speech and swallowing difficulties, for example, they identify children with early language delays.
- **Health promotion:** SLTs support the rehabilitation and enablement of people with acquired and developmental conditions, for example, they support people who have experienced a stroke.
- **Health improvement:** SLTs 'make every contact count' and, where appropriate, promote wider public health messages as part of their interactions with patients.
- **Wider determinants of health:** SLTs provide targeted support to patients in deprived communities due to the links between speech, language and

¹²¹⁴ NHS England (2015) The NHS is not just about doctors and nurses <https://www.england.nhs.uk/2015/06/ahp-fyfv/>

¹²¹⁵ House of Commons Health Select Committee (2015) Oral evidence: Primary care HC408

<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/primary-care/oral/24413.html>

¹²¹⁶ University College London (2016) London Speech and Language Therapy workforce scoping project, phase 2: modelling workforce transformation example, report available upon request.

¹²¹⁷ NHS England (2014) Five Year Forward View: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

communication needs and social disadvantage.¹²¹⁸ Research indicates that up to 50% of children in deprived communities start school with language delay.¹²¹⁹

6.2 We encourage the Select Committee to acknowledge the contribution that SLTs and the whole health workforce can make to the public health agenda and how a focus upon early intervention can avoid costs to the NHS. As highlighted by the Public Health England and Allied Health Professions Federation public health strategy for 2015-2018, the RCSLT and other AHP professional bodies are committed to developing the capacity and impact of AHPs in public health both now and in the future.¹²²⁰

7. Self-management of long-term conditions

7.1 15.4 million people in England have a long-term condition and their care absorbs 70% of hospital and primary care budgets in England.¹²²¹ SLTs assess, treat and support people with long-term conditions and develop personalised plans that support their needs. Using specialist skills, SLTs work directly with patients with long-term conditions, their families, and other professionals to develop personalised strategies that can help to maximise their health/abilities. For example, SLTs support safe swallowing amongst patients with Parkinson's disease.

7.2 By treating, supporting and providing care for children and adults in community settings SLTs help to prevent unnecessary hospital admissions and decrease the need for crisis management of conditions such as dysphagia (swallowing problems). SLTs also help to support financial savings and deliver improved care in acute settings by working with emergency care teams. As part of emergency care and discharge planning, SLTs work closely with other services, such as physiotherapists and occupational therapists, to assess and support patients' needs. They help to prevent a cycle of emergency readmissions by working with individuals and their families to develop personalised strategies to manage their speech, language, communication and swallowing difficulties.¹²²²

8. Delivering workforce transformation

8.1 As highlighted by recent research from the Nuffield Trust, there is a need to reshape the NHS workforce to deliver the care that patients need and maximise the skills and

¹²¹⁸ APPG on Speech and Language Difficulties (2014) The links between speech, language and communication needs and social disadvantage https://www.rcslt.org/governments/docs/all_party_parliamentary_group_on_slcn_inquiry_report

¹²¹⁹ 2 Law J, McBean K, Rush R (2011). Communication skills in a population of primary school-aged children raised in an area of pronounced social disadvantage, *International Journal of Language and Communication Disorders*, 46(6), pp. 657-64.

¹²²⁰ Public Health England and the Allied Health Professions Federation (2015) A strategy to develop the capacity, impact and profile of allied health professionals in public health 2015-2018 <http://www.ahpf.org.uk/files/AHP%20Public%20Health%20Strategy.pdf>

¹²²¹ NHS England (2016) Domain 2: Enhancing quality of life for people with long-term conditions: <https://www.england.nhs.uk/resources/resources-for-cgcs/out-frwrk/dom-2/>

¹²²² RCSLT (2016) Reducing pressures on urgent and emergency care: the role of speech and language therapists https://www.rcslt.org/governments/docs/reducing_pressures_on_care_factsheet

abilities of the non-medical workforce.¹²²³ The development and extension of skills within the current AHP workforce needs can help to support financial savings and unlock the full potential of existing NHS staff. The RCSLT is committed to supporting workforce transformation within the speech and language therapy profession and has been assisting members to take on extended and advanced roles where appropriate.

8.2 The RCSLT and professional bodies representing the allied health professions are working closely with the Chief Allied Health Professions Officer at NHS England to explore barriers and opportunities for workforce transformation. Due to growing drivers of future demand, such as an aging population, and on-going constraints on NHS funding, the RCSLT has been working with members to explore how services can be delivered in more efficient and innovative ways.

8.3 The RCSLT is continuing to monitor workforce trends that will impact on the future supply of SLTs and other health professionals within the NHS, such as changes to student funding and a growth of portfolio-working within the profession. It is important for the Committee to note that a growing number of SLTs are employed outside of the NHS, including in independent practice, the voluntary sector, education and the youth justice system. Increasing pressures upon the NHS may have a direct impact on the retention and recruitment of SLTs and other healthcare staff, and could cause an increase in the number of health professionals employed outside of the NHS.

23 September 2016

¹²²³ Nuffield Trust (2016) Reshaping the workforce to deliver the care patients need: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/reshaping_the_workforce_web_0.pdf

The Royal College of Surgeons of Edinburgh – written evidence (NHS0180)

The Royal College of Surgeons of Edinburgh [RCSEd] is the oldest and largest of the UK surgical Royal Colleges, and one of the largest of all the UK medical Royal Colleges. First incorporated as the Barber Surgeons of Edinburgh in 1505, the College has been at the vanguard of surgical innovation and developments for over 500 years.

Today we are a modern, thriving, global network of medical professionals with a membership of well over 23,000 professionals who live and work in more than 100 countries around the world. Over 10,500 of these live and work in England. Our membership includes people at every stage of their career, from medical students through to trainees, consultants and those who have retired from practice.

With our interest in professional standards, the College's primary role – and the main concern of our Fellows and Members - is to ensure the safety of our patients and provide them with the best possible care. We do this by championing the highest standards of surgical and dental practice; through our provision of courses and educational programmes, training, examinations and Continuous Professional Development; our liaison with external medical bodies; and by influencing healthcare policy across the UK.

The future healthcare system

1. *Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?*

To ensure the ongoing sustainability of the NHS a number of core services need to be redesigned. It is not sustainable or desirable to prop up a system where every hospital seeks to provide every surgical service. Centres of excellence will be required to deliver the most specialist procedures and a more generalist workforce is vital in meeting acute and emergency needs as well as the vast majority of common surgical procedures.

There also needs to be a fundamental shift from treatment to prevention. Whilst surgical intervention will always be required, improving the public's health will mean fewer people undergo surgery and those who do are more likely to experience better outcomes. This in turn will mean less time spent in hospital and a decreased chance of follow up interventions being required.

This must all be supported by a truly integrated system which supports clinicians to care for their patients as opposed to the current system which often slows, confuses and duplicates vital work. These systems must also support patients to take ownership of their own care, in their own homes, to the greatest extent possible.

Resource issues, including funding, productivity, demand management and resource use

2. *To what extent is the current funding envelope for the NHS realistic?*

- a. *Does the wider societal value of the healthcare system exceed its monetary cost?*
- b. *What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?*
- c. *What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?*
- d. *Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?*

It is clear that NHS cannot continue to deliver the same level of service within the current funding envelope. Whilst there is still hope that more efficiency savings could be found, there is no credible source that claims they could meet the funding gap predicted by 2020, let alone 2030. This is compounded by the fact that many efficiency savings that could be found would require some short term investment to be realised.

The alternatives – reduction in quality, rationing, charging, insurance contributions and tax increases – have been widely discussed and the merits of each will be familiar to members of the Committee. Any approach that is taken will require full support from the public but given evidence of support for differing approaches¹²²⁴ it might be advisable to widely consult on a single proposal.

In 2014 the Commonwealth Fund found that the NHS to be the best healthcare system of 11 developed countries, not least because of the efficiency and effectiveness of the system¹²²⁵. As well as further outlining the limited potential of efficiency savings, we believe that this report demonstrates the value of a tax-funded health system. Whilst support for a dedicated NHS tax¹²²⁶ shouldn't be taken for granted, we believe that an ongoing demarcated tax should be considered as part of any proposal presented to Parliament and the wider public.

We support sin taxes where they can be proven to have a disincentivising affect. Specific examples of the taxes we support can be found below, but those that can be shown to reduce the pressure on NHS services should be prioritised. Whilst the revenues raised by these taxes can be useful, the preventative nature of those that are successful will lead to much greater savings elsewhere in the system.

In addition to a dedicated NHS tax and sin taxes, a one off tax [such as the mansion tax] could be considered in order to fund the initial investment required to realise longer term efficiency savings. For example, an injection of funds would allow for the reconfiguration of

¹²²⁴ <https://www.theguardian.com/society/2014/jul/16/poll-raise-taxes-nhs-funding> - accessed 16/09/2016

¹²²⁵ <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror> - accessed 16/09/2016

¹²²⁶ <https://www.theguardian.com/society/2014/jul/16/poll-raise-taxes-nhs-funding> - accessed 16/09/2016

a specialist surgical service into a centre of excellence¹²²⁷, leaving more money and capacity for the most common procedures that will continue in the other hospitals.

Ultimately we believe that any future model should remain free at the point of need and funded through the taxation options discussed above. Any charges at the point of access can dissuade people from seeking care. This can prove to be a false economy when those with infectious diseases, for example, do not come forward, resulting in a threat to the wider public health. Also, wide spread support for the NHS is built upon an equality of access. Therefore, it is our opinion that means testing is only desirable when it comes to taxation.

Finally, we would strongly urge that simply reducing the quality of the service should not be entertained as an option. As a Royal College, our sole concern is maintaining the highest possible level of patient care. Loosening targets and accepting a lower standard of care goes against everything the NHS was created to do. Whilst there are difficult questions to answer about what the NHS can and cannot afford to do, all services that the NHS does deliver must be delivered to the highest possible standard.

Workforce

3. *What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?*
 - a. *What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?*
 - b. *What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?*
 - c. *What are the retention issues for key groups of healthcare workers and how should these be addressed?*
4. *How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?*
 - a. *What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?*
 - b. *What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?*
 - c. *What investment model would most speedily enhance and stabilise the workforce?*

As the UK's largest Surgical College, with a membership drawn from across all four UK home nations, we are only too aware of the size and complexity of the issues faced in the English NHS. However we believe that a number of practical steps can be taken in the short term that will both improve workplace cultures and ultimately patient care. In particular, we are concerned about the issues around safe and effective surgical training.

¹²²⁷ https://www.rcsed.ac.uk/media/167859/web_trauma%20care%20report%202012.pdf

First of all, it is essential that all contacts, whether for trainees or consultants, guarantee sufficient time for training and all flexibility in work plans. A workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients can only be created if clinicians are able to train and retrain alongside their responsibilities for service provision. Whilst the cost implications will need to be considered carefully, a model of credentialing based on patient need is vital to ensuring the sustainability of surgical provision within the NHS.

Secondly, we would support the reintroduction of the ‘apprenticeship’ model of surgical training. Both the GMC’s annual trainee survey and feedback from our own Members and our Trainees’ Committee which represents them, clearly indicate high levels of dissatisfaction with the quantity and quality of the training they receive. We believe that the NHS is far too reliant on trainees to deliver services and, where training and CPD is provided, it is often of poor educational quality. A return to a modern day apprenticeship model would not only restore the personal links between trainer and trainee but also enhance the value of the training experience. This would in turn help nurture a more effective and stable workforce, further contributing to the sustainability of the NHS.

We would also argue that a consultant’s ability to deliver excellent patient care is often hampered by the requirement placed upon them to fulfil a range of clinical, academic, educational and leadership roles. We would therefore ask that the role of consultants be simplified and streamlined, allowing them to focus on particular areas of responsibility. This would allow those consultants who are responsible for training and mentoring the next generation of practitioners to be given the time and space to do so; something which would not only benefit consultants, but trainees and patients. It would also enable those who would prefer to focus on academic research to help bring about the advances that ensure the NHS is a modern health system.

Finally we believe that nationwide structures need to be put in place to help develop the professional skills and competencies of non-medical staff. We strongly endorse the findings of the recent Nuffield Trust / NHS Employers report into this area and, as the only UK Surgical College with a Faculty of Perioperative Care which recognises the crucial role played by the whole surgical team, we would welcome the opportunity to play an active role in bringing this about. It is also vital that regressive and hierarchical workplace structures are removed to promote a more positive culture. One specific improvement would be to find a less pejorative term be found to describe ‘junior’ or ‘trainee’ doctors. These are highly skilled and highly dedicated professionals and should be recognised as such.

As a College we believe that these actions are essential if we are to retain the current NHS workforce, attract next generation of practitioners, and safeguard the NHS for patients now and in the future. We believe that these measures are essential to ensuring that everyone who works within the NHS, and all those who rely on its services, can continue to do so for many years to come.

Models of service delivery and integration

5. *What are the practical changes required to provide the population with an integrated National Health and Care Service?*
 - a. *How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?*
 - b. *How can local organisations be incentivised to work together?*
 - c. *How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?*

The College supports proposals of better integration health and social care and moves to reduce the NHS's general over-reliance on hospitals. We also welcome the concept of local services being configured to meet specific local needs.

However, we also believe that patients are best served in a NHS that has a national focus and offers the same standard of high quality care, regardless of where it is needed. Therefore all decisions over resources and services should meet nationally agreed clinical and patient safety standards and be as open and transparent as possible.

We welcome healthcare devolution in England and look forward to working with relevant partners in the city regions as the plans develop to ensure the highest standards of patient care are implemented.

Prevention and public engagement

6. *What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?*
 - a. *What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?*
 - b. *What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?*
 - c. *Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?*
 - d. *Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?*
 - e. *By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?*
 - f. *What are the barriers to taking on received knowledge about healthy places to live and work?*
 - g. *How could technology play a greater role in enhancing prevention and public health?*
7. *What are the best ways to engage the public in talking about what they want from a health service?*

NHS England's Five Year Forward View recognises the impact that smoking, alcohol abuse, obesity and inactivity are having on the NHS's finite resources. Recent public health cuts will

ultimately increase the pressure on these resources at a time when investment is required to integrate health and social care. Prevention is always better than cure. With surgery being one of the more expensive forms of treatments, initiatives that ultimately reduce the demand for surgery should be supported.

As a College we work closely with a number of organisations and participate in a number of health alliances with a preventative focus. As such, we would fully endorse the submissions made to this enquiry by Action on Smoking and Health¹²²⁸, the Obesity Health Alliance¹²²⁹ and the Alcohol Health Alliance¹²³⁰.

Digitisation of services, Big Data and informatics

8. *How can new technologies be used to ensure the sustainability of the NHS?*
 - a. *What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?*
 - b. *What is the role of 'Big Data' in reducing costs and managing demand?*
 - c. *What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?*
 - d. *How can healthcare providers be incentivised to take up new technologies?*
 - e. *Where is investment in technology and informatics most needed?*

Advances in information and telecommunication technologies have presented the NHS with a number of opportunities and challenges. The scale of the service means that rolling out any one system or technology nationwide can be fraught with danger, as care.data has demonstrated. However, individual trusts utilising incompatible systems is not desirable, plus the benefits for patients and the savings that can be realised mean that changes are worth pursuing. Although we would not comment on specific systems, we are working with the Academy of Royal Medical Colleges to develop a series of standards for any system or technology that are used with the NHS. Although these are yet to be finalised a number of them could be considered as part of this enquiry.

First of all it would be possible to reduce the amount of time wasted and stress generated by regularly re-capturing and re-entering patients' clinical data by creating a system that enables one source of data to be accessed by all provider organisations. Whilst there will be safeguarding risks that need to be mitigated against, a digital system that is present for all clinical encounters across the system would save resource and improve the quality of care received. This system would also be able to reduce prescription duplication.

In addition, a truly digital healthcare system would enable patients to interact with their clinician without having to travel to a hospital. Whilst it is important that patients are given the choice and that it is not forced upon those it will not benefit, clinicians should be able to interact virtually with patients to undertake consultations or support self-care where

¹²²⁸ <http://www.ash.org.uk/>

¹²²⁹ <http://obesityhealthalliance.org.uk/>

¹²³⁰ <http://ahauk.org/>

appropriate. Although this wouldn't be suitable for all patients with a number of conditions, it would go some way to relieving some of the pressure on our hospitals.

Finally, implementing a system that captures and utilises data fully across the NHS will help ensure its sustainability. Accurate data is essential for both the commissioning of clinical services, especially those specialist services which are commissioned on a nation level, and setting procurement levels to eliminate waste. Live data is essential to ensure that any negative outliers in performance are detected as early as possible in order to prevent escalation as well as ensuring that regulators are as efficient as possible. Ultimately accurate and accessible data is a crucial component of an efficient, and therefore sustainable, healthcare system.

3 October 2016

The Royal College of Surgeons and Faculty of Dental Surgery – Written evidence (NHS0121)

1. Introduction

- 1.1 The Royal College of Surgeons (RCS) is a professional membership organisation and registered charity, representing surgeons in the UK and abroad. We advance surgical standards and improve care for patients. This is joint evidence from the RCS and its Faculty of Dental Surgery (FDS), a professional body committed to enabling specialist dentists to achieve and maintain excellence in practice and patient care.
- 1.2 The NHS has made enormous efforts to improve efficiency, and continues to treat a growing number of people each year. Patients were seen over 15 million times in hospitals in 2014/15, a 30% increase since 2004/05.¹²³¹ Yet the service is currently under enormous pressure with ever-growing financial burdens due to underfunding, increasing demand from an ageing population, the rising costs of new treatments, and greater public expectations. There is an urgent need for an informed, reflective debate on how we make the NHS sustainable in its current form. We therefore welcome this inquiry.
- 1.3 The RCS is planning a commission on the future of surgery to set out the expected challenges and opportunities for surgical care. Therefore our response focuses more on the current sustainability challenges facing surgery around the themes identified by the Committee.

2. Summary

- 2.1 Surgical services are being affected by similar pressures experienced across the rest of the NHS. As demand for services increases, the number of referrals and hospital admissions for surgery has risen, particularly among older people who have complex needs and often require prolonged lengths of stay. This has resulted in longer waiting times, reduced bed capacity, growing staff shortages, variability in standards of care and an increase in policies to ration access to surgical care.
- 2.2 We strongly support calls for a cross-party commission to review the future funding and provision of health and care services, and encourage the Committee to echo this.
- 2.3 To improve workforce sustainability we recommend initiatives to attract more UK staff and women to surgery, the development of non-medical roles to support patient care and relieve the wider surgical team, and improvements in surgical training.

¹²³¹ Health and Social Care Information Centre. [Hospital Episode Statistics, Admitted Patient Care – England, 2014-15](#). 25 November 2015.

- 2.4 There is strong evidence that units and surgeons that treat greater volumes of patients are more likely to have better outcomes and be more sustainable.
- 2.5 The ‘Getting it Right First Time’ project is one of the few serious system-wide attempts to improve efficiency in clinical practice. We support its roll-out to other medical and dental specialties.
- 2.6 More needs to be done to prevent lifestyle-related diseases. In particular there should be more emphasis on tackling obesity and tooth decay through promoting physical activity and reducing sugar consumption.

3. Resource issues

- 3.1 In recent years the NHS has made significant strides to improve efficiencies and save money. Nevertheless there is still room for improvement. To address variations in standards of care and help NHS sustainability in the long term, we also point the Committee to Professor Tim Briggs, National Director for Clinical Quality and Efficiency and RCS Council member’s work from the ‘Getting it Right First Time’ (GIRFT) project that shed light on the huge variation in standards and costs of orthopaedic procedures across the country. Professor Briggs is now working with the Carter team at NHS Improvement to expand this project to other specialties. It is one of the few system-wide projects attempting to seriously address inefficiencies in clinical practice.
- 3.2 The commitment to extra money for the NHS in the recent Comprehensive Spending Review was welcome; however questions still remain about whether this secures the long-term sustainability of the NHS in its current form. In surgery we see the pressure on resources impacting on patient’s access to treatments through unproven and arbitrary thresholds that unfairly deny patients effective operations that can greatly improve their quality of life. Our recent report, *Smokers and overweight patients: soft targets for NHS savings?*¹²³² found more than one third of Clinical Commissioning Groups (CCGs) in England are restricting access to routine surgery on the basis of weight or smoking status, in contravention of national clinical guidance. There have also been reports of the rationing of specialist dental treatment.¹²³³
- 3.3 NHS surgical treatment should be based on clinical guidance and assessment of the individual patient, not determined by arbitrary criteria or the need to make savings. Although the College fully supports public health programmes that assist patients to attend weight management and smoking cessation services while awaiting surgery, blanket bans that deny or delay patients’ access to surgery are wrong. We urge the Committee to consider how to address the postcode lottery of surgical procedures in their evaluation of the use of NHS resources.

¹²³² Royal College of Surgeons. *Smokers and overweight patients: soft targets for NHS savings?* April 2016.

¹²³³ The Telegraph. [Head and neck cancer patients subject to 'postcode lottery'](#). 6 April 2015

Support a cross-party commission on health and social care

3.4 The funding pressures on both the health and social care sectors require an urgent response to review how we can better provide and fund the care of older people in the community. As the House of Lords' Select Committee's *Ready for Ageing?* report¹²³⁴ stated "The inter-dependent nature of health and social care means that the structural and budgetary split between them is not sustainable: healthcare and social care must be commissioned and funded jointly, so that professionals can work together more effectively and resources can be used more efficiently." The College urges the Committee to support the calls to establish a cross-party commission on health and social care, as proposed by Norman Lamb MP and others,¹²³⁵ in order to allow the issues to be scrutinised and solutions aired on a cross-party basis.

4. Workforce

4.1 A sufficiently resourced surgical workforce that is best used to facilitate service delivery and train the future surgical workforce is vital for the long-term sustainability of the NHS. The Committee is encouraged to look at the three following areas which we believe will be important in addressing some of the workforce challenges in surgery.

Train and retain more UK staff

4.2 The NHS would struggle to provide care without the very skilled healthcare professionals and support staff from outside the UK. With 22% of surgeons having trained in the European Economic Area (EEA) and a further 20% having trained in the rest of the world, surgery is disproportionately dependent on a non-UK workforce.¹²³⁶ The figures are similarly high in dentistry where 17% of dentists trained in the EEA and a further 11.4% trained in the rest of the world.¹²³⁷ In recent years this number has been growing and 42% of dentists added to the dental register in 2014 trained outside the UK. Patients are also served by the thousands of technicians, porters, cleaners and other staff who have moved to the UK. Toughened migration rules often particularly affect such groups of workers and the NHS also needs to continue to attract these vital staff.

4.3 Maintaining and enticing staff to work here has to be a top priority and there has never been a time in the NHS' history when we have not needed to recruit staff from overseas. However, the figures also demonstrate we are not training and retaining sufficient numbers of home-grown staff. A long-term reliance on recruiting from abroad is a risk to NHS sustainability if, for whatever reason, the UK becomes less attractive as a destination for work. To address this, we urge the Government to increase UK training

¹²³⁴ House of Lords Select Committee on Public Service and Demographic Change Report of Session 2012-13, *Ready for Ageing?*, 14 March 2013.

¹²³⁵ House of Commons Debates, Hansard. [National Health Service and Social Care \(Commission\)](#). 6 January 2016.

¹²³⁶ General Medical Council (2015) *The state of medical education and practice in the UK: 2015*

¹²³⁷ General Dental Council (2014) *Annual report*

numbers as soon as possible, especially in specialties which are disproportionately dependent on overseas recruitment to fill posts that the service depends on.

Women in surgery

4.4 The sustainability of the surgical workforce is also at risk if the NHS does not do more to attract women into surgery. Latest figures show around 57% of doctors in training are women but only 30% of surgical trainees and 11% of consultant surgeons are female. The failure to attract sufficient and growing female trainee numbers is a factor behind why we are now attracting fewer overall candidates into surgery. Unless we can reverse that trend and encourage and support more women to access surgery as a career, we risk reducing our choice from the overall talent pool which is increasingly female.

4.5 To attract more women into the profession, we believe medical leaders need to:

- Talk positively about the benefits of a career in surgery for women;
- Challenge the perception that a surgical career makes greater demands on work/life balance than other postgraduate careers;
- Be prepared to talk openly about these issues and offer practical solutions, including supporting men and women in less than full time training so they can balance their work, social and family commitments;
- Banish ‘all male short lists’ for interview panels and conferences; and
- Encourage and applaud men and women who sponsor their female peers in surgery.

Expand the role of non-medical practitioners

4.6 The College commissioned the report *A question of balance: The extended surgical team*¹²³⁸ to understand how non-medical practitioners in extended surgical teams can and do support patient care and enhance the training junior doctors receive. The report found that non-medical staff, such as physician associates, first surgical assistants and advanced nurse practitioners, often improved the co-ordination and continuity of patient care, providing a link between patients, consultants and trainees. They also helped free up junior doctors’ time for training, allowing them to leave wards to attend theatres and teaching. While some medical professionals are suspicious of whether these new roles will replace doctors, the evidence so far suggests these roles support not replace the role of doctors.

4.7 The report shows that growing numbers of non-medical staff can, with appropriate training, provide services to patients. The situation is similar in dentistry where therapists and technicians in general dentistry, restorative dentistry and orthodontics are being increasingly used to treat patients in certain circumstances. We urge the NHS, government and medical professionals to support the development of these roles to help relieve the pressures on the rest of the healthcare team. In particular, there is a

¹²³⁸ Royal College of Surgeons. *A question of balance: The extended surgical team*. May 2016.

need for professional regulation of these roles given their level of patient contact. This would facilitate prescribing rights, assure the public, and help employers to be clear about accountability and indemnity arrangements. Without regulation hospitals are limited to the tasks these roles can perform, especially in the delivery of out-of-hours care and prescribing.

Improve surgical training

4.8 The GMC's annual trainee survey consistently finds that surgical trainees are the least satisfied of all the medical specialties. Many have concerns about the time available for training, the demands placed upon them to cover the service, and their exposure to common surgical conditions.

4.9 While we did not support all of its conclusions, the College welcomed the Shape of Training Review's¹²³⁹ focus on ensuring that postgraduate medical education and training is responsive to changing demographic and patient needs. Patients need a balance of both generalist and specialist doctors to treat an ageing population with multiple conditions.

4.10 Following the review, the RCS was commissioned by Health Education England (HEE) to produce the Improving Surgical Training report¹²⁴⁰ to specifically consider how surgical training might change and become more sustainable. As a result of the report, the RCS is working with HEE to pilot a new surgical training programme for general surgery. The pilot will trial improvements in the quality of training, a better training-service balance for trainees, and look to develop a workforce from other professions to work alongside trainees to improve patient care. We would welcome the Committee's support for this project as ultimately we hope this will serve as a model for training in other surgical specialties.

5. Models of service delivery and integration

Reconfiguring surgery

5.1 Decisions to reconfigure or centralise services must be based on sound clinical evidence, have clinical backing and focus on ensuring the highest quality of patient care. Reshaping of complex surgical services should only take place where improvements in outcomes and quality of care are needed and can be realised.

5.2 There is strong evidence that units and surgeons that treat greater volumes of patients are more likely to have better outcomes and be more sustainable. A recent example is NHS England's plans to reduce the number of centres carrying out congenital heart surgery – something we support in order to raise standards of care.

¹²³⁹ Shape of Training, final report of the independent review. *Securing the future of excellent patient care*. October 2013.

¹²⁴⁰ Royal College of Surgeons. *Improving Surgical Training: proposal for a pilot surgical training programme*. October 2015.

5.3 We have a particular concern about the sustainability of emergency surgery services due to wide variation in standards of care for patients needing urgent treatment, including those who have gallstone disease, need their appendix removed, or who are suffering from a bowel or hernia obstruction. The UK Emergency Laparotomy Network found that mortality following emergency laparotomies varied from 3.6% to 41.7% across 35 hospitals.¹²⁴¹ The Nuffield Trust recently published the report, *Emergency General Surgery: Challenges and Opportunities*¹²⁴², commissioned by the College, that proposed a number of solutions to improve emergency general surgery. This included working with hospitals to improve patient pathways, the introduction of managed clinical networks, and proposals to improve training. We would welcome the Committee's support to help us implement these long term solutions and make emergency general surgery a higher priority for the NHS.

Older people's care and discharge

5.4 Hospitals are increasingly becoming expensive care homes for older people. Many are there unnecessarily, often due to delays in discharge or lack of available care in the community. For this group of patients in particular there is a need to re-examine the whole pathway of care for patients from primary care delivered by GPs to diagnostic tests, hospital treatment, discharge, follow-up and rehabilitation.

5.5 Integrated care is important for surgical patients, especially for frail older patients with multiple conditions. For example, effective transfer from hospital to other services requires good relationships between hospitals and primary, community, and social care so that patients are treated in the right place.

5.6 However the social care sector is under severe strain and 2015 witnessed the first fall in care home beds since records began¹²⁴³. The Committee will be well aware of the consequences on the NHS including contributing to a dramatic increase in delayed hospital discharges, which have seen an 80% rise in the last five years. In order to address delayed discharge, we need a comprehensive approach from trusts to tackle this issue, including better focus on the discharge planning from admission and personalised plans. It may also be beneficial to increase the number of emergency residential and nursing home places available as an immediate means to reduce DTOCs.

5.7 In addition, we recommend investment in enhanced recovery after surgery (ERAS) programmes to help reduce patients' length of stay and improve rehabilitation times. Although protocols exist in many surgical disciplines, implementation is variable, often reflecting a lack of essential support services. Specific services related to rehabilitation,

¹²⁴¹ D. I. Saunders et al. (2012) Variations in mortality after emergency laparotomy: the first report of the UK Emergency Laparotomy Network. *British Journal of Anaesthesia* 109 (3): 368–75.

¹²⁴² Nuffield Trust. *Emergency General Surgery: Challenges and Opportunities*. April 2016.

¹²⁴³ LaingBuisson. Press release: [Government austerity measures have created two-tier long term care market which is failing state supported residents](#). 30 September 2015.

such as physiotherapy and dietetics, are frequently under-resourced in relation to the patient volumes requiring these services.

Ensure sustainable seven day care

5.8 The RCS supports the valuable aim of providing the highest standards of care across all days of the week and believe resources should be focused on urgent and emergency care – not planned care. To date the Government has focused on encouraging the availability of hospital consultants and junior doctors at weekends and has erroneously conflated the junior doctors' contract with improving weekend care. Junior doctors already work at nights and weekends and as we have previously set out,¹²⁴⁴ the availability of other hospital services such as pharmacy and physiotherapy are just as important, alongside improvements in the accessibility of social care, community and primary care services at the weekend.

5.9 In order to ensure seven-day urgent and emergency care is sustainable, we recommend in-depth financial modelling to help hospitals anticipate the costs of implementing the model.

6. Prevention and public engagement

6.1 To build a sustainable NHS, we must reduce the number of patients requiring care through prevention. Lifestyle-related disease is on the increase worldwide, with tobacco, alcohol, and poor diet now three of the biggest global risk factors for disease.¹²⁴⁵ We have also moved towards a sedentary society with changing work and domestic habits leaving less time for physical activity.¹²⁴⁶ While we welcome the Government's recent childhood obesity strategy¹²⁴⁷, we believe there should be more emphasis on the need to tackle tooth decay alongside obesity given sugar consumption is a leading cause of both diseases.

Promote physical activity

6.2 Evidence shows that 30 minutes of moderately intense exercise five times per week can reduce the risk of developing heart disease, stroke, dementia, diabetes, depression and some cancers by at least 30%. It can also improve health for those with chronic conditions. Yet over 40% of adults do not reach this minimum target and many people are dangerously inactive.¹²⁴⁸

¹²⁴⁴ Royal College of Surgeons. Policy briefing: [Seven day care – our view](#). September 2015.

¹²⁴⁵ Horton R. [GBD 2010: understanding disease, injury, and risk](#). Lancet 2012; 380: 2053–2054

¹²⁴⁶ Academy of Medical Royal Colleges. Exercise: The miracle cure and the role of the doctor in promoting it. February 2015

¹²⁴⁷ HM Government. *Childhood Obesity: a plan for action*. August 2016.

¹²⁴⁸ Academy of Medical Royal Colleges' report, *op cit*

6.3 It is estimated that the costs of physical inactivity to the UK, the NHS and other public bodies are in excess of £15bn. Therefore it is clear that the Government needs to do more to support changes in infrastructure to increase access to places for physical activity.

Improve children’s oral health

6.4 Oral health is an area where investment in prevention would lead to significant savings. Despite the fact that approximately 90% of tooth decay is preventable,¹²⁴⁹ almost a third of five-year-olds are suffering from tooth decay and it is the most common single reason why five- to nine-year-olds are admitted to hospital. Approximately 46,500 children and young people under 19 were admitted to hospital for a primary diagnosis of dental caries in 2013–14, and this figure is increasing. NHS England spends £3.4 billion a year on dental care (and an estimated £2.3 billion on top of this is spent on private dental care)¹²⁵⁰ and hospitals spent £35 million on multiple teeth extraction in under 18s in 2014/15, a cost that has soared by 61% in the last five years.¹²⁵¹

6.5 The situation is alarming given most oral health problems are largely prevented through simple steps such as moderate consumption of sugar, adequate exposure to fluoride, regular brushing and routine visits to the dentist. While we welcome the Government’s proposal to introduce a new sugar levy on soft drinks, we urge the Committee to consider the other measures recommended by Public Health England to reduce sugar consumption.¹²⁵² Restricting price promotions and tightening advertising restrictions for high sugar products would have a significant impact on both tooth decay and obesity. In addition, we believe the Government should invest in a national oral health programme to drive improvements in children’s oral health; at a minimum this should be targeted at areas with poor oral health.

23 September 2016

¹²⁴⁹ Royal College of Surgeons Faculty of Dental Surgery. [The state of children’s oral health in England](#). January 2015.

¹²⁵⁰ Public Health England. [Improving oral health: an evidence-informed toolkit for local authorities](#). June 2014.

¹²⁵¹ Local Government Association. Press release: *Hospitals spending £35 million on ‘rotting teeth’ in children*. 13 May 2016.

¹²⁵² Public Health England. *Sugar Reduction: The evidence for action*. October 2015.

The Royal Crescent Surgery, Weymouth, Dorset – Written evidence (NHS0103)

Sustainable funding of the NHS

We are the 6th richest country in the world. We can afford the NHS.

The % GDP spend on health compared with France or Germany is low.
We are robbing the NHS of it's fair share of money for an advanced rich country.
<http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

It is a matter of choices.

We have chosen to favour the City of London and make the country subservient to the desire to be an offshore tax haven hub.
<http://treasureislands.org/>

We could choose to tax profits generated in this country.

<http://www.taxjustice.net/topics/more/size-of-the-problem/>

The problem is this.

Corporations generate large profits from business in UK, from selling phones, mail order or shampoo (Vodaphone, Amazon, Boots)

If their staff fall ill they are looked after and made fit for work by the NHS

If they are robbed they can call the police.

If their goods are delivered it is on our roads

If their offices catch fire the local brigade is called

If they need trained staff then most come from state comprehensives

So the corporations benefit from the common good of services provided by taxation.
Yet they themselves cunningly avoid paying by means of carefully contrived and fully legal loopholes in our law.

We have wilfully reduced the HMRC's staff dealing with corporations so it is harder to stop evasion.

We can afford the NHS.

It needs 4% increases a year and is currently billions of pounds cheaper than other western countries of similar wealth.

Yours sincerely
Dr J Orrell

The Royal Crescent Surgery, Weymouth, Dorset – Written evidence (NHS0103)

23 September 2016

The Royal Pharmaceutical Society – Written evidence (NHS0077)

The RPS is the professional body for pharmacists in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain. The RPS leads and supports the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

Pharmacists study the science of medicine and the actions of medicines on the human body for four years at University and they then undergo a year of supervised training. Their knowledge and skills make them experts in medicines and their use. We believe that if pharmacists were to be utilised to their full potential this would contribute to making the NHS sustainable as they would ensure people were only taking medicines appropriate for them (reducing medicines waste and unplanned hospital admissions), they would support people to take their medicines (improving adherence) and they would support the prevention agenda (reducing the number of people acquiring a long term condition (LTC) in the first instance).

1. The future healthcare system

The current healthcare system is fragmented and further joining up is required. Workforce decisions need to be made that benefit the health system as a whole rather than the competing priorities of individual organisations whether they are an NHS Trust, primary care organisation or an arms-length body. Consideration of the sustainability of decisions needs to take into account the impact on the whole system and mitigate risks of pushing workforce challenges to another part of the system e.g. using a workforce to meet demand in one part of the system creating a shortage elsewhere.

The recently published Community Pharmacy Forward View¹²⁵³ outlines a vision for the way in which community pharmacy can play its part in a future healthcare system. We believe that prevention and demand management will be key and will require efficient and effective use of resources.

There are some key elements that need to be addressed in order to make the future healthcare system sustainable:

- Consideration needs to be given to how outcome data is used as evidence to make decisions and where such data is not available how are decisions made?
- There needs to be a decrease in the use of acute care and a focus on supported self-management and empowering of people to self-care
- The behaviour of people in society needs to change as they take responsibility for their own health and the decisions they make around that
- Low cost interventions should be fast-tracked
- Invest to save in technology including IT infrastructure to allow effective communication between healthcare professionals and delivery of joined up care

¹²⁵³ <http://psnc.org.uk/services-commissioning/community-pharmacy-forward-view/>

- There needs to be a focus on population health and investment in social care
- There needs to be consistency across the country, key messages need to be kept simple and there needs to be some national commissioning of services like minor ailments in order to drive the right behaviour i.e. people access healthcare and support in a way that is convenient for them and puts least pressure on the NHS system.

2. Resourcing issues, including funding, productivity, demand management and resource use.

With an ever increasing aging population and an increasing proportion of people living with one or more long term conditions, the current funding envelope may not be realistic in terms of healthcare provision.

A recent report published by PricewaterhouseCoopers LLP¹²⁵⁴ demonstrated that community pharmacies contributed a net value of £3 billion to the NHS, public sector, patients and wider society in England in 2015 through just 12 services. The report states that the NHS received a net value of £1,352 million, including cash savings as a result of cost efficiencies, and avoided NHS treatment costs; other public sector bodies (e.g. local authorities) and wider society together received over £1 billion through increased output, avoided deaths and reduced pressure on other services such as social care and justice; and patients received around £600 million, mainly in the form of reduced travel time to alternative NHS settings. The report concludes that from these services alone, community pharmacy contributed an in-year benefit of £3 billion in 2015, with a further £1.9 billion expected to accrue over the next 20 years.

There is evidence that NHS Trust's workforce plans are driven by short-term financial plans rather than planning for a sustainable appropriately trained workforce balanced to patients' needs. In addition NHS Trusts do not seem to have the capacity for longer-term workforce planning and this means that there is inadequate consideration of how services are transformed to focus greater delivery outside of hospitals and cost-pressures are compounded by the need to use more agency staff because of seemingly unanticipated staff shortages¹²⁵⁵. Spending on education and training has also fallen from 5.1% to 4.3% as a proportion of total health spending¹. This will also have impacted on managing the workforce supply across the system.

However, there is much that could be done differently to use the current resources more efficiently and effectively. Much of this is related to using the workforce within the NHS in a better way, ensuring that treatments provided are actually used by patients, investing in technology so people can access their healthcare in a more efficient way, delivery of quality and outcomes is rewarded and that resources are devolved to ensure prevention of illness in the first place. All of these are explored in more detail in the sections below.

3. Workforce supply

An evolving healthcare workforce is one that can adapt its core roles and responsibilities to meet the new and emerging needs of patients and the public. For pharmacy, this means

¹²⁵⁴ <http://psnc.org.uk/our-news/pwc-report-quantifies-value-of-community-pharmacy/>

¹²⁵⁵ <https://www.nao.org.uk/wp-content/uploads/2016/02/Managing-the-supply-of-NHS-clinical-staff-in-England.pdf>

providing support to develop pharmacists across all sectors to meet the changing demography and healthcare needs of an ageing population with increasingly complex medicine regimens within a cost constrained healthcare system. A pharmacy workforce that can contribute to the public's health and deliver pharmaceutical care will be integral to delivering services that are holistic, using a patient-focused approach to getting the best from investment in and use of medicines. We recognise that this will require an enhanced level of patient centred professionalism, and partnership between scientific leaders, clinical professionals and the patients and the public.

The RPS believes there should be greater involvement of pharmacists, including prescribing pharmacists, in the optimisation of medicines for patients with long-term conditions¹²⁵⁶. There needs to be more funded prescribing training places made available to pharmacists to support delivery of this ambition. Also existing independent prescribing pharmacists should be able to act in lieu of designated medical practitioners for the practical training and support of prescribers. In addition, greater use should be made of community pharmacists, pharmacy technicians and pharmacy support staff in managing minor illness and advising people about their medicines.

Pharmacists currently have to complete a 4-year undergraduate degree (Master of Pharmacy or MPharm – accredited by the profession's regulator, the General Pharmaceutical Council (GPhC)) followed by a separate year of pre-registration practice-based training leading to registration. There has been an increase in the number of pharmacy graduates in the UK over the last 10 years or so (due to a growth in the number of schools of pharmacy and an increase in intake in some existing schools- although many of these are actually international students from outside of the EU). The impact of this may have been a reduction in the number of jobs that cannot be filled and a downward pressure on salaries - especially in desirable areas to live such as London.

There is a concern that there are currently insufficient pre-registration training places to enable all graduating pharmacists to become registered. The number of pre-registration pharmacy placements needs to increase in order to meet the enhanced role for pharmacists. These placements should include experience in community pharmacies and in general practices as well as in hospitals¹²⁵⁷.

Approximately 5% of the register of pharmacists in Great Britain are pharmacists who originally qualified in Europe. Furthermore, each year, approximately 13% of new entrants to the register originally qualified in Europe. The impact of Brexit is difficult to assess, though based on these percentages a significant supply of pharmacists will not be available for the workforce if free-movement is ended and UK residency is not granted to existing registrants. This loss of supply of European pharmacists may be mitigated by the current likely oversupply of pharmacy graduates from UK universities as long as there is an adequate number of pre-registration trainee pharmacist placements available for them to

¹²⁵⁶ The Royal Pharmaceutical Society. Transforming the pharmacy workforce in Great Britain – the RPS Vision. August 2015. Available at: <http://www.rpharms.com/workforce-pdfs/transforming-the-pharmacy-workforce-in-great-britain.pdf>

¹²⁵⁷ Primary Care Workforce Commission. The future of primary care. Creating teams for tomorrow. A report commissioned by Health Education England. July 2015. Available at: https://www.hee.nhs.uk/sites/default/files/documents/WES_The-future-of-primary-care.pdf

complete their training and register as a pharmacist and those from overseas can get work visas.

Funding from Health Education England should be equally accessible to all organisations who deliver front line services in healthcare. There should be equity in supporting protected learning time for those professionals providing NHS contracted services.

Excessive workload and work-based stress is an important issue for pharmacists and their teams. It is clear that a robust level of health and wellbeing of the workforce positively affects patient care and the patient experience. The RPS supports developing agility and resilience in workforce education and training to support the pharmacy team thereby improving retention of staff. However, workforce development must also be linked to service planning e.g. the current drive for developing seven day services in hospitals is often based on using the existing workforce across more hours of the week¹²⁵⁸; this may not be sustainable and adversely impact on the retention of staff.

4. Workforce agility

Current ways of working should be reviewed to ensure efficiency and the requirement for services to still be delivered in their current way including an assessment of skill mix, especially the generalist / specialist balance, and activities of pharmacists and pharmacy technicians, as well as further embedding innovation, including technology e.g. robotics, tele / digital-health, to create capacity (see section 8). Investment will be required to develop the workforce so it can flexibly work across all care sector / settings e.g. pharmacists in GP practices¹²⁵⁹.

The RPS considers that a focus on disease prevention, new, flexible models of service tailored to local populations and needs; integration between services and consistent leadership across the health and care system is required. Although the healthcare system is facing the challenge of significant and enduring financial pressures, there is a greater emphasis on and greater investment in primary care as well as taking steps that include building the public's understanding that pharmacies can help them deal with common ailments without the need for a GP appointment or a visit to an Accident & Emergency Department. New care models (see sections 5 and 6) will be required and will not become reality unless there is a workforce with the right numbers, skills, values and behaviours to deliver the services needed. In addition to those pharmacists delivering additional clinical services, community pharmacists and their teams need to be an integral part of the patient pathway around medicines use to support adherence and medication review¹²⁶⁰.

The RPS believes that there is a developing consensus amongst health care policy makers to suggest that a greater capacity for advanced generalist skills is required in the health and care system (rather than early and multiple entry into specialist training pathways for professionals), so that a more holistic approach to patient care can be taken. The right balance between generalists and specialists is required as the population is ageing with multiple morbidities and long term conditions and care currently delivered by a number of

¹²⁵⁸ The Royal Pharmaceutical Society. Seven Day Services in Hospital Pharmacy. Giving patients the care they deserve. August 2014. Available at: <http://www.rpharms.com/support-pdfs/rps---seven-day-report.pdf>

¹²⁵⁹ <https://www.england.nhs.uk/commissioning/primary-care-comm/gp-workforce/cp-gp-pilot/>

¹²⁶⁰ <http://psnc.org.uk/wp-content/uploads/2016/08/CPFV-Aug-2016.pdf>

specialists would be better delivered by fewer generalists to improve patient outcomes and the patient experience.

In many areas there are shortages of professions so use of other suitable healthcare professions can help meet demand, particularly with delivering services closer to the patient e.g. the pharmacy workforce can be better deployed and utilised in a cost-effective way to cover some shortages.

5. Models of service delivery and integration

Pharmacists are experts in medicines and their use. The NHS spends £15 billion on medicines¹²⁶¹, 30-50% of which are not taken as prescribed. Pharmacists across all care settings can do much more to ensure there is shared decision making with patients about their medicines and that patients are supported to get the most from their medicines.

Some suggestions on how models can help support service delivery and integration are:

- Develop and deliver some national services such as common ailment scheme to ensure consistency and to meet public expectations
- Ensure care is shared across pathways and healthcare professionals and is focused on the patient and their needs
- Align the primary care contracts or develop new contracts such as those for multispeciality community providers
- Educate patients to develop behavioural changes and to ensure realistic expectations of the NHS
- Enable other healthcare professionals to refer patients into acute or other services such as physiotherapy.

Some of the ways in which pharmacists could be used more effectively to ensure a sustainable NHS are outlined below:

Improving urgent and emergency care

Pharmacists working in the community provide a range of clinical services that reduce the pressure on A&E and GP practices and these include supply and advice around common ailments, supply of repeat urgent medicines and emergency hormonal contraception (EHC). When one of the first EHC services was introduced in London visits to A&E for EHC reduced by 52%¹²⁶².

Evidence demonstrates that if community pharmacists were commissioned to provide a common ailment service nationwide, the NHS could save £1.1 billion each year. The cost of treating common ailments in community pharmacies was found by the MINA study¹²⁶³ to be £29.30 per patient. The cost of treating the same problems at A&E was found to be nearly five times higher at £147.09 per patient and nearly three times higher at GP practices at £82.34 per patient. Treatment outcomes for patients were equally good regardless of whether patients were treated at a pharmacy, A&E or GP practice. 18% of GP workload is accounted for by minor ailments alone¹²⁶⁴ and this could be passed on to the community

¹²⁶¹ <http://www.hscic.gov.uk/pubs/precosthoseng15>

¹²⁶² Emerg Med J 2004;21:67–68

¹²⁶³ <http://www.pharmacyresearchuk.org/our-research/our-projects/the-minor-ailment-study-mina/>

¹²⁶⁴ <http://www.selfcareforum.org/wp-content/uploads/2011/07/Minorailmentsresearch09.pdf>

pharmacist, freeing up GP time. These common ailment services enable the provision of advice and treatment for a whole range of conditions such as athlete's foot, bacterial conjunctivitis, constipation, diarrhoea, earache, haemorrhoids, hay fever, head lice, insect bites and stings, sore throat, teething pain, temperature or fever, threadworm, toothache, vaginal thrush and warts and verrucas.

If pharmacists were commissioned to provide a repeat urgent medicines service this would relieve significant pressure on GP out of hours (OOH) services. An urgent repeat medication service was commissioned by NHS England through 316 Community Pharmacies across the whole of the North East Region encompassing 12 CCGs. Over a period of 5 months there have been 1475 successful referrals from 111 and 2485 walk-in patients. Potential savings (if contracts tariff based) of £85,794 have been realised over three months alone and of the patients accessing the service 10% would have gone to A&E, 34% would have gone to an urgent care or walk-in centre and 48% of patients with long term conditions such as hypertension and diabetes would have gone without their regular medication.¹²⁶⁵

With the coming together of NHS 111 and GP OOHs into integrated urgent care clinical hubs, it is crucial that pharmacists are considered as a key element of these. Locally a few organisations have employed pharmacists within their NHS 111 call centres or within their GP OOHs provision. For example Integrated Care 24 is planning to expand its pharmacist workforce in the OOHs services providing telephone advice and repeat prescriptions following referral from NHS 111. One pharmacist in the OOH service takes around 5 calls per hour on an 8 hour shift, mainly for repeat prescriptions, advising around medicines optimisation, medicines supply issues and other queries as required. These calls would normally be dealt with by a GP, thereby leaving them to deal with an additional 40 patients in a timely manner.

Pharmacists and GP surgeries

We are aware that the employment of a practice pharmacist within the general practice team can increase patient access to the primary care team. Practice pharmacists work as part of the general practice team to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, advice for those on multiple medications and better access to health checks. Having a practice pharmacist in GP practices allows GPs to focus their skills where they are most needed, for example on diagnosing and treating patients with complex conditions. This will help GPs manage the demands on their time and improve access for patients.

Pharmacists optimising care in care homes

Pharmacists, as part of the multidisciplinary team, should have overall responsibility for medicines and their use in care homes. This will result in significant benefits to care home residents, care home providers and the NHS. This could be an important role for pharmacists and their teams within community pharmacy who currently manage the safe supply of medicines to care homes.

¹²⁶⁵ <http://bmjopen.bmj.com/content/6/1/e009736.full>

If a clinical medicines review service involving patients, their representatives or carers, was to be commissioned for all 405,000 care home residents over the age of 65, the base cost of the pharmacist and the medication review would be approximately £13.4m–£15.8m. The potential costs savings to the NHS, if this service were to be delivered across all care homes in England, are estimated at £135 million (£65 million from medicines being stopped, started or changed and £70 million from reduced hospital admissions).¹²⁶⁶

We would like to see community pharmacists more fully integrated into local care models, particularly those models outlined in the FYFV, and supported to fully deliver the medicines optimisation agenda. By supporting patients to take their medicines this will reduce medicines wastage and improve health outcomes for patients, thereby reducing hospital admissions and readmissions as well as reducing the number of GP visits.

6. Prevention

Some of the wider practical changes that are needed across the NHS to move towards a preventative service are:

- Move towards an evidence based approach such as that from the behavioural insights team at the Department of Health
- Have consistent messages from all health care professionals
- Keep repeating messages to reinforce the right behaviours
- Potentially move towards an outcome based payment structure

Community pharmacists have regular contact with people; 1.6 million people visit a community pharmacy every day. A study in 2014 showed that the majority of the population can access a community pharmacy within a 20 min walk and crucially, access is greater in areas of highest deprivation—a positive pharmacy care law.¹²⁶⁷ Community pharmacists often see people who do not access other healthcare settings. Community pharmacists should be the first point of contact for health promotion and wellbeing advice.

The Healthy Living Pharmacy (HLP) model¹²⁶⁸ has demonstrated improvements in health. An evaluation of the HLP service¹²⁶⁹ demonstrated that 60% of the people who used the service would have gone to their GP had that service not been available.

Pharmacists in the community are ideally placed to make opportunistic public health interventions and provide advice on healthy lifestyles, thereby preventing or delaying the onset of long term conditions. Unfortunately, with the reduction in public health funding we are now seeing public health services being decommissioned from community pharmacies including services such as emergency hormonal contraception and stop smoking services

Three areas of focus that would help to sustain a prevention agenda are:

1. Accessibility and convenience of community pharmacies. Patients access community pharmacies more so than any other healthcare professional and this presents huge

¹²⁶⁶ <http://www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf>

¹²⁶⁷ <http://bmjopen.bmj.com/content/4/8/e005764.abstract>

¹²⁶⁸ <http://psnc.org.uk/wp-content/uploads/2013/08/HLP-evaluation.pdf>

¹²⁶⁹ <http://www.aston.ac.uk/lhs/research/health/pharmacy/hlp/>

opportunity to deliver preventative health and behavioural reinforcement. Particularly for patients who don't visit their GP.

