

NewStatesman



We can rebuild it

Developing sustainable health care for our future

In collaboration with



WITH

Andy Burnham Amanda Howe **Rachel Stancliffe**

PARTICIPANTS



David Buck
Senior Fellow, Public
Health and Inequalities
Kings Fund



Andy Burnham MP
Shadow Secretary of
State for Health



Dr Peter Carter
Chief Executive and
General Secretary
*Royal College of
Nursing*



Thomas Cawston
Research Director
Reform



Prof Amanda Howe
Honorary Secretary
*Royal College of
General Practitioners*



Branwen Jeffreys (chair)
Health Correspondent
BBC



Prof Jane Maher
Chief Medical Officer
*Macmillan Cancer
Support*



Rachel Stancliffe
Director
*Centre for Sustainable
Healthcare*



Sam Taylor
National Policy Lead
Pfizer UK



Prof Cathy Warwick
General Secretary
*Royal College of
Midwives*



Sarah Woolnough
Executive Director of
Policy and Information
Cancer Research UK

Contents

11-17 January 2013

New Statesman
7th Floor
John Carpenter House
John Carpenter Street
London EC4Y 0AN
Tel 020 7936 6400
Fax 020 7936 6501
info@newstatesman.co.uk
Subscription inquiries:
Stephen Brasher
sbrasher@
newstatesman.co.uk
0800 731 8496

Supplement Editor

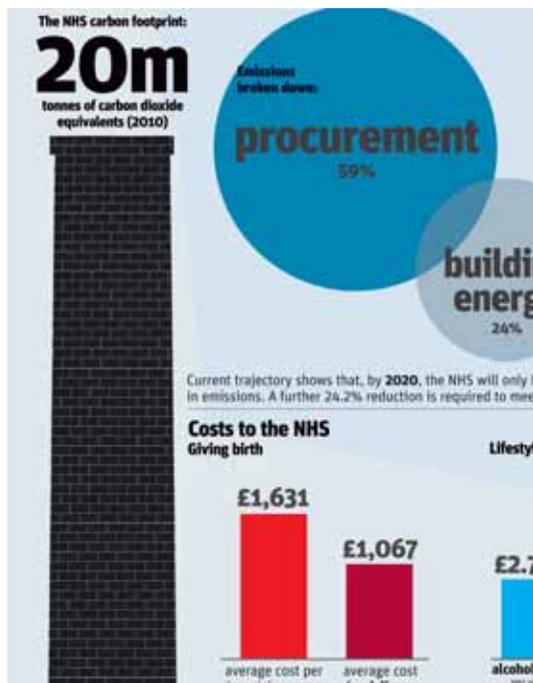
Caroline Stagg
Art Director
Anja Wohlstrom
Picture Editor
Rebecca McClelland
Production
Leon Parks
Graphic Design
Henrik Pettersson

Commercial Director

Peter Coombs
020 7336 5296
Partnerships and Events
Manager
Rosalind Goates

Reprints and

Syndication Rights
permissions@
newstatesman.co.uk



The true costs to the NHS, p15

“It’s clear to anybody in health care that the district general hospital model is not sustainable in its current form”

Andy Burnham, p12



Round table debate, p6

Health for the people and the planet

Like other developed countries, the UK is facing rising demand and costs in health services. More people live longer, but more people are living with long-term conditions that affect their health (estimates say more than 15 million). The government’s Health and Social Care Bill has requires the NHS to make efficiency savings of 4 per cent per year – the equivalent of £20bn of savings by 2015. With such a significant reduction in NHS funding, how can we maintain the current level of services?

A report by Sir Derek Wanless indicates that the two key variables which could affect the levels of funding required are the extent to which the NHS is able to achieve greater levels of productivity, and how far the general public becomes engaged with its own health, contributing to preventing disease rather than just treating it. Participants at our round table event explored how the NHS can maintain the standards of care it aspires to, while responding to the efficiency savings which have been imposed. ●

This supplement, and other policy reports, can be downloaded from the NS website at newstatesman.com/supplements

Articles

- | | |
|-----------|--|
| 4 | Three into one Andy Burnham outlines Labour’s emerging vision for health and social care, working towards a “whole-person” approach |
| 5 | Pulling together The NHS must continue to invest in innovative medicines to ensure discoveries reach patients, writes Sam Taylor |
| 6 | Working harder and smarter Our round table participants discuss new efficiencies and developing new working practices |
| 14 | Keeping pace Improvements in services and high-quality care are what matters and organisational changes miss the point, argues Anna Dixon |
| 15 | Facts and figures |

First published as a supplement to the New Statesman issue of 11-17 January 2013.
© New Statesman Ltd. All rights reserved. Registered as a newspaper in the UK and USA.

The New Statesman is printed on 100 per cent recycled eco-friendly paper

Three into one

By Andy Burnham MP

In England in 2012 we have a council-run and charged-for social care system, mainstream free-at-the-point of use NHS and a mental health system, in separate buildings, pushed to the fringes of society.

In the Department of Health, the NHS and social care issues are seen as very separate. This thinking has deep roots in the post-war Welfare State settlement, where physical and mental needs would be met by the NHS but not social needs. Even now we try to meet one person's needs through three separate care systems – this approach is not sustainable in the 21st century.

Labour's emerging vision for health and social care in the 21st century is of one system and one budget, working towards a "whole-person" approach to care.

What has changed between the 20th and 21st centuries that demand this change? First, the modern condition means people are living with much higher levels of stress and change in their lives which makes mental health support a mainstream requirement. Yet the separateness of our systems means that people with serious mental health problems still die on average 15 years earlier than everyone else, partly because people in the mental health system have their physical health needs neglected. It is a scandalous health inequality that we must reverse.

The second great trend we are dealing with is our ageing society. As we live longer, our needs become a complex mix of the social, physical and mental. But our three systems are rarely capable of meeting these three needs simultaneously. So we hear recurring stories of older people on hospital wards – dehydrated and disorientated – because they are simply not

geared up to provide the social and mental support people need. The 20th century model of care will be overwhelmed by the ageing society.

The reason I rejected the government's NHS reorganisation so fundamentally is because it is a fast track to fragmentation – leading to a broken-down, market-based system where an ever-increasing number of providers are responsible for one person's care and where it becomes even harder to sustain an integrated approach between the NHS and councils. The future demands integration and that's why I will repeal the Government's health Act.

Labour will build a one-system vision for whole-person care. It means building on the essential strength of a planned NHS, extending its values. In 2013 we will be taking out our health and care policy

It's about spending what we have much better than we do

review, asking the central question – can we build a one-system, whole-person health and care service.

This is not about new money, but about turning the system on its head and spending what we have much better than we do. Not cutting social care to the bone and spending millions on keeping older people on hospital wards. Not missing children's needs early in life – mental health needs, speech/language needs, or children on the autistic spectrum – and then spending millions as they end up in the criminal justice system. But giving whole-

person support to both so older people can enjoy retirement free from fear and young people can fulfil their potential.

Commissioning for prevention

This whole-person, whole-child approach is about commissioning for prevention, for good health. It is about turning incentives on their head, moving money out of hospitals, getting much better value from what we currently spend.

The 1948 World Health Organisation definition of health says that "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" – social, physical and mental care as part of one continuum.

If we can bring them together in one truly integrated system, there would be a single point of contact for individuals and families – instead of battling the system on a daily basis, being passed from pillar to post, falling between the gaps.

Politicians' fear of headlines about "death taxes" and the like means they are in effect happy for thousands and millions of families who don't feature on the media radar to carry on paying ever-increasing "dementia taxes". While politicians cower in Westminster, people are paying more and more for care out of their own pockets – they're doing it in the most unfair and random way imaginable. It is exactly the same as medical charges pre-NHS and just as cruel.