2. To change behaviour, interventions need to be of a national scale, so that patients get consistent messages regardless of who they come into contact with or via which media. There will need to be investment to promote awareness of national services available
3. Communication is key to deliver integrated, efficient and joined up care

7. Engaging the public

Engagement with the public must be opportunistic as well as planned. Pharmacy teams, particularly in community have contact with large numbers of people and are well placed to ask about what they want from the health service and how to improve it. Pharmacists and their teams can certainly make 'every contact count'

Some of the key actions to engage the public are:

- We need to talk to lots of people who will be the end users of the services rather than having a generic patient representative
- We need to understand what difference changes in service provision would actually make to people
- We need to engage with people who actually use the services

8. Digitisation of services, Big Data and informatics

To fully integrate healthcare there needs to be an investment in IT to ensure that relevant and appropriate information about patients can be shared between healthcare professionals, with patient consent. This saves duplication as patients only have to provide the information once, and also all healthcare professionals know the actions undertaken prior to them seeing the patient. Basically there should be a shared patient record that all relevant healthcare professionals can read and write to.

There needs to be systems and processes in place that enable the electronic referral of patients, and information, between one care setting and another.

The use of telehealth and apps can also support patients to manage the impact of their LTC on their life and to manage prescription orders and obtain health information. Information from these apps can be shared with healthcare professionals to demonstrate progress. Healthcare professionals need to embrace technology in order to make it more accessible, bearing in mind that any technological advances should enhance patient safety.

About us

The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors and specialisms of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession to deliver excellence of care and service to patients and the public. This includes the advancement of science, practice, education and knowledge in pharmacy and the provision of professional

standards and guidance to promote and deliver excellence. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

Leadership, representation and advocacy: Ensuring the expertise of the pharmacist is heard by governments, the media and the public.

Professional development, education and support: helping pharmacists deliver excellent care and also to advance their careers through professional advancement, career advice and guidance on good practice.

Professional networking and publications: hosting and facilitating a series of communication channels to enable pharmacists to discuss areas of common interest, develop and learn.

23 September 2016

Sense – Written evidence (NHS0048)

Sense is a national charity that supports and campaigns for children and adults who are deafblind, those with sensory impairments, and those with complex needs. We provide tailored support, advice and information to individuals, their families, carers and the professionals who work with them.

We believe that each person has the right to choose the support and lifestyle that is right for them; one that takes into account their long-term hopes and aspirations.

Our specialist services enable each individual to live as independently as possible, offering a range of housing, educational and leisure opportunities.

In response to this consultation we have chosen to focus on the financial stability of the adult social care sector and how this impacts upon the NHS. The sustainability of the NHS cannot be considered in isolation, we believe that the stability and capacity of the social care sector is key to supporting the long term stability of the NHS.

The future health care system

1. Demography shows that demand for health and social care services will continue to rise. Resources within the sector are finite and there is a recognised need for re-configuration of health and social care provision to ensure that needs can be met effectively and efficiently. This is recognised in the Five Year Forward View and the Care Act 2014.

Resource issues, including funding, productivity, demand management and resource use

2. The social care system is underfunded and running at a substantial deficit. The Association of Directors of Adult Social Services (ADASS) report that the adult social care sector would require an additional £1 billion per annum to sustain the current level of service provision. This follows a real terms budget reduction of local authority social services departments of £4.6 billion between 2010/11 and 2014/15.¹²⁷⁰
3. This has resulted in a considerable decrease in the number of people able to access social care services. Data recorded by NHS Digital (formally HSCIC) shows that the number of adults receiving local authority funded social care decreased by 28% between 2009/10 and 2013/14.¹²⁷¹
4. This decreased access to long and short term social care packages has had a causal impact upon the efficiency of the NHS. This is shown in expenditure on delayed transfers of care. In 2014/15 the NHS spent £1.15 billion on inpatient excess bed days at a unit cost of £303 per person per day.¹²⁷²

¹²⁷⁰ ADASS, *Budget Survey 2016*. Available at: <https://www.adass.org.uk/adass-budget-survey-2016-full-report>

¹²⁷¹ NHS Digital/HSCIC, *Community Care Statistics, Social Services Activity – England (2009/10 – 2013/14)*. Available at: <http://digital.nhs.uk/searchcatalogue?productid=16628&topics=1%2fSocial+care%2fSocial+care+activity&sort=Relevance&size=10&page=2#top>

¹²⁷² Department of Health, *NHS reference costs 2014 to 2015*. Available at: <https://www.gov.uk/government/publications/nhs-reference-costs-2014-to-2015>

5. The number of delayed transfers due to people awaiting social care has increased rapidly. Over the last two years the number of NHS bed days lost per month because people were experiencing a delayed transfer increased by 38%.¹²⁷³ This has been a persistent trend.
6. Social care providers and commissioners must be properly supported and funded to facilitate timely discharge from hospital into the community. However, we believe that the primary barrier to reducing the number of delayed transfers of care is a lack of capacity in the social care sector and the fact that the number of people accessing council funded social care services has decreased, as referenced in point 3.
7. The fact that fewer people are accessing social care has also placed demand side pressure on NHS services as the preventative capacity of social care provision has not been utilised. People with long term conditions who would benefit from social care have instead chosen to use A&E services at times of crisis.
8. Data shows that in July 2016 85.7% of people admitted to A&E were seen in four hours or fewer.¹²⁷⁴ This is substantially below the government's target of 95%. This is a matter of particular concern, given that this shortcoming has taken place in July, when demand side pressures should be at their least acute.

Workforce

9. One of the key factors impacting on capacity in the social care sector is the supply of workforce. In the adult social care sector the turnover rate for care workers is 32.6% per year. While the vacancy rate for care workers is 6.5%.¹²⁷⁵
10. Turnover and vacancy rates impact on the capacity of an individual provider, it will also impact upon the quality and consistency of care delivered – research has shown that people who use social care services value consistency of care worker very highly. It also represents a considerable cost-inefficiency as recruitment is considerably more expensive than retention.
11. These issues reflect the wider societal fact that care is not seen as an attractive career choice.
12. It is also vital that the workforce have sufficient training to meet the needs of people who are deafblind and people with complex needs. This training should include awareness of the Accessible Information Standard, which all health and social care providers must now comply with.¹²⁷⁶

Models of service delivery and integration

13. Sense fully supports the integration of health and social care services. Done properly it should provide people who use services with seamless experience of health and social care, support their wellbeing and improve the operational and cost-efficiency of service providers.

¹²⁷³ NHS England, *Delayed Transfers of Care Data*. Available at: <https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/2016-17-data/>

¹²⁷⁴ NHS England, *A&E Attendances and Emergency Admissions 2016-17*. Available at: <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areas-ae-waiting-times-and-activity-attendances-and-emergency-admissions-2016-17/>

¹²⁷⁵ NMDS-SC, Dashboards, England>All client groups>Private/Voluntary Sector>Care workers. Accessed 14/09/2016. Available at: <https://www.nmds-sc-online.org.uk/reportengine/GuestDashboard.aspx?type=VacancyRate>

¹²⁷⁶ Please see: <https://www.england.nhs.uk/ourwork/accessibleinfo/>

14. However, models of integration must be properly funded and their primary purpose must not be to reduce costs for providers and commissioners.
15. We have particular concerns around the Better Care Fund (BCF) and how effective it will be in addressing and reducing budget deficits in social care. In the Spending Review 2015 the Chancellor announced that the BCF would receive an additional £1.5 billion to further incentivise integration.
16. This additional funding would be distributed over the next four financial years. There will be no additional money in 2016/17. Incremental increases will be introduced until 2019/20. At which time the full £1.5 billion will have been allocated to the BCF.
17. The Nuffield Trust and the King's Fund project that by 2020 the adult social care sector will face a deficit between £2 billion and £2.7 billion.¹²⁷⁷
18. Any new models of integration and/or service delivery must reflect the fact that the social care sector is facing a substantial deficit and is in the midst of a financial crisis.

Prevention and public engagement

19. Prevention should be a key focus of care delivery, which focusses on enabling people with one more long term conditions to live independently and reduce the incidence of avoidable hospital admissions.
20. Prevention should also be achieved by public health and population health initiatives. Metrics should be in place to ensure that such measures are properly and appropriately targeted and the desired outcomes are achieved. NHS England has already developed the Patient Activation Measure (PAM).¹²⁷⁸
21. There should be a focus on 'getting it right the first time.' In point 15 we referred to the Accessible Information Standard. Compliance with this can be in prevention. The standard can help practitioners to ensure that people who are deafblind and those with complex needs have their needs appropriately met, their needs are communicated, their treatment is communicated and their treatment is understood and implemented. The importance and benefit of accessible healthcare services is also outlined in our 'Equal Access to Healthcare' report¹²⁷⁹.

Digitisation of services, Big Data and informatics

22. A key component of good structural integration of health and social care is the ability to efficiently and securely share data and patient information between providers. Good information sharing can facilitate timely discharges from hospital and avoid instances of unnecessary reassessment or repetition.
23. Technology can support secure information sharing. It is important that technologies and databases like secure e-mail and Summary Care Records continue to receive investment and providers of social care are given parity of access to such projects.
24. The Summary Care Record can only be updated by general practitioners; this has led to some criticism that the record does not give a holistic and accurate overview of a person's condition, care and treatment.
25. Many social care providers in the independent/voluntary sector do not benefit from information sharing agreements to the extent statutory sector providers do. This is

¹²⁷⁷ The King's Fund et al. *The Spending Review – what does it mean for health and social care?* Available at: <http://www.kingsfund.org.uk/publications/briefings-and-responses/spending-review-health-social-care>

¹²⁷⁸ Please see: <https://www.england.nhs.uk/ourwork/patients/patient-participation/self-care/patient-activation/>

¹²⁷⁹ Please see: www.sense.org.uk/healthreport

due to security of e-mail servers. Information can be securely shared between nhs.net and gov.uk email addresses. Information sent from a statutory sector address to a co.uk or org.uk will not be secure (with the exception of Outlook 365).

26. Technology can also be used to support people who are deafblind and those with complex needs to access and properly engage with services. Sense recommends that local authorities and the NHS:

- Work to extend accessible telecare/telehealth support to people who are deafblind;
- Develop specialist training programmes for professionals who work with people who are deafblind; and
- Urgently address the limited range of technologies offered by some local authorities.

14 September 2016

Shelford Group – Written evidence (NHS0134)

SUMMARY OF THE SHELFORD GROUP SUBMISSION TO THE HOUSE OF LORDS SELECT COMMITTEE ON THE LONG TERM SUSTAINABILITY OF THE NATIONAL HEALTH SERVICE

1. The Shelford Group represents ten of the leading multi-specialty academic healthcare centres in England, accounting for over 10% of the NHS. We are at the heart of the NHS and are deeply committed to its sustainability. We are seriously concerned by the medium and long term financial outlook and the risks to high quality, comprehensive and free-to-use health services.
2. A crucial question for long term sustainability is what proportion of the nation's resources should be spent on health and social care. We do not believe that the sustainability of health and social care should be detached. There is a growing weight of evidence to show that current and projected levels of spending are insufficient for our population's health and care needs. We see this playing out nationally with the NHS provider sector finishing 2015/16 with an aggregate deficit of £2.45bn, and an underlying position at least £1bn worse still. There are of course important opportunities to realise operational efficiencies. Nevertheless, when the vast majority of organisations are in deficit, some for the first time in their history, the problem is systemic underfunding relative to demand. History suggests the situation will worsen in the winter.
3. If we have to accept either more public funding or lower levels of service in this vital British institution, this should be the subject of an open and honest debate with the government and the public. We believe that there should be a new approach to determining the optimal level of spending. The Government could establish an independent expert committee to keep under review the best available international and domestic evidence and to publish recommendations on optimal levels of spending on advisory basis.
4. The NHS workforce is its greatest asset and we must invest in its long term future, rather than just treating it as a cost to be contained. The sustained pay restraint of recent years will not support the long term sustainability of a highly skilled, motivated and retained workforce. The current resource position is causing a mismatch between *appropriate* staffing levels and *affordable* staffing levels in many parts of the NHS.
5. We need a health system that focuses more on keeping people healthy, as well as treating them when they are sick, and that harnesses technological innovation to improve the quality and integration of care. Our member organisations are experimenting with the new models of care set out in the *Five Year Forward View*. However, fundamental redesign of complex health systems takes time and will not realise the level of savings required by 2020.
6. Whilst we support an NHS focused more on health promotion, we also believe that the demand for complex and specialised services will increase inexorably as people live

longer and medical science allows ever more complex and tailored treatments, driven by genomics and precision medicine. In seeking to design a health system that first aims to keep people healthy and out of hospital, it is essential that we do not under-invest in our leading centres of medical, educational and scientific excellence, which will design the health interventions of the future.

7. Sustainability for the long term can only be achieved by action in the short and medium term. Some of the challenges and potential solutions are so significant that they can only be addressed with government intervention. Equally, we are a central part of the NHS and we see it as our responsibility to lead changes in our own organisations and health systems to help deliver long term sustainability for the NHS to which we are so committed.

SHELFORD GROUP SUBMISSION TO THE HOUSE OF LORDS SELECT COMMITTEE ON THE LONG TERM SUSTAINABILITY OF THE NATIONAL HEALTH SERVICE

Introduction

8. The Shelford Group represents ten of the leading NHS multi-specialty academic healthcare centres in England (see membership at Appendix A).¹²⁸⁰ We have a track record over many years of delivering excellent patient care, clinical research and education. As a group, we aim to demonstrate system-wide leadership for the benefit of patients and the prosperity of our country, and to play a significant role in ensuring the sustainability of the NHS.
9. Our group welcomes wholeheartedly the decision of the House of Lords to establish a committee on the long term sustainability of the NHS. It is perhaps the most cherished of our public services, yet the scale of the challenge ahead is unprecedented. It has come through difficult times in the past, thanks to its importance to national society and the resilience and innovation of its many staff. These enduring qualities give us optimism for the long term future.
10. We find ourselves more pessimistic, however, about the medium term outlook, largely because of the daunting financial challenge and its potential impact on our ambition to provide high quality care. This merits a major national debate, which should be open, honest and informed by the best available evidence, in order to chart a path to long term sustainability.
11. Our organisations are core stakeholders for this inquiry, as large NHS providers delivering services worth in aggregate nearly £10bn per annum, which is around 10% of the total NHS England budget and over 13% of the NHS provider sector. Our trusts, with their relevant universities, are all Biomedical Research Centres, accounting for two thirds of National Institute for Health Research funding nationally.¹²⁸¹ Our ten Chief Executives

¹²⁸⁰ <http://shelfordgroup.org/>

¹²⁸¹ Department of Health, 'New £816 million investment in health research', (14 September 2016) <https://www.gov.uk/government/news/new-816-million-investment-in-health-research>

have over 150 years of CEO experience between them. We are not external commentators. We are at the heart of the NHS and we are deeply committed to its long term future.

12. Mindful of the guidance, we have kept our submission as concise as we felt possible, given the breadth of the subject. We have focused on the long term issues, but cited some near term examples where they provide relevant context. For brevity, we have not answered all of the questions posed, but we are very willing to elaborate on our submission and would welcome the opportunity to present evidence in person as well as in writing.

Resources

13. The question that is pivotal to the current challenges and the future sustainability of the NHS is what proportion of the nation's resources should be spent on health and social care, when set against other competing priorities. We include health and social care together because we do not believe that their sustainability should be detached; indeed the state of social care is one of the biggest risks to NHS sustainability.¹²⁸² Whilst this is a question to which there is not a clear 'right answer', there is a growing weight of evidence to show that current and projected levels of spending are the wrong answer for our population's health and care needs, assuming that we aim still to provide a high quality, comprehensive and largely free-to-use health service.
14. In common with all developed countries, the costs of health and social care in the UK are rising inexorably due to long term trends. The population is ageing and suffering more chronic disease caused by unhealthy lifestyles. Scientific advances are pushing the boundaries of medicine and well-informed patients understandably expect access to the latest medicines and therapies, as soon as their efficacy is demonstrated, however costly this may be to the public purse.
15. The near term imperative for the government to reduce the nation's structural deficit has meant that the NHS is having the lowest funding increases for a sustained period in its history,¹²⁸³ even though it has been comparatively well supported and has fared better than other parts of the public sector, including our partners in social care who have faced swingeing cuts. Nevertheless, the demands on health services continue to grow across virtually all parts of the sector.¹²⁸⁴ A number of independent analyses have found that there is a significant and growing mismatch between what the NHS and social care is expected to deliver and the amount of funding available.^{1285 1286 1287 1288 1289 1290}

¹²⁸² The King's Fund and the Nuffield Trust, *Social Care for Older People: home truths* (September 2016).

¹²⁸³ Appleby, J (for the King's Fund). 'NHS Spending: squeezed as never before', (20 October 2015)

<http://www.kingsfund.org.uk/blog/2015/10/nhs-spending-squeezed-never>

¹²⁸⁴ King's Fund Quarterly Monitoring Report (September 2016) <http://qmr.kingsfund.org.uk/2016/>

¹²⁸⁵ Health Select Committee, *Impact of the Spending Review on Health and Social Care* (July 2016).

¹²⁸⁶ The King's Fund, *Deficits in the NHS 2016* (July 2016).

¹²⁸⁷ Nuffield Trust, The Health Foundation and The King's Fund, *The Spending Review: what does it mean for health and social care* (December 2015).

¹²⁸⁸ Nuffield Trust, *Feeling the Crunch: NHS Finances to 2020* (5 August 2016).

¹²⁸⁹ Nuffield Trust's response to NHS 're-set' (21 July 2016) (<http://www.nuffieldtrust.org.uk/media-centre/press-releases/our-response-nhs-improvement-and-nhs-england-reset-and-department-health>).

16. We see this playing out nationally with the NHS provider sector finishing 2015/16 with an aggregate deficit of £2.45bn, almost three times greater than the previous year. The underlying position is likely to have been at least £1bn worse, with overall system balance only achieved by a series of non-recurrent measures.¹²⁹¹ Among them were transfers from capital to revenue that represent under-investment in infrastructure and store up problems for the future in order to shore up the bottom line in the short term. In tandem, there has been a steady decline across the board in operational performance against targets.
17. We also see this situation manifested locally in our organisations and health economies. The Shelford Group trusts have normally operated in surplus or balance, whilst meeting all major performance targets. In 2015/16, in common with most of the provider sector, many of our trusts registered a deficit, some for the first time. When a small minority of organisations are in deficit habitually, they may be considered to be the problem, but when the vast majority are in deficit, some for the first time in their history, the problem is systemic underfunding relative to demand.
18. Year-on-year real terms reductions in payment for activity have meant that we are at risk of normalising an NHS financial regime where even high performing organisations can only survive on bail outs. This ‘dependency culture’ will undo the good work of the last decade to promote fair funding and financial discipline in the NHS. It has a corrosive impact on the prevailing clinical management model when Clinical Directors cannot reconcile the provision of high quality care with a balanced budget for their clinical service.
19. As health economies come under severe financial pressure, and in the absence of national consistency about what can be restricted, we see Clinical Commissioning Groups making difficult and *ad hoc* rationing decisions.¹²⁹² ¹²⁹³ History suggests that financial and operational pressures will only rise as we go into the traditionally difficult winter period. As things stand, it seems inevitable that the financial pressures we face now and in the future will impact on the quality of care for patients, whether through lower than recommended staffing levels on wards, longer waiting times for emergency and elective care, or restricted availability of medicines and therapies.
20. There are of course opportunities to realise operational efficiencies, such as those helpfully identified by Lord Carter, which we must pursue vigorously.¹²⁹⁴ Indeed our group is working on a collaborative procurement programme to save £200m over five years by harnessing our purchasing power and clinical expertise to inform product

¹²⁹⁰ The Health Foundation, *A Perfect Storm: an impossible climate for NHS providers’ finances?* (March 2016).

¹²⁹¹ National Audit Office, *Reports on Department of Health, NHS England and NHS Foundation Trusts’ consolidated accounts 2015-16* (21 July 2016) <https://www.nao.org.uk/report/reports-on-department-of-health-nhs-england-and-nhs-foundation-trusts-consolidated-accounts-2015-16/>

¹²⁹² BBC News (online), ‘Obese patients “surgery ban” in York to be reviewed’ (3 September 2016) <http://www.bbc.co.uk/news/uk-england-york-north-yorkshire-37265752>

¹²⁹³ *The Telegraph* (online), ‘Health bosses perform U-turn over plan to delay all non-urgent surgery’ (11 August 2016) <http://www.telegraph.co.uk/science/2016/08/11/health-bosses-perform-u-turn-over-plan-to-delay-all-non-urgent-s/>

¹²⁹⁴ Lord Carter of Coles, *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations* (February 2016).

selection. However, even if the Carter recommendations could save £5bn, there would still remain a substantial gap to the £22bn of efficiency savings required by 2020, and no credible plan for achieving them to that timeframe. By international comparisons the NHS is already relatively efficient and effective overall, achieving strong outcomes relative to investment.¹²⁹⁵ Health service leaders are also mindful that any significant service changes designed to realise savings could potentially conclude, after formal consultation, in the period before the next General Election, which has often caused changes to stall in the past.

21. Should the country increase funding for health and social care therefore?
22. If we have to accept either more public funding or lower levels of service in this vital British institution, this should be the subject of an open and honest discussion with the government and the public, informed by the best available evidence.
23. As in any publicly funded service, there is an inherent tension between what patients and the public want to access and what taxpayers are prepared to fund. In the current circumstances, that tension is closer than ever to breaking point. Funding has to match ambition. We cannot have a first class health service with second class levels of funding. On one analysis, we ranked 10th of the original EU 15 on health spending as a proportion of GDP, which was behind Greece and about on a par with Slovenia¹²⁹⁶. We recognise that there is feverish academic debate about how to measure health spending as a proportion of GDP,¹²⁹⁷ but our real world experience is clear that frontline health services are being squeezed year-on-year, in some cases to the point of unsustainability.
24. To the extent that NHS funding was conflated with the referendum on Britain's membership of the European Union, it was apparent that there was public support for channeling more resources to the NHS. The government has dropped its previous target for the economy to achieve a structural surplus by 2020 and that might afford space for a reappraisal of current spending plans.
25. Long term sustainability requires appropriate investment in infrastructure, including clinical and research facilities, equipment and information technology. Current spending plans under-estimate the need for capital investment across the board, which has been exacerbated by the need to transfer capital to revenue.¹²⁹⁸ This could be addressed by a strategic and ambitious approach to selling parts of the existing NHS estate, where the buildings are crumbling but the land is valuable, and reinvesting in state-of-the-art infrastructure with better clinical and academic coadjacencies than we have now.¹²⁹⁹ We would also strongly support Simon Stevens's call for a new NHS infrastructure fund.¹³⁰⁰

¹²⁹⁵ The Commonwealth Fund, *Mirror, Mirror on the Wall* (June 2014).

¹²⁹⁶ The King's Fund, 'Health care spending compared to other countries', <http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/health-care-spending-compared> (11 January 2016)

¹²⁹⁷ Health Select Committee, *Impact of the Spending Review on Health and Social Care* (July 2016).

¹²⁹⁸ Health Select Committee, *Impact of the Spending Review on Health and Social Care* (July 2016).

¹²⁹⁹ Naylor R. National Strategy for NHS Property and Estates (forthcoming report).

¹³⁰⁰ Stevens S in *The Telegraph* (online), 'The radical blueprint the NHS needs to survive life after Brexit' (18 July 2016) <http://www.telegraph.co.uk/news/2016/07/18/the-radical-blueprint-the-nhs-needs-to-survive-life-after-brexite/>

26. As well as capital investment, it is of course equally important that there is sufficient revenue to meet demand for services on a recurrent basis. Whilst we do not attempt to define the 'right' amount of expenditure on health and social care, we do believe that there should be a new approach to determining an optimal level of spending. We note that there are several examples where the UK Government has set up independent expert panels or organisations to make, recommend or scrutinise significant financial decisions, such as the Bank of England setting interest rates; the Office of Budget Responsibility providing independent analysis of public finances; and independent review bodies making recommendations on public sector pay.
27. The Government could establish an independent expert committee to keep under review the best available international and domestic evidence and to publish recommendations on optimal levels of spending on health and social care. Accepting that any government of the day will wish to retain executive authority over spending plans, the recommendations could be advisory rather than binding, but would at least make visible 'target' levels of spending. It would also support longer term planning.
28. We note that it has proven entirely possible to set target levels of spending for a sector, as with the North Atlantic Treaty Organisation target for at least 2% of GDP being spent on defence,¹³⁰¹ and with 0.7% of GDP for international aid being enshrined in law.¹³⁰² The important caveats are that any such targets for health and social care would need to be kept under review for changes in demography, epidemiology and technology, and that the definition of what counted as health and social care spending would have to be similarly independent to prevent arbitrary redrawing of the boundaries.
29. Where actual spending levels on NHS and social care were to fall below the target level recommended by experts, the NHS would have to cut its cloth accordingly, for instance, by reducing unfunded cost pressures. This could offer a more credible alignment than we have now of what can be achieved for the resources available.
30. For the avoidance of doubt, we are not saying the *only* answer is more money. We have to be realistic about the prospect of additional resources in the current economic circumstances and with many competing claims on national resources. There is significant opportunity to drive efficiency savings, as evidenced by Lord Carter, to standardise good practice at pace and scale and to focus on new models of care that keep people healthy rather than just waiting to treat them when they are sick. We aim to do all of those things as leading organisations with a track record of delivery.
31. However, our experience leads us to the conclusion that with current levels of spending, and stretching but realistic efficiency gains, we cannot afford to deliver the high quality, comprehensive standards of care across the board to which we aspire as providers and which patients have come to expect. This is the reality of where we are now and where we are heading in the future.

¹³⁰¹ NATO, 'Funding NATO', http://www.nato.int/cps/en/natohq/topics_67655.htm?selectedLocale=en (3 June 2015).

¹³⁰² International Development (Official Development Assistance Target) Act 2015, http://www.legislation.gov.uk/ukpga/2015/12/pdfs/ukpga_20150012_en.pdf (1 June 2015).

32. It will always be the role of the government of the day to determine what the country *can afford* to spend on its publicly funded healthcare. That is not necessarily the same as what the country *ought to spend* to meet population health needs within defined service standards. The latter question could be answered with a greater degree of expertise, transparency and independence, at least on an advisory basis. That would make clear the gap between affordability and optimal spending and help to have an open dialogue about trade-offs. It would avert what we fear will be a growing spate of *ad hoc* rationing decisions breaking out unevenly across the country.

Workforce

33. The extremely high regard in which the NHS is held in this country and internationally is a testament to its talented and dedicated workforce. In our organisations, we employ over 100,000 NHS staff, including 15,000 doctors and dentists, 40,000 nurses, midwives and health visitors, and 15,000 scientists and allied health professionals. Each one is a dedicated public servant.

34. It has often been said that the greatest asset of the NHS is its staff. It is also frequently noted that staff are the largest cost in the NHS, representing over two thirds of recurrent spending. Both observations are of course true, but, regrettably, the thrust of central policies in recent times has been to treat the workforce more as a cost to be contained for short term cash control, than an asset to be nurtured for our long term investment.¹³⁰³

35. The previous Spending Review had already identified a need for £15bn of NHS savings between 2010 and 2015, much of which was achieved through sustained pay restraint that was replicated across the public sector. This may have been necessary for a period, but its continuation will not support the long term sustainability of a highly skilled, motivated and retained workforce. We are increasingly concerned by the difficulty in filling clinical posts.¹³⁰⁴ Central cuts to training budgets have left trusts increasingly reliant on agency and overseas staff.

36. It is essential that industrial relations between junior doctors and the Government are repaired and that there is no deterioration with other, equally important staff groups. This is entirely possible with constructive dialogue between the Government, the British Medical Association, NHS Employers and clinical leaders. As a group of large teaching hospitals, Shelford organisations aim to support constructive industrial relations, to act as exemplar employers for clinical training and to provide high quality care consistently.

37. The current resource position is causing a mismatch between *appropriate* staffing levels and *affordable* staffing levels in many parts of the NHS. The Mid Staffordshire scandal should have seared into our collective memory the importance of staffing healthcare services according to what is right and safe for levels of acuity and need, rather than staffing them based on what financially distressed organisations think they can

¹³⁰³ Lord Carter of Coles, *Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations* (February 2016).

¹³⁰⁴ Royal College of Physicians, *Underfunded. Underdoctored, Overstretched. The NHS in 2016* (21 September 2016).

afford.¹³⁰⁵ We forget that lesson at our peril. That is why the Shelford Group is continuing to develop a range of evidence-based tools on safe nurse staffing levels for the benefit of NHS organisations.¹³⁰⁶

38. The impact that Brexit will have on the NHS workforce is so far uncertain. There may be welcome opportunities to focus more attention on training our domestic workforce as part of a long term strategy. At the present time, however, 135,000 people from the EU work in health and social care in this country. In our member organisations based in London and the South East, EU staff represent around 10% of our workforce, and they make a significant contribution to organisations right across the country. They are highly skilled and valued members of our teams. We are members of the Cavendish Coalition which calls for swift reassurance for those staff that they will have the right to remain in the UK, advocates a reasonable level of international workforce mobility, and which calls for zero tolerance of discrimination towards staff or patients.¹³⁰⁷
39. An important, but currently neglected, element of the workforce to ensure long term sustainability is leadership. The leaders of our organisations hold themselves and others to the highest standards as stewards of public healthcare and taxpayers' money. However, the resource environment is making it increasingly difficult for leaders throughout the service to succeed. It risks discouraging future generations, including clinical leaders who see the financial strictures as incompatible with high quality care.¹³⁰⁸ At present, NHS leadership talent is currently spread too thinly across too many organisations and there is insufficient attention to nurturing a new and more diverse cadre of leaders.¹³⁰⁹ We would be delighted to work with other partners to ensure a renewed focus on leadership development in the NHS.

Service delivery and integration

40. We have long known that we need a health system that focuses more on keeping people healthy, as well as treating them when they are sick. Equally important is harnessing the potential of technological innovation to improve the quality and integration of primary and acute care, and to support individuals to manage their own health and care. These related aims remain central to long term sustainability, but have proven stubbornly difficult to achieve at scale, which is partly why hospitals and clinics up and down the country are immersed by a wave of demand.
41. We undoubtedly need more integration of services across the full continuum of care, and between physical and mental health, supported by investment in technology and better sharing of data. Those are key drivers of the innovative devolution settlement for Manchester. But we must be cautious about shifting resources from the NHS to local government, because recent experience has suggested that money gets channeled away from health promotion and social care when councils are under severe financial strain,

¹³⁰⁵ Francis R. *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry* (6 February 2013).

¹³⁰⁶ The Shelford Group Safer Nursing Care Tool, <http://shelfordgroup.org/resource/safer-nursing-care-tool1>

¹³⁰⁷ The Cavendish Coalition, <http://www.nhsemployers.org/your-workforce/need-to-know/brexit-and-the-nhs-eu-workforce/the-cavendish-coalition> (7 September 2016).

¹³⁰⁸ Health Service Journal: Future of NHS Leadership, *Ending the Crisis in NHS Leadership: a plan for renewal*, (June 2015).

¹³⁰⁹ The King's Fund, *Leadership and engagement for improvement in the NHS*, (23 May 2012).

as in recent years. That is partly why delayed transfers of care from hospital have risen by 163% in the last five years, placing a huge burden on the NHS, which is a higher cost environment in which to care for these vulnerable people.¹³¹⁰ There are other models, such as the one trialled successfully in Oxford, where the university hospital has taken greater responsibility for the social care needs of its patients, thus reducing delayed transfers of care by 50%.¹³¹¹

42. The NHS is still driven substantially by targets, which have both catalysed improvements for patients and led to some unintended consequences. In recent years, the financial and operational pressures on providers have seen a deterioration in performance. For the longer term, it would be preferable for there to be a shift away from top-down targets and to move towards more locally tailored goals, which incentivise health promotion and the reduction of inequalities, and join up services between physical and mental health and between the NHS and social care. However, any targets or objectives should be properly costed to ensure they are deliverable and affordable.
43. We support a thrust of policy that incentivises hospitals and other health services to focus on keeping people healthy and out of hospital, where possible and clinically appropriate. In that respect, the *NHS Five Year Forward View* and NHS England's new care models programme offer real promise.¹³¹² ¹³¹³ A number of our member organisations are experimenting with Primary and Acute Care Systems (also known as Accountable Care Organisations) and Acute Care Collaborations. We agree that there is not a one-size-fits-all solution for every locality. We aim to help build the evidence base for the various options, which is currently at an immature stage of development and must become more rigorous. However, we caution that fundamental redesign of complex health systems will take time and the return on investment might be over several years.
44. Any field needs pioneers and innovators to lead the way. Our organisations have been at the forefront of many of the most prominent health service reforms of recent decades, such as the creation of NHS Trusts, then NHS Foundation Trusts, Academic Health Science Centres and Biomedical Research Centres. A common theme of successful reform is a clear and evidence-based national policy framework, allied with local engagement and innovation. Whilst the organisational forms will change in the future, that theme should endure.
45. However, as the NHS overall slides into financial deficit, the regulatory diagnosis seems to have been of widespread local failure. The treatment regimen has therefore been to pull the reins ever more tightly from the centre, as exemplified by the so-called 'NHS reset' of July 2016.¹³¹⁴ This may help short term cash control, but will have an uncertain and risky impact on local service provision.

¹³¹⁰ The King's Fund and the Nuffield Trust, *Social Care for Older People: home truths* (September 2016).

¹³¹¹ *Health Service Journal*, 'New Oxford Hospitals chief reveals delayed transfers turnaround', (5 July 2016).

¹³¹² NHS England, *Five Year Forward View* (October 2014).

¹³¹³ <https://www.england.nhs.uk/tag/new-models-of-care/>

¹³¹⁴ NHS England and NHS Improvement, *Strengthening Financial Performance & Accountability in 2016/17* (21 July 2016).

46. Our diagnosis places far more emphasis on systemic underfunding of the NHS and social care relative to demand. That problem will not be cured by more central regulation and inspection of local providers. The reporting burden to various regulators and inspectors has already become so onerous that it is crowding out time and space to innovate. A health system cannot inspect and regulate its way to efficient, high quality care.¹³¹⁵
47. In the next phase of organisational change, we believe there must be a return to the principles behind the NHS Foundation Trust movement, namely that leading organisations should be given local freedom to innovate and invest, rather than being tightly managed from Whitehall or arm's-length bodies. There must also be clearer alignment between responsibility for service planning and accountability for delivery. There is much that is positive in Sustainability and Transformation Plans (STPs) and we welcome the principle of multi-year planning. However, STPs are not well aligned to the current framework of accountability that was set up in the Health and Social Care Act of 2012. That Act promoted a more competitive and market-based approach, which is quite different to the health economy wide planning of STPs. In the not-too-distant future, there should be a realignment of how health services are managed and the governing framework of accountability.
48. We have made clear our commitment to a health service that promotes health and manages illness in lower acuity settings where possible. Nevertheless, as our population ages, and biomedical science advances, we see, and are able to treat, ever more complex conditions and co-morbidities. For example, we are now able to treat HIV successfully as a chronic rather than a terminal condition, so some of our trusts have seen year-on-year growth of 5-10% in treatment costs. Over the last six years, one of our trusts has seen an average 12% year on year increase in kidney transplants, which adds significantly to short term costs, even though it is less expensive than the alternative of long term dialysis. Demographic changes and advances in assisted fertility have increased the demand for, and the costs of, IVF and that has also had an impact on the rising demand for specialised neonatal care. Right across the hospital sector, the cost of medicines has been rising significantly faster than income due to the introduction of new and innovative medicines and the pharmaceutical costs of specialised services.
49. These examples, among many others, demonstrate that the demand for, and cost of, NHS specialised services will accelerate apace. We welcome NHS England's recognition that the specialised commissioning budget will have to increase above headline NHS revenue growth,¹³¹⁶ although we are concerned that the projected increases will still be insufficient to meet fast growing demand.
50. In aggregate, the Shelford Group trusts deliver around a quarter of all specialised services commissioned by NHS England. Those services remain at the cutting edge of global biomedical science. They are a jewel in the crown of the NHS, not to be neglected or underfunded. We welcome the attention this vital area of provision has recently

¹³¹⁵ National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act*, <https://www.gov.uk/government/publications/berwick-review-into-patient-safety> (6 August 2013).

¹³¹⁶ NHS England Board Paper, 'Strategic Framework for Specialised Services' (26 May 2016).

received from the National Audit Office and others,¹³¹⁷ ¹³¹⁸ and we will continue to engage with NHS England on the strategy for specialised commissioning. We believe this should result in a significant rationalisation of the number of sites undertaking specialised services, for the sake of quality and efficiency, and this must be based on robust and transparent evidence to command public and professional confidence. There must also be closer network arrangements between specialised sites and their related services.

Science and research

51. As large and highly specialised providers, our organisations are national and international hubs for advanced healthcare, education and research. Five of the world's top ten clinical research universities are partnered with Shelford trusts.¹³¹⁹ In partnership with their universities, our organisations are all Biomedical Research Centres, and are responsible for two-thirds of National Institute for Health Research funding nationally.¹³²⁰ We also host eight of the NHS Genomic Medicine Centres in England.¹³²¹ As one of our globally competitive industries, we believe that the NHS and UK life sciences should feature prominently in the government's forthcoming industrial strategy. This will be of benefit for the sustainability of the NHS and the wider UK economy.
52. The impact that Brexit will have on science and research is unclear. There may be increased opportunities to develop domestic talent and to make new links with non-EU countries. However, we also believe that the continuing need for professional mobility, research collaboration and funding with Europe should be prioritised by the government in the forthcoming Brexit negotiations. In the meantime, we are aware of instances where UK researchers are not being included as Principal Investigators on research applications for EU funding. Until there is a clear alternative strategy, we are concerned this will affect clinical research in our organisations.
53. We should focus more research into ways to address the long term funding challenge. New ways of delivering care will be driven as much by scientific research as redesign of care pathways. Perhaps the most revolutionary change on the horizon is the use of genomics in precision medicine. Genomics will allow us to examine the underlying causes of ill-health and confront diseases before they have even started. This is particularly important in conditions such as diabetes, cancer and cardiovascular disease, where current therapies are effective in 30-60% of patients. By using precision medicine we will be able to tailor treatments and interventions to the individual rather than the average of the patient group. This holds the promise of radically increasing the effectiveness of treatments and eliminating extraneous costs.

¹³¹⁷ National Audit Office, *The commissioning of specialised services in the NHS*, <https://www.nao.org.uk/pressrelease/the-commissioning-of-specialised-services-in-the-nhs/> (27 April 2016).

¹³¹⁸ Lord Warner, *Report of the Specialised Services Commission*, (May 2016).

¹³¹⁹ *The Times Higher Education* rankings 2015/16.

¹³²⁰ <http://www.nihr.ac.uk/about/biomedical-research-centres.htm>

¹³²¹ Genomics England, 'NHS Genomic Medicine Centres', <https://www.genomicsengland.co.uk/taking-part/genomic-medicine-centres/>

54. Personalised medicine requires precision diagnostics to identify underlying conditions and to monitor the early and late effect of interventions. With £8bn a year spent on diagnostic testing and £15bn on medicines, there is clear potential to make savings through precision techniques and targeted interventional technologies.
55. As the largest integrated healthcare system in the world, the NHS is superbly well suited to translate genomic and other scientific breakthroughs quickly and efficiently to a large, diverse population. In seeking to design a health system that first aims to keep people healthy and out of hospital, it is essential that we do not under-invest in our leading centres of medical, educational and scientific excellence, which will design the health interventions of the future and act as centres for innovation and the introduction of new technologies.

Conclusion

56. From the benefit of our experience, we have attempted to lay out fully and frankly the challenges for the NHS as we see them. Sustainability for the long term can only be achieved by action in the short and medium term. Some of the challenges and potential solutions are so significant that they can only be addressed with government intervention. Equally, we are a central part of the NHS and we see it as our responsibility to lead changes in our own organisations and health systems to help deliver long term sustainability for the NHS to which we are so committed.
57. For our last words, we simply quote the first words of the NHS Constitution:

*'The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.'*¹³²²

58. Long may it be so.

Appendix A – Shelford Group members

- Cambridge University Hospitals NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- King's College London Hospital NHS Foundation Trust
- Newcastle-upon-Tyne Hospitals NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust

¹³²²https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

23 September 2016

Simple Shared Healthcare Limited – Written evidence (NHS0104)

I write on behalf of Simple Shared Healthcare Limited, a not-for-profit social enterprise, limited by guarantee and committed to improving the quality of self-care.

1. Our interest cuts across the committee's areas of interest as follows;
 - a. Resourcing issues - productivity and demand management.
 - b. Models of service delivery and integration
 - c. Prevention and public engagement - motivating people to take greater responsibility for their own health - Keeping people healthier for longer.
 - d. Digitisation.
2. The business case for each service commissioned by the NHS to achieve clinical and preventative outcomes assumes a particular level of patient engagement and adherence with their own healthcare.
 - a. The typical level of patient engagement and adherence presents the opportunity for significant room for improvement across all conditions, pathways and treatments.
 - b. Through increasing the level of engagement and adherence to the best practice health care currently delivered by the NHS, better clinical outcomes can be achieved faster and more cost effectively than is otherwise the case.
 - c. Such improvements can be achieved using evidence based techniques without re-engineering clinical pathways, changing clinical practice, or introduction of costly and/or unproven technology.
 - d. The current evidence base built using the NHS owned methodology 'Simple Telehealth' www.simple.uk.net uses psychological methods and zero footprint technology (uses the patients own mobile phone) to help patients. It motivates, engages, educates and increases adherence to their shared healthcare plans.
3. The application of this methodology enjoys support within the clinical community and is used in some primary, secondary, community and mental healthcare settings in England, Scotland and Wales. The NHS 'Simple Telehealth' methodology has been assessed and adopted by the United States Federal Government's Veterans Health Administration for national rollout and there is keen interest from other countries. The clinical community have also formed a Community of Practice through which they build a knowledge base and freely share their practice, achievements and evidence with others.
4. Practical use of the methodology through the 'Florence' system in England has been cited by the CQC as outstanding in a number of primary and secondary care inspections and improvements in engagement and adherence bring about productivity, efficiency and prescribing improvements
5. The evidence of clinical outcome improvement and high patient satisfaction through the impact of improved engagement and adherence is widespread ranging across all ages, geographic regions and demographics. A number of case studies and links to

medical journal articles can be seen at <http://www.simple.uk.net/home/casestudies> and <http://www.simple.uk.net/home/articles>

6. However the current fashion for the adoption of the latest technology and apps for self-care needs to be treated with caution in terms of attaining clinical outcomes and improving productivity for the NHS. The NHS has wasted many millions of pounds investing in technology for self care that has no basis in evidence and scant clinical support. In some cases today, managers are still persuaded by professional sales techniques citing overstated benefits to invest in equipment and apps for which there is no or little evidence or even evidence to the contrary or has been proven to be ineffective previously in other areas.
<http://www.simple.uk.net/home/blog/blogcontent/duediligenceforcommissioners/> / <http://www.bmj.com/content/347/bmj.f6070>
7. The long term sustainability of the NHS is critically dependent upon the level of Self Management Support provided to improve the engagement and adherence of patients. This impacts directly on the quality and efficacy of healthcare, productivity, cost of care episodes, avoidance and delaying of health complications and significantly the sustained and lasting impacts of patient behaviour change.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4964251/>
8. Should the Self Management Support results achieved to-date of improved engagement and adherence with over 40,000 patients via use of the NHS's Simple Telehealth methodology be replicated at scale, but only achieving a fraction of the improvements evidenced, the impact on the sustainability of the NHS would be substantial and achieved at an insignificant cost.

23 September 2016

The Society and College of Radiographers – Written evidence (NHS0186)

Thank you for the opportunity to comment on some of the evidence presented to the Lords Committee on Sustainability in the NHS this week.

Firstly, I should apologise that the Society and College of Radiographers did not submit a written response to your call for evidence in the summer. This was an oversight and I very much regret as a consequence not having the opportunity to speak to the committee personally.

Our purpose in writing is to comment further on some of the evidence presented to the committee on Tuesday 22nd November 2016 from about midday. The Society and College of Radiographers is concerned that the portrayal of radiographers and the profession of radiography was incomplete on a number of points and we should like to provide our perspective on these as follows:

- **The workforce shortage in radiography**

It is true that there is a shortage of radiographers in both diagnostic imaging and therapeutic disciplines. It is most acute in diagnostic imaging and in some NHS trust departments is resulting in a vacancy rate up to 15%. The impression may have been given that this was connected with a perception of radiography as an unpopular career choice with poor prospects of development. This is not the case.

The current under-supply is directly related to a long history of restriction of numbers of training places at UK universities, similar to the situation in physiotherapy related to the committee. Poor workforce planning centrally combined with a drive for cost savings has restricted the number of places made available, despite strong evidence of need.

Diagnostic radiography training programmes report that they are regularly oversubscribed, so there is no evidence that the profession is an unpopular choice. In the unregulated future, following the removal of training bursaries, the chief restriction on numbers of radiographers in training will be the capacity in clinical departments to provide the essential practical elements of the programme.

We have a number of concerns about the change to funded training places. However, the profession is determined to ensure that, as far as possible, these result in an increase in trained radiographers in the future.

- **Career progression for radiographers**

The committee may have understood from the evidence presented that there should be better progression opportunities for radiographers and specifically that specialist areas of practice should be capable of recognition within the NHS salary structure. Naturally, we have some sympathy with this view!

However, the committee will probably be aware that, for all its faults, the “Agenda for Change” NHS pay and recognition agreement does provide for salary band progression in line with increasing competence and expertise. The fact that employees experience frustration at lack of progression is more to do with financial pressures in the NHS than an actual inability to reward specialisation.

It would be regrettable if the committee had the impression that there are fewer opportunities for career progression for radiographers than are in fact in place. It is certainly incorrect to say that radiographers have no way to progress their career pathway.

Specifically, a development which offers considerable opportunity for further implementation is for radiographers to train as advanced practitioners in image reporting. It should not be accepted that radiographer advanced practice is a minority activity undertaken only as a result of frustration at limited progression.

It is understandable that some may feel that allowing a limited pool of radiographers to advance their practice would reduce the numbers of practitioners available to acquire images and perform scans. However, the committee should be aware that the Society and College of Radiographers supports a career framework for the profession which includes assistant practitioners to be trained to undertake some imaging tasks under supervision. This was developed with support from the Department of Health as long ago as 2003.

It is consequently not the case that advanced practice always depletes the capacity of the radiographic workforce. The use of assistant practice is very well established, for example, in the NHS Breast Screening service, where it in turn has released radiographers to train as reporting practitioners. It is this integration of practice that enables the breast screening programme to function in the UK. There is no reason why this model cannot work equally well and be increased in other imaging specialities.

- **The scope of radiography practice**

Linked to the previous point, the committee may have understood the evidence to show that better levels of reward may in some way prevent radiographers advancing the scope of their professional practice.

The Society and College of Radiographers asserts strongly that the scope of practice for radiography is defined by members of the profession responding to service need and to the motivation to provide the best possible service to patients. We believe, provided developments are underpinned with high quality training and rigorous competence checks, including ongoing comparative audit, that radiographers in common with other AHPs have a great deal to offer the NHS in low cost, highly effective service innovations. The committee should not be persuaded that advanced radiographic practice and particularly image reporting should be outside the scope of practice of radiographers.

- **Radiographer image reporting**

Radiographic advanced practice that provides definitive reports on diagnostic images is well established in the UK. Across England, 21% of all image reporting is undertaken by advanced practitioner radiographers.¹³²³

Reporting is most common in the specialities of ultrasound scanning, musculo-skeletal projection imaging and in breast imaging. These modalities would not be sustainable nationally without the contribution to the reporting burden by radiographers.

All advanced practitioner reporting radiographers undergo an accredited course of postgraduate education and work with consultant radiologists in the attainment of skills. Training and practice is always within specific speciality areas. There is no desire for radiographers to attain the breadth of scope across all areas of imaging such as may be possessed by some consultant radiologists. However, it is clearly important for efficient and safe service provision that within the scope of competence, any reporting radiographer is able to perform to the same level as a radiologist.

Typically on completion of the course, there will be a period of closely supervised reporting practice before the individual is deemed fully competent to report within the area of their trained expertise. Regular comparative audit is expected to ensure that all advanced practitioners continue to perform comparably to their consultant radiologist colleagues.

There is now a very compelling body of research evidence to support radiographer image reporting as safe, accurate and efficient in service provision. Naturally, the Society and College of Radiographers is very happy to provide references if these would be helpful.

- **Team working in diagnostic imaging and radiotherapy**

As implied in the previous section, advanced practitioner radiographers and consultant radiologists collaborate closely in providing imaging services at local level. This mutual commitment to patient care has been shown to support further innovation and improvement. I believe that this is an important element in seeking the contribution that Clinical Radiology as a speciality can make to NHS sustainability. If the best practice in team working was to become standard across the NHS, there would be extraordinary impact in service efficiency and consequent financial savings across the “health economy”.

The committee heard that radiology is central to most care pathways. It was also told that there is an enormous backlog of image reporting. We do not dispute these points. Improvement in efficiency and keeping up with technological development in the speciality could make an enormous contribution to sustainability. There are undoubtedly challenges due to shortages of radiologists and radiographers. However, practice in the UK, centred on good team working at local and national levels can develop further to help overcome these challenges. We believe that existing good practice in team working can be further extended to enable significant efficiencies in the service

¹³²³ NHS Benchmarking data 2016

The Society and College of Radiographers – Written evidence (NHS0186)

Despite our tardiness in entering the debate, the Society and College of Radiographers will be glad to help the committee with any further detail that may be helpful.

28 November 2016

Specialised Healthcare Alliance – Written evidence (NHS0042)

1. Introduction

- 1.1 The Specialised Healthcare Alliance (SHCA) is a coalition of 120 patient-related organisations and 15 corporate supporters which has campaigned on behalf of people with rare and complex conditions since 2003.
- 1.2 The Alliance does not get involved in any individual therapy-related issues, concentrating instead on the overarching policies and structures of NHS specialised care. This submission includes the Alliance's comments on topics under consideration by the Committee.
- 1.3 Specialised services are of fundamental importance for the NHS and are a vital component of comprehensive healthcare systems. Without high quality care for smaller patient populations, or the availability of more complex health services, patients are offered only partial health coverage. As such, their particular requirements must be considered as a vital component of a sustainable, comprehensive health service.
- 1.4 This submission draws upon the recommendations of the independent Specialised Services Commission chaired by Lord Warner, a member of the House of Lords Sustainability Committee. SHCA members provided use of the Alliance secretariat to facilitate the Commission's work, without prejudice to the Commission's policy positions, discussions and recommendations.
- 1.4 Baroness Redfern, another Committee member, is Vice-Chair of the SHCA.

2 Key points

- 2.1 Specialised services are those NHS services which cannot be sensibly planned and budgeted for at a local level, typically for rare and more complex conditions. These include rarer cancers, genetic conditions such as cystic fibrosis and haemophilia and severe burns and spinal injury services.
- 2.2 In 2015/16, the budget for specialised services was £14.6 billion. This is about 14% of the total NHS budget. Planning these services effectively will be crucial for enabling the NHS to adapt to increasing patient demand, new treatments and technologies and funding constraints. If NHS England is unable to keep its spending on specialised services within budget, this will affect its ability to resource other services, such as primary care, non-specialised hospital and community services, and wider health transformation set out in the Five Year Forward View.
- 2.3 Moreover, there is also a substantial opportunity to support the longer-term sustainability of the NHS by delivering the most efficient and high quality specialised

services for patients, reducing their reliance on other health services and helping to pioneer productive innovation throughout the NHS.

- 2.4 In developing its recommendations, the Committee should take into account the needs of specialised services and ensure that changes are not delivered at the expense of patients with rare and complex conditions.

3 Resourcing issues

Specialised commissioning finances

- 3.1 In April 2013, budget and accountability for specialised commissioning were transferred from Primary Care Trusts (PCTs) to NHS England in its capacity as the single national commissioner of specialised services.
- 3.2 The transition saw the halving of staff numbers in specialised commissioning at a time when the scope of prescribed services and associated spend was set to rise by almost 200%. Significant performance and operational problems ensued, leading to a £376.9m overspend on NHS England’s specialised commissioning budget in 2013/14.
- 3.3 The Alliance has argued that the mere fact of an overspend provides no evidence to support the theory that services are over-resourced and require cost savings, for example, by top-slicing the specialised services budget. In fact, the financial pressures have arisen principally from inaccurate budget-setting based on flawed assumptions about historic spending prior to the last NHS reforms, alongside an overspend in the Cancer Drugs Fund. Furthermore, NHS England’s national accountability for specialised services has crystallised costs and facilitated efficiencies in a manner unavailable to smaller commissioning bodies.

Financial outlook

- 3.4 Following the Comprehensive Spending Review in November 2015, NHS England allocated the following budget growth for specialised commissioning in the years ahead:

2016/17	2017/18	2018/19	2019/20	2020/21
+7.0%	+4.8%	+4.5%	+4.5%	+5.0%

- 3.5 While specialised services have been allocated an above average increase in spending rates, NHS England has described this as being at the lowest end of projected demand. As a result, there will be significant pressure on the specialised commissioning budget and there will be a greater need for NHS England to demonstrate clear delivery and assurance plans for the decisions it will need to take.

- 3.6 The risk is that financial pressures will see a gradual erosion of the arrangements, and budget, for specialised services. Previously, the Health Select Committee warned in 2010 that specialised services were at a higher risk of cuts from local commissioners in the period of financial constraint which would follow. A diminished national system for specialised commissioning would see costs transferred elsewhere, with potential replication and inefficiencies. Alternatively, a reduced offer of specialised services would see poorly treated patients call upon other health services to address the symptoms of any underlying specialised condition.
- 3.7 In addition, there has been increasing concern in recent years that the current funding model for the NHS does not sufficiently recognise the additional costs of delivering specialised care. In these circumstances, greater provider leadership, within national service standards, might be an answer.

4 Workforce

Developing the specialist workforce

- 4.1 Given the inherent complexity of some specialised services, they play an important role in developing clinical expertise across NHS providers. By nurturing specialism, professional skills are developed and this expertise can then be spread throughout the NHS.
- 4.2 Patients will need a balance of generalist and specialist clinicians and so consideration of how best to develop NHS specialised service provision in future should feature prominently in thinking about the long-term sustainability of the NHS.

5 Models of service delivery and integration

Concentration of specialised services

- 5.1 The need for a sufficient volume of patients to develop and sustain clinical expertise and outcomes is well recognised and applies with particular force to specialised services with relatively small patient numbers.
- 5.2 The positive correlation between volume and outcomes has favoured greater concentration of specialised care. However, attempts to reconfigure specialised care provision have typically met competing provider interests, political interventions and regulatory barriers preventing service change. Challenges such as these have historically stymied progress towards specialised services consolidation.
- 5.3 Since the establishment of NHS England, by describing the mandatory elements of a service, national service specifications have been a means of ensuring the

concentration of specialised care at centres capable of delivering the best outcomes, consistent with competition law.

- 5.4 If the NHS reverts to a more local, place-based approach, the risk is that the opportunity for clinically-led concentration of services would be forgone. The conventional choice between local and tertiary providers is also becoming less relevant as modern technology enables the latter to support patients in and close to their homes with support from general practice. The patient rather than the hospital should therefore be the hub of care.

New models of care delivery

- 5.5 The Alliance has been a longstanding supporter of national standards for specialised services as currently constituted. While supporting a flexible approach towards the model of service delivery, it is crucial that the delivery model is predicated on the underpinning service specifications, including detail on the shape of the service within each specification.
- 5.6 The Alliance firmly believes that a key strength of NHS England's specialised commissioning has been the equity it has delivered for patients, most notably through national service specifications. The Alliance is concerned that the proposed move towards more 'outcomes-based' specifications – if implemented poorly – would risk creating substantial variation across the country.
- 5.7 Furthermore, while service specifications should be refined and improved iteratively, taking into account their effectiveness to date, the wholesale stripping back of specifications to focus on outcomes could limit their value as a tool in commissioning providers with the right skills and capacity.

6 Public engagement

- 6.1 The Alliance continues to have serious concerns about the transparency and accountability of NHS England for its specialised commissioning performance. For example, the much reduced size of the Department of Health means that Ministers are increasingly dependent on NHS England to answer questions about its performance.
- 6.2 NHS England's internal committees are numerous and interlinked and the most senior committees (the Clinical Priorities Advisory Group, Specialised Commissioning Oversight Group and Specialised Commissioning Committee) do not conduct any public engagement. More troublingly, notes of their meetings are not made public, hampering any external assessment of the quality or justification for decisions which are taken about patient care.
- 6.3 This is recognised by the National Audit Office's recent report on specialised commissioning delivery, which states that "it is not clear to what extent patient concerns or views raised through these mechanisms have been reflected in the

commissioning decisions made by NHS England”. The Public Accounts Committee concurred with this view.

- 6.4 It is crucial that these issues are addressed to better enable the public, patients and patient groups to feed into the development of specialised services in England.
- 6.5 Furthermore, NHS England has no formal links with patient organisations across its specialised commissioning portfolios. Previously, there were some links through the Patient and Public Voice Assurance Group, but recent changes have seen organisations removed from its membership. Given the small patient groups concerned and the importance of taking patient organisations’ expertise on board in the planning of these services, clear routes for patient and public involvement should be established.

7 Digitisation, big data and informatics

- 7.1 While there are signs that data collection and usage is improving within NHS England’s specialised commissioning function, the standard of costing and outcomes data since April 2013 has generally been considered poor.
- 7.2 This was recognised by the National Audit Office’s recent report on specialised commissioning delivery, which states that: “NHS England is currently unable to assess and gain assurance about: how efficiently the services it commissions have been delivered; whether the level of access to specialised services has changed since 2013/14; and whether inequalities in access to services have reduced”. Similarly, the Public Accounts Committee report into NHS England’s delivery of specialised services stated that “NHS England does not have the information—on costs, access and outcomes— necessary to assess how to improve services”.
- 7.3 A more flexible approach to managing specialised services will only increase the need for sophisticated data on outcomes, in order to assure service standards in the context of any future changes. It is therefore vital that improvements in data and informatics are prioritised, fast-tracked and invested in.
- 7.4 More generally, the Alliance would recommend the development of a publicly available programme budgeting database for specialised services. This would support more robust prioritisation during the commissioning cycle and demonstrate to the public the effect of future investments and disinvestments in any given service area.

21 September 2016

Stephen Smith – Written evidence (NHS0001)

1. NHS is being improved in terms of integration of care, feedback etc.
1. NHS is being destroyed by competition, bureaucracy and funding deprivation
2. NHS is being abused by much inappropriate use
3. Calls for reinstatement of public system largely ignored
4. Closures & cuts causing fury in society
5. Many think NHS reduction leading to buy-outs or charging (min)
6. I just wanted to point out the anger in society is increasing and could eventually drive some to civil disobedience.
7. Matters aren't helped by Mr Hunt or lack of true proportional representation.
8. My declared interest is merely to see the quality of the NHS maintained and preferably through taxation as this may be the cheaper cause for us. Personally I'd pay more tax for it. People are never asked this.

19 July 2016

Petula Storey – Written evidence (NHS0025)

My name is Petula Storey, I am putting forward a submission as an individual but also from the experience I have professionally as a Head of Volunteering at an NHS Foundation Trust.

In looking at your themes and guidance, I noticed a glaring omission; there is no mention of volunteers and volunteering. Yet there are around three million volunteers supporting the NHS in the country, according to the Kings Fund report of 2013, Volunteering in Health and Social Care: <http://www.kingsfund.org.uk/publications/volunteering-health-and-care> They are making a substantial contribution to patient experience, they are an integral part of care teams and on a daily basis working in innovative ways to deliver services. This three million figure is the same number as the combined NHS and social care workforce.

In looking at the future sustainability of the NHS, this 'workforce' needs to be considered alongside the staff workforce. There are concerns about job substitution, but I and my peers in other Trusts work very hard to ensure that we are not creating roles which staff currently do or could do. Volunteers are there to improve patient and visitor experience and all roles are designed to complement and enhance, rather than be a substitute for the work of staff. There are challenges as well and this is due to resources, which are in short supply but experience has shown that, where volunteers are integrated well into a team, properly managed and supported, they make a difference to not only patients but staff as well. The Kings Fund report which I mentioned previously says that for every £1 invested, there is a ROI of around £11. For my trust this is just over £2 million.

So how have volunteers made a difference?

Volunteers have a positive impact on patient experience. The results of the Friends and Family Test surveys in my own Trust, have shown that, those patients who have had access to a volunteer, are more likely to recommend the Trust to their family and friends. These results demonstrate that our service fulfils its main aim to improve patient experience.

Volunteers are helping to meet the bigger challenges facing the health and social care sector and the potential for growth in this area is strong. Hospital 2 Home (H2H) programmes are set up to support people after discharge, to aid recovery, ensuring they are able to settle back into their lives after a stay in hospital. The programme has helped hundreds of vulnerable and isolated patients and has shown that volunteers can have a positive impact for people going home from hospital. This programme has also shown that volunteers can be the missing link by solving the wider determinants of health. We all know it's not just the physical issues that determine our well-being, but all the other things that make up our lives. Volunteers have helped patients resolve issues such as housing and nutrition but also, more importantly, reduced isolation by ensuring they are integrated into the community.

The Royal Voluntary Service report

http://www.royalvoluntaryservice.org.uk/Uploads/Documents/Reports%20and%20Reviews/Going_home_alone.pdf published in 2015, states that over the last 10 years, hospital discharges for those over 75 have been rising at a much faster rate than ageing trends in the population, almost four times faster. The growth in hospital readmissions has been higher still, up by 86%. If Hospital to Home Services could alter the underlying causes of

inappropriate admissions and were targeted appropriately with full coverage across England, it might reduce the cost of readmissions by around £40.4m per year.

Volunteers can help with cost savings. In one of our units, a volunteer calls patients to remind them about their follow up appointment. Since this initiative started, there has been a 40% reduction in DNAs for follow up appointment. Given that each DNA costs a trust circa £160.00, this represents an average saving of £1,300 per quarter. This initiative is relatively new but the impact will be substantial once spread across other areas of a Trust. Such a small task could easily be replicated across Trusts and also primary care thus producing significant cost savings for the NHS.

Volunteer Programmes have a positive impact on the individual who is volunteering: With the focus of the NHS on mobilising health communities and in this age of social prescribing, volunteering should be part of the mix: Volunteering is not a cure for all ills but should be part of the prescription.

15 September 2016

Stroke Association – Written evidence (NHS0130)

There are 1.2 million stroke survivors living in the UK and half of those people are living with a disability as a result of their stroke. As the leading charity in the UK for people affected by stroke, ensuring good quality health and social care for stroke survivors and their families is an essential part of our work.

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

Demographics

The health and social care system needs to take a wide range of current future demographic trends into account when planning and budgeting for an appropriate service. In some areas of England, as much as 8.7% of the population ‘do not speak English well’, and in large London boroughs like Newham, for example, that equates to around 25,000 people.¹³²⁴ Stroke services, in particular, need to be shaped to cope with changes to racial demographic because race is a key risk factor in stroke. If you are South Asian, black African or black Caribbean, you are at a higher risk of stroke than other people in the UK. Black people are twice as likely to have a stroke compared to white people and black and South Asian people tend to have strokes at a younger age compared to white people.¹³²⁵ While it is not fully understood why this is the case, it is probably connected to the fact people in these groups are more likely to have conditions such as high blood pressure or diabetes.¹³²⁶

Another key demographic change which the healthcare system is already acutely aware of is age. For the Stroke Association, this is an extremely important consideration. Age is the single most important risk factor in stroke. Similarly, the incidence of atrial fibrillation (an irregular heartbeat) increases with age. Atrial fibrillation is a stroke risk factor in stroke which contributes to the most deadly and debilitating strokes. As the Committee mentions in its background to the inquiry, England’s age demographics are forecast to shift dramatically over the coming decades, with more than half as many people aged over 65 in 2030 compared to 2010, and double the number of people aged over 85 over the same time period. As three quarters of all strokes happen in those over 65, this is a major issue for stroke services, as is the number of people living with multi-morbidities. Stroke survivors may, either as a result of their stroke or not, have to live with several long term conditions at once, further increasing demand on the healthcare system.

We would very much call for the third sector to be as integrated as possible into the health and social care system as a means of support and expertise.

¹³²⁴ <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/07/demographics.pdf>

¹³²⁵ https://www.stroke.org.uk/sites/default/files/stroke_statistics_2015.pdf

¹³²⁶ <https://www.stroke.org.uk/what-stroke/are-you-risk-stroke/what-makes-you-more-risk-stroke>

2. To what extent is the current funding envelope for the NHS realistic?

We have concerns about the long-term funding arrangements for the NHS in its current form, particularly the disproportionate focus on frontline NHS services and lack of focus on public health and social care in particular.

The House of Commons' Health Select Committee's inquiry into the impact of the Spending Review of health and social care provides some valuable insight on this issue.¹³²⁷ It describes the scale of the funding challenge facing health and social care as "colossal", particularly given the timescale for achieving the ambitions set out in NHS England's Five Year Forward View.

We obviously welcomed the £8 billion real terms increase to NHS England's budget announced last year as part of the Comprehensive Spending Review, which will provide much-needed support to frontline services and address, at least in part, financial pressures which most NHS leaders describe as they worst they have ever experienced.¹³²⁸ Much of this year's extra cash is likely to go on the attempt to eradicate NHS trusts' deficits, rather than improving services. This is not sustainable or realistic, particularly when three consecutive years of no real-terms growth in the NHS budget are planned. As the Health Select Committee pointed out, there is also a need for more clarity around where, exactly, this extra funding is coming from.

The situation is, however, still critical. According to a survey by The King's Fund, 67% of NHS providers ended 2015/16 in deficit, including 86% of acute trusts.¹³²⁹ While figures from Q1 of 2016/17 suggest the situation easing somewhat, it is clear that there is a fundamental problem going forward around the funding of NHS providers.

As we set out in our submission to the Health Select Committee's inquiry, we remain very concerned at the distribution of the extra NHS funding. While there has been a large funding increase (particularly compared to widespread cuts across most government departments) this year for the NHS, there will then follow years of flat or falling real-terms funding until 2020/21. This will only be exacerbated by lower economic growth (and resultant lower tax revenues) and increased inflation resulting from the UK's decision to leave the European Union, according to the Bank of England.¹³³⁰ It is also exacerbated by poor levels of efficiency within the NHS. According to a study by the Health Foundation, without improvement in NHS efficiency, there could be a funding gap in 2019/20 of £11.9 billion. The Five Year Forward View allows for a highly ambitious 2-3% efficiency growth by then, but that is more than double the long-term trend for efficiency growth since 1979/80.¹³³¹

While the funding challenges faced by the NHS will not be solved by £8bn over five years, those challenges are dwarfed by those in social care. Half of all stroke survivors are left with

¹³²⁷ <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/139/13903.htm>

¹³²⁸

<http://nhsconfed.org/~media/Confederation/Files/Publications/Documents/Paul%20Healy%20NHS%20Confederation.pdf>

¹³²⁹ <http://qmr.kingsfund.org.uk/2016/19/overview>

¹³³⁰ <http://www.ibtimes.co.uk/bank-englands-rates-decision-live-mark-carney-set-cut-rates-historic-low-1574275>

¹³³¹ The Health Foundation (2016) Briefing: NHS Finance Outside the EU p.12

a disability following their stroke and many are reliant on social care services to help them make as full a recovery as possible. We know, however, that stroke survivors are not receiving the care they are entitled to and expect and that there remain serious gaps and unacceptable variability in the quality and coverage of post-acute care.

There are around 1.2 million stroke survivors in the UK and half of these have a long term disability, requiring ongoing support.¹³³² Social care is absolutely essential to many stroke survivors' journey to recovery but we know that there are serious problems in the quality and coverage of social care once people have left hospital. These problems not only hamper and delay vital rehabilitation, but place extra strain on stroke survivors' families, who themselves are often deeply affected by their loved one's stroke.

Stroke Association research found that nearly half (48%) of stroke survivors and their carers had problems caused by either poor or non-existent co-working between health and social care providers.¹³³³ Evidence shows that too many areas are failing to commission comprehensive post-acute care, meaning survivors and their families are struggling needlessly.¹³³⁴ Also, stroke clinicians tell us that the lack of appropriate social care is a huge barrier to discharging stroke survivors from hospital – a problem which consequently impacts heavily upon budgets and the availability of beds in acute stroke wards. If social care packages are not put in place quickly and efficiently, stroke survivors can spend unnecessary and costly extra time in hospital.

During the last Parliament, the Department for Communities and Local Government (DCLG) had its budget reduced by 51% - the largest reduction of any department – and direct grants to local government fell by 37%, impacting on local social care services which many thousands of stroke survivors rely on.¹³³⁵ Changes to local government funding announced in the Spending Review will see central government support for local councils reduce by a further 56% by 2019/20.¹³³⁶

The Government is giving local authorities the power to increase council tax by up to 2% to help fund social care, but not all local authorities will implement this increase and even if they did, the potential revenue would not come close to filling the gap left by enormous cuts to local authority budgets which have already happened, and are planned to continue over the next five years. Liverpool City Council, for example, which has a social care bill of £172 million, has said it could only raise £3.2 million from the 2% levy.¹³³⁷ The Government has suggested that the precept could raise £2 billion, although it will only raise around £380 million this year – far short of the funding gap of £1 billion for this year alone.¹³³⁸

We have concerns that it is local authorities in better-off areas which will more easily be able to apply and collect the 2% levy if they choose to implement it, while the local

¹³³² https://www.stroke.org.uk/sites/default/files/stroke_statistics_2015.pdf

¹³³³ https://www.stroke.org.uk/sites/default/files/stroke_statistics_2015.pdf

¹³³⁴ <https://www.strokeaudit.org/Documents/Results/National/2015/2015-PAOrgPublicReport.aspx>

¹³³⁵ <http://www.bbc.co.uk/news/uk-politics-34790102>

¹³³⁶ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Spending-Review-Nuffield-Health-Kings-Fund-December-2015_0.pdf

¹³³⁷ <http://www.theguardian.com/society/2015/nov/25/local-government-councils-funding-gap-critical-budget-cuts-social-care-spending-review>

¹³³⁸ <http://www.kingsfund.org.uk/blog/2016/07/taking-control-our-social-care-system>

authorities in the most deprived areas are most in need of more social care funding. We know that people from the most economically deprived areas of the UK are around twice as likely to have a stroke than those from the least deprived, so this measure risks widening the health inequality gap further.¹³³⁹

Local authorities have, for six consecutive years now, been facing budget pressures as settlements from central government have reduced. This is having a substantial effect on services which stroke survivors rely on. £5.5 billion has been cut from social budgets since 2010 and adult social care directors have provided sobering assessments of the impact. 85% say that providers are facing “quality challenges” and 84% say that providers are facing financial difficulty.¹³⁴⁰ The King’s Fund has found that after six consecutive years of local authority budget cuts, 26% fewer older people are getting support.¹³⁴¹

The Government has said that it wants to integrate health and social care. Done properly and adequately resourced, this would address many of the problems faced by stroke survivors and their families, but it remains to be seen how this will be possible given the huge reductions to the budgets of local authorities which will surely impact on their ability to effectively integrate with health services.

a) Does the wider societal value of the healthcare system exceed its monetary cost?

It is not clear exactly what is meant by ‘wider societal value’. The NHS’s impact on the nation’s health since its conception is clear but, like any publicly-funded organisation, it needs to represent value for money. The NHS is clearly valued massively by the population, and polling consistently reinforces this. There is pride in the NHS and a desire to see it remain and improve, although people are not clear on how the NHS should be improved. A major poll last year found that discussing the practicalities of the NHS is actually quite difficult because the whole subject remains so emotive.

Sometimes the founding principles of the NHS and the fear of privatisation on any level reflects the idea that, perhaps, a wider ‘societal value’ exceeds monetary cost or efficiency in importance. In the same poll as mentioned above, a significant proportion of those questioned said that the private sector should not be allowed to provide NHS services “even if this would save money and improve treatment for patients.”¹³⁴² That said, around half said that the use of private companies was acceptable if they could provide higher quality, cheaper treatment.

b) What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

¹³³⁹ https://www.stroke.org.uk/sites/default/files/stroke_statistics_2015.pdf

¹³⁴⁰ <http://www.kingsfund.org.uk/blog/2016/07/taking-control-our-social-care-system>

¹³⁴¹ King’s Fund and Nuffield Trust, Social Care for Older People: Home Truths (2016): <http://www.kingsfund.org.uk/publications/social-care-older-people>

¹³⁴² <http://lordashcroftpolls.com/wp-content/uploads/2015/01/The-People-the-Parties-and-the-NHS-LORD-ASHCROFT-POLLS1.pdf>

We believe that more should be done to investigate the viability of financial incentives to encourage improved patient outcomes, particularly in the field of disease prevention.

- c) **What is the scope for changes to current funding streams such as hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes and expansion on co-payments (with agreed exceptions)?**
 - d) **Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?**
3. **What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses and other healthcare professionals and staff, be optimised for the long term needs of the NHS?**
- a) **What are the options for increasing supply, for instance through charging entry systems, overseas recruitment, internal development and progression?**
 - b) **What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?**

We are very concerned about the potential impact of leaving the European Union on the availability of stroke-trained health and social care professionals. Around 80,000 people working in social care are non-UK EU nationals.¹³⁴³ A further 55,000 work in the NHS.¹³⁴⁴ It remains to be seen what kind of negotiated settlement the UK Government will achieve after it has negotiated the UK's cessation from the EU, but the Leave campaign said that immigration controls on EU citizens would be tighter in the event of Brexit.

Large numbers of stroke survivors depend on adult social care – a sector which already has some 70,000 vacancies.¹³⁴⁵

Across the NHS, around 7.5% of all clinical posts across England are vacant, with the problem particularly bad in London.¹³⁴⁶ Vacancies are being filled by agency staff and the NHS is becoming increasingly reliant on this expensive alternative. The Secretary of State said that agency spending within NHS England was around £3.7 billion in 2015/16.¹³⁴⁷ Crucially for us, there is a stroke physician vacancy rate of 20-25%, with a recent survey by BASP (not yet published) showing this may have increased in the last year.¹³⁴⁸ We have seen some instances where stroke units have had to close due to consultants stepping down. Reconfiguring acute-stroke units to central Hyper-acute Stroke Units, which has been shown to save money and improve patient outcomes, can also help make better use of existing

¹³⁴³ <http://www.kingsfund.org.uk/publications/articles/brexit-and-nhs>

¹³⁴⁴ <http://digital.nhs.uk/searchcatalogue?topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top>

¹³⁴⁵ <http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/State-of-2014-ENGLAND-WEB-FINAL.pdf>

¹³⁴⁶ <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/139/13905.htm>

¹³⁴⁷ <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/139/13905.htm>

¹³⁴⁸ <http://www.basp.ac.uk/Portals/2/BASP%20Meeting%20the%20Future%20Challenge%20of%20Stroke%202011-15.pdf>

stroke physicians and alleviate some of these pressures.¹³⁴⁹ However, we need an overarching vision for stroke services that pushes this forward strategically, rather than reactively following staff vacancies.

c) What are the retention issues for key groups of healthcare workers and how should these be addressed?

Retention issues are widespread and complex but within the NHS, uncertainty around long-term funding, changes to contracts and – most recently – potential changes to the immigration status of non-UK EU nationals are all particularly relevant at the present time. With the NHS already struggling to recruit and retain staff, the profound uncertainty around the UK's decision to leave the European Union is a major issue. Non-UK EU nationals should be reassured that until the UK actually leaves the EU, their immigration status remains unaffected. The Government should work quickly to guarantee the status of EU nationals in the EU.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

- a) What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?**
- b) What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?**
- c) What investment model would most speedily enhance and stabilise the workforce?**

We want to see a well-qualified, fully staffed and stroke-aware workforce across the stroke care pathway. We are working with those representing the stroke-specific workforce, including the British Association of Stroke Physicians (BASP) to address the vacancy rate mentioned earlier in this submission.

While there continue to be issues with a high vacancy rate and a lack of stroke-specific training within the NHS, the problems are even worse in the social care sector. While social care is not the focus on the Committee's inquiry, both the health and social care sectors need to be properly staffed and trained so that the whole stroke pathway works for stroke survivors. Too often, stroke survivors are leaving hospital and then entering a social care system where there is no mandatory stroke training requirement and where 42% of the workforce hold no formal care-related qualification.

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

- a) How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?**
- b) How can local organisations be incentivised to work together?**

¹³⁴⁹ Ramsay AIG et al. (2015) 'Effects of centralising acute stroke services on stroke care provision in two large metropolitan areas in England' Stroke 2015 doi: 10.1161/STROKEAHA.115.009723

The Stroke Association carried out a survey earlier this year of over 1,100 stroke survivors in England. Over a third (39%) reported that they left hospital without a care plan, returning home without appropriate support in place for their recovery. Nearly half (47%) said they were not contacted by a healthcare professional when they returned home from hospital. This shows that much more needs to be done to improve joint working at a local level.

We also know from our engagement with Strategic Clinical Networks that geographical boundaries prevent important discussions about service improvement (for example, the reconfiguration of acute stroke services) moving forward. An overarching vision for stroke services is needed. In response to our survey, 78% of stroke survivors said that a new national stroke strategy is needed to drive forward the improvements that need to happen and that is why the Stroke Association is currently running a campaign which calls on the Government to commit to a new strategy.

c) How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

- a) What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?**
- b) What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?**
- c) Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?**
- d) Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?**

The Stroke Association – a member of the Richmond Group of leading health charities – supported the 'Living Longer, Living Well' report which was published earlier this year. The report called for the Government, health services, charities and individuals to work collectively to tackle long-term preventable health conditions.¹³⁵⁰

- e) By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?**
- f) What are the barriers to taking on received knowledge about health places to live and work?**

It follows simple logic that investment in prevention eases pressure on frontline NHS services and that is why we are so concerned at the Government's moves to focus

¹³⁵⁰ The Richmond Group of Charities (2016): 'Living Longer, Living Well: How we can achieve the World Health Organisation's '25 by 25' goals in the UK': https://richmondgroupofcharities.org.uk/sites/default/files/rg_living_longer_living_well_report_-_final_pdf_-_24_05_16.pdf

Department of Health funding away from Public Health England and local authorities, which have an increasingly important role in delivering public health.

Up to 80% of strokes can be prevented with lifestyle changes and more action to control hypertension and atrial fibrillation (AF). In the case of hypertension, we know that Quality Outcomes Framework targets and strong clinical leadership have helped drive progress, although there is still a lot of work to do to ensure that the 6.8 million people living with undiagnosed hypertension are found and effectively treated. In AF, despite clear policy and strong evidence supporting the use of anti-coagulation to reduce a person's risk of stroke, action in this area has been slow. Some of this is down to clinical reluctance and fear of bleeding, but NHS structures and silo budgets have a part to play in the slow adoption of this lifesaving treatment. Finding and treating people with AF takes money, but crucially, evidence from Greater Manchester's Academic Health Science Network has found that anti-coagulating everyone with AF provides significant cost savings from year 3. GM AHSN's project, the AF Data Landscape Tool, seeks to standardise at scale a pan Manchester approach to improving the pathway for care for those at risk of an AF-related Stroke, reducing stroke deaths by 365 per year. We are also working with our member organisations on AF-related projects in specific areas.

Atrial Fibrillation is common nationwide, but current data shows us that Greater Manchester has one of the worst rates of stroke, of anywhere in England. For us, therefore, finding a way of identifying early on who is most at risk, who is showing warning signs, and who is missing out on the correct medication – is vital.

The need to find in year costs savings to budgets prevents action which not only saves lives, but provides a significant return on investment. Secondly, action from GPs is required to find and treat people with hypertension and AF, yet will often not see the benefits, either financially or otherwise, of the strokes they prevent through their action. Stroke survivors constantly tell us that their GP did not know they had a stroke. Better data sharing would help, as would pooling of budgets, and ways to incentivise those who take action to prevent significant ill health. In addition, the significant pressure on primary care does nothing to promote GPs taking additional action to prevent ill health in future.

We know evidence-based public health interventions work. We would highlight the example of the hugely successful Act FAST campaign, which has increased the public's awareness of stroke. Since its launch in 2009, the Department of Health estimates an additional 41,382 people have got to hospital within the vital three hour window after the onset of symptoms. Public Health England figures also show that over 4,000 fewer people have become disabled as a result of stroke over that period.¹³⁵¹

There is clearly a mismatch between spending on public health and prevention, compared to that spent on treatment. We accept the political reasons behind this, but we would urge policymakers and politicians to recognise the benefits of public health interventions not only in preventing people from becoming ill in the first place, but in helping NHS England fulfil its legal obligation to reduce health inequalities.

¹³⁵¹ <http://www.bbc.co.uk/news/health-31057650>

We have called for this to be a priority for Public Health England. Evidence shows us that access to stroke treatment and support is highly dependent on where someone lives, their race, gender and socioeconomic status. PHE should prioritise the tackling of these inequalities and we would support the Health Select Committee's recent report which warned that reducing spending in public health risks widening the already unacceptable health inequalities in England.¹³⁵²

People from the most economically deprived areas of the UK are around twice as likely to have a stroke than those from the least deprived areas. People from the most economically deprived areas are also three times more likely to die from a stroke than those from the least deprived areas and this is therefore a key inequality which needs to be addressed.

7. What are the best ways to engage the public in talking about what they want from a health service?

Without patient engagement, the NHS can have no idea of what people want from their health service. As the NHS deals with severe budgetary pressures for the foreseeable future, it is even more crucial that as wide a scope of opinion is used to shape the NHS in the years ahead.

Relatively recent initiatives such as Clinical Reference Groups are important in making sure the public is front and centre when NHS services are planned. We were obviously concerned when, earlier this year, NHS England proposed reducing the number of public and patient voice representatives on these Clinical Reference Groups, and reducing the support available to patient and public voice membership.

We know that many stroke survivors and their families are enthusiastic when it comes to engaging with health professionals, patient groups and others looking to shape and improve services so it is important that platforms such as Clinical Reference Groups are retained and available to as many patient and public voices as possible.

Clinical Reference Groups are just one example of engaging the public in talking about the NHS. Of course, it is important for the NHS to use a wide range of methods and we would certainly highlight the role the third sector play as a constructive partner to encourage and facilitate engagement. We regularly canvass our beneficiaries for their opinions and experiences of the health service to shape our campaigns, policies, service improvement and responses to consultations.

8. How can new technologies be used to ensure the sustainability of the NHS?

a) What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

Technology also has an important role in prevention. Wearable blood pressure monitors can, for example, allow people to test themselves for a key risk factor in stroke – hypertension. Technology can make people more health aware but they

¹³⁵² <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news-parliament-20151/public-health-report-published-16-17/>

obviously risk entrenching existing health inequalities unless there is equitable provision.

b) What is the role of ‘Big Data’ in reducing costs and managing demand?

c) What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

In the case of ‘AliveCor’, a mobile ECG device, many local areas are piloting its use, but only at a very local level. They do not tend to publish their findings on its use or evaluate the technology in a way that adds to the existing evidence base which could promote the development of national best practice.

One of the central problems with the rolling out of new technologies and is the insufficient existing infrastructure which is not capable, in many cases, of supporting the adoption of those new technologies.

d) How can healthcare providers be incentivised to take up new technologies?

NHS Chief Executive Simon Stevens spoke in June this year about a new programme to fast-track cutting-edge innovations to the NHS front line. He introduced a new Innovation and Technology tariff to help speed up the introduction of exciting new technologies. The mobile ECG monitor, AliveCor (mentioned earlier) is covered by the new tariff, but it is important that the tariff brings with it as much choice as possible. The NHS should be wary of the new tariff cementing a preferred technology or brand which may not actually be the most appropriate product for all NHS providers.

e) Where is investment in technology and informatics most needed?

Technology is absolutely crucial to the sustainability of the NHS and it can help support with condition self-management.

In co-production with stroke survivors, we have developed My Stroke Guide, a unique online platform to support stroke survivors to make the best possible recovery. My Stroke Guide (MSG) is an interactive online platform accessed through computers, tablets and smartphones. We have created a central, easily updatable resource with accessible information tailored to individual needs, alongside an online stroke community that brings together stroke survivors, families, carers and health professionals, to support and motivate stroke survivors in their recovery.

All its content is NHS Information Standard accredited and is continually reviewed and updated and new content added by our MSG team. There are 200 videos, covering everything from pain management to exercise. We would encourage the NHS to promote self-management technology such as MSG.

23 September 2016

Sustainable Development Unit for NHS England and Public Health England – Written evidence (NHS0140)

Thank you for accepting this contribution to your House of Lords Select Committee on the Long-Term Sustainability of the NHS's inquiry into the issues facing the NHS now and over the next 15-20 years

This briefing has been put together by the NHS England/Public Health England Sustainable Development Unit for its Cross System Group, its partners and stakeholders, and any other organisation group or individual who would value help in submitting a response.

I have distilled some of the key points of the work of the Unit and its stakeholders and partners over the last 8 years that I hope will inform your inquiry. If there is additional evidence, in the form of peer reviewed material or real, evaluated case studies in the NHS that you would find useful and that are related to the points below, we would be happy to make every effort to supply it.

Our research in the health sector (predominantly the NHS , but also in the public health, social care and local government system) suggests the following issues are extremely important in assessing the long term financial sustainability of the NHS.

Financial sustainability will not be achieved without considering environmental and social sustainability as highly supporting (not competing) approaches.

The most efficient, productive, and ethical businesses in the world discovered this years ago and have succeeded accordingly. Health care systems like the NHS have even more to gain from this Triple Bottom Line approach. (Evidence of examples of financial win-wins at <http://www.sduhealth.org.uk/policy-strategy/engagement-resources/financial-value-of-sustainable-development.aspx>). There are examples of this being done all over the country and indeed all over the world that contributes to better health, better use of financial and other resources, less wastage, less pollution and harm and adding more economic value and prosperity to local communities as well as to the national exchequer.

As 7.5% of GDP, the way the NHS operates affects our local economies and our health, which in turn determines the demand for and sustainability of NHS services. In England as a whole and in all the communities the NHS serves, the NHS usually the largest employer, largest procurer of goods and services, one of the largest single causes of road traffic and traffic pollution and by far the largest source of public sector carbon emissions.

The long term sustainability of the NHS requires delivering savings now, that also directly and catalytically improve health in the communities that the health system supports, reducing demands on the health and social care system later. This can only be achieved by equally valuing social and environmental benefits in all decision making. This will ensure that financial savings and improvements in models of care will drive outcomes such as: improved air quality; local employment; the building of social capital; adaptation to and mitigation of climate change.

We must de-carbonise the health system asap:

- for financial reasons (we waste too much money on historic methods of energy use, unnecessary travel, waste management, models of care, lack of prevention.)
- for health reasons (decarbonising, waste reduction, valuing finite resources) leads to direct health improvement (40,000 premature deaths due to air pollution from fossil fuels) and less burden on the health system (less obesity, heart disease, and cancers from healthy diets and more active travel and physical activity)
- for legal reasons (Public Services [Social Value] Act 2012 and Climate Change Act 2008). If we do not show progress, we are liable for fines and prosecution and damage to reputation as a health sector.
- For exemplar reasons: the NHS employs 1.3 million people (Over 2 million social care and public health workforces included). That is a representative of the nation's population and c 10% of the local GDP in any region or locality.
- For wider economic reasons: see social value paragraph below.
- For social reasons: empowering communities by allowing them to use their own community assets, social and geographical networks, and personal technology to taken more control of their own health and that of the places they live reduces the (financial) burden on the health service by taking preventative strategies closer to people rather than focusing just treatment strategies in large, unaffordable, depersonalised, unnecessary and unsafe hospitals. Hospitals need to focus on only what they can do best: hubs in local systems, not the disproportionate consumer of almost every resource on the inaccessible outskirts of every town and city

All these benefits reinforce each other (they offer significant benefits in different areas (**co-benefits**) for health, for the NHS and for the health and care system, and all that makes living possible and desirable). These multiple reinforcing benefits are across different people groups (inequalities) different issues (from personally owned technology to new models of care for people living with dementia), and different timescales (immediate, medium term AND long term)

Even just for the purely financial reason of savings, and the reduced burden on the NHS through addressing preventable conditions by a sustainable and low carbon approach, the NHS should seize this opportunity to address all three dimensions of sustainability.

Key facts:

The cumulative savings from energy measures alone implemented in the NHS in England since 2007 amounts to c. £1.85bn, in addition to environmental and health benefits such as reduced air pollution. The NHS needs to continue realising and increasing these savings at the current expected rate to 2025 – this would return a cumulative saving of £6.2bn against a business as usual case. Ref below.

Key refs:

Securing Healthy Returns. <http://www.sduhealth.org.uk/policy-strategy/engagement-resources/financial-value-of-sustainable-development.aspx>

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Health returns infographic. www.sduhealth.org.uk/delivery/engage/health-returns-infographic.aspx

Key Case Studies

Case studies of where the NHS has become financially, socially and environmentally sustainable simultaneously:

Bart's whole organisation approach >£9m of savings <https://youtu.be/FCAskWHuye8>

Sussex Community NHS Trust £3m of savings <http://carewithoutcarbon.org/> and <http://www.sussexcommunity.nhs.uk/downloads/about-us/trust-reports/annual-strategic-reports/2015-2016/cwc-impact-report.pdf>

Key quotations: (quote from any of this in your submission: e.g. As Ed Smith, chair of NHS Improvement says “....”

“The £22bn efficiency saving is a huge challenge. We need to simultaneously exploit the financial opportunities of being socially and environmentally sustainable. The future of the sector and the health and wellbeing of the public depends on us living within the limits of our available resources, but we can only do this if we are able to identify where we can at the same time save money and ensure the sustainability of our environment, on which all health depends.” Sandra Easton, Finance Director, Chelsea & Westminster Hospital NHS Foundation Trust and Chair, Healthcare Financial Management Association (HFMA) NHS Environmental Sustainability Special Interest Group

How we improve and transform the health sector to be financially sustainable is an important part of delivering the Five Year Forward View. The evidence presented (in Securing Healthy Returns) shows that savings and investment are lasting and effective when the efficiencies and transformations we make are also socially and environmentally sustainable. Since 2007, NHS organisations, supported by the SDU, have ensured that in excess of £190m each year remains available for front line care, rather than being spent on energy, waste, water or fuel. We have exceeded the NHS and wider sector first target of a 10% reduction in carbon emissions, by 2015, contributing to the national and global public health challenge of mitigating climate change. (By acting on the evidence we already have) only then can we be sure that both the population and the exchequer gain from living within financial and environmental limits. The Carter Report highlighted opportunities for efficiency savings and environmental benefits with examples such as energy used in the health care system. This report highlights further opportunities for longer-term financial savings in areas such as procurement, public health and better models of care, all of which have clear positive environmental and health benefits. We need to develop a health system that is seen as the best possible investment in people and long term health for all, and not an unsustainable consumer of finite resources. We must allow the strong intrinsic motivation of our staff to perform to the best of their abilities; to be able to practice the values they have at home,

whilst at work. . By thinking and working in this way we can build on a Five Year Forward View to develop a longer term vision of a truly sustainable health service, now and for future generations.” Ed Smith, Chair, NHS Improvement

Related issues to the long term financial sustainability

Workforce

- Workforce: Ensuring sufficient, appropriately trained, healthcare professionals; retention; skill sets for future health care needs; (see: <http://www.sduhealth.org.uk/areas-of-focus/leadership-engagement-and-workforce-development.aspx> See “Leadership, engagement and workforce development” for narrative and the implementation notes for the data and case studies/

More financially sustainable models of prevention and care:

- Models of service delivery and integration: An integrated National Health and Care Service? Incentivisation for health and social care integration; Incentivisation *is key: for OUTCOMES and PREVENTION – NOT simply ACTIVITY....* <http://www.sduhealth.org.uk/areas-of-focus/clinical-and-care-models.aspx>

Public engagement

- Prevention and public engagement: Motivating people to take greater responsibility for their own health? How can people be kept healthier for longer? *Do the public think that a holistically sustainable NHS is desirable? Yes. Ipsos Mori has serial surveys on this – 2011, 2013, 2015: see* http://www.sduhealth.org.uk/documents/publications/2016/Ipsos_Mori_2015_report.pdf

Results:

- a) The percentage of the public who think it is important for the health system to work in a more sustainable way has increased to 92% in 2015*
 - b) The percentage of the public who said the health system should act in a more sustainable way even if it would cost more money is now 43% (36% in 2013 and 33% in 2011).*
 - c) When asked to state how high priority sustainability should be in the health system the responses increased with 25% (1 in 4) saying it should be a top priority (compared to 19% or 1 in 5 in both 2013 and 2011).*
- Digitisation, big data and informatics: New technology to ensure NHS sustainability?

Empowering communities by allowing them to use their own community assets and personal technology to take more control of their own health and that of the places they live reduces the (financial) burden on the health service by taking preventative strategies closer to people rather than focusing just treatment strategies in hospitals that are often

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large, nearly always unaffordable, frequently depersonalised, sometimes unnecessary and too often unsafe.

23 September 2016

Telecare Services Association – Written evidence (NHS0106)

The House of Lords Committee on the Long-term Sustainability of the NHS has called for submissions to its inquiry by 23 September 2016) as it tries to identify what the NHS of the future may look like.

This short paper sets out the response from Alyson Scurfield, Chief Executive from [TSA](#) (The Voice of Technology Enabled Care).

Background

The NHS in England is entering a critical stage in its history. Demand for services is unprecedented even in summer months. Hospital Trusts are struggling with overspends and deficits (some of these relating to agency spend to maintain staffing levels to meet demands). Waiting lists are increasing and many targets are routinely missed.

£22bn of efficiencies/savings have been promised as part of the Five Year Forward View (5YFV) and Comprehensive Spending Review (CSR) through to 2020/21.

2015/2016 saw the biggest ever NHS overspend (£2.45bn) and the first quarter of 2016/17 has a total deficit of £461m for secondary care AFTER a further £450m has been made available (from £1.8bn additional CSR funding for 2016/17 set aside for NHS Trusts).

At this stage last year, the deficit totalled over £900m, suggesting that spending curbs are having little impact at this time (however, the additional funding is showing a better position overall).

In the coming financial years, the budget rises for the NHS will be much smaller as part of the CSR.

A recent NHS Providers survey of Trust finance directors highlighted concerns about financial targets. Without major action, further overspends are inevitable.

So, we have reached a critical point in the sustainability of the 68 year history of the NHS.

As part of the approach to reduce overspends and stabilise the current position, the NHS in England has identified 44 ‘footprints’ that are all producing Sustainability and Transformation Plans (STPs).

The picture is still emerging as the development of STPs has not been transparent and widely publicised.

Additionally, 80+ Local Digital Roadmaps (LDRs) have been prepared and are not yet published.

Telecare Services Association – Written evidence (NHS0106)

There is some concern that many clinical commissioning groups (CCGs) and local authorities responsible for LDRs will not have sufficient funds to implement their plans (including paperless NHS).

There is a wider planning concern that the 44 STPs and 83 LDRs are attempting to cover 211 clinical commissioning groups (CCGs) and 152 local authorities (LAs).

A huge task.

These latter groups have the responsibilities for consulting the public over the coming months on the STPs which could include hospital and service closures.

This is yet to commence and could take time particularly if there are legal challenges.

The early STP documents that are available so far make reference to ward closures, cuts in bed numbers, changes in A&E and GP care as well as the extension of 'virtual care' using phone, video and remote support.

As well as the sustainability component to the plans, there is also expected to be some funding for transformation (although this may be very restricted with curbs on capital spend and no additional resources).

The transformation component of the STP and LDR is supported by a myriad of pilots, projects, programmes including 50 new care model sites/vanguards, 25 integration pioneers, 7 testbeds, NHS Innovation Accelerator Programme, 7 day working.

Funding is currently linked to agreed sustainability targets, new care models (vanguards) with some further potential transformation money for paperless NHS etc (although there are central pressures on capital programmes including IT).

It is currently unclear how savings/efficiencies will emerge and be validated against the £22bn overall 'target'.

It is also apparent that a number of NHS Trusts have not fully agreed their financial targets.

Following the NHS England/NHS Improvement sign-off of the STPs, clinical commissioning groups are expected to prepare a two year operational plan by the end of December 2016 with implementation from April 2017.

Again, the two year plan is expected to stabilise the current position but also set out more detailed transformation programmes eg more out-of-hospital care.

Local authorities (LAs) have been involved in aspects of this process but are not covered by the NHS Mandate.

LA funding is separate from the NHS, although there are some local joined up approaches such as the 151 Better Care Fund Plans.

Telecare Services Association – Written evidence (NHS0106)

It is now (finally) recognised that the future sustainability of the NHS is closely linked to the performance of local authorities.

Also, that social issues and where people live are now recognised as having a significant impact on peoples' health (for instance, housing that is cold and damp or poorly adapted could lead to increased demands on health and care services).

There are further uncertainties facing health and care – 'disputes' with NHS staff, the impact of the 'living wage' in the care sector, skill shortages, the future for workers from the EU after Brexit and possible 'rationing' of services to curb spending.

House of Lords Committee call for evidence

The House of Lords Committee on the Long-term Sustainability of the NHS has called for [submissions](#) to its inquiry as it tries to identify what the NHS of the future may look like.

The Committee has invited written evidence to be received by Friday 23 September 2016.

The Committee has identified five themes:

- Resourcing issues – including funding, productivity and demand management. Is the current funding model for the NHS realistic in the long-term? Should new models be considered? Is it time to review exactly what is provided free-at-the-point of use?
- Workforce – including supply, retention and skills. How can an adequate supply of appropriately trained healthcare professionals be guaranteed? Are enough being trained and how can they be retained? Do staff in the NHS have the right skills for future health care needs?
- Models of service delivery and integration – How can the move be made to an integrated National Health and Care Service? How can organisations in health and social care be incentivised to work together?
- Prevention and public engagement. How can people be motivated to take greater responsibility for their own health? How can people be kept healthier for longer?
- Digitisation, big data and informatics. How can new technology be used to ensure sustainability of the NHS?

In considering the themes, TSA supports:

- Realistic and adequate funding for the NHS and social care with an emphasis on prevention and support for self-care as part of the new care models being developed by NHS England
- Coordinated and connected care with better integration of health, housing and social care services with pooling of budgets where appropriate

- A workforce that can support virtual and remote care as well as traditional face-to-face care with more flexible roles and skill mix

The fifth theme and a part of the fourth theme refers to the role of technology. These are considered in more detail as follows:

Theme 4: How could technology play a greater role in enhancing prevention and public health?

The challenge for technology is to help support behaviour change in order to improve outcomes for physical and mental health, reduce unnecessary hospital admissions and limit the harmful effects of long term conditions (eg amputations for diabetics). There is evidence that apps and wearable devices can support smoking cessation, alcohol consumption and weight loss over the short term through increased exercise and dietary monitoring. There are many examples of the use of online forums and apps in mental health. There are examples of connected communities through online groups to support long term conditions and promote public health initiatives. Increased physical exercise with technology support could potentially reduce the likelihood of many diseases. Trusted products and services need to be made available through NHS and local authority routes as well as via personal budgets. Awareness needs to be raised through online (NHS Choices) and primary care (GP) interfaces so that individuals can benefit before crises occur.

Theme 5: Digitisation of services, Big Data and informatics

How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

Technology enabled care (TEC) including telecare and telehealth has been established in the UK over recent years. There have been improvements to approaches since a large scale trial in England in 2008 with more effective, personalised care at lower cost. 1.7+m people in the UK have some form of TEC and the number is growing as more smartphone apps, digital health programmes are rolled out.

We know from Pub Med that there are over 22,600 citations for [telehealth](#), over 21,800 citations for [telemedicine](#), over 1,000 for [health apps](#) and over 13,000 citations for [digital health](#).

To help with evaluating the evidence, the Agency for Healthcare Research and Quality (AHRQ) has recently published a report covering 58 major reviews of telehealth.

Links:

<http://www.chilmarkresearch.com/2016/07/11/finally-some-concrete-use-cases-for-telehealth/> <https://www.effectivehealthcare.ahrq.gov/ehc/products/624/2254/telehealth-report-160630.pdf>

b. What is the role of 'Big Data' in reducing costs and managing demand?

The use of data needs to be carefully thought through. It needs to be accurate, timely, robust and shared (with appropriate consent) to ensure that it can be used to provide insight to

support population-based health as well as individual care (eg personalised cancer treatment). The application of artificial intelligence could provide the opportunity to obtain greater value from big data. It is possible to overwhelm the NHS with data and care needs to be taken as this could add to costs. However, major projects to make sense of what we already have could lead to better, individual treatment plans for serious conditions including some cancers. Better real time data could lead to improved demand management in hospital and emergency services. Insight from big data is assisting health and care organisations with predictive analysis eg the likelihood of a hospital admission or a fall at home – these can be mitigated by using home-based technologies (TEC) with remote monitoring support.

c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

The barriers to 'industrial' roll out include:

- *Slow adoption of new technologies in health and care (evidence expectations, reluctance to explore new approaches, contract frameworks)*
- *Digital maturity issues with many health providers*
- *Traditional commissioning approaches that do not embrace innovation*
- *Lack of buy-in from clinicians as well as some users/patients and carers*
- *Tariffs that maintain hospital income and pay for admissions of sick patients rather than keeping people well in the community*
- *Lack of leadership to explore digital solutions and new care models at scale*
- *Lack of interoperability and concerns about standards*
- *Unproven and untested health apps and devices that are not robust enough to implement at scale*
- *Overarching focus on hospitals, medical models without patient/user involvement in designing products and services*
- *Lack of partnership working between sectors and with industry to explore new approaches*
- *Concerns over cyber security, data sharing and poor broadband infrastructure*
- *Fear of change and that technology and data will replace jobs and/or mean existing tasks take longer at higher costs*
- *Stop-start approaches from the National Information Board and others eg priority changes, withdrawal of health apps library and care.data/consent issues*
- *Mixed messages in the NHS cause confusion - top-down/bottom-up, central/local, flexible/restricted funding, stability/transformation*

d. How can healthcare providers be incentivised to take up new technologies?

Examples include:

- *Wider outcome-based specifications and procurement frameworks for services that include technology to improve individual outcomes and provide support for carers*
- *Changes in tariff to support care closer to home, reduce re-admissions and 'prescribe' trusted devices, apps and integrated services supported by technology enabled care with appropriate reimbursement*
- *Wider sharing of 'what works' through partnership working, innovation hubs, trusted sources of information and evidence*
- *Targeted transformation funding to enable major changes to how services are provided*

- *Improved broadband access in key areas, simpler interfaces that make record keeping easier*

In addition, Individual service users, patients, carers to be incentivised to take up new technologies that can help them manage daily living, health and wellbeing through local directories of trusted products/services and help with the use of personal budgets.

e. Where is investment in technology and informatics most needed?

Investment is most needed in settings where information must be shared across providers to produce improved outcomes and in care settings outside of hospital (community and care home settings). Investment should include appropriate training and skill mix changes. Some improvements in infrastructure and broadband are needed as well as tackling cyber security. Technology that prevents hospital admissions, supports discharges and maintains people in the community and their own homes is low cost compared to maintaining hospital beds. Investment is needed in understanding how technology can support behaviour change to address major health issues such as obesity. Investment should look at virtual care examples ([‘hospitals without beds’](#)). Investment is needed in aspects of artificial intelligence, new sensors/devices and helping to address future workforce shortages through virtual consultations, online coaching support and health and wellbeing platforms. Investment is needed in reviewing products and services to ensure they are safe and effective.

Transformation should focus on improved outcomes supported by technology. This will mean changes in how services are delivered. A mix of investment is needed as in some cases payback and efficiencies will only appear over a longer period.

TSA will publish a White Paper at its conference in October 2016 covering the procurement and impact on outcomes of cost-effective technology enabled care.

23 September 2016

Dr Tim Taylor – Written evidence (NHS0108)

Dr Tim Taylor, Senior Lecturer in Environmental and Public Health Economics, European Centre for Environment and Human Health, University of Exeter Medical School, Truro

The need is clear for better systems to help the NHS cope with emerging issues, including the increase in non-communicable disease and to better manage existing resources to meet the needs of the population. To help the NHS prepare for 2030 and beyond, it would be appropriate to consider the use of modelling systems to ensure that triple bottom line thinking is brought into decision making. Recent studies suggest that there is great potential for the use of such models to integrate environmental issues into decision making on resource allocation. Pollard et al (2013) uses existing data to populate a model to optimise service location choices, using constraints and existing resource deployment patterns to make this “real world”. The model allows for patient travel to be considered alongside other sources of greenhouse gases in NHS service delivery.