The public are far ahead of politicians on this and a big political dividend awaits the party that breaks this cycle of timidity and takes a bold approach. ●

Andy Burnham MP is Shadow Secretary of State for Health

Pull together

By Sam Taylor

The NHS is undergoing a considerable period of change – possibly the largest since its inception, but definitely its most significant. The NHS sits at the crossroads as demands on healthcare reach crisis point. The Government target to save £20bn in the NHS by 2015 is challenging, and there may be further efficiency savings on top of that need to be made. Without question, there is a huge task ahead to ensure value for money throughout the NHS for the foreseeable future.

At the same time as unprecedented cost savings needing to be made, we also face the increasing demand on health services with NHS cost inflation driven by an ageing population.

Part of ensuring that we can keep future healthcare sustainable and affordable is a commitment to innovation and helping best practice and technology spread throughout the NHS. The Department of Health is committed right from the top on determining how best to disseminate innovation through the system. Last year saw the publication of the Innovation, Health and Wealth (IHW) Report commissioned by Sir David Nicholson, and the subsequent launch of the IHW process to ensure the report findings are translated into real change.

Catalyst for innovation

Pfizer believes it can play its part as one of the biggest suppliers of medicines to the NHS. New medicines and vaccines can be a catalyst for innovation, enabling new ways of treating patients cost effectively and creating pathways that better match modern healthcare demands.



However, all too often, cutting medicines budgets is seen as an easy way to save money. But the NHS and patients can pay through poorer outcomes, and less effective care. So called ‘silo budgeting’ doesn’t recognise that spend on medicines in one area can make savings in another.

We also sometimes hear that medicines are a key cost driver in NHS spending, which is far from the reality. Less than 10 per cent of NHS spend is on medicines and spending is set to decline as a proportion of the NHS budget over the next few years. We get a good deal for our medicines in the UK – we currently pay less for them than most of Europe, and loss of patents on major branded medicines is projected to yield £3.4bn of cumulative savings to the NHS between 2012 and 2015. Despite these low prices, uptake of new medicines remains really low in the NHS, and in the UK use of new cancer medicines is 33 per cent lower than the European average.

Medicines are part of solution

We hope the government recognises that medicines are fundamentally part of the solution and not part of the problem to the future affordability of healthcare – one only has to look at the step change impact of medicines to see the value they bring.

For example, in chronic heart disease, the death rate among under 75s has been cut by nearly half in the last five years, thanks largely to significant improvements in treatment. The use of statins saves an estimated 10,000 lives every year, contributing to the lowest ever rates of premature death from Coronary Heart Disease. Medicines to treat stomach ulcers have meant that the NHS has been able to make major savings on ulcer surgery.

Medicines discovered and developed by industry help the NHS to save and transform the lives of millions of patients in the UK every year.

To this end, partnership between between industry, the Department of Health and the NHS is vitally important to a sustainable healthcare system in the UK. Working together we need to ensure medicines are used in a way that ensure patients get maximum benefit. Looking ahead there are many hugely exciting pharmaceutical innovations that will have transformative outcomes for patient care, and it is therefore vital that the NHS continues to invest in innovative medicines to ensure these discoveries continue and ultimately reach the patient. ●

Sam Taylor is National Policy Lead for Pfizer UK



The efficiency challenges mean that we need to take a radical look at how we provide services in the NHS.

BRANWEN JEFFREYS Our discussion this morning is about two fundamental questions: how much can we afford to spend on health care and what will that buy us in the future? These are the two critical questions that are going to face any political party that is in government after the next election. We know that there is particular pressure on health care; we have an ageing population and more people are living with long-term conditions. We have new technologies and treatments but, alongside that, there is an increased expectation from the public that they will be able to have access to any new treatments as they are developed.

At the same time, we have the massive efficiency drive underway in the NHS. In 2009, the NHS was told it had to find £15-20bn of savings by 2014/15. No one expects that pressure to ease up after 2015. In fact, academics expect the squeeze to continue at the same

extremely stringent rate. All of this forces some quite radical rethinking about how we deliver health care.