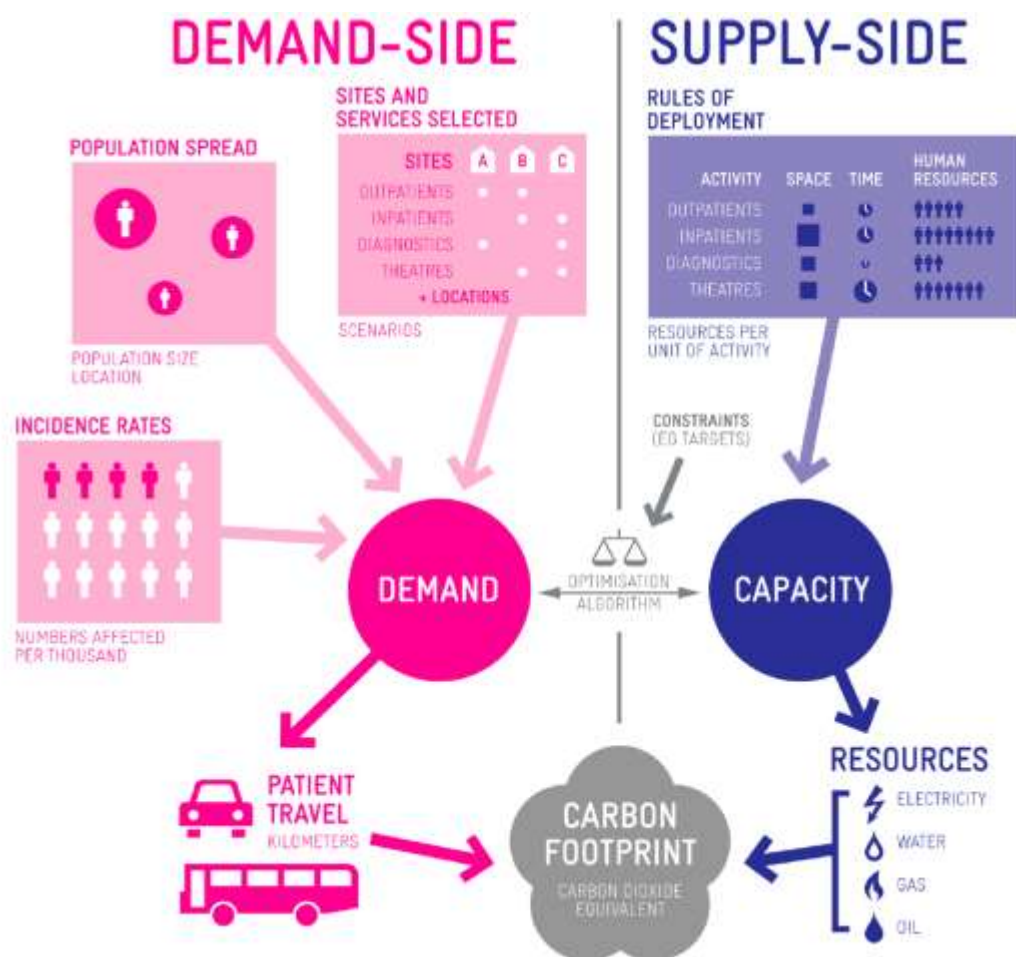


Figure 1: Conceptual diagram of the solution used within the carbon model (Source: Pollard et al, 2013).

This model has also been used in the context of dentistry in the NHS in Scotland (Duane et al, 2014). This shows how decision support tools such as the Pollard model could be used to aid in optimising service delivery to lead to cost savings, better productivity, enhanced environment and patient satisfaction.

These models as yet do not take into account future population trends or changes in the patterns of disease. This could certainly be done, but it would take some investment to develop the appropriate scenarios and to create better simulations of patient behaviour.

To ensure the long term sustainability of the NHS, more needs to be done in terms of preventing non-communicable disease. Work at the University of Exeter Medical School and Public Health England as part of the NIHR Health Protection Research Unit on Environmental Change and Health underlines some of the benefits derived from exercise in the natural environment, with over £2.2 billion in health benefits annually arising from “green exercise”, building on an analysis of the Quality Adjusted Life Year (QALY) gains from exercise in natural spaces (White et al, in press). The NHS Forest is one scheme that offers potential to increase the use of natural spaces for exercise, and other similar schemes need to be considered to reduce the burden on the health service.

In addition, more work is needed to assess the impact on the environment of the NHS. Little work has been done beyond carbon footprinting of services (e.g. Pollard et al, 2014) – and more work is needed in terms of estimating the overall environmental burden on the NHS. This could take the form of the development of green accounts for the NHS that factor in carbon and other environmental pollutants.

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23 September 2016

Together for Short Lives – Written evidence (NHS0158)

Summary

1. Government, the NHS and local government should become more aware of the way in which long-term conditions are changing and becoming more prevalent. Only in doing so can sufficient financial resources be budgeted for our health and care system. For example, as a result of advances in medical technology, the number of children and young people with life-shortening conditions is increasing. Worryingly, this number is not being monitored. We would like the UK Government to make sure that the number and needs of children and young people with life-shortening conditions is more accurately monitored.
2. Providers of health and care, particularly in the voluntary sector, can bring social value to their communities when funded by the state. This is in addition to the positive health and wellbeing outcomes they can achieve.
3. There are a range of commissioning funding models now available to commissioners of health and care in England to use. There are also a number of ways in which integrated budgets can be achieved. In England, the NHS and local authorities have a duty to jointly commission services for disabled children and young people aged 0-25. Personal budgets and initiatives such as Integrated Personal Commissioning also offer opportunities to join up budgets for children and young people with long-term conditions.
4. The extent to which these are being applied to commissioning palliative care for children and young people with life-shortening conditions varies widely across local areas. Government and NHS England have an important role in guiding health and care commissioners on how to apply these different models; making sure NHS and local government commissioners are aware of their responsibilities; gathering and sharing best practice; and holding commissioners to account for the outcomes they achieve.
5. We believe that sustainability and transformation plans (STPs) have potential to integrate planning and funding across health and care; we also believe that they can help to create economies of scale in commissioning services for small populations (such as children and young people with life-shortening conditions) which might not otherwise be prioritised by individual CCG and local authorities.
6. We do not have enough health and care professionals with the skills and experience needed to meet the increasingly complex needs of people with long-term conditions. This is certainly the case for children and young people with life-shortening conditions. A shortage of nurses is a particular issue and we call on the government to reverse the decision to remove student bursaries.

7. We believe that public health policy should include approaches to engage communities in playing a greater role in providing palliative care to children and young people.
8. We are concerned that the needs of children and young people with life shortening conditions are often overlooked or misunderstood by policy makers and commissioners. To address this, we would like to see the development of a coherent children's palliative care strategy from government. Such a strategy would need to be centred around children and their families. I would need to reach across health and social care as well as education. By planning, budgeting and working in a cross portfolio manner, we believe, can help avoid bureaucracy, use funding more effectively and ultimately contribute to achieving a sustainable NHS.

About Together for Short Lives

9. Together for Short Lives is a UK wide charity that, together with our members, speaks out for the 49,000 children and young people in the UK who are expected to have short lives. Together with everyone who provides care and support to these children and families we are here to help them have as fulfilling lives as possible and the very best care at the end of life. We can't change the diagnosis, but we can help children and families make the most of their time together.

Our written submission

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

10. As a result of advances in medical technology, the number of children and young people with life-shortening conditions is increasing. For example, a 2015 report showed a 50% increase over a ten-year period in the number of children and young people with life-shortening conditions in Scotland; their numbers have risen from 4,334 in 2004 to 6,661 in 2014¹³⁵³. This is a dramatic rise; if it has been replicated across the UK as a whole, the number of children and young people with life-shortening conditions could be much more than the current estimate of 49,000.
11. Worryingly, this number is not being monitored. As a result, the UK Government, the NHS and local councils are failing to budget enough money to meet the needs of children and young people with life-shortening conditions. The complex care they need

¹³⁵³ Fraser et al. (2015). Children in Scotland requiring Palliative Care: identifying needs and numbers. Available to download from: <http://bit.ly/1Krn2EU>

from multiple agencies and professionals is not joined up enough and families are having to fight to get the services they need.

12. Together for Short Lives would like the UK Government to make sure that the number and needs of children and young people with life-shortening conditions is more accurately monitored. This will mean that we can:

- ***all understand the true demand for children's palliative care***
- ***identify the gaps in care for children with life-shortening conditions***
- ***make sure that care is planned and funded more effectively to meet the needs of children with life-shortening conditions.***

13. In addition, we believe that health and care system must make the most effective use of the limited resources available to it. This means planners and funders of health and social care working much more closely together to jointly commission care and support for people with long-term conditions.

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?

a. Does the wider societal value of the healthcare system exceed its monetary cost?

14. Together for Short Lives believes that it does. Voluntary & Community Sector (VCS) healthcare providers, including children's hospices, bring social value to communities. VCS children's palliative care provider organisations can encourage volunteers to help to provide care and support to seriously ill children and young people. These organisations are part-funded from statutory sources, including from NHS England and clinical commissioning groups (CCGs).

15. Together for Short Lives' Family Support Volunteer Project, which is funded by two charitable trusts, co-ordinated by us and provided by organisations working in London, Bristol and Warwickshire, is recruiting and training volunteers to work with families in their homes and communities. Through this project, volunteers assist families caring for a life-shortening condition with practical support in their homes. This provides crucial support for families and helps to develop community cohesion.

16. The children's palliative care sector relies heavily on volunteers to provide care and support for children with life-shortening conditions. In 2014 it was conservatively estimated that there are 100,000 volunteers involved in hospice care (both children's and adult), which has an approximate economic value of £112m.¹³⁵⁴ Hospices and

¹³⁵⁴ [http://www.togetherforshortlives.org.uk/assets/0000/7989/TfSL_Volunteering - Vital to our Future_FINAL .pdf](http://www.togetherforshortlives.org.uk/assets/0000/7989/TfSL_Volunteering_-_Vital_to_our_Future_FINAL_.pdf)

children’s palliative care depends heavily on volunteers for service delivery, governance, income generation, and engagement with local communities.

17. Research shows that volunteers bring benefits to children with life-shortening conditions, their families and also to staff. Naylor et al. suggest that volunteers enhance the role of paid staff and also significantly enhance the care experience for the child.¹³⁵⁵
18. Gurguis-Younger, Kelley, and McKee suggest that professionals have increasingly moved to a more medical model of care, and that volunteers have an ever-more important role to play in bridging the gap by bringing a unique dimension of human compassion as they accompany patients on their journey to end of life.¹³⁵⁶
19. We believe that work to engage volunteers and wider communities is vital in helping remove the stigma and fear of talking about life-shortening conditions in children and young people. This is also crucial to make sure that professionals and organisations do not overlook the need of this small population which has highly complex needs.

b. What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

20. Together for Short Lives believes that the funding models set out in the NHS Five Year Forward View, in addition to those already available to NHS commissioners, can be used by commissioners to fund children’s palliative care. These include:

- grants (which can still be used in funding voluntary sector providers¹³⁵⁷)
- year of care models
- capitated budgets
- personal budgets
- per-patient models (including currencies and tariffs)
- spot purchases.

21. Together for Short Lives calls on the Department of Health, Department for Education and NHS England to work with us and the Local Government Association (LGA) and the

¹³⁵⁵ Naylor, C., Mundle, C., Weeks, L., & Buck, D. (2013). *Volunteering in Health and Care: Securing a Sustainable Future*. London: The Kings Fund.

¹³⁵⁶ Guirguis-Younger, M., Kelley, M., & McKee, M. (2005). Professionalization of hospice volunteer practices: what are the implications? *Palliative and Supportive Care* 3(2), 143-144.

¹³⁵⁷ NHS England. 2015. A bite sized guide to grants for the voluntary sector. Available to download at: <http://bit.ly/1LY0hdk>

Association for Directors of Children's Services (ADCS) to develop a guide for NHS and local government commissioners. This should set out how they can apply these different models in funding children's palliative care services in local areas.

c. What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

22. We note that in the last Spending Review the Chancellor announced a 2% precept on Council Tax for local authorities to spend on adult social care. We were curious to understand why this didn't apply to children's social care?

d. Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

23. We believe that the scope of what is funded by the state is already drawn too tightly for children and young people with life-shortening conditions: evidence gathered by Together for Short Lives¹³⁵⁸ shows, for example, that only 21% of the charitable costs incurred by children's hospices in England are reimbursed by the state (when taking NHS England's, CCGs' and local authorities' contributions into account). This is far less than adult hospices, which receive an average of a third of their funding from statutory sources.

24. Statutory funding for voluntary sector children's care palliative care providers is neither fair nor sustainable and varies according to local area. 39% of clinical commissioning group (CCG) funding across England supports just two hospices, while one hospice receives no funding at all from their CCG.

25. Anecdotally, local authorities tell us that there is less capacity in the statutory sector to meet the growing demand for short breaks (respite care).¹³⁵⁹ This is corroborated by voluntary sector children's palliative care providers: one, for example, has told us that due to significant cuts across all the local authority areas in which they work, it is experiencing an increase in requests for social care support for children with life-shortening conditions. One of its local authorities is planning to shut a funded respite centre for children with complex needs; the council is hoping to re-allocate children to respite foster homes and to the children's palliative care provider.

26. Similarly, a children's hospice told us that cuts to NHS and local authority services mean that they are no longer able to guarantee delivery of their own services, such as

¹³⁵⁸ Together for Short Lives and Hospice UK. 2015. Commissioning and statutory funding arrangements for hospices in England Survey results 2015. Available to download from: <http://bit.ly/1Rqayzr>

¹³⁵⁹ A definition of short breaks is available here: <https://www.bristol.gov.uk/social-care-health/short-breaks-for-disabled-children>

supporting patients and the end of life phases to be discharged home if that is their preference.

27. Seven CCGs (4%) and two local authorities (2%) have told us that they do not commission children's hospices because they are charities¹³⁶⁰. This is despite the Department of Health, NHS England and Public Health England recognising the voluntary, community and social enterprise (VCSE) sector is an important partner for statutory health and social care agencies in playing a key role in improving health, well-being and care outcomes¹³⁶¹.

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

a. What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

28. We are concerned that the removal of student bursaries for nurses, midwives and allied health professionals could have an adverse effect on the number of students choosing to study these courses. Although under the current UK government proposals students would still have access to funding through student loans, we share the concern of the Royal College of Nursing that potential students may be put off by the prospect of accruing more long-term debt. We call on the government to reverse the decision to remove student bursaries.

b. What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

29. EU workers make up 55,000 of the NHS's 1.3 million workforce and 80,000 of the 1.3 million workers in the adult social care sector. Many organisations are concerned about the impact of the UK withdrawal on workforce and several organisations, including the Royal College of Nursing, have issued statements in support of migrant from the EU working within the NHS:

- a. Nursing: EU immigrants make up 4% of registered nurses. [The editor of Nursing Times has written that she fears many nurses from overseas may leave due to insecurity over their future/visas and their career longevity](#). However, it is highly unlikely that future government policy would be designed to prevent overseas nurses from working within the UK – they are already listed on the 'shortage occupation list', allowing employers to recruit from outside the EU.

¹³⁶⁰ Together for Short Lives. 2016. Commissioning map of children's palliative care. Available to download from: www.togetherforshortlives.org.uk/datamap

¹³⁶¹ VCSE Review. 2016. <http://bit.ly/1XBY5ix>

- b. Social care: EU immigrants make up an estimated 6% of social care workers in England. These jobs are often low-paid and there is a fear that it will be impossible to fill these posts following the UK withdrawal from the EU. [Care England has pledged to lobby the government on this issue.](#)
- c. Doctors - 10% of doctors in the UK qualified in another EU country and over 25% of those registering each year are now from the EU. The president of the Royal College of Physicians has warned that these doctors are feeling 'anxious and confused' about their present and future situation.

c. What are the retention issues for key groups of healthcare workers and how should these be addressed?

- 30. There is very real and **growing pressure to have a sustainable children's palliative care nursing workforce** which must be addressed as a matter of urgency. Whether or not children are able to exercise choice over **how and where their care is provided** largely depends on whether they have access to skilled and competent professionals.
- 31. Together for Short Lives' survey of voluntary sector children's palliative care organisations (<http://bit.ly/1Ltfjqr>) shows that they employ approximately 1,500 nurses in the UK. The average vacancy rate for these organisations is 10%, which is higher than the 2015 NHS nurse vacancy rate (7%). This has resulted in two thirds of services reducing their offer of care to families - closing beds, reducing respite care, or having an effect on continuity of care. This survey also shows that over a quarter of nurses for voluntary sector children's palliative care organisations are over the age of 50 and many of these will be eligible to retire at 55.
- 32. Nearly 60% of vacancies reported by voluntary sector children's palliative care organisations were defined as hard to fill (vacant for over three months).
- 33. The voluntary and community children's palliative care sector has a further recruitment challenge caused by the difference in terms and conditions between NHS and voluntary sector providers – the most commonly suggested reason for nursing vacancies was terms and conditions, including salary, shift systems and annual leave. Our research shows that the voluntary children's palliative care sector provided placements for over 600 nursing students during 2014-15. Most of the students were in the second or third year of their training – but one third of organisations said they supported first year students too. The proposed increase in nurse training places offers an opportunity to further develop the links between universities that provide nurse training and voluntary organisations that deliver children's palliative care. However, currently 40% of voluntary sector children's palliative care providers receive no funding for providing these placements, while others receive approximately £80 per week. These organisations provide valuable experience to trainee nurses.

34. All universities have different systems for organising these placements and provide varying levels of funding. This makes it very difficult to predict the number of nurses who will be available to work within the children's palliative care in the coming years.

4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

a. What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

b. What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

c. What investment model would most speedily enhance and stabilise the workforce?

Our answer to a, b and c:

35. We would encourage the government and Health Education England to work together to plan the workforce needed to meet the rising numbers of children and young people with life-shortening conditions. This should involve better understanding the numbers and needs of this population and commissioning sufficient number of education and training places for prospective children's palliative care professionals.

36. We would like the university undergraduate nurse programmes to adopt Together for Short Lives' recognised best practice curricula for children's palliative care nurse training.

37. We ask that the Council of Deans to encourage university undergraduate nurse programmes to adopt Together for Short Lives' recognised best practice curricula for children's palliative care nurse training.

38. We want the UK government to reimburse voluntary sector children's palliative care providers for offering placements to people training to be nurses. This would help make sure that providers can maximise the number and quality of placements on offer.

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

a. How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

How integrated budgets can work

39. Children and young people with life-shortening conditions require holistic support from a range of providers spanning health, social care, education, leisure and housing services. CCGs should commission in partnership with local authorities using agreements under section 75 of the National Health Services Act 2006¹³⁶² to ensure an integrated service for children and young people with life-limiting conditions. The SEND Code of Practice⁹ describes how, under section 75 of the National Health Service Act 2006, local authorities and CCGs can pool resources and delegate certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.
40. CCGs and local authorities also need to be aware of their duties under the Children and Families Act 2014¹³⁶³. These **require** them to commission services for all disabled children and young people aged 0 to 25 jointly with local authorities. They **must** also co-operate with local authorities in ensuring that single assessments and education, health and care (EHC) plans are put in place. EHC plans are for children who have learning difficulties and disabilities which result in special educational needs. EHC plans should focus on the outcomes which young people wish to achieve. This will include some children and young people with life-limiting conditions.
41. The SEND code of practice⁹ explicitly states that joint commissioning must include services for 0-25 year old children and young people with SEN or disabilities, both with and without EHC plans. Children and young people with cancer or leukaemia may not have an SEN or EHC plan - but should still be able access jointly commissioned children's palliative care. The code also states that local authorities, NHS England and their partner CCGs must make arrangements for agreeing the education, health and social care reasonably required by local children and young people with SEN or disabilities.
42. The NHS and local authorities in England already have a duty to jointly commission services for disabled children and young people aged 0-25 as a result of the Children and Families Act 2014. Preparing for Adulthood [Joint Commissioning in Action](#) describes joint commissioning as "a method for two or more partner agencies to commission collaboratively to secure better outcomes for a defined population than either can achieve on their own".¹³⁶⁴ **We believe that the government and NHS England should hold clinical commissioning groups and local authorities to account to make sure that they implement the joint commissioning duty.**
43. Together for Short Lives provides a guide to help CCGs, local authorities and local health and wellbeing boards to jointly commission palliative care for children and young people

¹³⁶² Great Britain. National Health Services Act 2006: Elizabeth II. Part 3 (2006). Available to download from: bit.ly/11lcfQo.

¹³⁶³ Great Britain. Children and Families Act 2014: Elizabeth II. Part 3 (2014). Available to download from:

<http://bit.ly/1rmlG7b>

¹³⁶⁴ Preparing for Adulthood (2015). Joint Commissioning in action. Available to download from: <http://bit.ly/1du8oSU>

aged 0-25¹³⁶⁵. In the guide, we set out the steps that we think commissioners should take to follow the established joint commissioning cycle:

- establish the right local partnerships
- understand how many children and young people they need to commission services for - and plan for what they need
- create economies of scale
- plan a local journey for children and young people with life-limiting conditions
- ensure that services are provided jointly
- fund children’s palliative care services in the context of the development palliative care funding currency
- review services.

44. In commissioning jointly, we believe that health and care planners and funders have an opportunity to improve outcomes for people with long-term conditions in addition to making sure that limited resources are used more effectively. Families of children with life-shortening conditions tell us that they have to manage multiple appointments and relationships with a wide range of professionals. They often have to repeat their story several times and undertake a number of different assessments. More integrated plans, assessments and services will give time back to people with long-term conditions and their families; in the case of children and young people with life-shortening conditions, for whom time is limited, this is especially important.

45. We recognise that there are a range of approaches which the NHS and local authorities can take to integrate budgets. Specifically for children and young people with life-shortening conditions, these include:

- personal budgets
- capitated budgets
- year of care models
- grants made jointly by the NHS and local authorities to fund specific services.

¹³⁶⁵ Together for Short Lives (2015). Jointly commissioning palliative care for children and young people aged 0 – 25 - including short breaks. Available to download at: www.togetherforshortlives.org.uk/jointcommissioning

46. CCGs should take account of the relatively high proportion of young people with life-limiting conditions who are eligible for NHS children's continuing care and subsequently continuing healthcare - and have a right to a personal health budget. The Care Act 2014 statutory guide and the Children and Young People's Continuing Care National Framework¹³⁶⁶ both set out how CCGs and local authorities should work together to ensure a smooth transition for young people from children's continuing care to continuing healthcare.
47. Local areas **must** also offer personal budgets to children and young person aged 0 – 25 who have an EHC plan. Section 3.36 of the SEND Code of Practice¹³⁶⁷ states that local authorities and CCGs have a statutory duty to consider the extent to which children and young people's needs could be met more effectively by integrating services and aligning or pooling budgets in order to offer greater value for money - and improve outcomes and/or better integrating services for children and young people with SEN or disabilities.

The extent to which budgets are currently integrated for children and young people with life-shortening conditions

48. As medical interventions improve, the number of children and young people with life-shortening conditions is growing. Unfortunately, as need and demand for support is increasing, CCG awareness and understanding of this population remains low¹³⁶⁸. We have found that only 19% of local authorities say they commission children's palliative care. This means that a staggering 4 out of 5 local authorities are failing to plan and fund care for seriously ill children and young people. We welcome the fact that a majority (93%) of CCGs say they commission children's palliative care, yet we have no understating of the spend in this area. However, it is shocking that seriously ill children and young people are being forgotten or ignored by nearly one in 10 CCGs.
49. This is partly explained by the small geographic areas that CCGs cover, meaning that there may only be a small number of children for which services are required. The relatively small number of children also means that they do not register as a priority for many CCGs who are simply unaware of their needs and the complexity of their conditions.
50. We therefore think that the new sustainability and transformation plan (STPs) approach could help bring local health and care systems together over a wider geographic area. We would like the new footprint areas to commission children's palliative care over areas which create the economies of scale needed - and as recommended by the 2011

¹³⁶⁶ Department for Health. 2016. Children and young people's continuing care national framework. Available to download from: <http://bit.ly/2doRfyy>

¹³⁶⁷ Department for Education (2014). Special educational needs and disability code of practice: 0 to 25 years. Available to download from: <http://bit.ly/1kOCi5j>

¹³⁶⁸ Together for Short Lives. 2016. Commissioning map of children's palliative care. Available to download from: www.togetherforshortlives.org.uk/datamap

Independent Palliative Care Funding Review¹³⁶⁹, commissioned by the coalition government. We are keen to ensure we do not lose the opportunity for the new STPs to include the highly effective palliative care offered by a range of providers including children's hospices, NHS community children's nursing teams and others.

51. There is a responsibility and accountability vacuum for commissioning children's palliative care; some CCGs and local authorities do not understand what they should be commissioning: Six CCGs (4%) wrongly told us that NHS England are responsible for directly commissioning children's palliative care. While NHS England should directly commission specialised children's palliative care, including managing complex symptoms and prescribing unlicensed medicines, CCGs and local authorities are responsible for commissioning general children's palliative care. 32% of local authorities said we should ask the local CCG instead when we asked them if they commission children's palliative care, despite the vital role that local authorities should play commissioning short breaks and some equipment and emotional and psychological support services.

The extent to which care and support is being jointly commissioned for children and young people with life-shortening conditions

52. In December 2015 and January 2016, we held two masterclasses which aimed to help health and social care commissioners and providers to learn about jointly commissioning palliative care services for children aged 0-25, including short breaks. The event brought commissioners together to discuss and learn about successful joint commissioning and hear about cases in which joint commissioning has improved outcomes for children and young people.
53. Overall, while our delegates reported that joint commissioning of short breaks is being inconsistently implemented across England, there appears to some common traits of successful models which commissioners should seek to adopt as they fulfil their new duties under the Children and Families Act 2014.
54. Over the course of both masterclasses, we found that commissioners and providers are often **unable to determine the local demand for children's palliative care**. This is because of a lack of understanding in what this term means and difficulties in identifying children with life-shortening conditions. The lack of a register of children who need palliative care and barriers to sharing data about children also hinder work to identify those who are seriously ill. Those local areas which feel that they are successfully determining demand attribute this to common systems to store and share data - and their efforts to include the range of providers accessed by seriously ill children in multi-agency review meetings. The Education, Health and Care (EHC) planning process is reported as being helpful in some examples. Short breaks for children with life-

¹³⁶⁹ Craft A and Killen S (2007). Palliative care services for children and young people in England: an independent review for the Secretary of State for Health. Available to download from: bit.ly/YHZjsA.

shortening conditions are being offered by a range of statutory and voluntary sector providers across England.

55. Both good and bad practice was reported by delegates in applying the different stages of the joint commissioning cycle. Delegates told us that successful partnerships are created **when agencies communicate well with other** - and are clear about who funds and provides different services. Although good joint commissioning models and successful partnerships do not appear to depend on pooled budgets, some regarded a **lack of pooling as a barrier**. Other barriers included agencies not being willing to co-operate and/or having conflicting commissioning priorities.
56. Delegates shared a range of views and experiences of jointly planning children's palliative care. They reported that this is done well when it is timely and leads to agreed shared strategies, outcomes and budgets. **Joint groups to plan and review strategies and operations** seem to be a common trait of a well-planned local children's palliative care service. Making sure that plans are informed by the needs and wishes of children, young people and their families is crucial.
57. Planning challenges were identified where commissioning organisations do not have a lead responsible for commissioning children's palliative care. **A lack of data about the cost-effectiveness** of commissioning children's palliative care and poor links between commissioners and voluntary sector children's palliative care providers were cited as barriers.
58. Other positive aspects of a joint approach include **robust training and mentoring** - and reciprocal training arrangements between different providers. Locally agreed and adopted pathways of care are also seen as helpful. Overall, delegates were enthused by the examples of good practice which they learnt about during the sessions and expressed a willingness to try to apply these in their own local areas.
59. While different successful joint commissioning models are being used in some local areas, we believe that all have the same common traits of:
- good communications between commissioners, professionals and provider organisations
 - agreed joint commissioning strategies and funding arrangements (whether budgets are pooled or not)
 - making sure that the needs and wishes of children and families inform the joint commissioning approach.

The extent to which personal budgets are being used to integrate care for children and young people with life-shortening conditions

60. As part of our Department for Education-funded project to engage children’s palliative care in the special educational needs and disability (SEND) reforms in England, Together for Short Lives hosted a personal budgets workshop in March 2016. Delegates included commissioners and providers from health, education, social care, local authorities and children’s palliative care providers. We found that:

- Commissioners and service providers are taking a proactive approach to personal budgets, attending courses and training sessions to share best practice.
- In some areas, commissioners have robust systems and panels in place to holistically assess the needs of each individual and to conduct financial risk assessments.
- There remain wide regional disparities in the number of personal budgets in place and knowledge of personal budgets among commissioners.
- Engaging with commissioners can be difficult for service providers as their catchment area can include multiple CCGs and local authorities. This problem is compounded by high staff turnover at local authorities, which means that service providers have to regularly liaise with new commissioners.
- Young people and their families need additional help with the administrative burden of managing their own personal budget. This includes areas such as human resources and payroll services.
- Families want more non-clinical assistance in areas such as maintaining their home. They need commissioners to recognise that this type of support enables them to take care of their own children.
- Commissioners, service providers and service users all need better information and support regarding personal budgets. This should set out what each party can and can’t do using a personal budget and where they can access additional support or advice.

The changes required at national and local levels to make sure that truly integrated budgets for the NHS and social care smoothly

Joint commissioning

61. Together for Short Lives believes that:

- CCGs and local authorities should implement [Together for Short Lives’ guide to jointly commissioning palliative care for children and young people aged 0 – 25](#).

Together for Short Lives – Written evidence (NHS0158)

- The government and NHS England should communicate commissioning responsibilities more clearly to CCGs and local authorities.
- Government, NHS England, CCGs and local authorities should work with Together for Short Lives to better understand numbers and needs.
- The government and NHS England should hold CCGs and local authorities to account for the way they commission children’s palliative care.
- Parliamentarians and the public should press commissioners to do better for children with life-shortening conditions.

Personal budgets

62. Together for Short Lives believes that:

- The government should fund a designated website or staffed phone line to enable young people, their families, service providers and commissioners to access up to date and accurate information around personal budgets and to signpost them towards further support if necessary.
- Commissioners should broaden their offer of support to those with a personal budget, using expertise from within local authorities to offer further support in areas such as human resources and payroll.
- Children’s palliative care providers should continue to proactively communicate with one another through their existing networks to share best practice when engaging with commissioners and demonstrating their value.

b. How can local organisations be incentivised to work together?

63. Together for Short Lives believes that, in addition to being held to account by government, NHS England and regulators in implementing their joint commissioning duties, commissioners should be offered incentives.

64. We believe that NHS organisations and local authorities should jointly commission networks of providers to provide holistic pathways or models of care and achieve defined outcomes. We believe that financial incentives could be offered to commissioners by the government and NHS England whereby they would receive extra money for achieving better outcomes for defined population groups. These groups could include children and young people with life-shortening conditions.

c. How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

65. We believe that this could be done by commissioning better physical and mental health and wellbeing outcomes from networks of providers rather than activity from individual services. Commissioners can also play an important role by specifying in agreements with networks that people with long-term conditions must be allowed to choose how and where they receive their care. This way, networks will need to include providers which can offer care in hospitals, the community and at home - and who can address the physical and mental health of people with long-term conditions.

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a. What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

66. Local community support is fundamental to children's palliative care. We believe that communities have a vital role to play in supporting children with life-shortening conditions to lead ordinary lives and should be enabled to do so. To do this, a better understanding of childhood death and dying is needed so that diverse communities are better able to be involved with and support children, young people and families.
67. We are concerned that professional development of palliative care in the UK, combined with societal change, has, in part, diminished communities' ability to manage death, dying, loss and grief.
68. A community based approach is embedded in most areas of healthcare with the notable exception of palliative care. The greatest successes in overcoming public health challenges in recent years have been achieved through a community response. For example, in HIV and smoking, community responses have helped to prevent harmful behaviour and make it less prevalent. The challenge is to apply a community engagement response to children's palliative care.
69. Communities become more effectively and sustainably engaged when they are empowered and enabled to act themselves without external support intervening.
70. Community engagement in palliative care has traditionally focused on adult services and has recognised a spectrum of activity:
1. **Informing:** organisation provides information to the community.
 2. **Consulting:** organisation gathers views from the community.
 3. **Co-producing:** community has a role in determining how their views are used.

4. **Collaborating:** partnership between the community and organisation.
5. **Empowering:** a community has the power to develop their own solutions to issues facing them.

71. Together for Short Lives is working with the children's palliative care sector to encourage it to explore a community approach to children's palliative care and to strategically develop and invest in volunteering. We aim to:

- develop new models and approaches with community based organisation to enable communities to better support children and families to live ordinary lives
- encourage use of the models in practice by working with services to engage with their local communities
- work with services to support their service users to be able to make best use of community services and facilities
- support services in the strategic development of their volunteers to improve the care and support offered to children and their families.

b. What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

72. We welcome Public Health England's commitment¹³⁷⁰ to work in collaboration with the voluntary and community sector and others to support local approaches to improve health and reduce health inequalities for communities. We ask that Public Health England work with us to make sure that:

- providers of children's palliative care use the new models and approaches to engage with communities
- children and families are better supported by their local communities
- more volunteers become involved in delivering of services, particularly in roles that work directly with children and families
- The public health workforce is appropriately skilled to support babies, children and young people with life-shortening conditions.

¹³⁷⁰ Public Health England. 2016. Strategic plan for the next four years: better outcomes by 2020. Available to download from: <http://bit.ly/1ty25ql>

e. By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

73. As we state in paragraph 51, we believe that this could be done by commissioning better physical and mental health and wellbeing outcomes from networks of providers rather than activity from individual services.

7. What are the best ways to engage the public in talking about what they want from a health service?

74. We believe that CCGs and local authorities should involve parent carers and young people in jointly commissioning services for disabled children and young people with local authorities.

75. For example, commissioners should work with parent carers and young people to determine who is eligible and who would benefit from personal health budgets within their local area; this could include children and young people with life-shortening conditions.

76. Parent carers and young people should be able to suggest services to include in local offers. They should be able to review and comment on local offers and expect to receive a response from CCGs and local authorities following their suggestions.

77. Parent carers and young people could potentially be invited to train commissioners.

78. CCGs could be asked to publish their strategies for engaging parent carers and young people.

79. NHS England could assure these participation strategies to check that CCGs are broadly engaging with the right groups.

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?

a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

80. Telecare and telehealth can help maintain contact between children with life-shortening conditions, families and their care teams who can sometimes be a considerable way away from their tertiary consultants. It can be particularly helpful in caring for children and young people with life-shortening conditions, some of which can be rare and will need the care of a specialist tertiary consultant.

81. Wearable technologies can give children and young people freedom to live life without being tethered to life-sustaining technology. This helps them to achieve the outcomes they want from their lives, including accessing education and leisure activities.
82. Genome developments may fundamentally change the life-expectancy of a proportion of children and young people with life-shortening conditions such as Duchenne muscular dystrophy, metabolic conditions and cystic fibrosis.

b. What is the role of ‘Big Data’ in reducing costs and managing demand?

83. As we set out in our response to question 1, worryingly, the number of children and young people with life-shortening conditions is not being monitored. As a result, the UK Government, the NHS and local councils are failing to plan services and budget enough money to meet the needs of children and young people with life-shortening conditions. The complex care they need from multiple agencies and professionals is not joined up enough and families are having to fight to get the services they need. Gaps in services also mean that children and young people are being admitted to acute care settings unnecessarily when their conditions could be managed in the community or in children’s hospice settings.

84. ***Together for Short Lives would like the UK Government to make sure that the number and needs of children and young people with life-shortening conditions is more accurately monitored. This will mean that we can:***

- ***all understand the true demand for children’s palliative care***
- ***identify the gaps in care for children with life-shortening conditions***
- ***make sure that care is planned and funded more effectively to meet the needs of children with life-shortening conditions.***

c. What are the barriers to industrial roll out of new technologies and the use of ‘Big Data’?

85. In terms of gathering more data about children and young people with life-shortening conditions, we believe that the evidence base underpinning children’s palliative care needs to be expanded and be made robust. Challenges faced by researchers aiming to recruit children with life-shortening conditions and their families are numerous¹³⁷¹, including:

- small sample sizes

¹³⁷¹ Beecham, E., Hudson, B.F., Oostendorp, L., Candy, B., Jones, L., Vickerstaff, V., Lakhanpaul, M., Stone, P., Chambers, L., Hall, D., Hall, K., Ganeshamoorthy, T., Comac, M., Bluebond-Langner, M. (2016). A call for increased paediatric palliative care research: Identifying barriers. *Palliative Medicine*, pii: 0269216316648087).

- limited funding
- difficulties with research ethics committees
- the unpredictable nature of the illnesses
- society's perceptions of the potential physical and psychological burden for participants and their families.

86. Even when participants are successfully recruited, the lack of detailed, standardised reporting of how recruitment was achieved hinders our ability to decipher the applicability of research to our own populations of interest.

d. How can healthcare providers be incentivised to take up new technologies?

87. We believe that commissioners should specify the use of new technologies in contracts and agreements. There is also a role for government and statutory bodies to produce and disseminate guidance and to share examples of best practice with both commissioners and providers. Government should also consider seed funding pilot programmes to test and produce evidence about the use of new technologies.

e. Where is investment in technology and informatics most needed?

88. As we set out above, there is a pressing need for investment in better understanding the numbers and needs of children and young people with life-shortening conditions.

23 September 2016

Trade Union Congress – Written evidence (NHS0084)

Key Points

- The TUC believes that the starting point for any discussion should be an assertion of the benefits that derive from a universal, accessible service delivered free at the point of need and funded through general taxation. The long-term funding options must flow from that starting point.
- The TUC does not believe that the current funding settlement for the NHS is realistic, with average annual increases of less than 1 per cent over a ten year period failing to keep pace with demand, resulting in an alarming deterioration of provider finances and a negative impact on service quality.
- Social care funding has fared even worse with a 9 per cent real terms cut in funding since 2010 leading to over 400,000 fewer older people getting the paid-for care that they need and forced to turn to over-stretched NHS services or informal care instead.
- The TUC believes that the healthcare system of the future needs to deliver a more integrated service across social care, primary and secondary, community, mental health and public health services in order to design and deliver services that meet the needs of patients and drive productivity and innovation.
- The increasing need for health and social care integration means that both sectors must be considered as part of this review. The TUC believes there is merit in looking at the recommendation of the Barker Review for a “single ring-fenced budget for health and social care that is singly commissioned and within which entitlements are more closely aligned”.
- Providing health and care funding that provides free entitlements for all those with moderate to critical needs will entail a considerable increase in public spending but the work by the Barker Review and others suggests that this is both affordable, given the right political choices on taxation, and will have positive benefits on service users, their families, wider society and the economy, with the OECD pointing to a wide range of health and economic benefits derived from increased healthcare spending.
- The TUC believes that general taxation is the most appropriate model for funding a universal health and social care system in order to provide equality of access and fair funding without recourse to charges or means-testing that run counter to the founding principles of the NHS.
- This means that increased public spending of this order will require a serious and honest approach to the way that taxation will be used to lever the required resources. The TUC may not agree with all the tax and spending recommendations made in the Barker Review, but we agree that the government should explore a range of tax options that can be used to raise the required investment in public services as part of a wider process of tax reform.
- We would also make the fundamental point that efficiency, innovation and integration is best promoted through a model of public ownership that eradicates the additional costs

and the dysfunctional competition and fragmentation created by marketisation – most obviously exemplified by the reforms of the coalition government of 2012.

- There is little doubt that proposals to provide greater integration of services across and within the health and social care system, in order to boost productivity, innovation and provide tailored services to people with complex and long-term needs, will have significant impact on the health and social care workforce.
- In addition to meeting the challenges of the future direction of travel, there are a number of existing pressures that need addressing in order to both meet the needs of the current system and help facilitate the changes required to develop the workforce of the future – including staff shortages in a number of occupational groups, problems with recruitment and retention, workforce development and providing training routes into the NHS.
- In social care there are also very significant challenges in providing a workforce that is empowered, trained and equipped to deliver the changes required in an integrated health and social care system of the future.
- Given both the demands of the future proposals and existing pressure points and challenges across the health and social care workforce, it is imperative, as health unions argue, that we have a joined up workforce strategy that works at a national, regional and local level. However, workforce planning is a major gap.
- The TUC believes that there is a need for a workforce strategy that harnesses the NHS Staff Council refresh of the Agenda for Change pay structure, which is aligned with the initiatives in the national and regional partnership forums on culture, wellbeing and leadership and which engages trade unions in service and workforce transformation.
- A workforce strategy should focus on:
 - The impact of wage stagnation on recruitment and retention, morale and motivation
 - Future recruitment, including student commissions
 - Retention of existing staff including consideration of career progression, training opportunities, health and wellbeing
 - Pay and reward of staff delivering NHS services across the UK, across health and social care and those affected by transfer out of the NHS
 - Positive approaches to improve productivity, including: better rates for bank and overtime work; implementing the recommendations of the Boorman Review; and investment in staff.

Taking into account medical innovation, demographic changes and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

The challenge of meeting the demand for health and social care from a growing and ageing population with increasing frequency of long-term conditions and co-morbidities is well documented. According to the Lords Select Committee report *Ready for Ageing*, England will see a 51 per cent rise in those aged 65+ and a 101 per cent increase in those aged 85+ from 2010 to 2030 which, in the words of the committee “will have a profound impact on a wide range of public services”¹³⁷².

Evidence, however, shows that as well as living longer we are generally staying healthier and we would caution against exaggerating the impact of increasing numbers of older people on the NHS. As the King’s Fund point out, increasing demand driven by demographic change is greatly exceeded by increased costs of the provision of healthcare through technological change which both increases the supply and cost of care, rising patient expectations and the fact that, as a ‘luxury good’, health spending increases at a greater rate than GDP¹³⁷³.

The TUC believes that the starting point for any discussion should be an assertion of the benefits that derive from a universal, accessible service delivered free at the point of need and funded through general taxation. The funding options must flow from that starting point.

Furthermore, we agree with the point made by the Nuffield Trust in oral evidence to the Committee that with the demographic changes and the blurring of boundaries between health and social care, we need to consider both the future sustainability of the NHS and social care at the same time.

We agree with Kate Barker’s assertion that the current settlement for social care “lacks transparency, is inefficient, puts too much weight on individual rather than collective responsibility and is not equitable” and that “most importantly, the present situation does not respond sympathetically to the needs and preferences of users and their carers”¹³⁷⁴.

The TUC has had a long-standing commitment to a national social care service, free at the point of use and funded through general taxation. As such, we believe there is merit in looking further at the King’s Fund conclusion that “England needs to move towards a single ring-fenced budget for health and social care that is singly commissioned and within which entitlements are more closely aligned”¹³⁷⁵.

The TUC believes that the healthcare system of the future needs to deliver a more integrated service across social care, primary and secondary, community and mental health services and public health in order to design and deliver services that meet the needs of patients and drive productivity and innovation - and that these integrated services should be funded through general taxation.

This will entail a considerable increase in public spending but the work by the Barker Review and others suggests that this is both affordable, given the right political choices on taxation,

¹³⁷² <http://www.parliament.uk/business/committees/committees-a-z/lords-select/public-services-committee/report-ready-for-ageing/>

¹³⁷³ *Spending on health and social care over the next 50 years*, Kings Fund, 2013

¹³⁷⁴ *A new settlement for health and social care*, Kings Fund, 2013

¹³⁷⁵ *ibid*

and will have positive benefits on service users, their families, wider society and the economy, with the OECD pointing to a wide range of health and economic benefits derived from increased healthcare spending¹³⁷⁶.

The Barker Review makes the important point that the costs of meeting the care challenge do not go away just because they are not financed from the public purse – there needs to be an honest approach to how we meet this challenge as a society rather than relying on individual families to bear the financial cost and fill the gaps through the provision of informal care that many struggle to provide.

As the Barker Review states “overall spending on the cost of care for older people will inevitably rise given the ageing population. The question is not whether this money is spent. It is about where the cost fall – on collective provision through public expenditure, or on those individuals and families who are unlucky enough to have very high care needs”. Kate Barker herself rightly points out “more generous public funding is needed if we aim to be a civilised 21st-century society”.¹³⁷⁷

To what extent is the current funding envelope for the NHS realistic?

Despite the then Chancellor George Osborne’s claims that the 2015 Spending Review delivered the “biggest ever commitment to the NHS since its creation”¹³⁷⁸, the TUC does not believe that the current funding envelope for the NHS is realistic.

As research from the Health Foundation points out “the NHS in England is currently halfway through the most austere decade in its history” with the £4.5bn real terms increase in health funding provided in the 2015 Spending Review meaning that real terms annual increases will have been an average of 0.9 per cent from 2009/10 to 2020/21 – “the lowest ever rate of funding growth over a 10 year period”¹³⁷⁹. This contrasts with rising healthcare costs of 4 per cent and an historic average increase for the NHS of 3.8 per cent.

This has been reflected by a sharp increase in NHS provider deficits, reaching a record £2.45bn at the end of 2015/16 with 95 per cent of acute trusts in the red. The reason is plain - the costs of delivering care rose faster at 2.2 per cent than the income that providers received at 2 per cent¹³⁸⁰. Much of this can be attributed to rising staff costs, particularly agency costs, to meet shortfalls in safe staffing ratios and reductions in average tariff payments.

Over the lifetime of the last parliament, tariffs were cut across the board by an average of 10 per cent. But many more have received larger cuts, research by False Economy for the TUC and UNISON found that a quarter of hospital treatments have been cut by over 40 per cent, almost one in ten have had cuts of over 70 per cent¹³⁸¹.

Despite the best efforts of NHS staff, the deterioration in NHS provider finances has led to adverse impacts on the quality of services. This has impacted on a wide range of services, including in A&E, cancer care and mental health services:

¹³⁷⁶ *Health system priorities when money is tight*, OECD, October 2010

¹³⁷⁷ *A new settlement for health and social care*, Final Report, Kings Fund, 2013

¹³⁷⁸ *NHS secures further £3.8bn for patient care*, Financial Times, 24 November 2015

¹³⁷⁹ *A perfect storm; an impossible climate for NHS providers' finances?*, Nuffield Trust, March 2016

¹³⁸⁰ *ibid*

¹³⁸¹ <https://www.opendemocracy.net/ournhs/matt-dykes/death-by-thousand-tariff-cuts>

- Just over 2 per cent of patients waited over 4 hours for treatment in A&E in early 2010. Today, this number has risen to around 10 per cent¹³⁸². In January of this year, A&E performance reached its worst level on record, with ambulances frequently queueing over 30 minutes and record numbers of patients waiting for hours on trolleys¹³⁸³.
- Since 2006, patients have expected to be treated within 62 days of an urgent cancer referral from their GP. NHS providers are expected to meet this target for 85 per cent of patients. The figure has dropped from 86.7 per cent in April 2010 to 82.1 per cent this summer, with the NHS missing the target for six consecutive quarters now.¹³⁸⁴
- Since 2009 there has been a 12 per cent reduction in the number of beds available to mental health patients, the Royal College of Psychiatrists said that on one day in 2014 there were no beds available at all in England. ‘Out of area placements’ rose 23 per cent last year with patients facing journeys of up to 370 miles for beds¹³⁸⁵. Alongside the reduction of in-patient care, there has been a reduction in community based services, while referrals have increased by 1386 per cent.

Calling for “urgent action to increase capacity in A&E departments” Dr Clifford Mann of the Royal College of Emergency Medicine paints a grim picture of staff on the front line, explaining that “it is now routine for many staff to arrive at work faced with congested and overcrowded departments in which it is impossible to deliver best care. Similarly, many leave work, hours after their agreed finish time, exhausted by the scale of the task.”¹³⁸⁷

It is worth reminding ourselves that the Wanless Review in 2002, the last systematic review of the future funding requirements of the health service, concluded that increased health spending was required in order to address the care issues that had emerged through previous years of underinvestment. The Review concluded that “the UK must expect to devote a significantly larger share of its national income to health care over the next 20 years. It has projected the likely costs of reversing the significant cumulative underinvestment over past decades, to catch up with the standards of care seen in other countries and to deliver a wide-ranging, high quality service for the public and individual patients”.¹³⁸⁸

Social care funding has fared even worse. Between 2009/10 and 2014/15, adult social care received a real terms funding cut of 9 per cent. This has led to a fall of more than 25 per cent in the numbers of people aged over 65 receiving community-based, residential and nursing care services. That’s 400,000 fewer older people getting the paid-for care that they need and forced to turn to over-stretched NHS services or informal care instead¹³⁸⁹.

Local authority funding is set to decline still further as a result of the Spending Review, with very different outcomes for local authorities with low council tax and business rate incomes, who may be more dependent on the central government grants that will be halved by 2020. The 2 per cent precept to council tax will, at best, raise £2bn by 2020 – against a predicted

¹³⁸² *Quarterly Monitoring Report*, King’s Fund, September 2016

¹³⁸³ *A&E performance sinks to new low*, The Guardian, 21 January 2015

¹³⁸⁴ Provider-based cancer waiting times for Q2 2016/17, NHS England

¹³⁸⁵ *NHS mental health care pushed to breaking point by lack of beds*, The Guardian, 1 February 2015

¹³⁸⁶ *Fewer mental health patients seen in the community despite rising demand*, HSJ, 26 October 2015

¹³⁸⁷ *A&E figures ‘no surprise’ to emergency medicine body*, ITN, 14 April 2016

¹³⁸⁸ *Securing our future health: taking a long-term view*, Wanless, 2002

¹³⁸⁹ Spending Review Submission, King’s Fund, September 2015

funding gap twice that size¹³⁹⁰. Local authorities with high levels of council tax income could increase their social care spending by up to four times as much as more grant-reliant authorities through the precept. The postcode lottery for older people reliant on paid-for care is going to get a whole lot worse, with huge repercussions on local NHS services – ResPublica predicts additional costs of up to £3bn as a result.¹³⁹¹

The current review of local government funding reform also raises the prospects of a widening inequality between local authorities, as the effects of the replacement of formula grant with 100 per cent retention of business rates may well lead to greater disparities in income from 2020. Not only could this lead to a widening of income between local authorities but it will also mean that local authority income, and therefore funding for social care, will be entirely reliant on the extent or limitations of business growth in the local area – a situation made more precarious by the removal of large numbers of small businesses from the rates system altogether – as opposed to the needs of the local population.

The business rates review is also introducing the prospect of local authorities taking over responsibility for the administration of Attendance Allowance (AA), which we believe could lead to: reductions in the number of people accessing the benefit (as local authorities may use the non-ring fenced budgets to plug gaps elsewhere); varieties in the provision of AA, exacerbating post-code lotteries; and may restrict the freedom of choice that recipients currently have on the use of AA.

The government may point to the funding deal struck with NHS England as part of the Five Year Forward View, arguing that the £8bn it set out for NHS England in the Spending Review was in line with the funding requirement of the Forward View. However, there are four important points to make on this.

First, taking into account the 21 per cent cut to non-NHS England budgets¹³⁹², including training and public health, the actual real terms increase from 2015/16 to 2020/21 is closer to £4.5bn.

Cuts to public health will also weaken exactly the kind of local preventative interventions in areas such as obesity, sexual health and well-being that we need to manage demand on health services over the long run. Reducing funding to public health initiatives that keep people away from stretched GPs and hospitals is a false economy. For example, it is estimated that the cost to the UK economy of overweight and obesity was estimated at £15.8 billion per year in 2007, adding £4.2 billion in costs to the NHS¹³⁹³.

Second, £8bn requested by the NHS Forward View formed part of a funding call that was dependent on delivering significant year on year productivity gains, which were dependent on investing in new care models and sustaining social services. New care models require time and investment to work and the clinical outcomes and efficiencies will not be known for some time yet. And we have seen that social care continues to face funding cuts.