For the first time in its history, the NHS is having to live within a standstill budget; and that's probably as good as it's going to get within the next few years.

So, can we coax the population into being healthier? Can we deliver health care differently and, at the same time, more efficiently, as well as achieving all the outcomes that we would like to see in terms of improving people's health?

Perhaps hardest of all, how can we engage the public in the debate on the financial realities that are facing health care and the way that things might have to look in the future if we are to give them the type of modern health care that they need?

I want to start by asking David Buck to tell us about the King's Fund research into health inequalities, which took data from health-care checks around England.

DAVID BUCK Before I start, I'd just like to draw your attention to a couple of King's Fund reports. One is *Transforming the Delivery of Health and Social Care*, which looks at the future and what we're talking about today; and we'll be producing lots more substantive work around this very soon. Another report we produced in August, *Clustering of Unhealthy Behaviours Over Time*, looks at health behaviours. When I worked in government I thought that perhaps we weren't making the critical links between public-health policy and inequalities policy as much as we should do. So, this is the result of the work that I did when I came out of government.

I'm a pessimistic optimist; or an optimistic pessimist; I'm not sure which. There is some really good news: we know that a lot of young people are shunning alcohol, drugs, and tobacco. Actually there's some very positive news around the behaviours and choices of our

Working harder and smarter

We can create the NHS that we want if we are prepared to take on new efficiencies, listen to what people really want and develop new working practices



young people – albeit there are always pockets of issues. Demonising the young needs to stop, I think.

We tend to look at behaviours in isolation but we also need to think about how they cluster in people and what that may mean. So we looked at this for a period between 2005 and 2008. What we found was that having a cluster of three or four unhealthy behaviours – by that I mean smoking and not adhering to government guidelines on diet, physical activity and alcohol – can have an impact on mortality of reducing life expectancy by about 14 years.

We found some real improvements over time – about a 20 per cent reduction in the proportion of adults who had three or four of those behaviours. So I'm not going to sit here and say that everything's terrible. But the thing is that we weren't expecting to see that and we don't really know why it's happened. So we need to understand much better what has

happened and what we can learn from it.

The sting in the tail is around inequalities; people from lower social groups and people from lower educational backgrounds didn't really change their clustering behaviours. The good news is that it didn't get any worse – they weren't on a real decline – but they didn't improve. So relatively, inequalities have increased over time in clustering behaviours. This is an area that it is really critical for us to understand – the evolution of inequalities over time. In ten, 20 or 30 years, are these people going to be the real drivers of demand in the NHS?

Health and Wellbeing Boards are a very positive thing, as is the role of public health in local authorities but the message for us is that we need to understand what has led to the improvement that we've seen and we need to focus on the links between inequalities and public health.

BRANWEN JEFFREYS I think what you've done very well for us is to set out why this matters – that all of this is potentially one of the massive drivers for future health-care costs. Andy Burnham, how realistic is it to think that the health service will look anything like it does now in ten years' time?

ANDY BURNHAM I don't think it will – and it shouldn't. The efficiency challenges mean that we need to take a radical look at how we provide services, and that's what I'm doing now as I refresh Labour's health policy. It goes back to first principles. If you look back at the World Health Organisation's (WHO) definition of good health in 1948, it defined it as a state of social, physical and mental wellbeing, not the absence of disease or infirmity. When we created the NHS, we left out the social bit; and the mental side of it is in separate buildings and has separate organisations. But we can't

disaggregate people's needs and we haven't had a system that looks after the whole person.

This is my starting point for this period. The preventative side is the social side – helping people with their daily living before they fall ill and can't cope. We aren't incentivising investment in that, keeping people well in the first place. Instead, the system is paid by how many people come into hospital.

What we need is a one-budget, one-system approach where we look after the whole person, where the incentive is clearly to invest in prevention. We have to turn the whole thing on its head. The NHS is celebrated as being the most efficient health-care system in the world but it's only efficient within that bit in the middle. We can only maintain levels of service if we accept big changes to the ways that we deliver health care. Now, of course, that has implications for hospitals and politicians are going to have to agree some rules about how we allow clinicians and commissioners to make changes to hospitals, to allow the system to move decisively towards prevention, keeping people out of hospital and spending the money in a more efficient way.