¹³⁹⁰ *Social care funding: 2014 state of the nation report*, Local Government Association and Association of Directors of Adult Social Services, October 2014

¹³⁹¹ *Crisis in care home sector will cost NHS £3bn*, Nursing Times, 11 November 2015

¹³⁹² *Spending review reveals '21 per cent cut' to non-NHS England health budgets*, HSJ, 25 November 2015

¹³⁹³ https://www.noo.org.uk/NOO_about_obesity/obesity_and_health

Third, there remains a great deal of scepticism about the ability of the NHS to deliver the £22bn efficiency savings earmarked in the Forward View in the time required. Around three quarters of savings found in the last 5 years in the NHS have come through cuts to tariffs and capping NHS workers' pay. But neither are sustainable going forward, with many hospitals in dispute over tariff reductions and recruitment and retention and morale problems intensifying across all staff groups in the NHS.

While the long term solution may lie in productivity gains largely delivered through new ways of working with a greater focus on prevention and integration, we should caution against glib assumptions that greater integration and prevention will inevitably lead to significant savings even though it might be the right thing to do for patients.

A report¹³⁹⁴ by a commission put together by the Health Service Journal labelled NHS England's prediction of £22bn productivity gains as "a heroic assumption" and found "no evidence" to support assumptions that integration between health and social care would lead to significant cashable savings.¹³⁹⁵

They cite key research looking at integration across different countries, and found no evidence of reductions in hospital admissions or increased cost effectiveness resulting from integration, although there were better outcomes for patients.¹³⁹⁶ So while integration remains an essential, albeit often elusive, aspiration for improved health services, it may prove to be far from the silver bullet that many in NHS England and the Treasury are hoping it is.

Likewise, potential savings set out in the Carter Review worth up to £5bn represent only a quarter of the savings required in the Forward View. As the Health Foundation state "there is no clear guidance about how the NHS will achieve the full savings amount required"¹³⁹⁷.

Fourth, the Forward View was supposed to start from a balanced budget but with provider deficits in the region of £2.45bn and NHS employers meeting increasing pension and NI costs, much of the money provided for sustainability and transformation across the health service is likely to be focussed on the former rather than the latter.

This means that funding is being taken away from initiatives to implement the new models of care that are supposed to be the key to achieving more efficient and integrated services of the future. It was reported just this week that vanguard projects are having to be scaled back as they have received less than a third of the anticipated funding this year.¹³⁹⁸

There are also increasing concerns that the Sustainability and Transformation Plans established in order to achieve better coordination and collaboration between commissioners and providers in local health economies are driving through reconfigurations and cuts to services based on financial, rather than clinical, imperatives.¹³⁹⁹

The TUC shares the concerns voiced by Chris Ham of the King's Fund who, commenting on bed reduction proposals in North West London, STP stated that "It is hard to see how this

¹³⁹⁴ *The Commission for Hospital Care for Frail Older People*, HSJ and SERCO, November 2014

¹³⁹⁵ *Integration will not save money, HSJ commission concludes*, Health Service Journal, 19 November 2014

¹³⁹⁶ *What is the evidence of economic impacts of integrated care?*, European Observatory on Health Systems and Policies, 2014

¹³⁹⁷ *A perfect storm; an impossible climate for NHS providers' finances?*, Nuffield Trust, March 2016

¹³⁹⁸ *Vanguards scale back plans due to funding shortfall*, HSJ, 20 September 2016

¹³⁹⁹ *Concern as STP investigation reveals potential hospital closures*, National Health Executive, 26 August 2016

can be done with demand for hospital care rising inexorably, bed occupancy already at eye-wateringly high levels and services outside hospital not in a position to provide an alternative after years of under-investment”.¹⁴⁰⁰

Does the wider societal value of the healthcare system exceed its monetary cost?

The OECD lists a range of population health benefits that have accrued to OECD countries in recent decades, citing a 50 per cent cut in premature mortality since 1970, a ten year increase in life expectancy at birth since 1960 and large reductions in child mortality.

Over a shorter timescale, the OECD point to significant improvements since the mid-90s in breast cancer survival rates, improvements in cardio-vascular health and increased survival and lower disability rates following strokes.

The OECD states that there are a range of factors that have contributed to these successes but attributes much of this to investment in healthcare, stating that “up to 40 per cent of the increase in life expectancy since the early 1990s could be due to more and better health spending”. Furthermore, their report points to increased access to health care services, with OECD countries achieving “universal or near universal coverage for a range of core services”.

Finally, the OECD also states that “the health system contributes to economic performance. It is a major employer – it accounts for nearly one in every ten jobs in OECD countries; health spending helps stabilise the economy in times of crisis, and it is a contributor to the productive capacity of OECD economies”¹⁴⁰¹

The role that health care spending plays in supporting health, well-being and an individual’s productive capacity has knock on effects for other parts of government spending. The Work Foundation report that “in 2009, in the region of 11,000 people in England and Wales were enabled to return to work by hip replacement surgery, saving the UK welfare system £37.4m each year of their working lives”.¹⁴⁰²

According to the King’s Fund, health spending can have significant wider economic impacts. Evidence suggests that the average multiplier effect of public health care spending across a range of countries has been about 3.6 – larger than almost all other categories of spending¹⁴⁰³. While there are no NHS-specific figures, but the King’s Fund report estimates the NHS spending multiplier to be in the range of two to four.¹⁴⁰⁴

We would add one final point. The NHS forms an integral part of our cradle to grave welfare system that does not just provide key services to people but plays a fundamental role in social cohesion, binding our communities together, securing long-term investment and support for local economics as well as acting as an anchor for institutions in our local communities.

¹⁴⁰⁰ *ibid*

¹⁴⁰¹ *Health system priorities when money is tight*, OECD, October 2010

¹⁴⁰² *Adding value: the societal and economic benefits of medical technology*, The Work Foundation, November 2011

¹⁴⁰³ *Does investment in the health sector promote or inhibit economic growth*, Reeves et al, Globalization and Health, 2013

¹⁴⁰⁴ *Tackling poverty; making more of the NHS in England*, King’s Fund, November 2014

What funding model would best ensure financial stability and sustainability without compromising the quality of care?

As we set out above, the TUC supports a model of universal accessible services, free at the point of use and funded through general taxation. Given that the Commonwealth Fund placed the UK in overall first place in terms of efficiency, defined as a system that maximises “the quality of care and outcomes given the resources committed, while ensuring that additional investments yield net value over time”¹⁴⁰⁵ there seems little merit in reinventing the NHS.

We think that there is merit in exploring the recommendations of the Barker Review that, in order to address the lack of alignment in entitlements to health and social care, in funding and in organisation, there should be a single ring-fenced budget for a national health and social care system, jointly commissioned.

The Barker Review estimates that a model of this kind, with provision of free social care covering moderate as well as critical and substantial care needs for the over-65s, would entail an increase of spending from the current level of around 9.7 per cent to 11.3 per cent by 2025¹⁴⁰⁶. This would involve not only a large increase in the amount of spending on, but also an increase in, the proportion of public spending going to health and social care.

However, the TUC would make the following 3 points, echoing the Barker Review.

First, that if GDP were to grow in line with OBR projections (at the time of the review in 2013), this would still be affordable. Health and social care spending would be in the region of £204bn in 2025 out of a total GDP estimated to have grown to £1,800bn. As the Review states “public spending on health and social care would be taking a larger share of a much larger cake. The economy would be around more than one-third bigger, and that would still leave more money in real terms to spend on other things”¹⁴⁰⁷.

Of course GDP may well fail to grow in that order, particularly as the impact of the UK’s exit from the European Union becomes fully realised. Timescales for the full phasing and implementation of this funding model may need to be adjusted accordingly – free social care may be phased in at first for critical and substantial need, as one example.

Furthermore, the funding model must take into account scope to restore pay to levels that provide fair remuneration to NHS and social care staff and addresses growing recruitment and retention problems. Pay restraint cannot be factored among other things being equal within this model. Any model of service integration must also deal with harmonisation and levelling up between of two very different workforces, with different skills mixes and employed on different terms and conditions - the cost of which needs to be built into any future modelling.

Second, public spending as a proportion of GDP on health and social care in the region of 11 – 12 per cent of GDP would place the UK in line with the levels provided by a number of leading OECD countries currently. As Barker points out, England is not a big spender on health and social care in comparison to other leading countries, spending 1 per cent of GDP less on health than France, Germany, Denmark, the Netherlands, Austria and Canada. And

¹⁴⁰⁵ *UK NHS named best healthcare system by the Commonwealth Fund*, NHS Confederation, 1 July 2014

¹⁴⁰⁶ *A new settlement for health and social care*, Kings Fund, 2013

¹⁴⁰⁷ *ibid*

the UK spends considerably less than others on social care, with 0.9 per cent of GDP compared to 2.3 per cent in the Netherlands, 2.2 per cent in Denmark and over 1.1 per cent in New Zealand, Canada, Belgium and France¹⁴⁰⁸.

This suggests that while challenging, the figures proposed by the Barker Review are not unrealistic or unfeasible.

Third, the TUC believes that general taxation is the most appropriate model for funding a universal health and social care system in order to provide equality of access and fair funding without recourse to charges or means-testing that run counter to the founding principles of the NHS.

This means that increased public spending of this order will require a serious and honest approach to the way that taxation will be used to lever the required resources. The TUC may not agree with all the tax and spending recommendations made in the Barker Review, but we agree that the government should explore a range of tax options that can be used to raise the required investment in public services as part of a wider process of tax reform.

We believe that the current strong levels of support for tax increases as the preferred option for raising funds for the NHS would extend to a broader health and social care system if political leaders were able to have an honest and informed discussion with the public.

In the “national debate” on the future of care and support launched by the Labour administration in 2009, there was strong support for a tax-funded national care service with high levels of support for taxation that was seen as “the most equitable solution and that a collective approach to funding would pool risk and ensure that individuals were not left unable to pay for their care and support”. When participants were asked to consider who should bear the burden of the likely increase in the cost of social care, 82 per cent opted for “everyone in society” compared 8 per cent to “individuals who need care and support” and 8 per cent for “families of individuals who need care and support”.¹⁴⁰⁹

The TUC would also make the fundamental point that efficiency and the innovation and integration is best promoted through a model of public ownership that eradicates the additional costs and the dysfunctional competition and fragmentation created by marketisation – most obviously exemplified through the reforms of the coalition government in 2012.

We note that in many areas, from the joint commissioning board in Greater Manchester, to vanguard projects and, indeed, STPs (in theory), the direction of travel is away from the competitive, fragmented model brought in by the 2012 Health and Social Care Act towards a greater focus on collaboration and cooperation across health economies. A national, integrated service under public ownership would be the most appropriate vehicle for taking forward this approach in a sustainable way for the future.

Furthermore, it could provide significant efficiency savings. While there are several estimates of the costs of marketisation in the NHS, the Centre for Health and the Public Interest provide a conservative figure of £4.5bn a year.¹⁴¹⁰

¹⁴⁰⁸ *ibid*

¹⁴⁰⁹ *Engagement Findings*, COI, Ipsos MORI and Synovate for HMG, 2009

¹⁴¹⁰ *At what cost? Paying the price for the market in the English NHS*, CPHI, February 2014

Should the scope of what is free at the point of use be more tightly drawn?

The TUC would oppose any moves to restrict the provision of services (other than through the evidence based guidance and advice provided by NICE) or introduce charges with the aim of either reducing demand or raising revenue.

The TUC strongly supports the founding principles of the NHS encapsulated in Clause 4 of the 1946 White Paper which states that “all the service, or any part of it, is to be available to everyone in England and Wales. The Bill imposes no limitations on availability – e.g. limitations based on financial means, age, sex, employment or vocation, area of residence, or insurance qualification.”

Indeed, the TUC believes the range of free entitlements should be expanded through the provision of a unified national health and social care service.

Evidence suggests that the introduction of charges is counter-productive and penalises those with ill-health on lower incomes. The Barker Review points to a lack of rigorous evidence on the impact of charging, but reflects on the RAND study from the USA that found the one notable effect of charging on health service usage was that it had “a serious adverse effect on those who were poor and suffering from poor health”, and therefore the Review concludes that “at a time when concern over inequality is rising, this is a major argument against charging everyone. It would fail the criterion of equity”.¹⁴¹¹

Looking in more detail at the RAND study, researchers at the Health Policy Institute at the University of Texas found that “the deterrent effects of user charges bear more heavily upon those with lower incomes, as this group is more sensitive to increases in price. In fact, low-income persons reduced use of care that was judged by researchers to be highly effective more frequently than did their higher-income counterparts. Low-income individuals at elevated risk benefited most from free care, and low-income people in poor health who received free care experienced the largest reduction in serious symptoms. In conclusion, the greatest beneficiaries of free care were low-income persons with elevated health risks”.¹⁴¹²

In considering the implementation of charges for clinical services, the Wanless Review stated that “the ethos of the NHS – comprehensive care available to all – commands universal support. Over 90 per cent of people believe that the NHS should be available free of charge when they need it.”¹⁴¹³

While Wanless acknowledged that the funding of health care through general taxation obscured real costs to patients, the review found that “it is not evident that a greater exposure of patients to the costs involved would necessarily lead them to take more responsibility for their own care ... there is no evidence this constrains demand”. Wanless concluded that “it would be inappropriate to extend out-of-pocket payments to clinical services ... such charges are inequitable unless accompanied by adequate exemptions and risk increasing inequalities ... while they could yield substantial revenues, they would also involve additional administrative costs”¹⁴¹⁴

¹⁴¹¹ *A new settlement for health and social care*, Kings Fund, 2013

¹⁴¹² *Discussion Paper #10*, Health Policy Institute, University of Texas, March 1998

¹⁴¹³ *Securing our future health: taking a long-term view*, Wanless,, 2002

¹⁴¹⁴ *ibid*

What are the requirements of the future workforce going to be and how can the supply of key groups of healthcare workers such as doctors, nurses and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

There is little doubt that proposals to provide greater integration of services across and within the health and social care system, to boost productivity and innovation and provide tailored services to people with complex and long-term needs, will have significant impact on the health and social care workforce.

In Greater Manchester, where the move to integration is progressing as part of a wider devolution process, the GM Health and Social Care Partnership states that “the imperative to create, at scale, a health and social care workforce which is enabled to work within a ‘place based’ care system, across organisational boundaries will require a shift in the way in which we are developing the workforce for the future. The GM Strategy provides the health and social care system with a unique opportunity to review and reimagine the type of workforce we require for the future by adopting a parallel approach to educational reform supporting workforce transformation for the current and future workforce, at pace and scale”.¹⁴¹⁵

The Greater Manchester workforce strategy paper claims that the scale of change proposed “will impact significantly on ways of working, challenging traditional roles, introducing new relationships, new teams and indeed new professions including the vocationally qualified”.¹⁴¹⁶

These changes to roles, relationships and ways of working may arise from plans to, among other things:

- integrate health and social care
- shift resources away from hospitals and into community services
- create single shared services for acute hospital services and specialist services
- enable standardisation of information management and technology.

While these proposals are specific to the current strategy adopted in the Greater Manchester plan for health and social care, it is reasonable to assume that this reflects thinking across the wider NHS and social care system and will be applied elsewhere.

In addition to meeting the challenges of the future direction of travel, there are a number of existing pressures that need addressing in order to both meet the needs of the current system and help facilitate the changes required to develop the workforce of the future.

In their joint staff-side submission to the NHS Pay Review Body for 2016/17, health unions set out their concerns about “the impact of pay restraint on recruitment and retention, as well as problems with workforce supply and staffing levels.” The unions argued that “these issues will cause lasting damage to the NHS workforce unless they are dealt with through a long-term co-ordinated strategy”¹⁴¹⁷

¹⁴¹⁵ *Enabling better care transformation programme workforce work stream*, paper to GMCA Strategic Partnership Board Executive, September 2016

¹⁴¹⁶ *ibid*

¹⁴¹⁷ Staff side submission to NHS Pay Review Body, 2016/17

In social care there are also very significant challenges in providing a workforce that is empowered, trained and equipped to deliver the changes required in an integrated health and social care system of the future.

The 1.7m, mainly female, workers in social care are employed across a diverse range of largely private providers, many employed directly through personal budgets and direct payments. Many parts of the sector are characterized by low pay, low skills, under-investment in training and development and high turnover of staff. Much of this results from the flawed commissioning models used by most local authorities, where providers are not given certainty over the number of hours they will be asked to deliver and where cost is usually the determinant factor in the award of contract. These cost constraints, uncertainty and risk are passed on to the care workforce, resulting in a proliferation of zero hours contracts, 15 minute visits and infringements of the National Minimum Wage through unpaid travelling time¹⁴¹⁸.

In the joint staff-side submission to the NHS Pay Review Body for 2016/17, health unions argued that a workforce strategy for the NHS should address:

- The impact of wage stagnation on recruitment and retention, morale and motivation
- Future recruitment, including student commissions
- Retention of existing staff including consideration of career progression, training opportunities, health and wellbeing
- Pay and reward of staff delivering NHS services across the UK, across health and social care and those affected by transfer out of the NHS
- Positive approaches to improve productivity: including better rates for bank and overtime work; implementing the recommendations of the Boorman Review; and investment in staff.¹⁴¹⁹

A further set of specific existing issues related to both the health and social care workforce that a workforce strategy would need to address might include:

- Shortages of clinicians and nurses in order to provide safe staffing levels
- Workforce shortages in a range of occupations including specialist nurses, middle grade doctors, social workers
- Demographic pressures in the workforce, including the large numbers of GPs and nurses nearing retirement
- Recruitment, retention and training of a high quality workforce in the residential and domiciliary care sector – incorporating uplifts to the National Minimum Wage – and creating a commissioning and employment model that is fit for purpose
- Investment in the quality, development and skills accreditation of support staff, including Health Care Assistants

¹⁴¹⁸ UNISON submission to CLG Select Committee inquiry on Adult Social Care, August 2016

¹⁴¹⁹ Staff side submission to NHS Pay Review Body, 2016/17

- Provision of high quality apprenticeships across health and social care, while delivering the 28,000 starts required in the NHS as part of the public sector apprenticeship levy and target
- Shifting towards more flexible career options in order to meet the needs of an increasing proportion of women and older workers with caring responsibilities among both clinical, medical and support staff
- The timescales involved in training new staff, the impact of previous training commissioning decisions and the impact of reforms to training bursaries.

Given both the demands of the future proposals and existing pressure points and challenges across the health and social care workforce, it is imperative, as health unions argue, that we have a joined up workforce strategy that works at a national, regional and local level.

However, workforce planning is a major gap. Apart from in Scotland where the workforce planning system is centralised and mandatory, the approaches in other parts of the UK are hit and miss. Service transformation projects related to the Five Year Forward plan for England are varied and diverse. Trade unions are not routinely involved or engaged and it is difficult to assess the implications for the workforce or potential impact. In Wales, there are workforce planning structures and a system, but the focus is on maintenance rather than forward thinking and innovation. There is no joined up workforce planning across the UK.

In the absence of an effective national workforce plan, health unions are planning to set out a draft workforce strategy in their forthcoming staff side response to the Pay Review Body for 2017/18.

Health unions believe that there is a need for a workforce strategy that harnesses the NHS Staff Council refresh of the Agenda for Change pay structure; which is aligned with the initiatives in the national and regional partnership forums on culture, wellbeing and leadership and which engages trade unions in service and workforce transformation.

At the time of writing, it is proposed that a workforce strategy should include the following strategic aims:

- Changes to the Agenda for Change pay structure that make it simpler to explain, understand and operate; with shorter pay bands, fewer points and no overlaps between bands; that make it fair and affordable for now and the future - achieved through the ongoing NHS Staff Council review of Agenda for Change
- Maintaining the current NHS Job Evaluation system which delivers equal pay for work of equal value as the basis of Agenda for Change underpinning the pay structure - achieved by NHS Staff Council Leadership, dynamic and interactive training for local evaluation and healthy engagement with the process by local employers and unions
- Supporting a healthy and safe workplace with high quality employment practices and procedures which promote a good work-life balance, dignity at work, promotion and protection of employees' health, well-being and safety at work, job design which provides employees with autonomy and control and equitable access to training and learning and development opportunities for all employees - achieved by coordinated and consistent national and local activity in the NHS Staff Council, national partnership forums and employing organisations

Trade Union Congress – Written evidence (NHS0084)

- Safe staffing levels with the right number of skilled professionals in the right settings - achieved by evidence based workforce planning at all levels, national and local and the engagement of the trade unions and professional bodies
- Promoting the NHS as an attractive place to work and an employer of choice. Terms and conditions that support good recruitment and retention of staff, motivating staff at all levels and supporting staff development and career progression underpinned by well-structured appraisals - achieved through the ongoing NHS Staff Council review of Agenda for Change
- Effective change management through engagement with trade unions locally and nationally and sound policies agreed jointly by employers and trade unions - achieved through positive participation on the part of employers, trade unions and the respective departments of health
- Promotion of quality, diversity and inclusion
- Promotion of the NHS as a learning organisation – the NHS facilitates the learning of all its members and continuously transforms itself through support for staff development and career progression underpinned by well-structured appraisals at all levels in all employers
- A focus on leadership at all levels.

Health unions believe that these aims support and reward the improvement of staff productivity and are supportive of the longer term health and social Care agenda and the corresponding workforce needs across all four countries of the UK, and that this will help achieve ongoing improvement in the quality of patient care.

Returning to Greater Manchester, it is therefore encouraging to see that the GM Health and Social Care Partnership workforce strategy paper adopts many of these principles including:

- CPD Opportunities - All staff to be afforded CPD opportunities as appropriate to individual work role and responsibilities and aligned to new ways of working
- Equality, Diversity and Inclusion - All staff to be treated with dignity and respect and within an agreed values based culture
- GM HR/Workforce Strategies - Development of a suite of common HR/Workforce Strategies to support a standardised approach
- Safe Staffing – to ensure adoption of national strategies on safe staffing levels
- Joint education and commissioning arrangements – To work with Universities, employers and providers (HEE, Skills for Care, Further education etc.) to deliver the future health and social care workforce
- Engagement – to work with trade unions and employer representatives to facilitate integrated working between health and social care unions and management representatives. Positive and meaningful employee engagement is integral to the successful achievement of GM ambitions and the delivery of the devolution agenda

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- Good Employer practices – to develop a brand for GM as a good place to work through looking after staff well-being, providing good career and personal development opportunities and offering high employment security (dependent on role flexibility).¹⁴²⁰

21 September 2016

¹⁴²⁰ Enabling better care transformation programme workforce work stream, paper to GMCA Strategic Partnership Board Executive, September 2016

UK Health Forum – Written evidence (NHS0142)

1. About the UK Health Forum

2. The UK Health Forum (UKHF), a registered charity, is both a UK forum and an international centre for the prevention of non-communicable diseases (NCDs) including coronary heart disease, stroke, cancer, diabetes, chronic kidney disease and dementia through a focus on up-stream measures targeted at the four shared modifiable risk factors of poor nutrition, physical inactivity, tobacco use and alcohol misuse. UKHF undertakes policy research and advocacy to support action by government, the public sector and commercial operators. As an alliance, the UKHF is uniquely placed to develop and promote consensus-based healthy public policy and to coordinate public health advocacy.

3. We appreciate the opportunity to submit to this inquiry.

4. Summary

5. The current and escalating future burden of non-communicable disease on the NHS is unsustainable: Non-communicable diseases (NCDs) are now the world's biggest killers and account for the greatest burden of death and ill health in the UK. NCDs include cardiovascular disease, stroke, type 2 diabetes, cancer, respiratory disease, hypertensive disease, chronic kidney disease, liver disease and dementia.¹⁴²¹ 40% of premature mortality in the UK is caused by preventable CVD, diabetes, cancer, and COPD.¹⁴²²

6. Many patients with NCDs have multiple-morbidities of long-term conditions. Such patients are becoming the norm rather than the exception and the number of people with comorbidities is set to increase in England from 1.9 million in 2008 to 2.9 million by 2018. Comorbidity is one of the most important issues facing the health and social care systems and the single disease approach is unable to address this problem appropriately.¹⁴²³

7. There are many common causes and pathologies that interlink many of today's major contributors to ill health. The common NCD risk factors include tobacco use, poor diets, physical inactivity, and alcohol consumption. The burden on the NHS and the wider health and social care systems attributable to diet-related conditions is significant and unsustainable, for example, ill health caused by poor diets alone is estimated to cost the NHS £6bn a year. Tackling these risk factors demands action to address the wider economic, social and environmental determinants of disease, and doing so will have potential co-benefits for health inequalities, sustainable development, climate change and social justice. Investing in prevention is cost-effective and will reduce short and long-term demands on both health and social care services.^{1424,1425,1426}

¹⁴²¹ UN. 2016. *What Government Ministries Need to Know about Non-communicable Diseases*. Available at: <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/what-government-ministries-need-to-know-about-non-communicable-diseases.html>

¹⁴²² World Health Organization. 2014. *Noncommunicable Diseases (NCD) Country Profiles – United Kingdom*. Accessed on 31 May 2016: http://www.who.int/nmh/countries/gbr_en.pdf

¹⁴²³ www.gov.uk/government/uploads/system/uploads/attachment_data/file/307143/Comorbidities_framework.pdf

¹⁴²⁴ Lozano R, Naghavi M, Foreman K, et al. 2012, Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*. Vol: 380. Pages: 2095-2128.

8. NCDs are a threat to the economy while the cost of the NHS is forecast to rise by 1.8 per cent of GDP by 2066.¹⁴²⁷ The Government has the primary role and responsibility of responding to the challenge of NCDs, requiring all sectors to work together. The planning for the prevention of NCDs should be the framework with which the NHS and Government follow – not tackling individual diseases as though they are un-linked.¹⁴²⁸

9. Major focus needed on primary prevention: The entire system must be incentivised to invest in and deliver prevention. The most effective and most impactful in the short and longer term are upstream measures that provide benefits across the whole population.

10. Additionally, the approach by the Commission on the Social Determinants of Health to give every child the best start in life; create fair employment and good work for all; ensure a healthy standard of living for all; create and develop healthy and sustainable places and communities; and strengthen the role and impact of ill-health prevention, will have a significant impact on the prevention of ill health.¹⁴²⁹

11. Health in All Policies: To significantly reduce the burden on the NHS and social care systems and establish its long-term sustainability a Health in All Policies approach is needed by Government. Most importantly, an integration of public health goals and indicators within the policies of other Government departments, including those responsible for climate change and sustainable development. Examples might include access to sustainable public transport; population intakes of saturated fat and meat which are related to greenhouse gas emissions; and population exposure to air pollution.

12. Furthermore, the way in which the benefits to health are measured needs to take account of the many additional social, economic and environmental co- benefits of primary prevention, across Government. The benefits are enormous but are under assessed. Currently most prevention programs only assess specific chronic diseases and do not take account of their interlinked nature.

13. Greater focus on the commercial determinants of health: The major vectors of NCD's are unhealthy commodities of tobacco, ultra processed food (which is high in fat, salt and sugar) and alcohol. To date most policy measures have focused on individual responsibility and not on the health-damaging behaviour of industry. For example, in 2014 the UK food industry spent £256 million promoting 'unhealthy' foods sold in retail alone.¹⁴³⁰ Price promotions in Britain are the highest in Europe, with around 40% of expenditure on food and drinks consumed at home being spent on products on promotion.¹⁴³¹ The majority of

¹⁴²⁵ Department of Health. 2014. *Annual Report of the Chief Medical Officer*. London: Crown Copyright.

¹⁴²⁶ Organisation for Economic Co-operation and Development. 2012. *The Economics of Prevention: Obesity Update 2012*. OECD.

¹⁴²⁷ http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf

¹⁴²⁸ UN. 2011. *High Level Meeting on Prevention and Control of Non-communicable Diseases*. Available at: <http://www.un.org/en/ga/ncdmeeting2011/>

¹⁴²⁹ The Marmot Review. 2010. *Fair Society, Healthy Lives*.

¹⁴³⁰ Public Health England. 2015. *Sugar Reduction: The evidence for action*. Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/470179/Sugar_reduction_The_evidence_for_action.pdf

¹⁴³¹ Public Health England. 2015.

these promotions are for unhealthy foods and drinks and they increase the total amount of household food and drink purchased by around 22%. An estimated 9% of the population's excessive sugar intake is a direct result of extra food and drink promotions.¹⁴³²

14. There must be a focus on shaping markets so that the UK produces a health creating not damaging economy. A collection of policies are needed to address product formulation, marketing, promotions, price, placement and availability simultaneously. Many of these measures are widely supported by the public, especially in the context of protecting children and young people.

15. As a priority, the Government must take strategic action on the marketing of foods high in fat, salt and sugar, particularly to children.¹⁴³³

16. New models of monitoring and surveillance of NCDs: The Government, in part through the NHS, should increase investment in national and local monitoring, enforcement, evaluation and sharing of best practice. Investment in surveillance and enforcement of the commercial practices of consumption and marketing industries is needed. The government should establish observatories for the food, tobacco and alcohol industries to monitor developments in the market and marketing practices, and enable rapid measures to be taken to reduce attractiveness and consumption of harmful products.

17. The INFORMAS network provides a useful model in the area of obesity and NCDs (The International Network for Food and Obesity / Non-communicable Diseases Research, Monitoring and Action Support). It has developed a suite of tools to monitor, benchmark and support public and private sector actions to create healthy food environments and reduce obesity and non-communicable diseases.¹⁴³⁴

18. Need for better strategic planning tools: To ensure long-term sustainability, the NHS should support the development and utilisation of better strategic planning tools for health. It should also support the development of an independent Office of Public Health Responsibility function for forecasting disease and risk factor trends and the impact of interventions. These should be complemented by, economic analysis such as ROI. This would fit well with the functions of Public Health England and its scientific and operational independence, and strengthen its role in undertaking HIA's across Government and economic sectors. Like the OBR, a joint analytical relationship with the Treasury and PHE would help with investment in effective measures to improve the public's health and better inform fiscal and economic planning.

23 September 2016

¹⁴³² Public Health England. 2015.

¹⁴³³ Sustain. 2016. *Who sets the agenda?* Available at: https://www.sustainweb.org/publications/who_sets_the_agenda/

¹⁴³⁴ World Obesity Forum. Available at: <http://www.worldobesity.org/what-we-do/policy-prevention/projects/informas/>

UNISON – Written evidence (NHS0081)

Executive summary

- There is a need to consider the future sustainability of social care alongside that of the NHS.
- Mental health and tackling health inequalities need greater priority attached to them.
- The future healthcare system should abandon the failed experiment with markets.
- The comprehensive NHS model of care being delivered free at the point of need should be retained, and ultimately extended into the social care sector.
- The sustainability of the NHS model as a healthcare system has been assessed recently by a number of organisations with a consistent picture emerging of strong support for the NHS.
- The Committee should therefore accept this consensus as a starting point and deal with other areas such as healthcare funding, models of service delivery and the crisis in social care.
- There should be no moves to restrict what is free at the point of use on the NHS.
- Within the current funding envelope, the NHS is fast approaching a state of financial meltdown.
- While the headline decision to front-load NHS funding was preferable to leaving increases until later in the Parliament, this still represents a relatively meagre settlement for the NHS.
- And the wider Department for Health budget has been slashed, meaning less money for public health, health education and the operation of arm's length bodies.
- The NHS is also under pressure to deliver an unrealistic £22bn of "efficiency savings".
- The situation in social care is far worse, with the council tax precept and Better Care Fund insufficient to bridge the widening gap between funding and need.
- UNISON has long pointed to the folly of government attempts to restrict the supply of overseas healthcare staff to the UK; the situation will not be helped by the UK leaving the EU.
- UNISON, along with many others in health and social care, is calling on the government to make a firm commitment that EU migrant workers should be permitted to remain in the UK.
- Staffing shortages and the mounting agency bill all point to the fact that the government's policy of pay restraint in the NHS is no longer sustainable.
- The removal of bursary funding for healthcare students and the impact of Brexit on the supply of staff to work in the NHS are set to make a bad recruitment situation even worse.
- The lowest NHS pay scales need to be restructured to build in a sustainable Living Wage commitment for the whole of the NHS.
- The NHS Pension Scheme remains a key element of the overall reward package for NHS staff and, if undermined, also has the potential to affect future recruitment and retention.
- Removing the NHS bursary is likely to affect the supply of healthcare staff to the NHS, exacerbating current shortages and affecting patient safety.

- With the current mismatch between skills shortages and availability of apprenticeships, the apprenticeship levy means that the NHS is unlikely to recoup its money in the first years.
- There is likely to be a shortfall in funds to support planned learning, with particular implications for the provision of continuing professional development in the NHS.
- The ambulance sector illustrates how failings in workforce planning, problems around recruitment and retention, and issues with skill mix are affecting staff and the quality of service.
- There are even more pressing issues concerning the social care workforce, with non-payment of the national minimum wage endemic in the sector.
- UNISON is encouraging councils to improve the delivery of homecare services by adopting the Ethical Care Charter, which has already had positive results for both staff and service users.
- UNISON supports the principles of health and social care integration, but with caveats around the need for engagement, protecting terms and conditions, and it not being a cover for cuts.
- There is also a need to challenge the assumption that integration will automatically bring about substantial cost savings.

Introduction

1. UNISON is the major trade union in health and social care and the largest public service union in the UK. We represent more than 450,000 healthcare staff employed in the NHS, and by private contractors, the voluntary sector and general practitioners. In addition, UNISON represents over 300,000 members in social care. The union's community and voluntary sector has an expanding membership of more than 60,000 and UNISON has a large retired membership of more than 165,000 with a particular interest in the future of health and social care. In addition, there is a wider interest among our total membership of more than 1.3 million people who use, or have family members who use, health and social care services.
2. The TUC has produced a comprehensive submission to this inquiry, which UNISON fully endorses. Rather than repeating the same points this submission includes some additional ones, particularly focused on resource issues and the workforce section of the call for evidence. Many of the specific questions posed by the Committee are inter-related, so this response is structured around the main headings outlined by the Committee rather than addressing each of the questions individually.

The future healthcare system

3. Demographic change and an ageing population undoubtedly provide greater challenges to the future health and care system, but we should begin by welcoming the fact that many more people are living for longer and enjoying many more healthy life years than previously. This is testament to the success of the NHS – and those that work in it – in bringing through medical advances and new ways of working.

4. In terms of how the health and social care system needs to change by 2030, UNISON echoes the submission by the TUC and the evidence of the Nuffield Trust to the Committee, around the need to consider the future sustainability of social care alongside that of the NHS. Decades of chronic underfunding means that social care is not only experiencing a crisis of its own, but is also having an increasingly detrimental impact on the NHS. Delayed discharges from hospital are now at record levels, with patients taking up hospital beds they no longer require accounting for more than 184,000 days in July 2016.¹⁴³⁵ While a lack of social care capacity is not the only reason for this, it is a major factor. The Respublica think tank predicts additional costs of up to £3bn for the NHS as a result of the loss of social care beds.¹⁴³⁶
5. Mental health is another area that needs to have greater priority attached to it. Parity of esteem for mental health is a policy that UNISON supports and the extra funding for mental health as a result of the Comprehensive Spending Review (CSR) and in response to the work of NHS England’s mental health taskforce is welcome. However, there are real question marks over whether this will be enough to reverse the decades-long trend of mental health being seen as a Cinderella service, and whether the money will actually make it through to where it is most needed. UNISON notes the findings of the recent Public Accounts Committee report that only a quarter of people estimated to need mental health services have access to them, and that current government plans to improve services are unrealistic due to budget pressures.¹⁴³⁷ Similarly, recent reports suggest that more than half of clinical commissioning groups plan to actually reduce the proportion of their budget they spend on mental health.¹⁴³⁸
6. The universal nature of the NHS is essential to our healthcare system remaining amongst the most equitable in the world. However, health inequalities persist and need to be tackled in a more concerted manner. For example, greater investigation is needed into the impact of various initiatives to boost patient choice by successive governments and the potential this has to put poorer people or migrant workers, for example, at a disadvantage compared to those who are more used to asserting their rights to choose or who are more familiar with the workings of the UK health system.
7. Related to this, the future healthcare system should abandon the failed experiment with markets. This has largely been resisted in Scotland and Wales anyway, and now in England the success of the Five Year Forward View, particularly its Sustainability and Transformation Plans, depends on the NHS being able to operate free of the shackles of the full-blown NHS market that the Health and Social Care Act 2012 sought to bring about. The use of competition law and economic regulation should no longer be an impediment to different parts of the NHS working together to further the interests of patients.

Resource issues, including funding, productivity, demand management and resource use

¹⁴³⁵ www.telegraph.co.uk/news/2016/09/08/nhs-bed-blocking-at-monthly-worst-level-on-record

¹⁴³⁶ Emily Crawford & Claire Read, *The care collapse: the imminent crisis in residential care and its impact on the NHS*,

11 November 2015, www.respublica.org.uk/wp-content/uploads/2015/11/ResPublica-The-Care-Collapse.pdf

¹⁴³⁷ www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/80/8002.htm

¹⁴³⁸ www.independent.co.uk/life-style/health-and-families/health-news/jeremy-hunt-nhs-mental-health-funding-broken-promises-a7322506.html

8. In terms of future funding models for the health and care system, UNISON favours the retention of the comprehensive NHS model of care being delivered free at the point of need, and ultimately the extension of such a model into the social care sector. UNISON is not the only organisation that supports such an ambitious settlement; the Barker Commission for the King’s Fund recommended that in the long run much more social care should become free at the point of use.¹⁴³⁹
9. There should be little need for the Committee to revisit the sustainability of the NHS model as a healthcare system, as this has been assessed very recently by a number of august organisations and commentators with a consistent picture emerging of strong support for the current set-up. For example, the Barker Commission in 2013 found no reason to do away with the model; instead, as noted above, looking to expand it into parts of social care. In 2014 the NHS Five Year Forward View provided definitive confirmation that the NHS model of tax-funded comprehensive services is sustainable.¹⁴⁴⁰ And the New York-based think tank the Commonwealth Fund rated the NHS top overall in its most recent survey of comparable health systems; it was particularly significant that the NHS came top on the question of efficiency.¹⁴⁴¹ UNISON therefore calls upon the Committee to accept this consensus as a starting point for the rest of its inquiry and move on swiftly to deal with the more vexed questions about healthcare funding, models of service delivery and how to tackle the crisis in social care.
10. Similarly, there should be no moves to restrict what is free at the point of use on the NHS. There are already worrying plans in parts of the English NHS to scale back crucial services that make a real difference to people lives, such as bariatric surgery for weight loss, dermatology, rheumatology, hip and knee replacements. Recent research from charities has revealed increased rationing of cataract operations across the NHS as finances deteriorate¹⁴⁴², and that provision of free IVF on the NHS in England has fallen to its lowest level since guidelines were introduced in 2004.¹⁴⁴³ Yet evidence suggests that the introduction of charges is counter-productive and unfairly penalises those with poor health on lower incomes. For example, the Barker Commission found that “most options for charges seem likely to raise administrative problems and the risk of adverse impacts, which make them unattractive”.¹⁴⁴⁴
11. In terms of the realism of the current funding envelope for the NHS, it is increasingly clear that the service is approaching a state of financial meltdown – if it has not reached that stage already. Health staff have been warning about impending crisis for months, and now the heads of NHS trusts are cautioning that the service is close to collapse.¹⁴⁴⁵ The NHS ended the last financial year with an official deficit of nearly £2.5bn, although

¹⁴³⁹ www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf, p38

¹⁴⁴⁰ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

¹⁴⁴¹ www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

¹⁴⁴² *Surgery deferred, sight denied: variation in cataract service provision across England three years on*, August 2016, www.rnib.org.uk/removing-arbitrary-restrictions-cataract-surgery

¹⁴⁴³ www.bbc.co.uk/news/health-37430380

¹⁴⁴⁴ www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf, p x

¹⁴⁴⁵ NHS Providers, <https://www.nhsproviders.org/news-blogs/news/the-nhs-can-no-longer-deliver-what-is-being-asked-of-it-for-the-funding-available>

most experts think the true figure was closer to £3bn. On the surface the latest quarterly figures showed an improved situation, but this was only as a result of the extra money pumped in to trusts as part of the Sustainability and Transformation Fund. Providers are now routinely reporting their struggle to make ends meet with demand continuing to increase; the Royal College of Surgeons even referred to the pressures on the NHS representing a “perpetual winter of Narnia”.¹⁴⁴⁶

12. The government’s headline decision in the last CSR to front-load a significant slice of the promised extra £8bn for the NHS in England was certainly preferable to leaving these increases until later in the Parliament. However, this extra money needs to be put in context. As the Health Foundation has pointed out, the total health budget is rising by £4.5bn in real terms up to 2020, an increase of less than 1% a year above inflation – this means real terms health spending per person will be around the same in 2020 as it was in 2010, despite the pressures exerted on the system by an ageing population and the costs of new technologies and treatments. The CSR means that the share of GDP going on healthcare will be just 6.7% in 2020-21, down from an already very low figure of 7.3% in 2015-16.¹⁴⁴⁷ Parliamentary figures show the NHS funding settlement during the last Parliament was the most austere in its history, with funding growing by just 0.9% over the last five years¹⁴⁴⁸, and this figure is set to be the average yearly increase for the whole of the 2009/10 – 2020/21 period.¹⁴⁴⁹ When this is placed in the international context, the picture is even bleaker with health economists pointing out how the UK has fallen further behind other European countries, and is now ranked thirteenth out of the original 15 EU countries.¹⁴⁵⁰

13. Moreover, while NHS England spending may have been protected, the wider Department for Health budget has been cut by 25%, which will mean less money for public health and the operation of arm’s length bodies such as Health Education England (HEE) and the Care Quality Commission (CQC). The capital budget will be frozen in cash terms over the five years of the spending review period too. In the words of the Health Foundation, “the Spending Review has substantially redefined and shrunk the scope of NHS services to be protected from reductions in spending”.¹⁴⁵¹ The CQC has had its government grant cut by 25% over four years¹⁴⁵² and public health spending will be cut by 4% a year in real terms. This is likely to prove highly counter-productive, as a failure to tackle issues such as obesity and sexual ill health stores up future costs for the wider NHS. There have already been warnings that cuts to sexual health services will lead to an “explosion” in infections.¹⁴⁵³

¹⁴⁴⁶ www.rcseng.ac.uk/news/surgeons-warn-nhs-has-entered-constant-winter-of-narnia

¹⁴⁴⁷ “Health Foundation responds to government’s spending review”, 25 November 2015, www.health.org.uk/news/health-foundation-responds-government%E2%80%99s-spending-review#sthash.ZvvFO117.dpuf

¹⁴⁴⁸ House of Commons Library, “NHS funding and productivity: key issues for the 2015 Parliament”, May 2015, www.parliament.uk/business/publications/research/key-issues-parliament-2015/health/nhs-funding/

¹⁴⁴⁹ The King’s Fund, “The NHS budget and how it has changed”, 15 January 2016, www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget

¹⁴⁵⁰ John Appleby, “How does NHS spending compare with health spending internationally?”, 20 January 2016, www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally

¹⁴⁵¹ “Health Foundation responds to government’s spending review”, 25 November 2015, cited above

¹⁴⁵² *Health Service Journal*, “CQC to have government grant cut by a quarter”, 6 January 2016, www.hsj.co.uk/newsletter/topics/policy-and-regulation/cqc-to-have-government-grant-cut-by-a-quarter/7001390.article

¹⁴⁵³ *The Guardian*, “Cuts to sexual health services will lead to STI ‘explosion’, warn experts”, 3 January 2016,

14. A further reason to doubt the impact of the extra spending on the NHS is the £22bn of so-called “efficiency savings” which the service is expected to make, but which no one in the NHS seems to think achievable.¹⁴⁵⁴ The vast majority of savings over the last Parliament were made by freezing staff salaries and squeezing the tariff for the amount paid to hospitals for procedures¹⁴⁵⁵, but neither of these is a sustainable option for the future. It has become increasingly clear that there is little obvious left to cut in the NHS; the National Audit Office has pointed out that it is getting harder for trusts to make efficiency savings, with a 7% reduction in planned efficiencies made in 2014-15 compared to the previous financial year.¹⁴⁵⁶
15. It is abundantly clear therefore that the current funding envelope for the NHS is insufficient. But the situation in social care is far worse. Councils have shouldered more spending cuts than the rest of government, with central government funding for local authorities having been cut by 37% in real terms over the last spending period.¹⁴⁵⁷ Even though care spending has been protected relative to other areas of council expenditure, estimates from within the sector are that – when demand increases are taken into account – local authority spending on adult social care has still fallen by nearly a third since 2010.¹⁴⁵⁸ The cut in central government funding is only part of the story, as it is taking place at the same time as other budget pressures stemming from inflation and an increase in demand. By the time of the November 2015 CSR a shocking state of affairs had been reached in which spending on social care as a percentage of GDP was set to be barely more than a half of one per cent by 2020/21.¹⁴⁵⁹
16. The consequence has been a fall of more than 25% in the number of people aged over 65 receiving community-based, residential and nursing care services, with much stricter eligibility criteria.¹⁴⁶⁰ Nearly 400,000 fewer people were receiving social care last year than in 2005-06, and Age UK has shown that there are 900,000 older people who have unmet social care needs.¹⁴⁶¹ NHS England has suggested that pressure on local authority funding will see a widening gap between the availability of, and the demand for, adult social care over the next few years.¹⁴⁶² Following the CSR, analysts Laing-Buisson pointed to a “real and imminent danger” of a care home bed capacity crisis, with the sector

www.theguardian.com/society/2016/jan/03/cuts-to-sexual-health-services-will-lead-to-sti-explosion-warn-experts
¹⁴⁵⁴ *The Guardian*, “NHS cannot make £22bn cut sought by government, finance chiefs warn”, 18 November 2015, www.theguardian.com/society/2015/nov/18/nhs-cannot-make-22bn-cut-sought-by-government-finance-chiefs-warn

¹⁴⁵⁵ House of Commons Library, May 2015, cited above

¹⁴⁵⁶ National Audit Office, *Sustainability and financial performance of acute hospital trusts*, 16 December 2015, p35, www.nao.org.uk/wp-content/uploads/2015/12/Sustainability-and-financial-performance-acute-hospital-trusts.pdf

¹⁴⁵⁷ National Audit Office, *Financial Sustainability of Local Authorities*, November 2014, <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/833/833.pdf>

¹⁴⁵⁸ Public Accounts Committee, *Personal Budgets in Social Care*, May 2016, <http://www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/74/74.pdf>, p3

¹⁴⁵⁹ Richard Humphries & John Appleby, “Social care: a future we don’t yet know”, 8 November 2015, www.kingsfund.org.uk/blog/2015/11/social-care-future

¹⁴⁶⁰ The King’s Fund, *Health and social care funding: the short, medium and long-term outlook*, 14 September 2015 www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/kings-fund-spending-review-submission-sep-2015.pdf

¹⁴⁶¹ Age UK, “Social care funding falls by 1.1billion”, January 2015, <http://www.ageuk.org.uk/latest-press/archive/social-care-funding-falls-by-billion/>

¹⁴⁶² NHS England evidence to Public Accounts Committee, June 2016, quoted at http://www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/76/7606.htm#_idTextAnchor013

closing more beds than it is opening for the first time since 2005, with a net loss of 3,000 across the UK last year.¹⁴⁶³

17. The CSR attempted to begin addressing the funding problem by introducing the council tax precept, in which councils in England are now allowed to add an extra 2% to annual council tax bills to raise extra money to pay for adult social care. Unfortunately such measures are painfully inadequate. From the outset think tanks predicted that the proposal would fall well short of raising the £2bn a year by 2020 that government figures projected¹⁴⁶⁴ and some in the sector warned that councils would need the power to raise council tax by more than 10% to plug the social care funding gap.¹⁴⁶⁵ Subsequent analysis from the Strategic Society Centre has found that local authorities will still confront “significant shortfalls” in their adult social care budgets despite the precept and that the precept “cannot be maintained forever in its current form.” The many problems associated with the precept include the regressive effects of council tax among households; a perception of “blame-shifting”; and incoherence with the integrated care agenda and wider reform of local government financing.¹⁴⁶⁶
18. In addition, although the plan is that poorer councils will get more Better Care Fund (BCF) money¹⁴⁶⁷, the precept plan seems set to intensify inequalities in social care provision. There were already major problems with much of the north of England having seen bigger cuts to care spending than other regions in recent years.¹⁴⁶⁸ And the fear when the precept plan was announced was that local authorities with high levels of council tax income could potentially increase their social care spending by much larger amounts than more grant-reliant authorities through the precept.¹⁴⁶⁹
19. The CSR confirmed the continuation of the BCF as a means of boosting the integration of health and social care services, with £1.5bn of extra money announced. However, only £700m of this is new money with the rest coming from the “new homes bonus” and it seems that the bulk of this funding will be held back until the second half of the current Parliament, with the BCF frozen in real terms in 2016-17 and apparently worth just £100m in 2017-18.¹⁴⁷⁰ In common with UNISON, other bodies such as the Local Government Association and the County Councils Network have called on the

¹⁴⁶³ “More than a cash injection needed to fix social care”, 26 November 2015,

www.laingbuisson.co.uk/MediaCentre/PressReleases/SocialCareWhitePaper.aspx

¹⁴⁶⁴ *The Guardian*, “Using council tax to offset care cuts will widen gap between rich and poor”, 6 December 2015,

www.theguardian.com/politics/2015/dec/06/council-tax-offset-care-cuts-widen-gap-rich-and-poor-kings-fund

¹⁴⁶⁵ Independent Age, “Response to the Comprehensive Spending Review and Autumn Statement”, 25 November 2015,

www.independentage.org/news-media/press-releases/response-to-comprehensive-spending-review-and-autumn-statement

¹⁴⁶⁶ James Lloyd, *Reforming the social care precept: a stepping-stone to sustainable care*, July 2016

<http://strategicsociety.org.uk/wp-content/uploads/2016/07/Reforming-the-Precept.pdf>

¹⁴⁶⁷ *Health Service Journal*, “Poorer councils to get more better care fund cash”, 17 December 2015,

www.hsj.co.uk/topics/integration/poorer-councils-to-get-more-better-care-fund-cash/7001207.article

¹⁴⁶⁸ *Health Service Journal*, “Which areas have seen the biggest social care spending cuts?”, 23 November 2015,

www.hsj.co.uk/newsletter/sectors/commissioning/analysis-which-areas-have-seen-the-biggest-social-care-spending-cuts/7000405.article

¹⁴⁶⁹ *Local Government Chronicle*, “Social care precept threatens to widen the income gap”, 24 November 2015,

www.lgcplus.com/politics-and-policy/finance/exclusive-social-care-precept-threatens-to-widen-the-income-gap/7000563.article

¹⁴⁷⁰ *Health Service Journal*, “Extra BCF cash worth £100m in first year”, 7 December 2015,

www.hsj.co.uk/newsletter/topics/integration/extra-bcf-cash-worth-100m-in-first-year/7000899.article

government to “front-load BCF with additional funding from 2017/18 in a similar manner to NHS funding”.¹⁴⁷¹

Workforce

20. UNISON has long pointed to the folly of government attempts to restrict the supply of overseas healthcare staff to the UK. At a time when there are serious shortages in a number of professions, the NHS needs all the help it can get. UNISON therefore welcomed the decision of the Migration Advisory Committee to keep nurses on the shortage occupation list. Unless the current nursing shortage is addressed this will need to remain the case for the foreseeable future.
21. The situation will not be helped by the UK leaving the European Union. Around 50,000 EU citizens work in the NHS and a further 84,000 in social care. The Social Market Foundation has estimated that almost 90% of EU nationals working in the public sector are unlikely to meet the current visa rules under Brexit.¹⁴⁷² Issues such as work permit problems, a tougher migration regime and passport difficulties seem likely to deter others from trying to come to the UK to work. In the past two years thousands of EU nurses have been recruited to the NHS to cover gaps in staffing. Any further reduction would place even greater pressure on services and staff.
22. Post-referendum there is much uncertainty for Europeans working in the NHS and social care which, unless it is addressed, has the potential to drive staff away from our crucial public services at a time when they are needed most. UNISON is part of the recently convened “Cavendish Coalition”, and as such is calling on the government to make a firm commitment to EU migrant workers currently working in the NHS (and in other sectors) that they should be permitted to remain in the UK.
23. A timely report from the International Longevity Centre warned that, with more than 90% of EEA migrant workers currently working in social care not holding British citizenship, any changes to migration policy resulting from the EU referendum could have serious implications for adult social care and exacerbate current recruitment and retention issues in the sector.¹⁴⁷³
24. Below UNISON tackles a variety of issues – specifically those on pay, pensions, the NHS bursary and apprenticeships – that affect the future ability of the NHS to recruit and retain the necessary level of healthcare staff.
25. Staffing shortages and the mounting agency bill all point to the fact that the government’s policy of pay restraint in the NHS is no longer sustainable. The Five Year Forward View contained a welcome admission that NHS pay would have to increase and “stay broadly in line with private sector wages in order to recruit and retain frontline

¹⁴⁷¹ County Councils Network, *Consultation response: Local government finance settlement 2016/17*, January 2016, www.countycouncilsnetwork.org.uk/library/july-2013/file115/

¹⁴⁷² www.smf.co.uk/publications/working-together-the-impact-of-the-eu-referendum-on-uk-employers

¹⁴⁷³ www.independentage.org/sites/default/files/2016-09/IA-Brexit-Migration-report.pdf

staff”.¹⁴⁷⁴ Between 2010 and 2016 over £4.3bn has been cut from NHS staff salaries. This means a loss of between 12% and 19% of their real value since 2010. This has coincided with a growing recruitment and retention crisis for key staff groups. For example, the Public Accounts Committee recently reported that the proportion of nurses leaving their jobs increased from 6.8% in 2010–11 to 9.2% in 2014–15¹⁴⁷⁵. The removal of bursary funding for healthcare students and the impact of Brexit on the supply of staff to work in the NHS are set to make a bad recruitment situation even worse.

26. The government also plans to raid the measly 1% a year paybill provision it has made for general staff pay rises in order to fund NHS implementation of the statutory minimum wage for those aged 25 and over (the so-called “national living wage”). Expecting staff to accept an award of less than 1% in order to pay for an unfunded Treasury commitment will only drive even more of these staff to the exit. UNISON believes that tackling low pay in the NHS is critically important and must be properly funded through a sustainable living wage policy, while recognising that staff at all levels of the NHS need a fair pay settlement. NHS staff in Scotland and Wales currently have the peace of mind that comes from the Living Wage commitments made by their devolved governments. Meanwhile, in England and Northern Ireland the lowest paid NHS staff continue to struggle on poverty pay. Far from matching the Living Wage, the lowest pay points in England, for example, are set to be overtaken even by the projected statutory minimum wage for those aged over 25 by 2018/19. UNISON wants to avoid the NHS pay structure being dragged down to the legal bare minimum. The lowest pay scales need to be restructured to build in a sustainable Living Wage commitment for the whole of the NHS. Tackling poverty pay is essential to ensure the NHS can attract and retain the staff it needs to deliver quality patient care, and keep morale and motivation high.
27. The NHS Pension Scheme remains a key element of the overall reward package for NHS staff and is another element which, if undermined, has the potential to affect future recruitment and retention in the NHS. Over the past year there have been a number of worrying developments that, if sustained, could threaten the long term viability of the NHS Pension Scheme. A combination of NHS funding and recruitment and retention issues has seen two NHS trusts – Oxleas NHS Foundation Trust and East and North Hertfordshire NHS Trust – offer enhanced salaries to certain groups of staff in exchange for leaving or opting out of the NHS Pension Scheme. With many NHS organisations faced with similar situations it is likely this cost free approach to solving recruitment and retention problems will become more frequent, which in turn has serious implications for the long term viability of the pension scheme.
28. Further to this, a number of government-led initiatives have seen the employer and employee costs associated with the NHS Pension Scheme increase. The introduction of the new State Pension from April 2016 ended contracting out and increased national insurance costs by 3.4% for employers and by 1.4% for employees. It is also expected that from April 2017 the scheme administration charge will be passed from the

¹⁴⁷⁴ www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf, p35

¹⁴⁷⁵ <http://www.publications.parliament.uk/pa/cm201516/cmselect/cmpublic/731/73105.htm>

Department of Health to individual employers. Initially, the additional cost is projected to be 0.08% of pensionable pay.

29. In July 2016, the Government confirmed that it would be going ahead with its plans to remove the NHS bursary and replace it with tuition fees and loans. London Economics calculated that the replacement of student maintenance grants with repayable loans, as well as the introduction of tuition fee loans, may result in a 71% increase in the cost borne by a representative student/graduate completing a three year degree in nursing, midwifery or the allied health professions; with an increase in cost comes a drop in demand.¹⁴⁷⁶
30. The government argue that this drop in demand will not be felt because there are currently far more people wanting to do the courses than places available. In 2015, UCAS data shows that there were 186,260 applications for nursing courses, including midwifery. (However, according to UCAS, there are 4.41 applications per applicant, which suggests that the number of unique applicants is closer to 45,000.) From a recent Freedom of information request made to higher education institutions, UNISON understands that 17.8% of applications in nursing, midwifery and the allied health professions are assessed as having come from applicants meeting the eligibility and suitability criteria, and who would have been offered a place. This means that only 33,154 applications would have met requirements in 2015.
31. Moreover, the crucial question is how sensitive applications are to changes in price. London Economics argue that it is probable that applications are more responsive to increases in price than actual participation in higher education. We also know that following the introduction of £9,000 fees in 2012 (an increase in costs of approximately 10%) applications declined by 10% the following year. Five years later, applications from English domiciled students were still 3-4% lower than in 2011. This suggests that the elasticity of applications is anywhere in the region of -0.3 to -1.04. If one takes the middle of this range (-0.5) as a starting point, it implies that a 10% increase in the cost of undertaking a degree will be associated with a reduction in applicants by 5%. Using London Economics' analysis relating to the expected price increase, this implies that the 71% increase in price would be expected to reduce the number of applicants by approximately 35.5% - leaving just 21,384 suitable applicants (66 fewer than in 2015).
32. The government claim that removing the bursary will create 10,000 additional training places by 2020. It may be the case that universities will be able to offer more course places but, as the estimates above indicate, there will not be the students to fill them unless universities drop their entry requirements – something that UNISON and patients would not be able to support. There is therefore a very real risk that these changes will exacerbate current shortages and have serious consequences for patient safety, as it will

¹⁴⁷⁶ <http://londoneconomics.co.uk/wp-content/uploads/2016/05/UNISON-NUS-Report-Nurse-fees-and-funding-24-05-2016-FINAL-VERSION-LONDON-ECONOMICS.pdf>;

<http://londoneconomics.co.uk/wp-content/uploads/2016/06/London-Economics-Response-to-Council-of-Deans-of-Health-on-UNISON-NUS-Report-08-06-2016.pdf>

become more difficult to maintain safe staffing levels with fewer nurses, midwives and allied health professionals coming through the training system.

33. Employment of apprentices in the NHS continues to grow with policy commitments in all four UK administrations to increase the number of apprenticeships in the economy generally, with an expectation that the public sector will lead by example. From April 2017, employers with paybills over £3m will be required to pay 0.5% of paybill into the government's apprenticeship levy. In England alone the levy will extract £200m a year from the NHS and there is considerable concern that, due to the current mismatch between skills shortages and availability of apprenticeships, the NHS will not in the first years be able to recoup all this money. It is expected that any funds unused by NHS employers after 18 months would be redistributed for use by employers in other sectors. This is a particularly perverse prospect in view of the financial situation in the NHS.
34. There is concern about the distorting effects of the imperative for employers to recoup the maximum, and the knock-on impact on recruitment and retention. This is driving some employers to convert all vacancies in Bands 1-4 of Agenda for Change into apprenticeships with no strategic approach – and no assessment of suitability, the capacity among other staff to support apprentices, or the impact on retention of staff recruited as apprentices. Many employers are looking to divert money currently in their learning and development budgets to meet their levy payments. This will leave a shortfall in funds to support planned learning with particular implications for the provision of continuing professional development as this cannot be funded through apprenticeships. Such short-termism may also mean existing staff not receiving the training they need unless it can be shoe-horned into an apprenticeship programme.
35. In England the effects of the levy on the NHS will be compounded by considerably increased targets for apprenticeship starts which will now be set at individual employer level. The government has consulted on statutory targets for public sector employers for the number of apprentices they start each year – to be set at 2.3% of each employer's headcount. Across the NHS, this will add up to a target of 28,000 starts per year. In 2015/16, Health Education England reports that there were nearly 20,000 starts. The concern about a crude approach based on starts per year is that there is a considerable disincentive for employers to consider investing in higher value apprenticeships which last longer than a year. This is because the employer can only count them as a "start" in the first year but must continue to invest the resources needed to support them through their whole apprenticeship.
36. Currently there are few apprenticeships available in the areas of greatest clinical shortage. An employer-led "Trailblazer" group is now working on developing a nursing apprenticeship but this is expected to take another couple of years. There may be similar developments for allied health professionals but again these will not be available in the short-term. As a result, the primary focus of apprenticeship development has been in Bands 1-3 with some provision for Band 4 roles. HEE data shows that the majority of apprenticeships in the NHS are delivering at educational level 2 – equivalent to GCSE A-Cs. It is far from certain whether there will be an appetite from NHS

employers to invest in degree-level apprenticeships in the NHS, even if more do become available. This reflects in part the short-term one-year target cycle for starts, and also the uncertainty over the effects of the removal of the student bursary. As the levy only pays for training and assessment but not for salaries there will be further pressure to drive down wages of apprentices in order to make up for the levy outlay, and as a more general means of cutting paybills.

37. The current situation in the ambulance sector illustrates how failings in workforce planning, problems around recruitment and retention, and issues with skill mix are affecting staff and the quality of service they provide to patients. Changes from vocational training to reliance on higher education, coupled with a period of poor workforce planning, has led to a critical shortage of trained paramedics. Despite attempts to recruit from overseas, the vacancy rate has remained stubbornly high (around 10%, with regional variations). One of the problems facing ambulance services is the gap between paramedic leavers and the number of new graduate paramedics qualifying from university. Key retention issues for ambulance staff are pay and grading; operational pressures, such as demand on 999 services, shift over-runs, lack of adequate breaks; and health and wellbeing issues such as work-life balance, stress, ill health, violence and aggression. Investment in vocational training to convert existing ambulance staff to paramedics would provide a way to rectify skill mix problems.
38. Paramedics have an adaptable skill mix enabling them to deliver a range of responses to patients. However, current time-based performance measures limit the innovation ambulance services are able to make by selecting the right skill mix for the patient. The Ambulance Response Programme, led by NHS England, is the first attempt at looking at how to send the right response to the right patient and Wales now has a clinical model that is showing promising results. Currently, paramedics are being poached from ambulance services to work in minor injury units, GP surgeries and the private sector, as they have a very wide set of assessment and clinical skills.
39. There are even more pressing issues concerning the social care workforce. UNISON's recent submission to the Communities and Local Government Committee¹⁴⁷⁷ covered the most significant of these: there is inadequate funding for hourly rates and a glaring failure to tackle non-compliance with the National Minimum Wage (NMW), with non-payment endemic in the sector; less than a quarter of councils in England and Wales make it a contractual condition for care providers to pay for workers' travel time, the main reason for NMW non-compliance; illegally low pay rates fuel staff turnover and send out a message that care workers do not deserve to be respected for their work; and the focus on personal budgets has produced further insecurity for those employed through direct payments, who may find that their employment rights are not properly observed. Several of these concerns were brought in to sharp relief in September 2016 by UNISON members taking a case against the care contractor Sevacare and Haringey

¹⁴⁷⁷ <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/communities-and-local-government-committee/social-care/written/35557.html>

council over their failure to receive the minimum wage.¹⁴⁷⁸ An estimated 160,000 to 220,000 direct care workers in the UK are paid below the national minimum wage.¹⁴⁷⁹

40. In terms of a practical measure for countering some of this abuse, UNISON has been encouraging councils to improve the delivery of their homecare services by adopting the union's Ethical Care Charter.¹⁴⁸⁰ The Charter was designed as a simple way for councils to improve homecare standards for both the vulnerable people they are responsible for and for the workers who provide care. The Charter is a set of commitments that councils make which fix minimum standards that will protect the dignity and quality of life for those people and the workers who care for them when they commission their homecare services. The commitments include ensuring that there is continuity of care, ending 15 minute visits for personal care, paying staff a living wage and ensuring that they are paid for their travel time.
41. Eighteen local councils in England, Wales and Scotland have now adopted the Ethical Care Charter and UNISON expects the number to continue to increase in the coming months. The Charter has already had positive results for both care workers and care users. Southwark Council was one of the first councils to adopt the Charter and they carried out an evaluation of the performance of their homecare services since then.¹⁴⁸¹ They found concrete evidence of an improvement in service, based on staff recruitment and retention rates, take-up of training, and service user outcomes. Islington Council, which has also adopted the Charter, had similarly positive feedback. As well as witnessing improvements in the morale of homecare workers, providers commissioned by the council also reported significant improvements in staff retention rates since the Charter was implemented.¹⁴⁸² One of the private providers commissioned by Islington Council pointed to notable improvements in staff well-being as a result of higher wages. Prior to introducing the London Living Wage turnover amongst its staff averaged over 10% but now it is less than 3%. The policy director of the provider stated that “retention and recruitment – serious struggles in social care – improved dramatically. Care workers became more motivated and so became more reliable, supportive, happier and healthier – all of which directly benefits service users...stable, reliable, high quality care services deliver improved outcomes for individuals and save the health and care system money.”
42. UNISON is in the process of carrying out a more detailed evaluation at a larger spread of councils to gauge the impact of the Charter. The union is hopeful that the results will be used to encourage more councils to adopt the Charter. The success of the Charter to date shows that in order for care standards and outcomes to improve, steps must be taken to improve the terms and conditions of the workforce.

¹⁴⁷⁸ www.unison.org.uk/news/press-release/2016/09/unisons-biggest-ever-homecare-legal-case-over-workers-paid-as-little-as-3-27-an-hour/

¹⁴⁷⁹ National Audit Office, *Adult Social Care in England: Overview*, March 2014, www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf

¹⁴⁸⁰ www.savecarenow.org.uk/ethical-care-charter

¹⁴⁸¹

<http://moderngov.southwark.gov.uk/documents/s58403/Report%20Home%20Care%20Annual%20Contract%20Performance.pdf>

¹⁴⁸² Islington Council, “Living Wage a welcome boost for homecare firms, staff and clients in Islington”, November 2015 www.islington.media/r/6221/living_wage_a_welcome_boost_for_homecare_firms_staff_and_clients_in_islington

Models of service delivery and integration

43. The integration of health and social care services is something that has long been sought by various governments and those involved in delivering care. UNISON has adopted a position of support for the principles of integration, but with a number of important caveats: integration should only proceed on the basis of full staff and patient / service user involvement; it should not be used as a cover of cuts; and, where it involves integrating workforces from the NHS and local government, integration should harmonise upwards rather than level down terms and conditions.
44. Any merging of two models of care with such different funding models is bound to create concerns about bad practices from one seeping into the other. There is a need to ensure that no element of means-testing in social care is allowed to creep into the NHS through such a process. Equally, there are staff concerns about the track record of local authorities in contracting out social care services to the cheapest bidders at the expense of quality, and the driving down of fees which has contributed to the downward spiral in employment conditions, as outlined above.
45. Moreover, there is a need to challenge the somewhat lazy assumption that integration will automatically bring about substantial cost savings. To begin with, integration is not something that can be attempted overnight; in the oft-quoted case study of Torbay for example, it took the best part of a decade for service integration to take shape.¹⁴⁸³ There is no particularly convincing evidence about the amounts of money that integration can be expected to save, and in the short term there should be an expectation of increased funding to pay for things such as double-running costs and re-training. A recent *Health Service Journal* investigation found no evidence that integration would lead to significant savings¹⁴⁸⁴ and pointed to international case studies which found that, although there were better outcomes for patients, there was no evidence of reductions in hospital admissions or improved cost effectiveness.¹⁴⁸⁵

Submission produced by the UNISON Policy Unit

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¹⁴⁸³ King's Fund, *Integrating health and social care in Torbay: improving care for Mrs Smith*, March 2011, www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf

¹⁴⁸⁴ Barnes, S, "Integration will not save money, HSJ commission concludes", *Health Service Journal*, 19 Nov 2014

¹⁴⁸⁵ Nolte, E and Pitchforth, E, "What is the evidence of economic impacts of integrated care?", *European Observatory on Health Systems and Policies*, 2014

Unite the Union – Written evidence (NHS0100)

Executive Summary

- **Six years of wasteful reorganisation and underfunding has left the NHS in an extremely precarious.**
- **This crisis is caused by poor political decisions and should not be used to create a space to challenge the basic tenants of our NHS system.**
- **Unite is advocating:**
 - **Full integration of the social care system into the NHS across all UK countries, bringing social care services up to the higher quality standards and efficiencies of the NHS to produce a National Health and Social Care service to be run on the same principles as the NHS – universal, free at the point of need, publicly funded and run.**
 - **Proper funding the Health and Social care services bringing them up to EU average spend as a proportion of GDP, through increases in progressive general taxation.**
 - **Introducing the NHS Reinstatement Bill that will remove the costly and wasteful market systems from both health and care sectors and deliver a return to fully comprehensive systems of care under the full responsibility of the publicly accountable Secretary of State for Health and Care.**
 - **Public health must be returned to the NHS with much more resource and focus dedicated to this crucial preventative arm of the NHS across all areas of government social policy.**
 - **Ending the cuts to NHS and Social Care staff pay and terms, and the protecting and expanding of collective agreements across the sector in order to raise standards and improve patient care.**
 - **All service redesigns to be clinically evidences, fully accountable and consulted on with both staff and the public.**
- **This submission is supplemented by a separate but complimentary submission from the Medical Practitioners Union, that represents doctor members of Unite.**

Introduction

- i. This evidence is submitted by Unite the Union - the country's largest trade union. Unite's members work in a range of industries including manufacturing, transport, financial services, print, media, construction, not-for-profit sectors and public services.

- ii. Unite is the third largest trade union in the National Health Service and represents 100,000 health sector workers. This includes seven professional associations – the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.
- iii. Unite also has 80,000 members in local authorities including members working in social care and public health functions such as public health specialist, consultants and directors of public health, school nurses, health visitors and sexual health advisors.

1. The future healthcare system

- **Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?**

- 1.1. Unite welcomes this timely Lords Select Committee investigation. The Coalition and Conservative Governments have left the NHS in an extremely precarious position following a combination of wasteful reorganisations and the worst financial settlement in the history of the NHS.
- 1.2. It is widely recognised that the NHS is facing new challenges and cost pressures resulting from technological and demographic changes and it is right and proper that plans are put in place to respond to these developments. The response from the Unite's MPU section in the appendix looks in detail at some suggested solutions to this.
- 1.3. These issues are often presented as insurmountable and Unite believes that this should not be overstated. For example, as well as people living longer they are also generally staying healthier, while a combination of migration and increased birth rates have meant that we should not exaggerate the impact of increasing numbers of older people on the NHS. Technological change and scientific breakthroughs can increase costs to the NHS by both increasing the cost of treatments and raising patient expectations but can also offer hope of solutions to costly health problems such as dementia or cancer that could save money in the long term.
- 1.4. While the problems faced are real Unite believes that in some cases they have been used to justify politically motivated reforms that have made the NHS less able to rise to the challenges, rather than more. The rhetoric of pending crisis has created a space for policy options that would otherwise be unthinkable and that challenge the basic tenants of our NHS system, such as calls for charging and top up insurance, which Unite strongly rejects.

- 1.5. Unite believes that discussions about the future reform of the NHS must remain firmly within the founding principles of the NHS, – i.e. a universal system of publicly provided health service, accessible, delivered free at the point of need and funded from progressive taxation. Our response to any rising costs must be met by society collectively through progressive general taxation rather than transferred to those unlucky enough to be sick, as happens in many other countries.
- 1.6. Before the Conservative-led Coalition came to power, the NHS had its highest approval ratings on record (70% in 2011). This has rapidly fallen since the coalition took office (58% in 2012) The Commonwealth Fund also found the NHS to be the most efficient and cost effective health service in the world in 2014¹⁴⁸⁶ using data that predated the Health and Social Care Act 2012.
- 1.7. It is clear then that many of the current problems facing the NHS and social care systems in the UK are the creation of the UK Government and policy failures that have made the service, more fragmented, bureaucratic and cumbersome, while stripping resources from them and constantly forcing staff to do more for less (see section 4). Government policy has been riddled with false economies and ideological decisions that have little basis in scientific evidence or what the public want and need.
- 1.8. Unite strongly believes that for the NHS and social care system to be sustainable by 2030 significant changes must be made. Firstly, the services must be properly funded and brought back up to EU average spend as a proportion of GDP. It is impossible to meet the demographic challenges without properly resourcing the system.
- 1.9. There must be full integration of the social care system into the NHS across all UK countries, bringing social care services up to the higher quality standards and efficiencies of the NHS, with professional employment structures and a single ring-fenced pooled budget to avoid the current silos. This single system should cover the needs of the whole person, including a much stronger emphasis on mental health services. Unite policy calls for this National Health and Social Care service to be run on the same principles as the NHS – universal, free at the point of need, publicly funded and run.
- 1.10. Efficiency and clinical decision making must be improved through the removal of the costly and wasteful market systems from both health and care sectors and a return to fully comprehensive systems of care under the full responsibility of the publicly accountable Secretary of State for Health and Care.
- 1.11. Lastly public health must be brought back into the NHS and much more resources and focus must be dedicated to this crucial preventative arm of the NHS. Public health policy should not be confined to the health service but should be central to wider government social policy, including through concrete plans to tackle poverty and inequality that have such damaging effects on our health through poor housing, education, conditions of employment and diet.

¹⁴⁸⁶ <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>

2. Resource issues, including funding, productivity, demand management and resource use

- **To what extent is the current funding envelope for the NHS realistic?**

- 2.1. Despite government claims that the NHS budget has grown in real terms, analysts at The Health Foundation and The Kings Fund have shown that from 2010 until 2015 government spending on the NHS rose at just 0.9% a year in real terms with government planned spending increases remaining at 0.9% until 2020/21. This is a lot less than the average real terms increase of 3.7% per year since the NHS was created in 1948 and it is way below the average increase of 8.6% per year between 2001/02 and 2004/05. These figures do not take into account the required efficiency savings of £20 billion from 2010 to 2015 and a further £22 billion from 2015/16 to 2020/21 or the huge levels of waste introduced by the Health and Social Care Act 2012.
- 2.2. In contrast the UK's GDP is forecast to grow in real terms by 15.2% between 2014/2015 and 2020/21. As a result, spending on the NHS as a proportion of GDP will fall to just 6.6% compared to 7.3% in 2014/2015. In 2010 the UK spent 9.6% of GDP on health. This was slightly above the OECD average (9.5%) but far less than many comparator countries such as Germany (11.6%) France (11.6%), Canada (11.4%) and the US (17.6%). The Kings Fund estimated that if the funding had matched GDP this would have meant an extra £16 billion going into NHS services¹⁴⁸⁷. The UK has fallen significantly behind many other European countries in terms of health funding with the UK now 13th out of the original 15 EU members in terms of investment. Given that health inflation runs faster than other prices and the recognised increases in demand, this funding settlement is insufficient.
- 2.3. The results have been a sharp increase in NHS provider deficits, reaching a record £2.45bn at the end of 2015/16 with 95 per cent of acute trusts in the red. These deficits are simply explained - the costs of delivering care rose faster than the income that providers received¹⁴⁸⁸, recruitment issues have been met with rising staff costs, particularly agency costs and average tariff payments have been cut by 10 percent over the last parliament.
- 2.4. In England these issues have been made worse by an expensive and unnecessary reorganisation through the Health and Social Care Act that turned 175 organisations into over 400 and introduced expensive layers of contracting and market bureaucracy throughout the system. A full competitive market has eroded cooperation and fragmented service delivery while forcing commissioners into expensive tendering processes that divert money from clinical care. NHS Support Federation research has shown that over £16 billion of NHS clinical contracts have been awarded through the market since April 2013 (411 contracts). Over this time the private sector has won nearly £5.5 billion worth. In total around £30 billion

¹⁴⁸⁷ <http://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally>

¹⁴⁸⁸ https://improvement.nhs.uk/uploads/documents/BM1653_Q4_sector_performance_report.pdf

worth of NHS contracts have gone before the market, although just over half this value has been awarded.

- 2.5. Another unnecessary drain on NHS resources has been the Private Finance Initiatives (PFI) that are creating financial instability in many Trusts. Nearly a third (31%) of NHS providers have a PFI scheme and the NHS spends £1.8 billion a year on PFI payments¹⁴⁸⁹. Reducing and ending this burden would release resources as PFI payments are taken from funds that should be spent on delivering services to patients and users.
- 2.6. The results of these financial pressures have been felt across NHS services, despite the continued commitment from staff to make it work. The NHS is missing a wide range of targets of services, including in A&E, cancer care and mental health services. For example there has been a tripling of the number of people waiting over 4 hours in A&E¹⁴⁹⁰ putting A&E performance at their worst levels on record; rising waiting times for cancer referrals¹⁴⁹¹ and a 12% reduction in the number of beds available to mental health patients since 2009 and ‘out of area placements’ rising 23% in the last year¹⁴⁹², reductions in in-patient care, and community based services, despite increased referrals¹⁴⁹³.
- 2.7. Social care has faced an even more difficult financial climate. Social care budgets in England have been cut by £4.6 billion – a real-terms net budget cut of 31% since 2011. Earlier this year a joint report¹⁴⁹⁴ published by The King’s Fund and The Nuffield Trust warned six years of budget cuts, rising demand and staff shortages have meant social care services were facing a funding gap of ‘*at least £2.8bn*’ by the end of the decade. Six years of cuts to local authority budgets have seen 26% fewer people receive help. In addition, rising demand for services and staff shortages had led to a “*failing system that leaves older people, their families and carers to pick up the pieces.*” The £2.8bn funding gap forecast for 2019-20 will result from public spending on adult social care shrinks to less than 1% of gross domestic product. Social care in the devolved countries is also under pressure although the devolved Governments have in some cases done more to protect services from cuts.
- 2.8. Underfunding of social care places huge pressures on NHS services with broad consensus that many of the NHS’s current challenges are due to significant failure of the overall social care system, for example with older people being held in hospital longer than needed, to the detriment to their physical and mental health, because there is a delay in putting in place the appropriate social care arrangements. The National Audit Office has estimated a gross cost of around £800 million a year for

¹⁴⁸⁹ Committee of Public Accounts, [Financial Stability of NHS](#), January 2015

¹⁴⁹⁰ <http://qmr.kingsfund.org.uk/2015/17/>

¹⁴⁹¹ <https://www.england.nhs.uk/statistics/2015/08/13/provider-based-cancer-waiting-times-for-q1-2015-16/>

¹⁴⁹² <https://www.theguardian.com/society/2015/feb/01/mental-health-care-pushed-breaking-point-lack-beds-psychiatrists-nhs-hospitals>

¹⁴⁹³ <https://www.hsj.co.uk/news/fewer-mental-health-patients-seen-in-community-despite-rising-demand/5091429.article?blocktitle=Mental-health-news&contentID=554#.VjySAs4nwr4>

¹⁴⁹⁴ [Social care for older people: Home truths](#)

the NHS of older patients delayed in hospital when they no longer benefit from being there¹⁴⁹⁵.

- 2.9. These trends urgently need to be reversed and this will require a considerable increase in public spending. The Barker Review¹⁴⁹⁶ and other reports suggest that this is affordable and will have positive benefits on patients, society and the economy. The Barker Review rightly recognises that the costs of care do not disappear if the public sector does not fund them, they are just born by individual families paying for private support and in many cases informal care in very difficult circumstances. The Barker Review states *“overall spending on the cost of care for older people will inevitably rise given the ageing population. The question is not whether this money is spent. It is about where the cost fall – on collective provision through public expenditure, or on those individuals and families who are unlucky enough to have very high care needs”*¹⁴⁹⁷. Care needs are not predictable and the unfairness of this brute luck need is exactly the reason universal public services were created in the first place. They also recognise the social benefit of increased economic activity and contribution caused by supporting families and lifting their care responsibilities.
- 2.10. Rising care need means that we must be honest about taxation in order to build a fair and progressive way to bring in the resources. Unite believes that taxation should be based on ability to pay rather than health and care need and therefore does not endorse many of the suggested tax and spending recommendations highlighted in this call to evidence. Unite does agree however that within those principles government should explore a range of asset, wealth and transaction taxes to raise the required investment in public services as part of a wider process of tax reform.
- 2.11. At the same time Unite has always stressed that the austerity agenda was a political choice rather than a necessity. It is an economically illiterate policy that has stifled economic recovery by reducing demand. There is strong evidence that spending on core public services like Health and Social Care have a significant multiplier effect that stimulate further positive economy activity across the economy. Research has shown that across countries, the average multiplier effect of public health care spending has been about 3.6 – larger than almost all other categories of spending¹⁴⁹⁸. While there are limited studies of the multiplier effect of the NHS, a report by the Joseph Roundtree Foundation and Kings Fund in 2014 estimated that the economic multiplier effect of NHS spending is somewhere in the range of two to four.¹⁴⁹⁹ The Doctor’s in Unite (MPU) submission (appended) points to evidence of a multiplier of between 5 and 10. The OECD also points to a wide

¹⁴⁹⁵ <https://www.nao.org.uk/report/discharging-older-patients-from-hospital/>

¹⁴⁹⁶ <http://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care>

¹⁴⁹⁷ A new settlement for health and social care, Final Report, Kings Fund, 2013

¹⁴⁹⁸ <http://www.biomedcentral.com/content/pdf/1744-8603-9-43.pdf>

¹⁴⁹⁹ http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/tackling-poverty-research-paper-jrf-kingsfund-nov14.pdf

range of health and economic benefits derived from increased healthcare spending¹⁵⁰⁰.

- 2.12. It is not just health spending cuts that are a false economy. Our public services are not silos and have profound costs and implications on each other. That is not just true for health and social care, but for other services that have faced huge cuts from advice and housing, community centres, elderly and child care services as well as sports facilities, the arts, libraries, theatre and museums – all play a role in improving people’s lives, physical and mental health and well-being.
- 2.13. The current economic model that is increasing inequality and poverty is causing a negative drag on our health. The Joseph Rowntree Foundation recently published work showing that £1 in every £5 spent on public services is making up for the way poverty damages people’s lives¹⁵⁰¹. They report that *“Health care accounts for the largest portion of additional public spending associated with poverty, around £29 billion per year”*. The evidence is clear, by tackling these social ills and building a more equal society we all save in reduced spend on acute services and live healthier lives. This evidence builds on research, such as that of Wilkinson and Pickett, which established that more unequal societies have lower levels of physical health and life expectancy and poorer mental health.

3. Workforce

- **What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?**
 - **How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?**
- 3.1. The funding and reorganisation issues loom large over the NHS workforce and have had a major impact on recruitment and retention, staff morale and, as a result, service outcomes.
- 3.2. In order to raise NHS efficiency, the Government and employers have forced NHS staff to deliver more for less. NHS staff have faced multiple years of pay freezes and below inflation pay caps which have led to health sector workers losing an average of 17% of take home pay pushing many into poverty. This capping of public sector pay at 1% was intended to continue until 2019 and so far there is no evidence that the new Chancellor will change this.
- 3.3. The pay policy has put huge strains on NHS staff morale. In Unite’s annual NHS members survey (July 2016) compared to the previous 12 months, 90% of members said morale and motivation was worse or a lot worse, with 79% having experienced increased workplace stress. 64% said they had seriously considered leaving their

¹⁵⁰⁰ <https://www.oecd.org/health/2010-ministerial/46098466.pdf>

¹⁵⁰¹ <https://www.jrf.org.uk/press/poverty-costs-uk-78-billion-year>

job, with 56% thinking of leaving the NHS altogether. It is not hard to find reasons why as 79% said that their pay was worse compared to the cost of living, 68% reported always or frequently working more than their contractual hours with 41% saying their additional hours are all unpaid. 83% said that workloads have increased with 52% saying they had increased a lot. 68% reported frequent staff shortages while 58% reported that their department had been restructured in the last 12 months.

- 3.4. Staff have also faced a range of cuts to their overall terms and conditions over and above pay caps. These include cuts to on-call, sickness allowance, pensions, recruitment and retention premia, performance related pay, exit payments, overtime and shift allowances. Some Unite members have reported cuts to take home pay of around 30% over the past few years due to changes in their terms and conditions. At the same time the divergence of health pay policy across the four UK countries has begun to unpick national bargaining arrangements and meant that the national pay structure has ended up being split into four distinct pay spines.
- 3.5. Trusts are experiencing serious staff shortages evidenced by the dramatic growth of agency staff use in the NHS and the growth of private provider use (e.g. ambulances) in some Trusts to plug gaps. These short term stop gaps are much more expensive and are not a sustainable solution to staffing issues. While it is too early to tell, the impact of the Brexit vote, and indeed stricter migration controls on non-EU migrants, on staff numbers will have to be seriously considered as currently the NHS is heavily reliant on foreign born staff in many areas.
- 3.6. Government has deliberately chosen to confront staff unions, rather than listen to their concerns, further exacerbating the problems. For example, Government attempts to impose a damaging new contract have led to unprecedented industrial action by Junior Doctors despite widespread recognition that new contract lacks clinical evidence, with the potential to put patients at risk and drive discrimination. The similarly short-sited proposals to abolish bursaries for nursing and allied health professions have been brought in, which unions calculate will leave those studying nursing, speech and language therapy, radiology, occupational therapy, mental health nursing, midwifery and other professions with debts of over £50,000 from April 2017. Unless a satisfactory alternative is brought in this is likely to deter many people from working in the health service, particularly the large numbers of mature students, parents and people of BAEM backgrounds.
- 3.7. Again social care has fared even worse. As funding has declined the serious structural failings of our social care system have been highlighted with a fragmented low paid delivery model, relying on rapid race to the bottom competition, funding linked to 15 minute visits, exploitative zero hour contracts, with staff employed directly through personal budgets and direct payments and in many case placing huge costs on the individual people receiving care and their families. The Labour commissioned Kingsmill Review in 2014 reported that between 160,000 and 220,000 Care Workers are unlawfully paid less than the National Minimum Wage, with an HMRC investigation into 80 Care Providers found that almost half (47%) were not compliant with National Minimum Wage regulations. Much of this was

because there was an estimated 307,000 Care Workers, or a fifth of the Adult Social Care Workforce, on 'Zero Hours Contracts' and there is little sign that this has changed despite greater awareness. There are 1.7 million, mainly women, workers in social care employed across a diverse range of largely private providers (around 40,000¹⁵⁰²), characterized by low pay, low skills, under-investment in training and development and high turnover of staff.

- 3.8. Unite is strongly advocating that as part of the full integration of the health and social care sectors that the social care workforce are brought into the same Agenda for Change pay and terms structure as NHS staff bringing them into the same career structures and national pay frameworks. This would go a long way to improving standards in the sector and would result in full meaningful integration.
- 3.9. Agenda for Change is currently being reviewed through NHS staff council and as part of these discussions Unite, along with other NHS unions, are calling for a joined up workforce strategy that works at a national, regional and local level. As it stands only Scotland has a centralised and mandatory workforce planning system in place, while in Wales there is a system in place but it does not focus on innovation in the same way. In England service transformation projects are varied and divergent, currently being driven through the Sustainability and Transformation Plans that are cloaked in secrecy with little staff or public engagement.
- 3.10. Given the absence of an effective national workforce plan, Unite alongside other Health Unions, are setting out a draft workforce strategy in our forthcoming staff side response to the Pay Review Body for 2017/18. Health unions believe that the following aims support and reward the improvement of staff productivity and will provide the basis for health and social care integration will help achieve ongoing improvement in the quality of patient care. The key aims include:
 - Changes to the Agenda for Change pay structure that make it simpler to explain, understand and operate;
 - Maintenance of the current NHS Job Evaluation system as the basis of Agenda for Change which delivers equal pay for work of equal value;
 - Support for healthy and safe workplaces with high quality employment practices and procedures which promote a good work-life balance, dignity at work, promotion and protection of employees' health, well-being and safety at work;
 - Job design which provides employees with autonomy and control and equitable access to training and learning and development opportunities for all employees;
 - Safe staffing levels with the right number of skilled professionals in the right settings
 - Promoting the NHS as an attractive place to work and an employer of choice, with good terms and conditions that support recruitment and retention of staff, motivating staff at all levels and supporting staff development and career progression underpinned by well-structured appraisals;

¹⁵⁰² *Care of Elderly People UK Market Survey 2010* (Laing & Buisson)

- Effective change management through engagement with trade unions locally and nationally and sound policies agreed jointly by employers and trade unions;
- Promotion of equality, diversity and inclusion;
- Promotion of the NHS as a learning organisation;
- A focus on leadership at all levels

4. Models of service delivery and integration

- **What are the practical changes required to provide the population with an integrated National Health and Care Service?**

4.1. Unite is a supporter of the NHS Reinstatement Bill¹⁵⁰³ that was successfully presented in the House of Commons, by Margaret Greenwood, Labour MP for Wirral West in July and is due a second reading on 4th November 2016. The Bill proposes to fully restore the NHS as an accountable public service by abolishing the purchaser-provider split, ending contracting and re-establishing public bodies and public services accountable to local communities. Scotland and Wales have already reversed marketisation and restored their NHS without massive upheaval and Unite believes that England can too. The Bill gives flexibility in how it would be implemented, led by local authorities and current bodies and Unite believes that this is the best model framework for the needed integration of Health and Social care.

4.2. Key elements of the Bill are:

- Reinstating the Government's duty to provide the key NHS services throughout England, including hospitals, medical and nursing services, primary care, mental health and community services, making Government fully accountable for the service and report on an annual basis.
- Integration of health and social care services, making it a truly universal service again (e.g. abolition of charges for immigrants)
- Exempting health and social care services from international trade agreements such as TTIP or CETA, cementing UK sovereignty over the delivery of health and care services,
- Abolishing the wasteful and unnecessary market structures (e.g. Monitor) and private sector contracts (including PFI) and bringing in planning and providing services without contracts through Health Boards, which could cover more than one local authority area if there was local support.
- The full integration of public health services, and the duty to reduce inequalities, into the NHS,
- Requiring national terms and conditions under the NHS Staff Council and Agenda for Change system for relevant NHS staff
- And the re-establishment of Community Health Councils to represent the interest of the public in the NHS.

¹⁵⁰³ <http://www.nhsbill2015.org/the-bill/>

- 4.3. It is also vitally important that resources are properly balanced and mental health services are given parity of esteem and funding. Currently one in four people experience mental ill health and it is estimated to cost the economy £100 billion annually through lost working days, benefits and treating preventable diseases. Yet only 13% of NHS spend goes on treating mental ill health. Britain has a mental health crisis and this government is making it worse through cuts in funding, services and support and by creating a more insecure society. Only 6% of spend on mental health is directed towards children and adolescents despite evidence that half of lifetime mental illnesses, excluding dementia, start by the age of 14.
- 4.4. Unite strongly believes that this needs to be addressed and a full reappraisal takes place that recognises the importance of mental health services, as well as placing prevention of mental ill health at the heart of our broader public health and social policy.

5. Prevention and public engagement

- **What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?**

5.1. Public health is the vital preventative arm of the NHS and as described above plays a crucial role in the future sustainability of our health service. From that perspective Unite was extremely concerned by the transfer of public health to English local authorities in 2013 because it felt there was the potential to fragment public health from the wider NHS and lead to substantial cuts due to local government's tighter budget constraints. It was also predicted to lead to cuts to staff terms and conditions as they were taken out of Agenda for Change.

5.2. Unfortunately, Unite's fears have been confirmed with Unite members reporting:

- swingeing cuts to public health services
- reductions in staff terms and conditions, training and pay
- poor morale and de-professionalisation
- loss of status, independence and innovation within the service
- false economies as reduced services and quality leads to greater costs in acute services down the line

5.3. Unite submitted evidence to the Health Select Committee last year¹⁵⁰⁴ on the urgent need for Public Health budgets and services to be protected. Solutions include making public health either an independent NHS body in its own right with the secretariat and governance provided by local authorities, employing them as part of Public Health England, or for the specialist workforce to hold their contracts within the NHS (eg. CCGs), whilst being based within a local authority.

5.4. The Health Select committee has recently published its findings to that investigation and echoed many of Unite's concerns. Unite recommends that the Lords Committee

¹⁵⁰⁴ https://apps.groupdocs.com/document-viewer/Embed/f55410dd6161821013a506b15355a7aea1fee22dbcd5d90fc8b7163373b0d870?quality=50&use_pdf=False&download=True&print=False&signature=KYLmyWr59IiAGw2MttwZKjz69VI

looks closely at the evidence provided to that committee and their conclusions¹⁵⁰⁵ as the current direction of travel is leading the NHS in completely the wrong direction.

6. What are the best ways to engage the public in talking about what they want from a health service?

- 6.1. Unite believes that there needs to be a careful balance taken between public engagement and the role of professional knowledge, clinical and scientific evidence. These two elements are not mutually exclusive and as discussed Unite is a supporter of the NHS Reinstatement Bill that offers some important solutions to the conundrum.
- 6.2. Unfortunately current practice is the worst of both worlds, with arbitrary decisions made about the health service either on political whims, using distorted evidence, or based on the advice of non-clinically trained management consultancies or market forces.
- 6.3. The current Sustainability and Transformation Plan process is a case in point. The NHS is being forced potentially to go through yet another top down reorganisation of services based on the political decision to underfund the NHS and frankly to find the £22 billion of efficiencies prescribed by the Government and enshrined by the Five Year Forward View. The reorganisation plans are being conducted outside of the statutory structures, with no consultation process and very little evidence. Neither staff nor their unions are involved in these plans and there are examples of local councillors being asked to sign them off without having read them. Those plans that have been leaked so far are extremely evidence light and make assumptions about the health of the local population and the possibility to make efficiency savings that would be considered nothing short of miracles. Without seeing all the content of the plans it is difficult to judge them all, but it is clear that the accountability processes being used are extremely poor. We are concerned by edicts from NHS improvement to ask Trusts and STPs to consolidate Pathology and back office functions. We believe this could amount to further outsourcing and privatisation and It remains unclear what would be the benefit to patients.
- 6.4. Unite is adamant that changes to the health service should never be done in a panic, they should be carefully planned, incremental and above all evidence led. The public and NHS staff are core stakeholders in this process and should be involved in evidencing necessary changes, rather than arbitrary decisions being made that staff and the public have to scramble to understand and in the worst cases mobilise local campaigns to prevent poor decisions.

23 September 2016

¹⁵⁰⁵http://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/140/14011.htm?utm_source=140&utm_medium=crbullet&utm_campaign=modulereports

University of Nottingham – Written evidence (NHS0069)

1. This submission has been prepared by Dr Penelope Siebert and Dr Paul Windrum, researchers for Centre for Health Innovation Learning and Leadership (CHILL), a research unit at the Nottingham University Business School. CHILL specialises in programme evaluation, and the translation and application of organisational and management research to contemporary problems in healthcare organisation and delivery. Evaluation projects and partner organisations include the NIHR, EU, RCUK and charities, and in applied health services research that includes Biomedical Research Units, NIHR CLAHRC East Midlands and the longstanding relationships with public, private, and third sector healthcare providers. Key evaluation projects range from change projects with local primary care commissioning groups to evaluations of national policy programmes, such as the Prime Minister’s Challenge Fund for Improving Access in Primary Care.
2. The sustainability of the NHS is becoming more dependent on the successful implementation of innovations aimed at improving efficiencies in terms of cost, quality of care and health outcomes. Effective implementation and evaluation of these innovations can only take place if the right resources and competences are present. Significant changes in the way innovations are implemented and evaluated in the NHS is necessary for it to continue to operate within its current financial constraints.
3. The CHILL evaluation of the GP-Access fund projects, piloted in Nottinghamshire and Derbyshire in 2014-15, identified that most staff lacked the resources and competences necessary to support the implementation and evaluation of innovations in primary care. Innovations in this context of this evaluation were regarded as the introduction of a change in service or new way for working in the CCG, practices, their staff and patients. In the case of the GP access fund pilots, CCG and practice staff were invited to introduce pilot projects, and have a key role in implementing and evaluating the impact of the pilots.
4. During our evaluation, CHILL found that CCG and practice staff were expected to manage the implementation process, and test the pilot projects alongside their clinical and primary health care roles and responsibilities. They drew on their existing of healthcare service commissioning, management and service evaluation knowledge and skills. Whilst these skills are appropriate for everyday administration and the management of established services, they were found not to be adequate to support the implementation and evaluation of innovations.
5. There was a lack of knowledge and understanding of the established principles of implementation and evaluation. Few individuals had the necessary leadership skills and change management expertise to lead implementation, and to act as innovation champions.

6. We found that key stages of the implementation process were missed, such as collecting and interpreting evidence required to inform and improve design, the selection of pilot projects, and to determine their suitability to achieve the desired outcomes. There were very few example plans in place to support the implementation process, or to monitor and manage the performance of pilots once they were up and running.
7. All project teams considered carrying out an evaluation but few had developed an evaluation plan, or used an evaluation approach to generate the information that would inform them of the effectiveness and cost effectiveness of their pilot projects. Furthermore, many project teams had not put in place effective methods for gathering data to support an evaluation of their pilot projects. As a consequence, teams were unable to independently assess or demonstrate whether projects were suitable for future development, scaling up, or could be fully rolled out.
8. Based on the findings of the evaluation it was recommend that investment in education and training to develop the skills and expertise around implementation and evaluation of innovations, similar to that currently provided for the development of leadership skills, is needed.

23 September 2016

Urgent Health UK – Written evidence (NHS0045)

Dear Lord Patel,

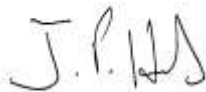
Re: Lord’s Select Committee Inquiry on the Long-Term Sustainability of the NHS

I am writing in my capacity as Chief Executive of Urgent Health UK (UHUK), a federation of 23 social enterprises providing primary care-led out-of-hospital urgent care, in response to the Committee’s inquiry into the long-term sustainability of the NHS, particularly in regard to models of service delivery and integration.

I would be delighted to provide oral evidence at one of the Committee’s sessions to discuss these important issues in greater detail. Furthermore, UHUK would welcome the opportunity to host Committee members on a tour of one of our member sites.

For more information about UHUK please visit <http://www.urgenthealthuk.com>. I hope you find the content of this submission informative. Please do not hesitate to get in touch if UHUK can be of any further assistance to the Committee.

Yours sincerely,



Dr. John Horrocks
Chief Executive, Urgent Health UK

1. ABOUT URGENT HEALTH UK

- 1.1 UHUK's 23 social enterprise members are experts in delivering a wide range of high quality out-of-hospital services, including out-of-hours, NHS 111, urgent care centres, GP led 8-8 practices, emergency and community dental services, community nursing and admissions avoidance schemes.
- 1.2 Our members provide a fit for purpose, value for money model whilst also delivering invaluable services for over 23 million patients. UHUK members currently provide 43% of the out of hours urgent GP services.
- 1.3 UHUK's members act as an integrator function, underpinning the wider health economy and providing 'whole care' coordination, which significantly improves patient experience. Our members already provide the 'wrap around service' for primary care, working collaboratively with in-hours providers.
- 1.4 The Care Quality Commission's (CQC's) report on the first comprehensive inspections of NHS GP out-of-hours services noted the external auditing and benchmarking used by UHUK members and described out of hours services, including many of our members, as "safe, effective, caring, responsive and well led.
- 1.5 In addition, our members offer a learning environment for GPs, nurses and medical students through urgent care programmes.
- 1.6 UHUK provides members with auditing and benchmarking, information and resources, a purchasing consortium, market intelligence, joint national representation initiatives and opportunities for staff development. This helps to ensure continuous learning and improvement.
- 1.7 Through their social enterprise model, UHUK members' approach is aligned with the values of the NHS; UHUK acts for the communities we serve and we are keen to see enhanced opportunities for social enterprises in the provision of healthcare.

2. RESOURCE ISSUES: FUNDING AND DEMAND MANAGEMENT

- 2.1 Our members have experienced a significant increase in activity, particularly over the winter period as patients were rightly being encouraged to refrain from attending A&E or dialling 999 except in emergencies. Whilst we are able to provide flexible initiatives during high pressure periods, we believe that there needs to be a greater focus on out-of-hospital urgent care so that our members' services are central to the NHS all year round. As nimble and responsive organisations, our members can care for patients who should not be attending A&E; however, these services require an appropriate level of resource and a system designed in a way that draws on the significant benefits of out-of-hospital urgent care. Policy makers must take a long-term view of the situation, and this is where our members can provide the greatest value to the NHS

- 2.2 UHUK calls on the Department of Health and NHS England to direct funding to out-of-hospital urgent care rather than supporting underperforming A&E departments. This will help to ensure a long-term sustainable solution for the system, allowing out-of-hospital urgent care to take on more activity and flourish.
- 2.3 Research indicates that a significant percentage of patients attending A&E present symptoms that would be more appropriately treated by General Practice. With this in mind, it is essential that “front ending” primary care teams are firmly supported and encouraged by the NHS. UHUK’s members are able to mobilise and respond to demand rapidly and make an important contribution to integrating services and providing a 24/7 health service.
- 2.4 The inclusion of out-of-hospital urgent care in the General Practice Forward View and Sustainability and Transformation Planning Guidance is positive, building on NHS England’s Urgent and Emergency Care Review. Our sector must be central to all of these and future important initiatives in order for the NHS to take a firmer grip on the current challenges.
- 2.5 In order to drive change, services must be commissioned in a way that fosters partnership working. Effective integration underpinned by genuine collaboration between providers and other key stakeholders requires longer-term contracts – seven years at minimum – than is typically the case in order to develop and embed partnerships and collaboration across local health economies.

UHUK urges the Department of Health and NHS England to direct further funding to out-of-hospital urgent care for the long-term rather than struggling A&E departments in the short-term in order to put in place a sustainable solution to avoid pressures arising in acute care.

UHUK urges commissioners of out-of-hospital urgent care to prioritise investment and resource for contracts to deliver out-of-hospital urgent care.
UHUK urges commissioners to design local services in a way that fosters partnership working, notably by tendering longer-term contracts of at least seven years.

3. WORKFORCE

- 3.1 The Committee is right to consider the issue of workforce; our members face a number of grave challenges which threaten to damage the invaluable services they provide. The General Practice Forward View, published by NHS England, rightly identified a number of these as a priority for the body; we hope to see progress over the coming months.
- 3.2 Crucially, workforce shortages in primary care must be addressed as an urgent priority. Shortages are stretching the current workforce, whilst patients do not always receive the best experience of care. Health Education England, NHS England and the Government’s plans to increase recruitment of trainee GPs is an important step, but

progress must be rapid to cope with the here and now, as well as long-term. We estimate that services will need the availability of 30% more GPs than currently work in these services.

3.3 In our view, part of the solution to easing workforce pressures should include a broadening of the primary health care team to include more Advanced Nurse Practitioners, Paramedics, Pharmacists and Physician Associates. Expanding the skill mix will enable the right treatment in the right place at the right time.

3.4 An issue that is deterring current staff from undertaking GP-led out-of-hours shifts is the unsustainable cost of clinical indemnity. The results of a previous UHUK survey revealed that, of 430 GPs, 79% said that indemnity fees are limiting the number of out-of-hours shifts they undertook, whilst 68% suggested that they would reduce or stop undertaking shifts if fees rise significantly this year.

3.5 We welcome NHS England's willingness to engage with UHUK on this important topic, and the announcement in July of interim arrangements to provide support to GPs on the cost of indemnity is a positive step. It is crucial that a long-term solution is put in place that works for all parties, such as fundamental reform of claims laws.

UHUK urges NHS England, the Department of Health and Health Education England to take further steps to increase the recruitment and retention of GPs.

UHUK urges NHS England, the Department of Health and Health Education England to take steps to broaden primary health care teams to expand the skill mix.

UHUK urges NHS England and the Department of Health to put in place a permanent and appropriate solution to the rising cost of clinical indemnity.

4. MODELS OF SERVICE DELIVERY AND INTEGRATION

4.1 UHUK's members are delivering and designing other innovative models of urgent and emergency care services, working with hospitals and other partners. A high quality primary care sector is central to the successful implementation of the Five Year Forward View.

4.2 UHUK is firmly supportive of NHS England's focus on developing new models of care. The announcement of urgent and emergency care networks vanguards is an important step, and will support the joining up of services. Some of UHUK's members are involved in the important work of the vanguard sites in moving towards fully integrated and co-ordinated locality based services. It is essential the out-of-hospital urgent care sector is supported to play its role in this agenda.

4.3 We are also supportive of NHS England's desire to see the development of clinical hubs to coordinate urgent and emergency care. This is very much aligned with UHUK's position statement published in November 2015 and available on our website.