The days are gone when we can have the NHS arguing with councils about which budget continuing care comes from. It's a one-budget, one-system approach. Our ageing society is demanding that this change comes and that it comes quickly.

JANE MAHER One of the things that has been quite important in cancer care is the impact of having a national patient experience survey and a national patient reported outcomes survey. I've observed, going round hospitals, that chief executives are actually talking about patient experience for the first time. And the patient experience survey is probably one of the most sensitive indicators of whether you have integrated care. The patient experience survey indicates that, on the whole, there is probably very poor transition between primary and secondary care and that it is badly managed across the board. We need to make sure that we link process data and patient reported outcome data, so that you can measure things that are important to people as well as the resource use and the activity data.

The second thing is to make sure that

there are bodies in place to insist that health and social care is integrated; bodies that look at the whole pathway. If we're going to look at the whole person, we've got to have measures in place to make sure it is being documented.

SARAH WOOLNOUGH There is reason to be optimistic about changing behaviours with regards to risk factors. Think what we have done with tobacco. Yes, there's still a long way to go but by taking a

I've observed, going round hospitals, that chief executives are talking about patient experience for the first time

Jane Maher

comprehensive approach, a mix of legislation and cessation support at local level, and media campaigns, we have shifted culture, shifted the paradigm really, and we are seeing the impact of that.

Another example is breast-cancer awareness; we really have seen such a huge culture shift. So, if we put our minds to it, there is reason to be optimistic. We can change the culture towards leading healthier lives but you need to sustain it long term, you need to make sure the system is joined up. For example, interventions from health services and public-health professionals are incredibly effective, there are 'teachable moments', particularly around secondary prevention in after-care when you can reinforce healthy-living messages.

Cancer is a complex condition, I absolutely agree with what Jane has said. We've got to be careful we don't dismantle the infrastructure that has spread best practice. We can see some pockets of very good practice in cancer but not everywhere, and we've seen cancer networks and strategic health authorities, and others who have been the drivers, spread some of that good practice.

One final example might be early diagnosis of cancer. It's a huge problem that we diagnose cancer late – one-quarter of all cancers are diagnosed via A&E. We are really starting to gain traction by shifting behaviours and

various other interventions. We can't dismantle the infrastructure that's leading that and, in many instances, that's been the cancer networks.

BRANWEN JEFFREYS Sam Taylor, one of the drivers of costs has been around cancer. There have been some fantastic new therapies going on. Do you expect that the financial pressures around that will continue to increase? Will we continue to see the same pressure on new therapies emerging?

SAM TAYLOR From the medicines side, because it's been seen as an easy target, we've probably seen a lot more pressure than other areas. One of

the issues around how sustainable things are is that, if you see medicines appropriately and value their delivery of innovation in the system, their development should be seen as an investment in delivering a different type of care in a different pathway. However, at the moment it's regarded as a cost and as something we can take out of system; that's the concern from our perspective. When you look at the current cost of medicine: it's flat; and when you look at the cost of medicine going forward: it's flat.

So, despite the perception in the system that medicines can actually reduce the spend, the reality is that the medicines are not growing. Therefore, it's more about how we invest money appropriately. Certainly with new medicines, particularly cancer medicines, they are becoming more expensive because they are more personalised. Either we put sticking plasters in place that treat certain conditions differently to others, or we get a situation where we restrict availability, creating greater inequality, and greater variation. We certainly look at that as being quite a significant risk. We need to ensure that we get medicines used in the right place in the right way, so that they deliver the right outcomes, as opposed to a short-term perspective, which I think we've seen quite a lot of through things like QIPP, where medicines have probably been targeted inappropriately.

A HEALTHY FUTURE

ANDY BURNHAM Are medicines opening up opportunities for efficiency? For instance, cutting length of stay or perhaps offering more treatment at home?