4.4 Some UHUK members are taking the lead to drive forward the roll-out of clinical hubs. The potential is significant and will help to proactively manage demand to take activity away from A&E, and into primary care closer to the community.

4.5 Furthermore, co-locating primary care services with A&E would ensure patients are seen in the right place at the right time. There are a range of different forms of co-location. However, progress is hampered by one area of the tariff system; reform is required to breakdown disincentives and encourage this type of innovation. In the past, Emergency Departments have been obliged to cross subsidise from the treatment of more minor illness and injury streams in order to reduce net revenue deficits.

4.6 Furthermore, a greater focus on new models requires integrated IT systems, which has long been a barrier to progress. Currently, joining up systems is complex and costly. We believe a set of agreed interoperability standards, similar to the Interoperability Toolkit for NHS 111, would be beneficial. It is important that the system embraces technology and makes use of the vast amount of data in the NHS. UHUK members will be better equipped to enhance services if progress is made on this issue.

UHUK urges vanguard sites to engage with providers of out-of-hospital urgent care in order to put in place sustainable arrangements to deal with patients.

UHUK urges NHS England to publish further guidance on examples of best practice in urgent and emergency care to support commissioners and providers.

UHUK urges NHS England and the Department of Health to overhaul the elements of national tariff that hinder co-location models.

UHUK urges NHS England to develop interoperability standards to join up IT systems in urgent and emergency care.

21 September 2016

Vanguard Healthcare – Written evidence (NHS0095)

I am writing in my capacity as Chief Executive of Vanguard Healthcare to provide evidence to the Select Committee on the Long-Term Sustainability of the NHS, which is set out below. We welcome this important work and would relish the opportunity to provide evidence during future sessions.

Yours sincerely,

Ian Gillespie
Chief Executive

1. ABOUT VANGUARD HEALTHCARE

- 1.1 Vanguard Healthcare is the leading supplier of high quality portable surgical health centres to the NHS. For over fourteen years, Vanguard has worked in partnership with NHS providers to improve patient access. We have supported nearly half of all NHS acute trusts in England enabling over 235,000 procedures to be performed by NHS clinicians within our centres.
- 1.2 Vanguard supports NHS organisations by offering total flexibility in the location and duration of hire of our state-of-the-art facilities, equipment and qualified nursing and operating department practitioner teams. Using this service NHS clinicians can lead initiatives to attend to a wide range of clinical specialities.
- 1.3 We are committed to supporting healthcare systems and are confident our solutions can make an important contribution to the Committee’s work on the NHS’s sustainability. Crucially, helping our partners to navigate ongoing priorities, but also, over time, we believe that portable surgical health centres can play an even greater role by being adopted in a community setting.

2. RESOURCE ISSUES

- 2.1 Portable surgical health centres can, and do, help providers manage demand more effectively – the pressures of high waiting times are not going away any time soon. Vanguard welcome the current efforts being made to meet the ‘must-dos’ of the Sustainability and Transformation Plan process, notably, adhering to referral to treatment targets. It is positive that the Government and NHS England has recognised that missing these targets on a regular basis is putting substantial strain on the system and impacting on patient care; portable surgical health centres can provide an immediate fix, offering a flexible solution which can be used for days or years at a time.

- 2.2 Moreover, they can be provided with or without qualified nursing and operating department practitioner teams and can be moved across different locations as required. It is important to recognise that patient demand will always be unpredictable and with an ageing population and increasing strain on the system, it is paramount that long waiting lists are dealt with now.
- 2.3 As well as enhancing access to care, there is a clear financial benefit to using portable surgical health centres. Portable surgical health centres allow providers to maintain control of the patient pathway, thus, keeping funds in the NHS system. By using portable centres, trusts can therefore improve their underlying financial and clinical performance by delivering increased volumes of elective activity, whilst generating additional revenue that otherwise may have been lost if outsourced to the private sector. The NHS financial re-set underlined the urgent need to make use of solutions that protect and increase limited resources, both for trusts and Clinical Commissioning Groups; portable surgical health centres must be considered as a long-term viable solution to support NHS partners.
- 2.4 In addition, inefficient use of estates and activity taking place in inappropriate settings are two significant issues that must be addressed if the NHS is to overcome its £22bn efficiency challenge. Portable surgical health centres can make a significant contribution to solving both and put the NHS onto a more sustainable footing long-term. Physically increasing the NHS's capacity takes millions of pounds, years of planning and months of building; that is only once the complex planning process has been navigated. This is no longer sustainable; a more flexible healthcare system makes capacity management more sustainable long-term. Buildings will consistently need to be reconfigured to meet patient demand and the nature of 'bricks and mortar' means that the capacity of facilities in the NHS currently is fixed, so this begs the question of what to do when they reach capacity.

3. MODELS OF SERVICE DELIVERY AND INTEGRATION

- 3.1 Responding to short-term urgent capacity management is crucial during high pressure periods; however, challenging patient demand has become a 365 day task, and ultimately the system needs to explore new and innovative ways of working to ensure the long-term sustainability of the NHS.
- 3.2 Vanguard commends the continued efforts to encourage and foster integration through new models of care across the country – we view our solutions as an enabler of new and improved ways of working fit for the 21st Century. This important work must continue to deliver a health service that is sustainable for the long-term. Health portability is a unique model of community healthcare delivery allowing providers of all types and sizes to offer a range of surgical procedures previously unachievable outside of acute hospitals. This flexible solution for healthcare delivery should be promoted as a key facet of future plans for service transformation and the development of integrated new models of care, which require community services and primary care working at scale.

- 3.3 Health portability can give providers, from GP surgeries to community hospitals, an unparalleled level of autonomy – with the option to offer a range of clinical services previously unseen in a community setting. New models of care, notably multispecialty community providers, require primary care at scale in order to breakdown the historical dominance of hospitals over activity – portable surgical health centres make this achievable. The General Practice Forward View places great importance on primary care providers; portable surgical health centres can enable these organisations to meet expectations and fulfil their potential. Crucially, this flexibility will help to ease pressure on the most challenged parts of the local health economy, whilst patients will receive timely treatment closer to home. In a system faced with an ageing population and growing number of multiple long-term conditions, care closer to home must be a vital principle for the future model.
- 3.4 A barrier facing the roll out of new models of care is the current estate, which is not fit for the new models being explored. As referenced earlier, increasing the NHS's capacity is a costly and unsustainable process. Portable surgical health centres make service redesign easier and more sustainable long-term.

Our recommendation to the Committee would be for the Department of Health, NHS England and NHS Improvement to encourage the use of portable surgical health centres as a core solution to the challenges facing the NHS.

23 September 2016

Voluntary Organisations Disability Group – Written evidence (NHS0119)

Key messages

The future of the NHS and that of social care are inextricably linked. A sustainable NHS is predicated on a sustainable social care system.

People are using care services at a time of unprecedented demographic changes and financial austerity. Fewer and fewer disabled people are eligible for services and unmet need is on the rise. A return to investment in preventative services is necessary to stem this trend.

The continued squeeze on fees has led to social care markets, worth over £43 billion per year, being fragmented and unstable. Without adequate funding providers will exit the market, increasing pressure on the NHS as demand for emergency and hospital services rises.

Sustainable funding for the social care sector will enable disability organisations to invest in their people – to further build careers in the sector, to recruit and retain the right staff and to pay the workforce at a rate which recognises the value of the work they do in society.

Not-for-profit social care providers should be engaged in the development of Sustainability and Transformation Plans (STPs). They need clear routes for engaging with Clinical Commissioning Groups (CCGs).

There is further scope for supporting people with complex needs in social care, rather than NHS settings, assuming this provision attracts realistic funding.

Significant up-front investment is needed in order to mainstream technological developments in social care which can generate long-term savings, but local authorities rarely commission these solutions.

Introduction

1. VODG (Voluntary Organisations Disability Group) is a national charity that represents leading not-for-profit organisations who provide services to disabled people in ways that promote independence, choice and control. Our members work with around a million disabled people, employ more than 85,000 staff and have a combined annual turnover in excess of £2.5 billion. Though diverse in terms of their size, history and individual strategies, our members share common values. These are clearly discernible through work that promotes the rights of disabled people, approaches to citizenship, user choice and control and in successfully delivering person-centred services.

2. VODG works on behalf of members to influence the development of social care policy, build relationships with government and other key agencies, promote best practice and keep members up to date on matters that affect service delivery. Our overarching aim is to ensure that VODG members, working in partnership with commissioners, people who use services and their families can provide progressive, high quality and sustainable services that reflect *Think Local, Act Personal*¹⁵⁰⁶ principles, uphold rights and meet the requirements of disabled people.
3. VODG welcomes the opportunity to submit this representation to the Select Committee on the sustainability of the NHS. We use this submission to draw out those issues most relevant to voluntary disability care and support providers and to the people they support.

Context

4. There are 9.9 million disabled people living in England who represents 19 per cent of the overall population¹⁵⁰⁷. This includes a significant number of working age adults who require support with their mental health, physical disability, or who have learning and social or behavioural impairments.
5. The Centre for Disability Studies¹⁵⁰⁸ estimates the growth in the numbers of adults with physical and learning disabilities:
 - Support will be required for an additional 6,000 to 46,000 young adults with physical disabilities over ten years. This equates to a ten-year growth rate of between 32% and 239%.
 - Between 37,000 and 52,000 adults with learning disabilities will require support over the next ten-year period, resulting in a growth rate of 26% to 37%.
6. Alongside these ‘working age’ trends, the number of older people is rising. The latest Census data demonstrate 9.2 million older people aged 65 years and over, with 52 per cent of people living with a long-term health problem or disability. This includes a far greater proportion of the population aged 85 and over.

The future healthcare system

7. The future of the NHS and that of social care are inextricably linked. A sustainable NHS is predicated on a sustainable social care system. A social care system that is working well:
 - Prevents hospital admissions by helping people to live healthy lives
 - Responds quickly and supports people to access health services appropriately if they become unwell
 - Enables people to leave hospital as soon as they are ready

¹⁵⁰⁶ Think Local, Act Personal www.thinklocalactpersonal.org.uk/

¹⁵⁰⁷ Department for Work and Pensions (2015) *Family resources survey*. Accessed: www.gov.uk/government/uploads/system/uploads/attachment_data/file/437481/family-resources-survey-2013-14.pdf

¹⁵⁰⁸ Centre for Disability Studies (2012) *Estimating the need for social care services for adults with disabilities in England 2012-2030*. Lancaster: University of Lancaster.

8. Therefore we believe that the following steps will contribute to enabling the NHS to respond effectively to demographic changes described above:
- Delivering a fair and sustainable deal for social care providers
 - Enabling more people to be treated at home by:
 - Better integration of services
 - Better equipping social care staff to support people with complex health conditions
 - Increased take up of technology to support people to maintain their independence and stay well at home
 - Continuing to recruit both qualified and unqualified staff from within the EU¹⁵⁰⁹

Resources issues

9. Pressures which are currently impacting on charitable care and support providers are:
- Cuts in public sector spending
 - Increasing costs associated primarily with the introduction of the national living wage, pensions auto-enrollment, apprenticeships levy, regulation and red tape and other pressures
 - Approaches to public sector commissioning
 - Staff recruitment and retention
 - Public perceptions of care services
10. Funding to support disabled and older people has been significantly reduced since 2010. In the five years to 2015/16 local authority funding of adult social care reduced by £4.6 billion (a 31% reduction in net budgets). In 2015/16, 82% of directors of adult social services report that the quality of care is compromised as a result of these savings being made.
11. The continued squeeze on fees for services is leading to an ever widening gulf between the real costs of delivering care and that which commissioners are prepared, or able, to pay for. For 2016/17 directors of adult social care report that they plan to make further savings of £941m or 7% of the overall budget. They estimate that a quarter of these savings will come from *cutting services or reducing personal budgets* for those people who receive care and support¹⁵¹⁰. Insufficient funding is resulting in fragmented social care markets, and councils struggling to manage the market.
12. The 2015 Autumn Statement enabled local authorities to raise council tax by 2% for adult social care in 2016/17. This has meant a slight rise in the overall budget. However the Association of Directors of Adult Social Services (ADASS) calculates that this raises less than two thirds of the overall costs of implementing the national living wage¹⁵¹¹.

¹⁵⁰⁹ VODG is a member of the Cavendish Coalition which is committed to working together to ensure a high calibre workforce for the NHS and social care through both domestic and international recruitment; see <http://www.nhsemployers.org/your-workforce/need-to-know/brexit-and-the-nhs-eu-workforce/the-cavendish-coalition>

¹⁵¹⁰ Association of Directors of Adult Services (ADASS 2016) *ADASS budget survey 2016*. Accessed www.adass.org.uk/budget-survey-2016/

¹⁵¹¹ Association of Directors of Adult Services (ADASS 2016) *ADASS budget survey 2016*. Accessed www.adass.org.uk/budget-survey-2016/

Meanwhile not-for-profit providers have received no additional funding to offset increased take up in pensions as a result of pension auto-enrollment.

13. The Local Government Association and Association of Directors of Adult Social Services estimate a £4.3 billion funding gap in adult social care by the end of the decade¹⁵¹². In this context providers experience the real tension between delivering high quality of care in a sustainable way at a price that is affordable for commissioners. They are increasingly concerned that this will lead to the closure of services which have become financially unviable. Without adequate funding voluntary organisations may exit the market completely causing further market instability, negatively impacting on the lives of the many people who use their services and increasing pressure on the NHS. This is not inevitable, but the situation is urgent.

Workforce

14. Skills for Care (SfC) estimate that 1.2 million people work in direct care roles in England¹⁵¹³, with some 60,000 vacancies at any one time and an overall turnover rate of 25.4%. Providers report many reasons for challenges in the recruitment and retention of staff. A key aspect is the increasing complexity of the needs of people who use services. This means that social care work is becoming more skilled and specialised, in an industry that is still relatively low paid.
15. Recruitment and retention issues are compounded by the demographic demands identified earlier. A 2015 report from the Centre for Workforce Intelligence¹⁵¹⁴ estimates that the workforce will need to increase by 41% over the next 20 years to meet increasing demand from people with disabilities. This increases to 51% for people with a learning disability.
16. There is concern amongst providers about the instability that may result from the decision for Britain to leave the EU. There are an estimated 80,000 EU migrants filling 6%¹⁵¹⁵ of jobs in the social care in England. A VODG report on the impact of Brexit¹⁵¹⁶ provides a more detailed discussion of the likely implications of this.
17. The negative media representations of the care sector are perceived as a further barrier to those seeking employment, particularly with regards to the low status given to it. A report from Bournemouth University¹⁵¹⁷ suggests that:

¹⁵¹² Local Government Association and Association of Directors of Adult Social Services (2014) *Adult social care funding: 2014 state of the nation report*. Accessed: www.local.gov.uk/documents/10180/5854661/Adult+social+care+funding+2014+state+of+the+nation+report/e32866fa-d512-4e77-9961-8861d2d93238

¹⁵¹³ Skills for Care (SfC 2016) *The size and structure of the adult social care sector and workforce in England, 2016*. Accessed: www.nmds-sc-online.org.uk/Get.aspx?id=971293

¹⁵¹⁴ Centre for Workforce Intelligence (CfWI 2015) *Forecasting the adult social care workforce to 2035*. Accessed: www.cfwl.org.uk/publications/forecasting-the-adult-social-care-workforce-to-2035-workforce-intelligence-report/@@publication-detail

¹⁵¹⁵ NMDs-SC data. Accessed: www.nmds-sc-online.org.uk/reportengine/GuestDashboard.aspx?type=AgeBand

¹⁵¹⁶ VODG (2016) Post-Brexit: What next for voluntary sector disability organisations? Accessed: www.vodg.org.uk/news/476/111/A-focus-on-the-future-new-VODG-report-on-the-impact-of-Brexit.html

¹⁵¹⁷ Bournemouth University (2015) Pathways to recruitment: perceptions of employment in the health and social care sector. Accessed: www.ncpgsw.com/publications/pathways-to-recruitment/

“At a national level, more needs to be done to value those who work in the care sector by highlighting the benefits and rewards of care sector employment and not just the negative aspects of this type of work. Raising the status of the care sector through the provision of career progression pathways, clear qualification requirements, and enhanced pay levels would help to inspire future workers to join the sector”.

Models of service delivery and integration

18. As social care providers we share many of the same concerns as our NHS partners, including improving health and wellbeing and the outcomes of care services. We are concerned that STPs are being developed without the involvement of the voluntary sector, although not-for-profit providers will be integral to delivering them.¹⁵¹⁸
19. Over the last few years there has been much discussion about developing more out-of-hospital services, but we have seen little progress in this area. Social care providers regularly express extreme difficulty to us in engaging with CCGs and need clear routes for doing so. For more information see VODG’s report on *What can the voluntary sector do to encourage greater engagement and collaboration with the health system?*¹⁵¹⁹

Prevention

20. New technologies are enabling provider organisations to improve the efficiency of their back office functions and are making a significant difference to the wellbeing and autonomy of people who use services. VODG members support disabled people to access and use a wide range of personalized technology such as telecare, environmental controls, communication aids and prompting devices.
21. However, there is a dilemma around mainstreaming technological developments; innovation requires significant up-front investment, which can generate long-term savings, for instance by reducing a person’s reliance on paid staff. But local authorities rarely commission these technological solutions. VODG has called on local authorities to commission services based on outcomes delivered through the whole life of a contract rather than fixed hourly rates¹⁵²⁰. This would give providers the confidence to invest in technologies that can simultaneously improve quality of life and reduce long-term care costs.

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¹⁵¹⁸ Kings Fund (2016) Separating the noise of contract negotiations from the signal of STPs. Accessed: <http://www.kingsfund.org.uk/blog/2016/04/contract-negotiations-stps>

¹⁵¹⁹ VODG (2016) *What can the voluntary sector do to encourage greater engagement and collaboration with the health system?* Accessed: <http://www.vodg.org.uk/uploads/pdfs/2016%20What%20can%20the%20voluntary%20sector%20do%20to%20encourage%20greater%20engagement....pdf>

¹⁵²⁰ VODG (2016) *Technology is changing the way we live. Can it also transform the way we deliver adult social care?* Accessed www.vodg.org.uk/uploads/pdfs/2016%20VODG%20technology.pdf

Walgreens Boots Alliance – Written evidence (NHS0120)

Executive summary

- The NHS need to become a system that is focused on ensuring that **all citizens remain in a state of good physical and mental wellbeing**, anticipating and preventing poor outcomes
- Community pharmacies will have a central role to play in delivering services that focus on maintaining and improving health among wide populations
- As well as prevention, there is a clear need for **more demand management** in the short term. A national minor ailment and advice service, provided by community pharmacies and including referrals from NHS 111 and GP surgeries has the potential to manage demand and save £1bn a year
- While many healthcare professional are grappling with workforce shortages, pharmacy is currently producing a potential excess of graduates. This offers a real opportunity to **reallocate work**, taking much broader view of productivity, demand management and resource use will ensure that patients get timely treatment, advice and support in the most convenient locations
- Health Education England (HEE) funding should be available to all organisations providing NHS services and should be made available to support protected learning time for healthcare professionals
- The NHS needs to have a clear ambition to **deliver evidence-based preventative services at scale** across the whole of the country, rather than relying on fragmented local service commissioning
- Walgreens Boots Alliance would be willing to give oral evidence to discuss these issues in detail and to describe the work our pharmacies are involved in.

Responses to Questions

1. Q1. How must the health and care systems change to cope by 2030?

- 1.1. The future for the NHS and the wider health and care system has long been clear – it needs to become a system that is focused on ensuring that **all citizens remain in a state of good physical and mental wellbeing**, anticipating and preventing poor outcomes, moving away from being a system that just focuses on picking up the pieces. Clear political will, including allocation of funding, is needed to achieve this.
- 1.2. The *NHS Plan* (2000) recognised this, stating an aim that “the NHS will focus on preventing as well as treating ill health”. This was followed by a series of reports by banker and economist Derek Wanless (2002-2004) saying that the UK should aim to have a population “fully engaged” with its own health and a greater focus

on prevention if it wanted to avoid an unaffordable spiralling of costs across the NHS and social care systems.

- 1.3. Regrettably, these warnings were not heeded. The *Five Year Forward View* (FYFV, 2014), published by NHS England and its partners, following nearly half a decade of flat funding for the NHS, notes that the current NHS is now “on the hook” for failing to address prevention. “The sustainability of the NHS and the economic prosperity of Britain all now depend on a radical approach to prevention,” the FYFV says.
 - 1.4. Community pharmacies, supported by their supply chain partners, will have a central role to play in delivering services that focus on maintaining and improving health among wide populations. Wanless (2002) set out a vision of a sustainable future in which “patients seek more advice from pharmacists who handle routine prescribing and help manage their medicines effectively”. We support this.
 - 1.5. There are more than 14,000 community pharmacies widely distributed across Great Britain, covering all socio-demographic areas and in all the places where people live, work, shop and travel. Most are open for long hours, including weekends, providing great accessibility to free healthcare advice as well as NHS and private services.
 - 1.6. Community pharmacies are visited by millions of people every day, most of whom do not consider themselves to be ill. Pharmacies range from small businesses serving local communities through to the largest destination stores that draw in custom from across whole regions. Their highly trained staff, including many registered healthcare professionals, play a vital role in delivering services that enhance public health at scale and in volume. This provides an ideal platform from which to build a more preventative health and care service.
 - 1.7. As well as prevention, to reduce costs in the long term, there is a clear need for **more demand management** in the short term. It is regrettable that, in the public mind, the answers to every medical problem now appear to be “Ask a GP” or “Visit A&E”, two of the more expensive ways of seeking advice, especially for minor and self-limiting conditions. A national minor ailment and advice service, provided by community pharmacies and including referrals from NHS 111 and GP surgeries, has the potential to manage demand and save £1bn a year.
- 2. Q2a. Does the wider societal value of the healthcare system exceed its monetary cost?**
- 2.1. Given the size of the NHS, in terms of its budget and its wider contribution as an employer and major purchaser of goods and services, we believe that it could be very difficult to effectively estimate the wider value of the NHS to society as a whole. However, it is possible to look at parts of the NHS in isolation as an indicator.
 - 2.2. A new report on the social value of community pharmacy (2016), compiled by PricewaterhouseCoopers LLP (PwC) for the Pharmaceutical Services Negotiating Committee (PSNC), provides evidence that the pharmacy and health services delivered by pharmacies produce a **net increase in value to society of £3bn in a year**, with a further £1.9bn in benefits over the following two decades.
 - 2.3. PwC collected information on 12 services. These cover public health issues such as supervised consumption of treatments for drug users, and emergency hormonal contraception (EHC); support for self-care and treating minor ailments; and medicines optimisation work around managing prescribing errors, managing

medicines shortages and making emergency supplies. These services are delivered in addition to pharmacies' core role in the safe and efficient supply of prescription medicines.

- 2.4. By delivering these services through pharmacies, gross costs of £1.77bn were avoided by the NHS and £1.25bn by other parts of the public sector. Avoided costs included inappropriate use of other staff time (eg, GP appointments); avoided treatment or compensation costs where prescribing errors were addressed before they reached patients; and improved wellbeing, time savings or value of life for patients, carers and wider society. These savings of £3bn are larger than the total funding for community pharmacy services, including dispensing, of around £2.8bn annually.
- 2.5. It is clear from this that the NHS needs to focus more funding on providing services that have positive benefits for the rest of the NHS and wider society, as well as providing direct benefit to individual patients. Services that help prevent disease, promote healthy lifestyles and identify diseases at much earlier stages (so as to gain the most future benefit from treatments) would all fall in to these categories. The Community Pharmacy Future programme (2014), a collaboration between the largest pharmacy chains, has provided clear evidence that community pharmacies can deliver such services at scale right across the country. The current phase of this work is focusing on empowering patients to achieve self-selected health goals working towards the Wanless vision of a "fully engaged" and activated population.

3. Q3. What are the requirements of the future workforce and how can the supply of key groups of staff be optimised?

- 3.1. While many healthcare professional are grappling with workforce shortages, pharmacy is currently producing a potential excess of graduates. From an NHS point of view, this offers a real opportunity to **reallocate work** in ways that will address current workforce issues, such as in general practice.
- 3.2. This is not simply a case of moving a few services from GP surgeries to community pharmacies (which could happen) or putting a few pharmacists in to GP surgeries (which will take time to roll out across the whole country).
- 3.3. A much **broader view of productivity, demand management and resource use** will ensure that patients get timely treatment, advice and support in the most convenient locations in ways that will impact positively on wider society. The key aim should be to keep the population as healthy as possible and to offer support and treatments in ways that keep patients mobile, economically active and resident in their own homes for as long as possible, as well as supporting the rising number of carers. Supporting large numbers of people in community pharmacies, at much earlier stages, will release time for GPs to take on work currently done in hospitals.
- 3.4. Pharmacists should be seen as a hinge point and a vital link between primary and secondary care, facilitating joined-up, patient-centred care before and after hospital admission. Shared access to patient records (see Para 6.7) and better use of IT infrastructure already in place, such as electronic Repeat Dispensing (eRD), will enhance this pivotal role.

- 3.5. The *Community Pharmacy Forward View* (2016) published by Pharmacy Voice, PSNC and endorsed by the English Pharmacy Board of the Royal Pharmaceutical Society, sets out a vision of how this could happen.
- 3.6. Pharmacy technicians are another group of registered healthcare professionals that are currently underused, both in hospital and community settings. It is clear at present that the NHS is not training enough pharmacy technicians within the hospital sector. This leads to cross-setting recruitment of community technicians, reducing the ability of community pharmacies to develop enhanced roles for both pharmacists and technicians that would help deliver the new services set out earlier in this submission. There needs to be a more realistic estimate of the number of pharmacy technicians needed in both settings.

4. Q4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

- 4.1. Health Education England (HEE) funding should be **available to all organisations providing NHS services** to the public, not just NHS bodies. As well as supporting the basic training of new entrants, this funding should be made available to **support protected learning time** for healthcare professionals providing NHS contracted services. This will help support continuing fitness to practice as well as giving opportunities to identify research and innovation.
- 4.2. There is a need to consider the broad mix of skills that are available to the NHS and across different settings. Frontline staff need a broad mix of skills that allow them to identify and support less serious conditions while making internal or external referrals of more serious cases. These staff would then be supported by healthcare professionals with more specialist knowledge who are able to handle follow-up and ongoing management of cases referred to them.
- 4.3. There are core skills around communication, record keeping and resource management that all healthcare staff need, but there will always be a need for deep knowledge and experience in specialist areas – such as pharmacists have in the use of medicines.

5. Q5. Models of service delivery and integration

- 5.1. We have no comment to make.

6. Q6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

- 6.1. If the NHS is to “get serious about prevention”, as set out in the FYFV (2014), then it needs to have a clear ambition to **deliver evidence-based preventative services at scale** across the whole of the country, rather than relying on fragmented local service commissioning.
- 6.2. The PwC/PSNC report on the value of community pharmacy illustrates clearly the drawbacks of local commissioning in this respect. Even the best value public health services are not universally available across England – emergency hormonal contraception is only available through pharmacies to an estimated 86% of the population, needle and syringe exchange to 73% and supervised

- consumption to 86%, even though there is no suggestion that these services are not needed in the remaining parts of the country.
- 6.3. Local commissioning also means that efficiencies of scale cannot be realised – there are variations in training and reporting requirements, and in levels and methods of payment. The lack of universal coverage reduces opportunities for effective promotion that would raise awareness among potential service users, which is especially critical for time-sensitive services such as emergency contraception or services aimed at hard-to-reach groups who are not in regular contact with other parts of the NHS.
 - 6.4. We want to see a more **evidence-based approach to commissioning decisions**, as well as “tipping points” where it is recognised that commissioning should move to a national basis using agreed common standards. This could apply once, for example, more than half of local authorities or clinical commissioning groups (CCGs) are commissioning a similar service.
 - 6.5. Effective prevention requires changes in public behaviour that can take decades to work through the population. Previous examples of this include smokers falling from around 50% of adults in the 1950s to below 20% at present, and the use of seat belts in cars becoming an unconscious action that is almost universal among drivers and passengers. This requires clear messaging (“smoking is bad for you”/“clunk-click, every trip”) that is easy to understand and which is repeated widely and consistently over many years.
 - 6.6. Community pharmacies are situated at the heart of the local communities they serve. Many pharmacy businesses, like Boots, pre-date the NHS by some considerable time. They are widely recognised as an authoritative source of free healthcare advice and the place to go for support with healthcare. They will have a major role to play in delivering health promoting services and advice that helps local populations to make long-term changes towards living healthier lives.
 - 6.7. Effective **sharing of patient information and clinical records** – with all the necessary security and consents – will make a big difference to both patients and healthcare professionals. Patients should be able to “pick up where they left off” when moving between healthcare professionals, not having to tell their stories over and over again. This would reduce or eliminate unproductive time right across health and social care.
 - 6.8. The *Community Pharmacy Forward View* identifies three core areas where community pharmacies can contribute to maintaining the health of the public and delivering efficiencies that support the sustainability of the NHS:
 - **Supporting public health** as the neighbourhood health and wellbeing hub, providing public health services, brief interventions and healthy living advice
 - Being the trusted, convenient **first port of call for episodic healthcare advice** and treatment, including minor ailments, and being part of urgent care pathways
 - Facilitating **personalised care for people with long-term conditions**, with a particular focus on supporting the safe and optimal use of medicines
 - 6.9. The NHS needs to invest in services that are aimed at preventing and maintaining health and wellbeing across wide populations, including primary care and public health services delivered by community pharmacies, and building a healthier

future. It will never be sustainable to simply focus all its time, energy and money on supporting services designed primarily to “patch and mend” today’s problems.

- 6.10. Walgreens Boots Alliance would be willing to give oral evidence to discuss these issues in detail and to describe the work our pharmacies are involved in.

7. Walgreens Boots Alliance

- 7.1. Walgreens Boots Alliance is the first global pharmacy-led, health and wellbeing enterprise. We have a presence in more than 25 countries and interests in all aspects of the medicines supply chain, from manufacturing, pre-wholesale and wholesale through to community pharmacies and pharmaceutical services for patients.
- 7.2. Within the UK, our operating businesses include Almus (generic medicines), Alloga (pre-wholesale), Alliance Healthcare (full-line wholesale), Alcura (specialty medicines) and Boots UK (community pharmacy).
- 7.3. Operating from 12 Service Centres across the UK, Alliance Healthcare has over 1,000 delivery vehicles reaching more than 16,500 community pharmacies, dispensing doctors and hospital dispensing points twice a day. We engage a team of 5,300 dedicated people who deliver over 2.2 million products daily.
- 7.4. Boots operates the largest chain of community pharmacies in the UK. It is synonymous with pharmacy in the public mind and is one of the country’s most trusted brands. We have over 2,500 health and beauty stores in the UK, most of which include a pharmacy.¹⁵²¹ Our pharmacies dispense over 220 million NHS prescription items every year and provide a wide range of other NHS and private pharmaceutical services.
- 7.5. As a business, we have a clear interest in the long-term sustainability of the NHS, both as our largest customer and as a vital part of the fabric of the society that we operate within. We are pleased to respond to the call for evidence.

8. References

- 1) *“The NHS Plan: a plan for investment, a plan for reform”*, Department of Health, July 2000 [Cm 4818]
- 2) *“Securing our future health: taking a long-term view: final report”*, Derek Wanless, HM Treasury, April 2002
- 3) *“Five Year Forward View”*, NHS England, October 2014
<https://www.england.nhs.uk/ourwork/futurenhs/>
- 4) *“Community Pharmacy Forward View”*, Pharmacy Voice, August 2016
<http://pharmacyvoice.com/forwardview/>
- 5) *“The value of community pharmacy”*, PricewaterhouseCoopers LLP for PSNC, September 2016
<http://psnc.org.uk/our-news/pwc-report-quantifies-value-of-community-pharmacy/>
- 6) Community Pharmacy Future project
<http://www.communitypharmacyfuture.org.uk/>

Evidence submitted on behalf of Walgreens Boots Alliance by:

¹⁵²¹ Figures from Walgreens Boots Alliance Annual Report for year ending 31st August 2015, excluding equity method investments

Walgreens Boots Alliance – Written evidence (NHS0120)

Jonathan Buisson MFRPSII MRPharmS
International Pharmacy & Policy Manager
Walgreens Boots Alliance

23 September 2016

Wellcome Trust – Written evidence (NHS0051)

Key points

- A vibrant research and innovation culture is critical to a sustainable healthcare system that meets the needs of patients.
- Measures are needed to reaffirm the NHS as a unique asset and world leading place for research and innovation. These include improving workforce training and public confidence, and streamlining research and innovation systems.
- To realise the benefits of new technologies such as genomics and ‘big data’, there must be robust dialogue with the public and training and resource for the NHS workforce.

Introduction

1. Wellcome is the UK’s largest charity. Over the next five years, we plan to invest up to £5 billion in biomedical research and the medical humanities. We are pleased to respond to this inquiry on the long-term sustainability of the NHS. Given Wellcome’s position as a funder, our response focuses on how a thriving environment for research and innovation will benefit the health service in the long-term.

Future Healthcare, Resource & Productivity

1. As NHS resources are stretched by chronic disease and an ageing population, research and innovation have a critical role to play in developing new interventions; testing whether they are effective; rolling out those offering the greatest benefits for patients; and stopping less productive, potentially wasteful, practices. Research and innovation will therefore be central to an effective, evidence-informed and sustainable healthcare system.
2. The NHS is one of the UK’s unique assets and could be one of the best places in the world to trial and launch promising innovations. The Accelerated Access Review, coordinated by the Government’s Office for Life Sciences and supported by Wellcome, aims to speed up access to transformative drugs, devices and diagnostics for NHS patients, provide a stronger system of advice for innovators, and use Academic Health Science Networks to promote adoption by bringing together academic and clinical expertise. The final report will be published later this year and the Committee should consider its recommendations as part of its inquiry.
3. Research must be ‘business as usual’ in an evidence-informed, sustainable NHS. To develop a vibrant research culture there must be high-level recognition of the value of research and championing of research at all levels. The wider workforce also has a vital role to play, and career pathways must support clinicians who drive research and innovation. In addition, it is important that the wider clinical workforce is

sufficiently research aware to build the capacity of the NHS to apply findings and spread benefits.

4. Other barriers must also be addressed to make to the NHS a world-leading location for health research. The development of a ‘single approval’ for NHS studies by the Health Research Authority (HRA) Authority has the potential to make a transformative difference to study set up. Single approval will address long-standing concerns about the huge administrative burden associated with seeking separate R&D permissions at every NHS site where research takes place. We are confident that the HRA can overcome existing technical and cultural barriers to deliver this, but it must receive ongoing financial support from the Government to achieve this.
5. We are pleased that NHS England has committed to resolving issues around the payment of excess treatment costs — where the costs of including a participant in a study are greater than those of standard care. However, it is essential that NHS England now fulfils its duty to promote research by ensuring these plans are implemented.

New Technologies

6. New technologies will thrive in a research- and innovation-friendly NHS, and have significant potential to transform care. For example, the greater specificity provided by genomic medicine is leading to a transformation in diagnosis and therapy. In the Deciphering Developmental Disorders project – a pioneering collaboration between the Wellcome Trust Sanger Institute and UK NHS Genetics Services – the genomes of 12,000 families of a child with an undiagnosed developmental disorder have been sequenced. Diagnosis provided targeted therapies for the children; improving quality of life and allowing their families to make informed choices. Its success drove the Department of Health’s 100,000 Genomes project.
7. To ensure that the NHS benefits from new technologies it is essential that healthcare professionals have appropriate education, training and resources to use them. New technologies, such as genomics, must be adopted into generalist and specialist curricula in a timely fashion to facilitate the uptake of innovation across the NHS.
8. As well as engaging the public to talk about their health service, it is vital that there is an effective dialogue with patients about the risks and benefits of emerging health technologies, such as mitochondria donation or genomic medicine.

Data

9. Developing ‘big data’ technologies has the potential to improve both NHS services and the research underpinning advances in healthcare. The value of this critical resource will only be realised if citizens have confidence that their data are used in the public interest and with appropriate safeguards. For example, people are often suspicious about companies accessing their personal information; it is imperative that the systems of governance for managing patient data are trustworthy, robust and transparent.

10. To address these concerns, Wellcome is supporting a new independent taskforce that will develop a framework for clear discussions with the public, patients and healthcare professionals about how data can be used to improve health. As the National Data Guardian for Health and Social Care has recognised, this is an essential part of building a trustworthy system for protecting patient data, while maximising its enormous value for improving NHS services and creating a more efficient, innovative healthcare system.
11. The use of big data depends on an effective and pragmatic legal framework. It is not yet clear whether the EU Data Protection Regulation or something similar will be implemented in the UK following its adoption by the EU institutions. This regulation creates a supportive framework for scientific research, including safeguards to ensure personal information is used appropriately and remains secure. Should the UK's data protection laws develop in a way that is incompatible with the EU regulation it could undermine research that relies on sharing health data across borders, such as genomic projects run at the Wellcome Trust Sanger Institute and European projects including the European Bioinformatics Institute.

22 September 2016

Professor Peter Wells – Written evidence (NHS0033)

1. Introduction

1.1. My name is Peter Neil Temple Wells. I am a medical engineer with more than 55 years of experience

in the NHS and academia, mainly in England. In parallel with my activities in science and engineering as applied to medicine, I have held numerous senior NHS managerial appointments. My distinctions include CBE, FRS, FEng, FMedSci, FLSW and MAE. Currently, I am a Distinguished Research Professor at Cardiff University.

1.2. My evidence seeks to promote the creation of a National Health Care System – initially for England – based on a financially sustainable partnership of patients, health care professionals, the NHS, independent health care providers, health care insurers, citizens and the Government. It does not set out to be prescriptive. Rather, its purpose is to encourage optimism that it will be possible to create a de-politicised National Health Care System, fit for the 21st century, and to stimulate the development and implementation of the process to make this a reality.

2. Resource issues, including funding, productivity, demand management and resource use

2.1. When the economy is growing, the budget of the NHS can be increased without proportionately increasing the fraction of the gross domestic product (GDP) allocated to health care. But this perpetuates and exacerbates the inefficiencies of the NHS, with its top-down management, excessive layers of bureaucracy, resistance to change (as exemplified currently by the dispute between the Secretary of State for Health and the junior doctors) and – perhaps most important of all – its lack of competition (for which the so-called “internal market” has proved not be an effective substitute).

2.2. Probably because it is (generally) free at the point of access, and because the expectations of the citizens are continuously rising, coupled with advances in drugs and medical technology and the increasing health care needs of the growing elderly population, the demands on the NHS are growing inexorably. The principal mechanism by which the NHS currently seeks to control expenditure is by not providing services that are judged not to be cost-effective or affordable (this is guided by the National Institute for Health and Clinical Excellence). It is also a fact that having waiting lists for access to services reduces both the demand on the resources of the NHS and the popularity of the politicians who happen to be in power. This rationing of NHS provision often drives individual patients to pay for care in the private sector, which currently accounts for about 17% of total health care expenditure.

2.3. Ultimately, the proportion of a nation’s GDP that is allocated to health and social care is determined by politicians. In 2013, representative data were approximately as shown in the table:

	Population (millions)	GDP (£billions)	%GDP (health)	£ per capita (health)	Life expectancy (years)
UK	64	1848	9.1	2628	82
Belgium	11	362	10.9	3587	80
France	66	1936	11.7	3432	83
Germany	81	2574	11.3	3591	81
Sweden	9.6	400	9.7	4042	82
USA	319	11,571	17.1	6203	79

Thus, of all the countries included in the table, the UK allocates the smallest proportion of its GDP and the smallest amount per head to health care costs. Clearly, the health care system in the USA is bloated by European standards and there is certainly no reason for it to be envied or emulated in the UK.

2.4. Although politicians may be mindful of these data, they do not seem publicly to take into account, when considering the net cost of the NHS, that, in the developed world, where individual capability is key to economic success, healthy populations are vital for quality of life and wealth creation. For example, hypothetically returning the 2.5 million people on Incapacity Benefits (to be replaced by an Employment and Support Allowance) to work would increase UK GDP by £80 billion per annum – an increase of five percentage points. Also, they do not seem to take into account the fact that that the NHS pay bill is around 41% of the total cost of the NHS and that this is liable for national insurance contributions and income tax, so the net cost to the Treasury of the NHS is at least 10% less than the gross cost. Moreover, NHS activity supports a significant proportion of the economy, both locally and nationally.

2.5. Thus, it is wrong to consider the cost of the NHS as being merely a drain on the economy. In addition, the NHS is a hugely valuable test-bed for medical research.

3. Workforce

3.1. In order to function, the NHS requires supplies of highly skilled people. In partnership with universities, the NHS makes substantial contributions to the education and training of junior doctors (around £300k per head), medical students, student nurses and midwives etc. For several years, there has been a shortfall between demand and supply (mainly due to poor manpower planning), so many trained staff are recruited from abroad. It can be argued that it is unethical for a civilised and developed country such as the UK to drain less fortunate nations of the skilled workforce needed in their home countries.

3.2. Highly skilled people trained in the NHS work in the private health care sector in the UK. Ignoring the contentious issue of tuition fees, however, this does not seem to be unreasonable, seeing that people educated in the UK at least partly at the expense of the state work in all sectors of the economy.

4. Models of service delivery and integration

4.1. Current overview

4.1.1. There have always existed in the UK organisations that provide health care outwith the NHS, individual access to which may be either by self-funding or through private insurance schemes. The relationship between the NHS and these private providers has had a chequered history, ranging from dogmatically complete separation to the current pragmatic partnership in which the NHS has a mechanism to purchase services from “Any Qualified Provider” for NHS patients, for instance when the NHS lacks the capacity to achieve its waiting list targets. Also, under some circumstances, NHS patients have the right to demand to be treated in private hospitals through the NHS e-Referral service, with the NHS meeting the full cost. This frequently leads to a situation in which two patients can at the same time receive the same treatment and enjoy the same facilities in a private hospital, with one paying the full cost through their private insurance or out of their own savings and the other, at the expense of the NHS. Moreover, the NHS often negotiates low-cost tariffs which must mean that NHS patients are subsidised by private patients. Moreover, private patients relieve the NHS of the entire cost of their treatment and so are in effect paying twice for the same treatment. Dentistry is an extreme case: here, the private sector dominates and in some places it is virtually impossible to find a NHS practice. Those who understand the process realise that it is unfair and it is hard to see that it can be sustained. It highlights one of the divisive dogmas of the NHS: this is that co-funding with the NHS by the individual patient is generally not permitted. Even here, however, the boundaries can be permeable. For instance, “free” prescriptions are now only available for certain groups of patients (eg, the young, the pregnant and the elderly): most people are required to pay a fixed charge for each prescription, irrespective of its actual cost. Dentistry is an extreme case: individual NHS patients are required to co-fund their treatment (currently by between £18.80 and £222.50, depending on its complexity).

4.1.2. The inflexibility of the past, when a patient was prohibited from switching between self-funding (or insurance funding) in the private sector and the NHS during a course of treatment, has been relaxed. The current situation is that the individual is responsible for all their costs in the private sector (for clarification, if an individual is being treated as a private patient – not as an e-Referral patient – in the private facilities of a NHS hospital, the patient is required to pay in full for both the treatment costs and the private facilities costs).

4.1.3. In the past, all NHS facilities (hospitals, clinics, laboratories, diagnostic centres and the like) were entirely publicly owned. This is still often the case, with NHS (Foundation) Trusts having legal ownership as Public Benefit Corporations. Now, however, many such facilities are privately owned (having been built, for instance, under the Private Finance Initiative) and leased to the NHS. The equipment in some facilities (such as in many Radiology Departments) is owned, maintained and updated by private companies, often linked to a single manufacturer. The facilities that accommodate many group general practices are owned by the GPs who work in them. Moreover, consultant medical staff and GPs are technically private contractors to the NHS. There are further complications, for example, with agency staff (often they are “moonlighting” NHS staff, being paid at excessively high rates) and with University-employed medical staff.

The interface between health care and social care is blurred. For instance, the health care costs (for example, for medicines and nursing care) of people self-funded in residential care should normally be met by the NHS, but there are almost always disputes and delays in setting up the arrangements.

4.1.4. Therefore, there is considerable interest in following the results of the Government's recent initiative to transfer the health care budget to local control in Greater Manchester (and the Government has indicated its intention that more such schemes should follow). The total budget for health and social care is £6 billion in Greater Manchester and NHS England is providing a £450 million transformation fund. If the status quo had been maintained, the predicted shortfall would have been £2 billion by 2021. The proponents of the scheme are confident that any shortfall will be manageable, partly because of the economies that should result from integrating health and social care services, but only time will tell.

4.2. *Current NHS initiatives*

The NHS Five Year Forward View was published on 23 October 2014. It sets out a shared vision for the future of the NHS based around the new models of care. It was developed by the partner organisations that deliver and oversee health and care services, including the Care Quality Commission, Public Health England and NHS Improvement (previously Monitor and NHS Trust Development Authority). Patient groups, clinicians and independent experts also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The Five-Year Forward View puts forward many good ideas, including:

- That the budgets for health and social care might be combined. This could provide an incentive for NHS costs to be reduced by speeding up the transfer of treated patients into residential or home care.
- That there might be radical new delivery options.
- That primary care and hospital providers might be integrated into “primary and acute care systems”.
- That the NHS might “raise its game” on health technology, to improve the patients' experience.
- That the NHS might provide [more] “test bed” sites for worldwide innovators.
- That the NHS might develop new “green field” sites where completely new NHS services might be designed from scratch.
- That the NHS should take [more] action on prevention of disease and ill-health.

4.3. *Best European practice*

France has a two-tier healthcare system, with a state-run equivalent of the NHS – Couverture Maladie Universelle (CMU) – and the private sector. In 2000, the World Health Organisation said that France ran the best national health care system. Hospitals act as the centre of health care in liaison with the GP practice. Almost all state health interactions are

[carried out using a smart card \(carte vitale\)](#). This contains details of the individual and their family's rights to medical treatment and comes with a paper form – an attestation – that is used to augment the card in identifying citizens to state-run health care professionals. A GP visit costs €23 and, after the card is swiped, the money is paid back into the cardholder's bank account by the state, usually within a few days. Currently, €1 is “voluntarily” withheld to fund a number of worthy healthcare activities. Outpatient and pharmacy interactions are similarly smart-card-enabled, but the carte vitale system reimbursement rate is between 70% and 100%, depending on the type and point of treatment. Most French citizens belong to a mutual society (mutuelle) that tops up the reimbursement to 100%. The mutual also liaises with the state healthcare operation – the CPAM (Caisse Primaire d'Assurance Maladie) – on reimbursements. Some citizens are also privately insured and a few patients are treated privately in the state system. Inpatient treatment is more complex, as the carte vitale is augmented by forms and the paper attestation for treatment in the private sector.

4.4. *Provisional specification of proposed National Health Care System*

4.4.1. The proposed National Health Care System would embody the best features of the French system, modernised and adapted to the UK (English) environment.

4.4.2. Three factors are crucial for a health care system that is both responsive to consumers and that supports a fitter, healthier population:

- that the system provides universal coverage;
- that it has a substantial component of insurance; and
- that it has strong elements of competition.

4.4.3. Voluntary insurance coverage is ineffective (due to the problem of adverse selection – the natural process of individuals making insurance purchasing decisions that reflect their own personal circumstances, as a result of which people tend to seek insurance only if they know that their benefits are likely to exceed their payments) and inequitable.

4.4.4. The NHS lacks the elements of insurance that are common elsewhere. International case studies show that schemes that involve insurance have the following benefits:

- they provide reasons for individuals and authorities to value long term improvements in health and wellbeing;
- they define exactly what individuals are covered for, ending the postcode lottery and empowering individuals to demand their rights from providers;
- they achieve greater value for money; and
- they de-politicise healthcare.

4.4.5. These benefits could be introduced by transforming the National Health Service into a National Health Care System (NHCS). Taxpayer funding and guaranteed access would continue, but individuals would be empowered to decide which approved Health Care Insurer (HCI) to use, or to remain under the umbrella of their local (reformed) Clinical Commissioning Group (CCG). (Subject to defined conditions, they would be free to switch between the two.) For those using an HCI, custody of individual health outcomes would

belong to the individual patient: it would no longer be in the hands of politicians. The purchasing decisions of the HCIs would provide the health care providers with the competition necessary to incentivise improvement in their performances.

4.4.6. The end result would be:

- The creation of a notional Government Health Subvention (currently this would equate to about £2500 per annum) for every citizen residing in England. This could be adjusted according to the regional burdens of illness and demography.
- The establishment of the right of every citizen to opt out of having their health care services financed by their local (reformed) Clinical Commissioning Group (CCG) (of which there are currently about 210 in England) and for NHS England to transfer their Government Health Subvention (reduced by an amount to compensate for the costs of services – such as ambulance, accident and emergency, public health etc – that currently can only be purchased from NHS providers) to a Health Care Insurer (HCI) of their choice
- The reform of CCGs to remove the conflict-of-interest whereby CCGs can disproportionately allocate resources to the GPs who control them.

4.4.7. The licensing of at least three and up to about 10 independent Health Care Insurers (the number should be large enough for competition to be effective, but not so large as either to confuse potential members or to exacerbate the problem of adverse selection), each guaranteeing to meet the costs of a defined core entitlement to health services as agreed, monitored and enforced by a new Health Standards Regulatory Agency (to be set up) for all HCI members, the cost being covered by the “pot” of the Government Health Subventions of all citizens, paid by NHS England. The core entitlement would be similar to that provided by representative Clinical Commissioning Groups and members of HCIs would pay at least the same access charges as those paid by individuals covered by Clinical Commissioning Groups (but these charges could be fully or partly covered by their HCI).

4.4.8. Probably (and perhaps ideally), all of the HCIs should be not-for-profit companies (some might be charities, or they might be mutuals, owned by their members).

4.4.9. Each HCI would negotiate for the provision of health services for its members from what are currently NHS providers and private GPs, surgeons, physicians, hospitals etc. Mental health services would be included. There would be universal guaranteed ambulance, accident and emergency etc cover through a general agreement with (usually what are currently NHS) providers.

4.4.10. Each HCI would be allowed to charge premiums to cover the costs of health services in addition to the core entitlement of individual members, such as treatment and accommodation in a private hospital. (For the avoidance of doubt, this would mean that the Government would cover the costs of health care of all the members of an HCI from that HCI’s “pot” of Government Health Subventions, with excess costs being paid from the sum of the insurance premiums collected from all its members. Thus, each HCI would carry the risk that the premiums might be insufficient and doubtless would reinsure this risk in the customary fashion.) This co-funding would be a new departure for the Government. Ageing

members of HCIs would be likely to remain members permanently or at least long after the point at which most people currently cancel their private insurance policy because of its increasing cost and revert to the NHS, so the eventual overall impact on Government funding might even be a net gain.

4.4.11. Health Care Providers might pay fees to their relevant social care service providers, to accelerate the transfer of their members (ie, their patients) out of hospitals and into less expensive social care.

4.4.12. Additional services that HCIs might provide include:

- Support for social care. Currently, it is virtually impossible to purchase insurance to meet the costs of long-term social care: the only insurance product available is an immediate-need annuity. This involves putting down a large lump sum when an individual goes into care, to guarantee that the fees can be met. A 75-year-old individual with Alzheimer's disease would typically have to pay £170,827 to protect £20,000 worth of annual fees, £258,599 to protect £30,000 worth and £326,693 to protect £40,000 annual fees until they died. Note that annual average fees range from £19,344 in the North-West of England to £40,508 in the South-East. HCIs might offer combined insurance and savings plans for health and social care. Over a (long) period of time, the savings would be allowed to accumulate to become sufficient to meet the lifetime average cost of social care. If the actual social care cost for an individual exceeded the savings, the insurance plan would cover the shortfall; but if not fully used, a proportion of the residual savings could be preserved for the individual's beneficiaries.
- Support for healthy living. Different incentives might be offered for gym membership, smoking cessation, and action against alcohol and obesity, to attract individuals to join particular competing HCIs. A caveat here is that such incentives could exacerbate the problem of adverse selection.

5. Prevention and public engagement

Nothing to contribute.

6. Digitisation of services, Big Data and informatics

Please refer to "Digital healthcare: the impact of information and clinical technologies on health and healthcare" (The Royal Society 2006). I was the chair of the Working Group that produced this Policy Report

19 September 2016

Dr Stephen West – Written evidence (NHS0004)

Many thanks for considering my submission for the sustainability of the National Health Service.

I work as a doctor within the NHS and have worked overseas in New Zealand. I have spent all my working life on the front line in hospitals, so I am unable to provide insight into primary and the social care sectors.

The main point I want to press is for any system to be sustainable it must be based upon evidence. The foundation of all medical practice, where possible, is a basis in rigorous science. This means we are able to justify the risks we expose our patients to and the resources that we use. Unfortunately the same can't be said for government policy. Too many decisions are made on an ideological basis with no evidence to support their ideas, the recent junior doctors contract fiasco is a classical example of policy before evidence. To implement changes government must present the evidence behind their policy. This can't just be some statistics that they have misinterpreted to make their point. Independent statistic criticism should be included, published and presented with the policy. If the evidence is not available then the policy should only be able to advance as a trial. Policy must be measurable and the aimed outcomes clear. Again clear statistical analysis is required to determine whether a policy is successful, in a similar way that research studies are interpreted. This could easily be titled evidence-based politics and it should be mandatory. If this is currently the approved methodology that is encouraging but more work is required to strengthen the approach. Without this strong foundation of testing and knowing what worked previously there is no hope for sustainability. This is what has led to the current mess that allows people to make ideological changes in the absence of evidence.

While I accept that this does not offer an outline for how to take the NHS forward it should provide a methodology to approach the trialling of ideas. It would be marvellous if a politician proposes an idea tried decades ago, which always happens, and we are able to stop a wasteful reorganisation by publishing strong evidence that showed that the approach was unsuccessful previously. Sustainability requires building on past successes not tearing everything down and starting again every parliamentary term.

25 July 2016

Professor Chris Whitty – Written evidence (NHS0194)

What assessment has been made of the likely changes in England's demography and the burden of disease over the longer-term, and what impact will these changes have on the health and social care systems by 2030? Will this lead to ever greater funding pressures? What do [you] consider to be the most impactful driver of change? Is there planning in place?

As always for a Chief Scientific Adviser the technical opinions expressed are my own.

- 1) On the broad trends in demography, I do not think there are major points to add to my oral evidence and that of others. The increase in the overall elderly population, and the elderly population relative to the working population, are well known.
- 2) The less recognised relative increase in the rural elderly population due to the tendency of cities to import young adults who leave in early or late middle age was raised in my oral evidence. This has important implications for health service provision (for example stroke units, hospital-at-home) as well as social care provision. To illustrate this see Figure 1, maps of concentration of people aged over 85 over time (ONS data).
- 3) As important is the change in disease mix we can expect to see over the next 20 years (not covered in oral evidence). Whilst it is not easy to predict which scientific advances will have the greatest impact, it is possible to use trend lines in incidence, prevalence and survival over the last 30 years. Where for any disease they are straight lines over many years we can reasonably assume they will continue broadly on current trends. Based on this, improvements in primary and secondary prevention mean that *incidence* of cardiovascular disease (heart disease, acute stroke, some vascular dementia) and some major cancers (eg lung, cervical, gastric) will reduce (Figure 2, 3). Because of steady improvements in treatment the trend toward improved *survival* from several major diseases will also continue, including several major cancers (including breast, prostate, bowel) where most people can already expect to be alive and well 10 years post diagnosis (Figure 4, 5, 6). Some diseases will reduce in incidence but increase in prevalence due to better survival—stroke is an example. This has significant implications for the skills mix needed in the professions 20 years out.
- 4) The success against first infectious diseases, then cardiovascular disease, and more recently some cancers inevitably means prevalence of other diseases of old age will increase. Of these the most prominent is dementia (Figure 7), especially in women. An even larger issue is the rise in multi-morbidity (2 or more significant conditions) and frailty in the later years of life (Figure 8, schematic). The relative contribution of specialist medicine compared to general medicine and social care will need to shift. This point is worth making because although the trend is well recognised the planning for this has not yet begun seriously in the professions.

- 5) On whether demographic trends will lead to greater funding pressure in medicine and healthcare the answer is yes but the relative contribution of other trends are often underestimated. I agree with the assessment of the Office for Budget Responsibility (OBR) that the greater propensity of wealthier societies and individuals to consume healthcare and the opportunities that medical advances from science give for expanded treatment are likely to be strong drivers of demand and increased healthcare expenditure in the UK. The evidence that wealthier people and societies with the same 'need' by historic standards choose to consume more healthcare (increase demand) is clear and I think the OBR assessment on this point is a reasonable one. Although the OBR state that it is not settled whether the improvements in longevity lead to longer periods spent in disability, no difference or reduced period in disability, my reading of the evidence is that overall it is currently being accompanied by a significant expansion in time in ill health, and I think planning should be on that basis.
- 6) Demography and improved survival provides an inexorable upward pressure on social care costs in addition to health costs.
- 7) Demographic changes in other countries mean that global competition for the supply of health and social care professionals is likely to increase sharply over the next 20 years with implications for availability of workers in the UK especially those with long training lead times. The demographic expansion in the elderly in the UK is slower (so more manageable) than in many other countries in Europe and Asia. The need in several major countries for additional health and social care workers will therefore have a faster onset than the UK.
- 8) The expansion in demand from scientific advance is primarily due to expansion in the range of things medicine can do (increasing activity). The common assumption that new scientific advances in medicine are always more expensive is flawed viewed over the long run. Some transformational interventions are cost saving from the start (an example was the findings that aspirin reduces mortality from heart attacks by around 20%, and reduced risk of a TIA leading to a stroke). Many are mixed; for example the shift from cardiac surgery to angioplasty has led to shifting from a more expensive to a cheaper intervention, but also to an increase in the number of interventions performed (Figure 9). For most there is a period of increased expense whilst they are innovative and in the case of drugs or devices on patent, and then a steady reduction in cost provided the market works normally and competition emerges. Antibiotics are an historic example; more recently the overall cost of cardiovascular drugs has steadily decreased as the market matures (Figure 10). The substantial number of new (on-patent) cancer drugs is an example of a medium-term financial pressure which may well be stabilising or decreasing in 20 years time as markets mature. One of the main things we can do to meet the challenge that increased demand will produce for health and social care is research ways to optimise efficiency.

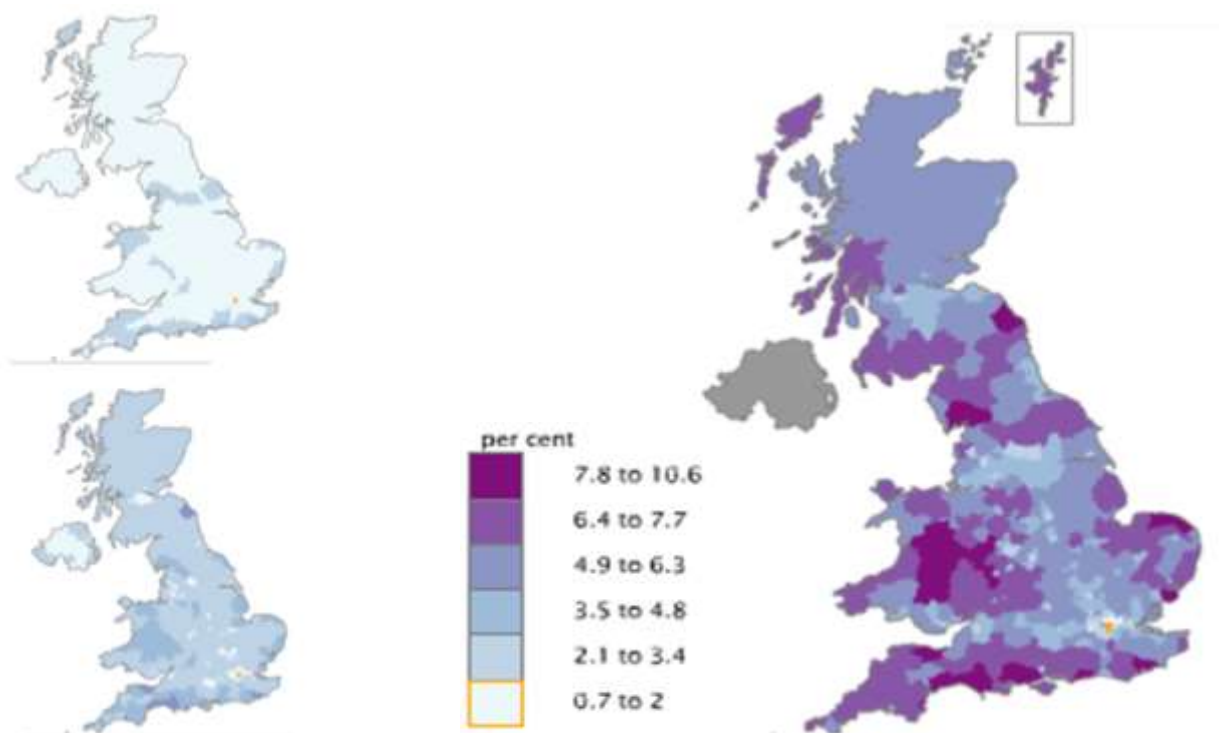


Figure 1. Population aged 85 and over: 1992 (top), 2015 (bottom) and projected 2033 (right). (ONS)

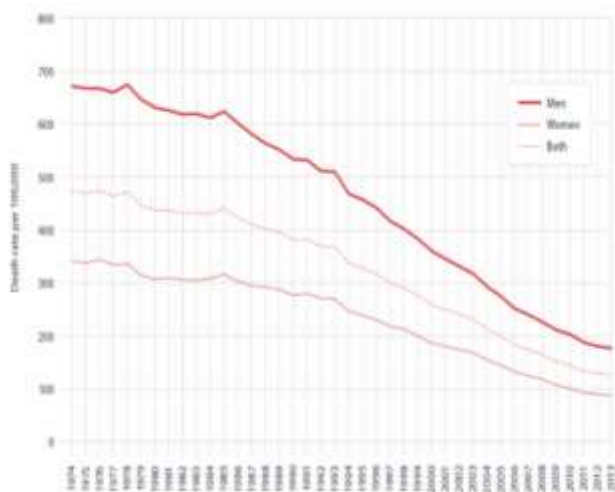


Figure 2. Age-standardised coronary heart disease mortality rates, UK 1974 – 2013. 73% reduction overall, 81% reduction on those under 75 years.

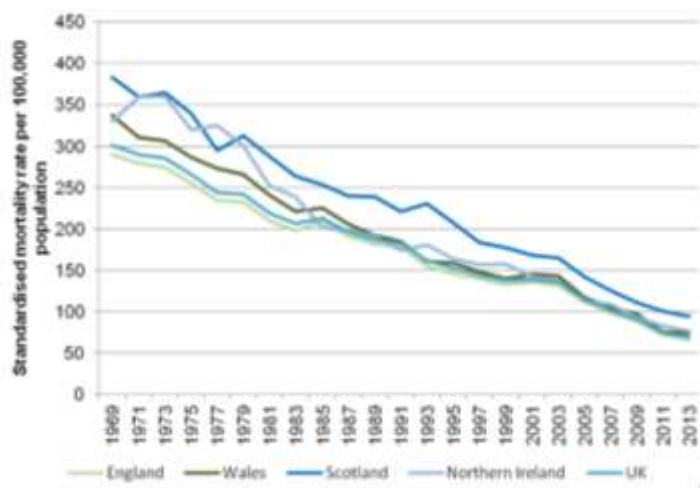


Figure 3. Stroke mortality in the UK 1969 – 2013 (Age standardised mortality/100,000 population (BHF data)

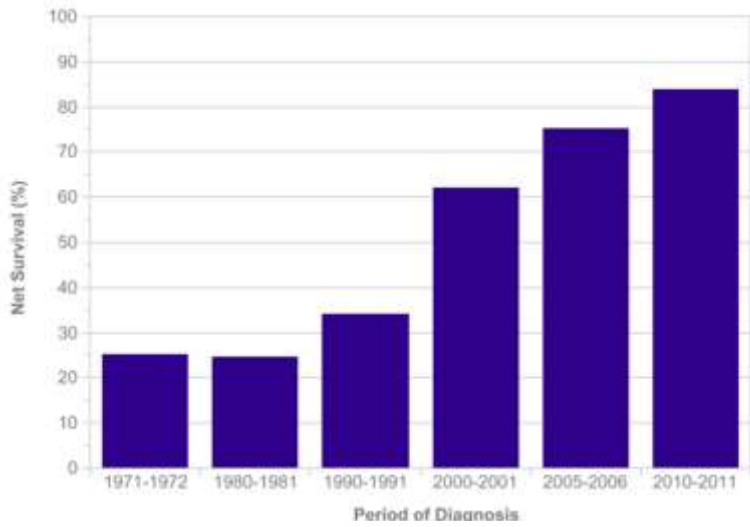


Figure 4. 10 year prostate cancer survival 1971 – 2011 (CRUK)

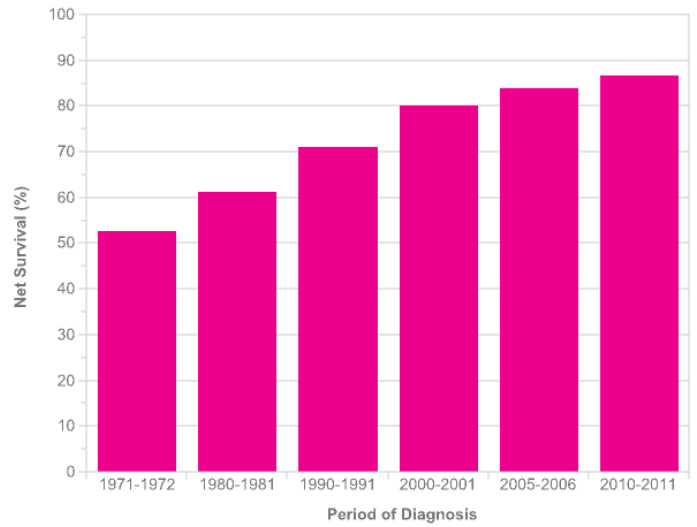


Figure 5. 10 year breast cancer survival 1971 – 2011 (CRUK)

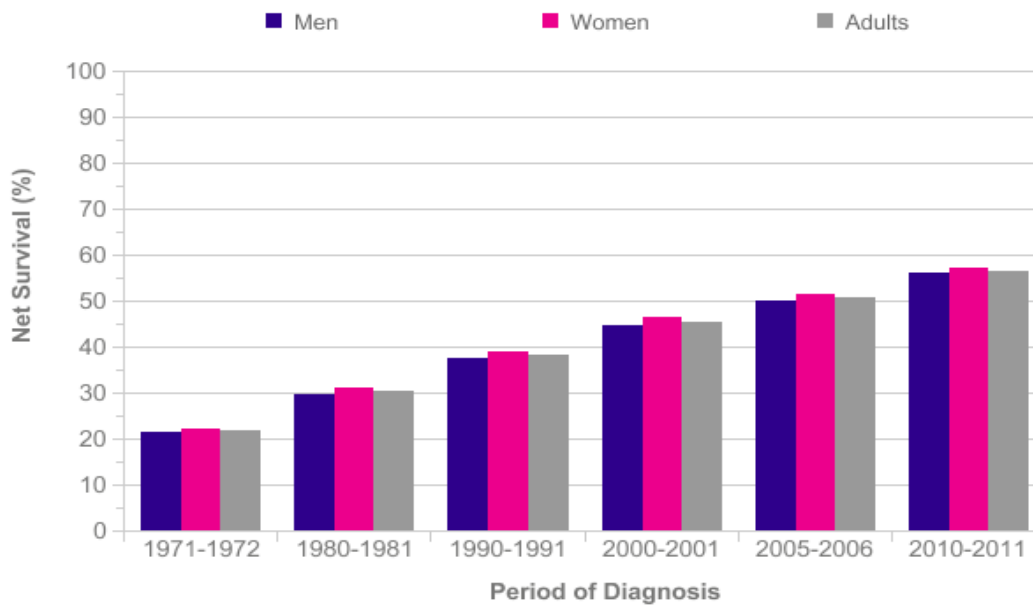


Figure 6. 10 year bowel cancer survival 1971-2011 (CRUK)

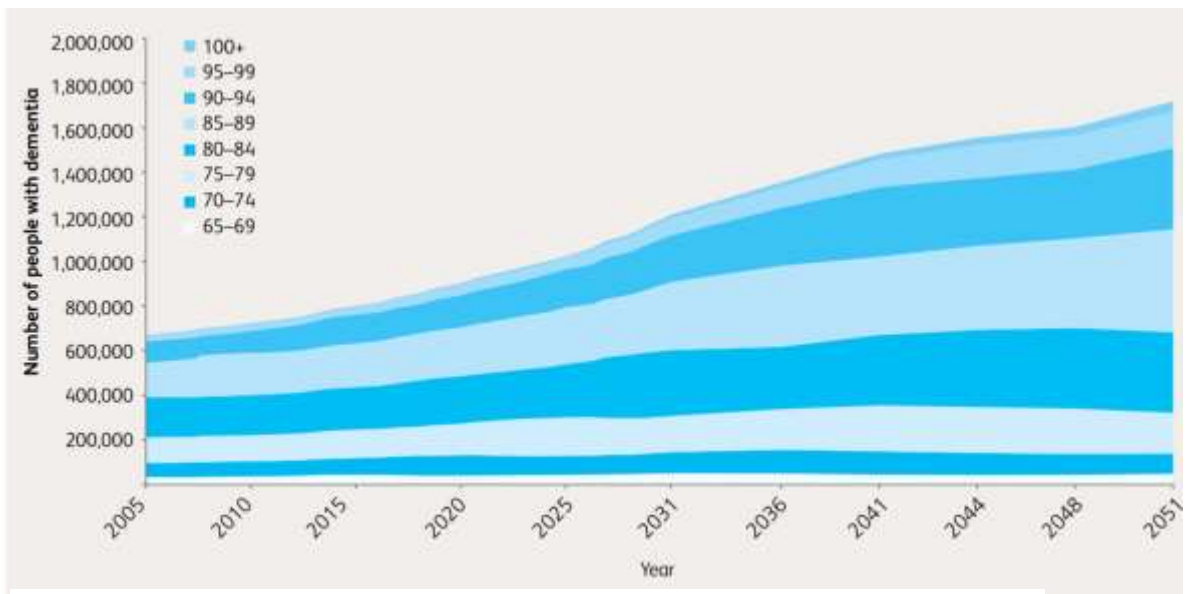


Figure 7. Projected numbers of people with dementia in the UK, 2005 – 2015 (*Prince et al. 2015*)

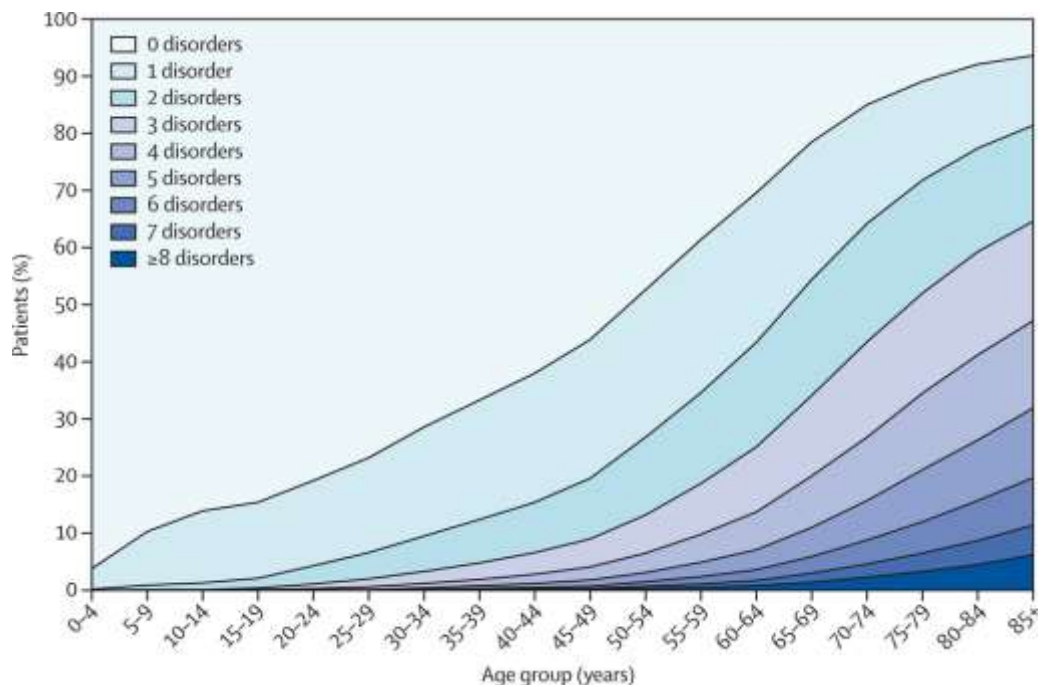


Figure 8. Multi-morbidity with increasing age. (*Barnett et al. 2012*)

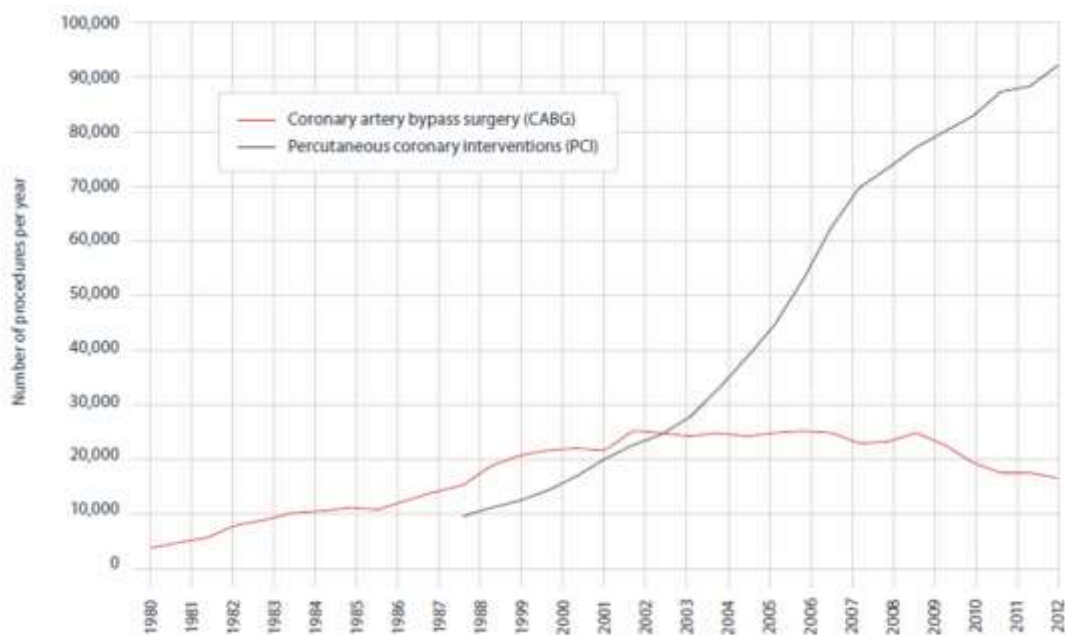


Figure 9. Coronary artery bypass operations compared to angioplasty 1980-2012 (data BHF)

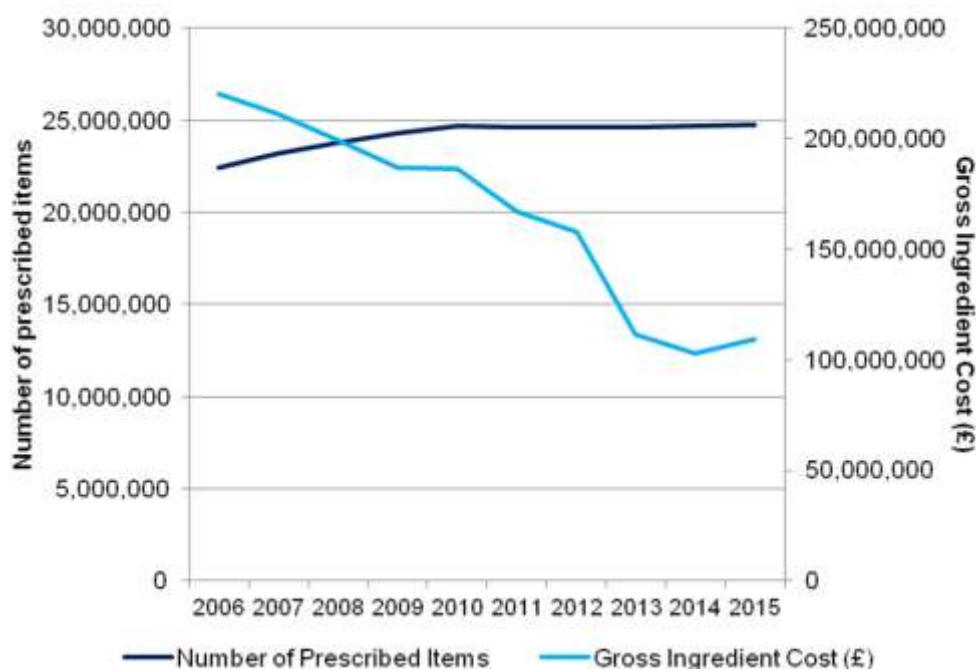


Figure 10. Volume and cost of cardiovascular prescribing, 2006-2015, Scotland. (Information Services Division, Scotland) December 30, 2017

Dr Graham Willis – Supplementary written evidence (NHS0188)

Thank you for the opportunity to give evidence before the Lords Select Committee looking into the Long Term Sustainability of the NHS, on Tuesday 8th November 2016. You asked me to attend in my previous capacity as Head of Research and Development at the Centre for Workforce Intelligence (CfWI). The role of the CfWI was to produce independent analysis of the health and care system.

In the session you made the following request:

“Dr Willis, you gave me a figure that included unpaid workers, the carers... Can you give a figure that is solely based on paid employed people, and what that number will look like in 2035?”

The CfWI model produced a high-level view of how the need for skills may change in future, across the whole health and care system, using the currency of skill hours. A description of the model and results is available in their publication: *Future Demand for Skills: Initial Results, August 2015*, available at:

<https://www.gov.uk/government/publications/horizon-2035-future-demand-for-skills-initial-results>

Figure 4 in the CfWI report (page 7) shows projections for how total hours by skill level might change over the period 2013-2035. Level 1 represents the unskilled and unpaid workforce. Levels 2 to 6 represent the skilled and paid workforce groups.

Paid workforce skill hours growth will be the sum of the hours change for Level 2 to Level 6 skills.

We also discussed the importance of aligning skill mix to models of care. This raises the question of scope of practice – what a health and care professional is allowed to do, as defined by a legal framework.

There is an excellent report from the Canadian Academy of Health Sciences which considers this area in depth and addresses the question: What are the scopes of practice that will be most effective to support innovative models of care for a transformed health care system to serve all Canadians? This is the report noted by Professor Buchan.

It is available at:

http://www.caahs-acss.ca/wp-content/uploads/2014/08/Optimizing-Scopes-of-Practice_REPORT-English.pdf

We have professional contacts with the project team if you require further information.

29 November 2016

Wilmington Healthcare – Written evidence (NHS0155)

Summary

- This evidence submission is from Wilmington Healthcare, a company working with healthcare customers to turn high quality data into meaningful intelligence that supports their business objectives and the improvement of healthcare.
- The authors have spent many years working in and around the NHS, including in senior roles. Lending weight to their evidence, this submission also features primary research among healthcare professionals, conducted in September 2016 exclusively for the House of Lords Select Committee. The respondents' views are compelling and give significant insight from the frontline about the challenges that lie ahead.
- Key themes to emerge are around joint working, funding and innovation. Better use of data and engagement with the workforce and with patients are also key. The submission explores the optimal balance between primary and secondary care, giving best practice examples and reinforcing the importance of co-created care pathways, better deployment of emergency triage, etc.
- We give reasons for scepticism around the current funding model and make the case for a 'carrot and stick approach' with patients.
- The submission gives a glimpse into NHS resourcing levels, comparing year-on-year totals and examining the balance between management and other grades.
- The authors, supported by research, explore key workforce issues, including new findings about the almost universal poor morale. We consider the reasons for such high levels of dissatisfaction and give suggestions as to how this dire situation might be improved.
- Vanguard, and their growing importance, are considered in detail. We look at early successes and ask how their good work can be replicated on a much larger scale.
- Issues around service delivery and integration are analysed and we offer a series of practical steps which could bring about radical change for the benefit of both patients and the long-term sustainability of the NHS.
- Finally, we offer evidence around the role of prevention, public engagement and the use of technology. In respect of technology, and specifically the use of patient data, we make parallels with the retail sector and suggest how learnings could be transferred.

1) The future healthcare system

- 1.1) It's our view that the key levers available to be used to achieve a sustainable NHS are joint working, funding and innovation. These levers are reflected in our evidence, which is based on extensive knowledge of working with the NHS and healthcare more generally. We have also conducted exclusive research among over 2,000 healthcare professionals to support this submission.

Use of data

- 1.2) It's our opinion that the NHS should unify primary, secondary and social care data sources with controlled access for care teams, working with a common diagnostic language. The NHS should also utilise unified longitudinal anonymised real world data as this will support evidence based therapy development and service refinement

Engaging the workforce and patients

- 1.3) There is an opportunity for the NHS to engage patients at multiple levels, increasingly through digital media, on issues including:
- 1.3.1) Their own wellbeing – tax unhealthy food and charge minimum price for alcohol
- 1.3.2) Service engagement – manage appropriate access e.g. when to see a pharmacist instead of a GP, or a GP instead of A&E
- 1.3.3) Treatment engagement - 30-50% of pharmaceuticals are not taken as directed.

Long term conditions and re-balancing of focus from secondary to primary care

- 1.4) A lot of treatments are expensive, but the cost of long term care and supporting people in the community has to be balanced. We have to keep people independent for longer. To achieve this, we need to optimise self-care through education and easy access to advice. There is a need to manage social care integration (aka Devo Manc) to prevent bed blocking which has been increasing as social services are overstretched
- 1.5) Constant organisational change within the NHS has the potential to diminish innovation and workforce morale. *See the workforce's views in our bespoke NHS workforce survey supporting this submission in section 3.*
- 1.6) We need truly integrated services within STPs, so that providers are encouraged to build the most cost effective models of care not empires. Only then will rapid decommissioning occur effectively.
- 1.7) Early detection and intervention in disease through harnessing genetics will have the biggest improvement in quality of life and ROI for individuals and the wider tax funded system.

2) Resource issues, including funding, productivity, demand management and resource use

- 2.1) The current evidence of performance indicates that the NHS will not manage within the predicted cost envelope.
- 2.2) The perception is that the NHS is free at the point of delivery and a key ‘jewel in the crown’ of UK public services. A primary care co-payment (similar to NZ) is probably the most sensible solution, but politically would be hard to swallow.
- 2.3) Taxes on goods, such as cigarettes and alcohol, will encourage people to adopt healthier lifestyles. However, in order to reduce the burden on the NHS, we also need to change mindsets and motivate the public collectively through employers, schools and colleges.
- 2.4) To achieve this, there should be more incentives for employers to run workplace schemes that promote healthy lifestyles and reduce absenteeism and ‘presenteeism’.
- 2.5) The ‘One You’ programme, which is aimed at 40-50 year olds, is a good example. However, there needs to be a greater level of engagement with employers/HR departments and NHS England/Public Health England/DWP/treasury/DTI to join up thinking

3) Workforce

- 3.1) Over the past 10 years, it’s clear that there has been much organisational change within the NHS. Despite the extensive changes, a proportion of employees have emerged in newly titled roles in newly named organisations. Perhaps NHS reorganisation more a question of shuffling the pack, rather than meaningful change which improves patient outcomes? It is probably too difficult to prove this statistically given the number of other external and internal forces at play in the NHS.
- 3.2) From May 2002 – August 2012, illustrating the direct comparison between PCTs and the change to CCGs (at the implementation date of the Health and Social Care Bill) we compared the number of NHS organisation types and the number of individual organisation. The study showed that there were 12 organisation types and 850 individual organisations in 2002. This grew to 25 organisation types in 2012, with a roughly similar number of individual organisations (784). In 2016, there are 10% of named individuals in new NHS organisation types that were employed in similar roles 10 years ago (within PCTs/trusts and equivalents).

Year	Management	Total Employees	Percentage
2012	10,304	975,616	1.06%
2013	10,322	963,515	1.07%
2014	13,716	985,878	1.39%
2015	13,354	1,002,549	1.33%
2016	14,348	1,027,271	1.40%

- 3.3) Employee numbers have steadily increased within NHS England over the past few years, with an increasing proportion of those people holding management roles. Given the level of management grade personnel within the NHS, it is surprising that the results of an exclusive survey that we conducted especially for this Committee in September 2016 reveal huge issues managing the organisation and maintaining morale. The survey involved more than 2,000 GPs, secondary care doctors and nurses in the UK.

The key findings of our research for this Committee were as follows:

- 3.4) The overwhelming majority of respondents (92%) said that low morale was a key issue affecting NHS staff retention. When asked why this was the case, seventy-two percent cited poor pay and rewards; while 64 percent said continued national changes in NHS workforce planning since 2000 and 63 percent said unsociable/long working hours.
- 3.5) The majority of respondents (85%) said that access to training and development was the key requirement of the future NHS workforce, closely followed by pay & rewards (84%) and flexible working and career progression (both 78%).
- 3.6) Asked what effect the UK's departure from the EU would have on the continued supply of healthcare workers from overseas, a large proportion of respondents (48%) said it would be more difficult to recruit and retain staff. Just under half (45%) said it would make no difference and only seven percent said it would be easier to recruit and retain staff. When asked whether scrapping NHS bursaries, in favour of the same student loans system used by other students, would help the Government to achieve its ambition to train more nurses, midwives and allied health professionals for the NHS, the majority of respondents (88%) said no. Only three percent said yes and nine percent did not know.
- 3.7) A shortage of GPs has been identified as one of the current critical workforce constraints in England. When we asked respondents how the supply of GPs can be optimised for the NHS, better integration with other health service services/ integrated team working was the preferred option chosen by 72% of respondents. This was followed by the provision of financial incentives for doctors to practise in underserved areas (52%) and the promotion of innovations in health service delivery and telemedicine (49%).
- 3.8) The global strategy on human resources for health, adopted by the UK and all other WHO member states in May 2016, says that 'by 2030, all countries will have made

progress towards halving their dependency on foreign-trained health professionals.' However, the recent trend in England, for nurses at least, is for growing rather than reducing dependency. When we asked our respondents what needs to happen within the NHS to reverse this trend, the majority of respondents (85%) cited 'improve pay and rewards'. This was followed by create more career progression opportunities (60%) and improve unsociable/long working hours (55%).

4) NHS Vanguards

- 4.1) Some parts of the NHS workforce are already widening out in terms of the services that they provide e.g. pharmacists, physiotherapists and occupational therapists are taking on some of the roles previously assumed by nurses. This is really important to help the NHS manage demand and to provide more care outside hospitals.
- 4.2) NHS Vanguard
s are leading the way in showing how support can be better provided within the community. For example, with many emergency departments in acute hospitals overwhelmed by patients (who often use them inappropriately for non-acute issues) and consequently struggling to meet waiting time targets, one GP super-practice has placed senior primary care clinicians in emergency departments to provide a triage system that redirects non-emergency patients to appropriate services – e.g. pharmacies or GPs.- 4.3) This has cut down average waiting times to an hour and is minimising the number of breaches. Standard operating protocols are vital to cover all eventualities, so that everyone involved in the process understands what is expected and can refer patients to the appropriate responsible team member or care pathway. Children and elderly people are the biggest drivers of attendance at emergency departments; new pathways have meant they can be offered a community- or home-based care package rather than being admitted. In another organisation, clear structured pathways for stroke patients have led to significant reductions in length of stay.

Education in schools

- 4.4) We should not forget the importance of educating children and encouraging them to adopt healthy lifestyle behaviours and beliefs, both for their own wellbeing and also to remind/educate their parents and wider families. For example, Manchester is training children and young adults to be 'dementia friendly' and to take on voluntary roles at school to support people with dementia. This should foster better understanding of the problems faced by people with dementia and help youngsters grow up with understanding of these people's needs.

Educating stakeholders

- 4.5) We also need to educate all stakeholders in how the health and care system works – including patients. Currently workforce training is professionally focused on a single discipline. There needs to be a focus on how decisions on funding are made, and on

‘business’ and ‘leadership’ skills as part of the professional training for all HCPs, both whilst in training to qualify, and as continuing professional development once full qualified. Clinical Leadership is much talked about, but in short supply due to a lack of training.

5) Models of service delivery and integration

Radical change

- 5.1) The NHS and Social Care Planning guidance and financial settlement window is currently two years and we recommend this needs to become a minimum of three years. It's essential to put in place formal links between the budgets of health, social care, public health, housing, police, criminal justice system, and any other agencies that are interlinked (including Department of Work and Pensions) which enables the Treasury to recognise the benefits of an investment in one area (e.g. NHS, such as investing in a treatment). This can have a positive financial impact on another Government department, and enable a claw back/rebate from the other's budget. It is essential in order to accelerate innovation and transformation of inter-linked public services.

Integration

- 5.2) Integration can mean different things to different people. For some people it means integrating budgets and organisations; for others it may involve smaller, but equally powerful changes, such as integrating IT systems. Work currently being undertaken by the East Midlands Radiology Consortium (EMRAD) Vanguard is an excellent example of the latter - www.emrad.org.
- 5.3) Not understanding what integration is and failing to get clinicians on board are significant barriers to doing things differently. Experience shows that small changes can make a big difference and making changes from the bottom up rather than the top down can be a more effective way of getting clinicians on board and making them part of making change happen. For example, a new best practice pathway for the use of non-oral treatments in Parkinson's was recently devised by clinicians to make the referral process for these therapies more explicit. See: <https://www.parkinsons.org.uk/nonoralpathway>
- 5.4) Developing new patient pathways is key to improving healthcare. However, rather than looking at certain aspects of a condition, we need to manage patients across the whole pathway of that condition from diagnosis to death. We need to define what care is required for each patient, map their needs in line with NICE guidelines and provide an end to end service.
- 5.5) The Health Management Organisation (HMO) style management is particularly useful for the management of individual conditions and should be considered for the future with patient identification - pre symptom identification and early detection. Once identified, the condition should be managed proactively by an

HMO. However, in addition to HMOs, the NHS also needs to consider - and potentially provide more specially trained staff - to tackle co-morbidity issues and the complex health needs of the nation's ageing population.

5.6) True service integration has to be the long term objective. The 5YFV recognises this, and the fact that success will look different in different localities. Key factors are:

5.6.1) Leadership managing the vision and strategy, through inevitable political policy changes, both at a local and national level. At a local level this leadership currently occurs in individual organisations acute FTs/Community Trust/CCG/GP federation. The vision must move from the individual local organisation to the whole health economy. Empowered leadership teams that can make decisions that affect all the encompassed organisations are essential. This is not yet the case within STPs where some organisations have strong unit identity although they see the need to federate, there is parochial resistance.

Providing this level of leadership and motivating talented directors means encouraging training and development in NHS management skills. The private sector does not always understand the complexities of the NHS or have all the answers, but can bring cross fertilisation to help the move from an institutionalised thinking and strategy to a more flexible, lean approach.

5.6.2) Integrated data is essential for the operation of any accountable care model which can only really operate with patient care/cost and outcome tracking throughout the whole patient pathway.

Where this aggregated data is continuously testing current practice and innovation in terms of intervention whether pharmaceutical, clinical or social. It is imperative that this data is supplied in a useable form to support service redesign.

5.6.3) Public engagement with change is essential, we should utilise existing bodies such as the Academic Health Science Networks, some of whom have set up expert patient senates (such as in the East Midlands), to lead the public debate locally, then pool this across the 15 AHSN areas, to drive a full national public debate on the future of the Health and Care system. Democratic debate has to be seen to have been engaged in, as previous processes, such as the Lansley reform, and again the STP programme, are seen as top down and tokenistic at best in terms of bringing the public along in the change debate.

6) Prevention and public engagement

6.1) It is important to understand the local drivers of burden on health and social care services. Devo Manc has said alcohol, homelessness and drugs are their most pressing drivers on use. This scenario may be true for many other areas; hence in the future it may be increasingly important to provide this type of service earlier as opposed to treating ill health

- 6.2) NHS Vanguards are already aiming to take this approach. For example, in order to tackle the burden of alcohol on the healthcare system, one Vanguard has instituted a system for rapid assessment, identification and diversion/transfer of patients presenting to hospital who want to stop drinking and require detoxification, and who would otherwise have been admitted to an acute bed.
- 6.3) In this system, patients from acute hospitals across Greater Manchester have rapid access to medically managed detoxification at a specialist facility 24 hours a day. This has involved closer working with alcohol nurse specialists within acute hospitals, who provide gate keeping and referrals, a 5–7-day admission multi-disciplinary team, 24-hour hospital services, and medical support for specialist individual and group psychosocial interventions, with an emphasis on supporting engagement in aftercare and recovery communities.
- 6.4) Although the money invested has not yet been recouped, the programme is expected to result in savings to the local health economy of about £2 million over a 12-month period.

Public Engagement

- 6.5) NHIS, which is part of Wilmington Healthcare, has facilitated what it calls ‘Big Conversations’ with the public as part of patient and public engagement (PPE), asking them what they want from the health service and also enabling them to make the difficult choices on where limited funding should go. This was conducted in Worcestershire and York.
- 6.6) Many patients want more information and the ability to self-care rather than expensive support. Organisations like Age Concern and the MS Society have done a great deal to provide services in partnership with local authorities to meet identified need.
- 6.7) The Government could for example set up a Prime Minister’s *Great Health and Care Challenge* - a national debate in schools, colleges, universities, workplaces, pubs, community organisations, online and via written response, accessible in libraries, in multiple languages, where the Government makes these key questions available for comment, alongside an opportunity for those involved to see what others have already contributed. This will then provide the biggest democratic opportunity for the widest possible engagement before the next Government makes a decision about the future structure and funding of the successor system for health and care.

Technology

- 6.8) A recent report by NHIS Commissioning Excellence and helps the NHS to plan and commission patient services, shows that the NHS must invest in new technology if innovative models of care being trialled by its Vanguards are to be rolled out. The

report, which is based on a recent advisory panel discussion involving eight Vanguard, found that technologies that enable risk stratification, early detection, appropriate intervention and remote monitoring are key.

- 6.9) Entitled *'The Role of Vanguard in the Development of New NHS Commissioning Structures'*, the report says risk stratification (the process of identifying the potential care requirements of patients by analysing their medical history, to improve the type and quality of care delivered) is important in primary care to help identify patients with complex needs and to determine onward specialist referral. For example, clinicians in one GP super-practice Vanguard have access to the entire electronic patient record, including primary and secondary care notes and results of imaging and laboratory tests, so they can make fully informed decisions about patients.
- 6.10) Turning to early intervention, which is crucial for many cancer patients, decision support software can be invaluable in helping to identify at-risk individuals early and thereby improve outcomes. A unique cancer Vanguard, which was involved in the discussions, plans to install decision support software in GP surgeries to help them identify the disease in patients who have symptoms that appear vague. This software is designed to raise awareness of symptoms, and to encourage clinicians to 'think cancer'. Features can include symptom checkers, risk calculators and information to identify 'low risk but not no risk' patients.
- 6.11) Echoing the recent announcement from NHS England CEO Simon Stevens, that there would be an NHS payment system overhaul that will help technology companies gain fast-track approval, Vanguard representatives also agreed that the NHS services must use modern technologies to provide alternatives to traditional face-to-face consultations and remove barriers to communication between different services.
- 6.12) Many Vanguard already provide telephone triage in primary care and others are offering call-in consultant services that allow GPs to talk directly to consultants and obtain advice without having to send the patient to the hospital.
- 6.13) Simplifying the NHS is important as many areas run the same services with different standards and practices, and best practice is rarely shared. New strategies are needed to facilitate sharing and collaboration, and these could involve the use of new technologies for cross-organisational discussion and sharing best practice.
- 6.14) As healthcare and social care serve the same population, there is an appetite for the two to work together to commission and deliver services jointly for their patients and the local population. Technology and innovation could be key enablers and the creation of a new tariff offering an incentive to hospitals to make better use of these is likely to support wider spread adoption.

7) Digitisation of services, Big Data and informatics

- 7.1) The connected person is generating more data than ever before and in the retail world, companies are capturing and integrating as much of this data as they can in order to understand each customer better with every interaction. In Wilmington Healthcare's survey, and given the wealth of personal information held digitally, we asked HCPs if they believed patients' data is being protected at the expense of their own health. More than a quarter of respondents (29%) thought this was true; while 35% didn't know and 37% said 'no'.
- 7.2) Advances have been enabled by the advent and integration of 'big data', such as information gathered about customers' online browsing and social media activities, and information generated via smart devices in the home, which have dramatically enhanced insights from traditional sales, loyalty and retail data.
- 7.3) Indeed, it is thanks to the sophisticated use of big data that, for example, Tesco can send each one of its 15m Clubcard customers in the UK 12 vouchers that have been personally tailored to their needs. Interestingly even this data could be used to support healthy eating options providing gradual changes in diet through menu/recipe suggestions and offers.
- 7.4) The success of fitness apps such as My Fitness Pal and Fitbits, shows there is already a real appetite for people to share data on their physical activity and this could, in turn, be used to help patients take more control of their health. But applying the retail customer model to NHS users, many of whom may not have access to technologies such as Skype, is hugely challenging. However, it is well recognised that big data brings data overload. Key development is the utilisation of smart algorithms to ensure that clinicians are presented with relevant trends and changes only.
- 7.5) Initiatives such as the data sharing social enterprise 'Patients Know Best', which aims to solve a problem faced by healthcare organisations worldwide: how to get data moving between silos and eradicate incomplete and inaccurate data that can lead to fragmented, expensive and dangerous care – are showing how things can be done differently.
- 7.6) We should encourage patients to be genetically screened for serious life-limiting illnesses that are known to be preventable/curable with known interventions. Potentially by taking DNA samples at birth of all new-borns and databasing the population's DNA profiles, we can identify risk factors in the population and opportunities every time a new treatment for a genetically mediated condition is licensed. We could then pro-actively plan the interventions for all people for whom such a treatment could be applicable, follow them up, and identify if they are a candidate for that treatment now or in the future. This would also require a national ID scheme linked to the NHS number or some other tracking system. This

would ensure that potentially life limiting or quality of life affecting conditions were prevented or treated at very early stages, reducing healthcare burden and improving quality of life. Given the great expense up front of such systems, an insurance-based approach would probably be required, looking actuarially at short term cost/investment versus long term savings.

23 September 2016

Mrs Carole Woodman – Written evidence (NHS0047)

LONG-TERM SUSTAINABILITY OF THE NHS

Background

Elected Copeland Councillor (2011-2015), Member Link steering committee, Governor Cumbria Partnership Foundation Trust (up to September 2016) and current board member West Cumbria Medical Education Campus, Westlakes, Whitehaven.

Helped set up West Cumbrians' voice for Healthcare (WCVforHC) in September 2015. WCVforHC are a constituted group with the aim of ensuring that the people of West Cumbria (Allerdale and Copeland) have easy and equitable access to health and social care services. To work in partnership with the community, third sector organisations and the statutory sector commissioners/providers to address the challenges facing the delivery of health and social care services in West Cumbria.

One of our main priorities was to ensure that the West, North East Cumbria Success Regime carried out a meaningful engagement with community stakeholders on their strategy for health care in WNE Cumbria.

Details of the challenges/demography of our rural and remote Cumbria population can be found in the Success Regime papers.
http://www.successregimecumbria.nhs.uk/images/Key_challenges_and_baseline_facts_and_figures.pdf

Resource Issues.

The current funding for rural and remote area's such as West Cumbria are unfair. The payments -on -activity discriminates against services that do not have the economies of scale. It costs more to deliver equitable healthcare in rural areas with poor road infra structure. We have 2 District General Hospitals an hour apart in Carlisle and Whitehaven which are also between 1-2 hours away from the nearest tertiary centre in Newcastle.

Rural proofing is recognised as being essential for the equitable delivery of services.

<https://www.gov.uk/government/publications/rural-proofing-independent-implementation-review-lord-cameron-review>

Royal College of Obstetricians & Gynaecologists Report 18-20 November 2014 stated that 2 consultant led maternity units were justified in Whitehaven and Carlisle despite the small number of births (around 1500 each) but that it must be accepted that this would require more funding.

Funding does not incentivise the community to take responsibility for their health care or encourage public health initiatives. Funding should more closely reflect the population, deprivation and health inequalities.

If there was increased accountability and greater co-production of services local communities and businesses would feel more confident about greater funding including local increases in Council tax.

Long term efficiency improvements and greater collaboration between different parts of the system, rather than competition and separate Trusts should lead to significant savings but this will need to be matched with increases to match population increase and use of “sin taxes”.

Workforce

GP recruitment and retention. Our local Seascale surgery has received less and less funding and is now under threat. Rural proofing which was accepted by all Government Departments appears to have been removed. For example the Minimum practise income guarantee MPIG is being phased out from 2014/15 which makes the practise unviable. The difficulties recruiting and decrease in income are making rural GP practises less attractive for new entrants. Graduates wishing to become GP's has decreased from 50% to 15%. The son of one of the Dr at the Seascale practise on his first year at Leeds Medical School reported that none of his year wished to become GP's.

We are not training sufficient healthcare professionals to meet demand. UCLAN Westlakes campus was able to offer places for self-funded overseas students but not for UK based students.

Need more flexible workforce and life-long training options.

- Examples more use of Physician Associates. Training programme (2 year post-graduate course) at WCMEC.
- Development of composite workforce model for acute medicine at West Cumberland Hospital, Whitehaven to address workforce recruitment and retention problems; clinical competency, up to and including ST3 capability, can be delivered by clinicians of any clinical background who are appropriately trained and experienced such as: SpR Trainee/Trust Doctor, Advanced nurse practitioner, advanced paramedic, Physicians Associate, GPS1/GP.

PREVENTION AND PUBLIC ENGAGEMENT

Genuine accountability has been reduced over the last decade. Healthwatch in Cumbria has not linked meaningfully with already stable 3rd sector and volunteer organisations. Instead recruiting its own Healthwatch champions. The competitive tendering aspect works against this with a different organisation People's First gaining the contract over Cumbria Volunteer Association who previously ran LINK.

NCUHT has removed the shadow Governors. The valuable resource and expertise of Governors needs to be more valued and used by NHS organisations.

Total lack of co-production of services in the current Success Regime. Lack of understanding (or willingness) to undertake this. Need to build up an army of valued volunteers to

undertake a variety of activities to fully involve the community in the hospital; visiting; involvement in service improvement etc.

Local League of Friends disbanded at Whitehaven acute hospital because of lack of support from managers.

Alston League of Friends and Medical Practises in Alston have produced a joint report showing how services can support one of the most isolated rural community in England. (Dr Mark Crick Alston and Malcom Forster forsayle@btinternet.com

Community need to be effectively involved in decision making; feel their Voice matters. This has not happened in Cumbria. High level of distrust which has not been addressed by the Success Regime. Leading to marches, angry public meetings, and a vocal Facebook page which causes stress to both the public and the staff. The result of long standing imposition of inappropriate centralised models and de-stabilisation of the local health care system by many management changes and unsustainable funding mechanisms. Engagement needs to be meaningful with sufficient data and involvement of lay people in deciding the options. Healthwatch report on engagement 1300 responses out of a population of 327,000, totally inadequate.

Relying on elected member forums is not always appropriate as most members do not understand health issues, the core, for example of Health and wellbeing Boards should be 3rd sector stakeholders and informed community representatives with an interest in health, with training and guidance provided. Similarly for Overview and Scrutiny; most members had very little understanding of the issues, which is crucial if this statutory body is to carry out its role effectively.

Genuine co-production of services, listening and acting on the communities concerns will build the trust necessary to tackle future health and wellbeing. Only by supporting grassroots initiatives will health inequalities be tackled, parachuting in health and wellbeing co-ordinators will not do that unless asked for by the community.

DIGITISATION OF SERVICES

Urgently needed for out of hospital care, integration of services and improved training. Refer to Cairns Hospital, Australia which is the first large scale regional digital hospital in Australia.

In conclusion, over the last few years being involved in trying to improve our health service; particularly the acute hospital, I have been disappointed that the many solutions to our problems have not been acted on. There needs to be support for the local and regional initiatives that understand the issues in rural and remote areas, with appropriate funding and leadership support, rather than imposing inappropriate centralised models, only then will be have solutions to the long term sustainability of the NHS.

21 September 2016