SAM TAYLOR That's one of the things we're keen to develop opportunities for. We want to develop our understanding of how to use medicines; that's quite important. We're looking more at medicines that have been used in secondary settings and whether they can be used in primary settings. How can we redesign services to make that more effective?

At the moment I'm working with the National Institute for Health and Clinical Excellence (NICE) implementation collaborative, where we're looking at case studies of certain medicines that haven't had the uptake in the system that they should have done. One of the challenges that you can see in one of those pilots is very much that of "actually this should be being used more in primary care, where it's actually more cost-effective". But the reality at the moment is that it's still being used in the wrong setting. How we help the system redesign and develop is really important.

BRANWEN JEFFREYS Peter Carter, do you welcome the offer of a new political dialogue around this, without MPs rushing to the barricades at the first sign of any change in local services?

PETER CARTER Of course we welcome it and would want to work with any government on it. As an organisation, we came to terms with the fact that money had to be saved. Our disappointment is first of all that there's no overarching plan. I think you need a mixed economy of interventions. You do need to allow individual trusts and employers to see how they can best meet some of these challenges, but also there should have been some overarching plan that sought to get some of these organisations to work together.

I'm a great fan of foundation trusts but one of their downsides is that they've led to a very parochial, narrow approach and some individuals treat them like their personal fiefdoms.

You can tinker around the edges but you're never going to make the real paradigm shift that's needed until you get the NHS and local authority working

in tandem on how to move forward.

On the medicines management issue, two years ago the National Audit Office published a very interesting report, which was sent to every NHS trust chief executive. One of the findings was that, every day, people admitted to hospital for elective interventions are asked to bring with them any medicines that they are taking. Most hospitals routinely throw it away – that happens every day. The National Audit Office estimates that that wastes about half a billion pounds a year. That's a massive number.

We think QIPP has been an illusion; there's very little evidence that these cuts have been efficiency savings and intelligent service redesign.

Yes, local MPs are often one of the biggest impediments to facilitating change. Take the review of the children's cardiac services. This was a clinically led review, which we think makes sense. Everyone was happy with it, until it came to the decision about which four centres we were going to lose. I thought it was appalling that they took the NHS Authority for London to court. They wasted a million pounds; they won on process; NHS London appealed it. Millions of pounds of public money wasted, as we see it. The component parts of the health service should be



We're looking at medicines that have been used in secondary settings and whether they can be used in primary settings

Sam Taylor

talking with each other and not everybody can – as they would see it – win.

BRANWEN JEFFREYS We're already seeing massive reorganisation in maternity services. Professor Warwick, how do you reconcile this tension between the need to deliver good, safe services within the money available and the concerns of local communities, which are often what local politicians are voicing?

CATHY WARWICK I think we've got an awful lot of work to do and it is about working with the public and working with the media to a large extent. Every time there's a threat to a local obstetric unit, to change it into a midwifery-led unit, you get this word "downgrading" across the top of the newspapers. We know from the evidence that it isn't downgrading, that it's probably going to create a better service. So I think it's really down to the professionals to talk about safety in different terms. Whether you're talking about money or greener issues, I think it works in relation to maternity services. We've known for a long time really that good care isn't just about physical safety; it's about emotional safety as well. It's really interesting in maternity because you can find a woman who's had, in theory, a very good outcome – she's healthy and her baby's healthy – but actually she is severely traumatised. On the other hand, you can find a woman who has had a very poor outcome, such as a stillbirth, who's actually had fantastic care and, while the experience is very bad obviously, it is still sustainable in terms of the rest of her life.

Women want choice, they want respect, they want to be able to trust their caregivers and they want individualised care. We've really got to drive forward service reconfiguration that can deliver that. We could have many, many more births at home, for example. We know that that is the cheapest way of delivering care to low-risk women, and yet we're not delivering it; the home birth rate has

stayed resolutely around 2 per cent for ages.

What we do know is that it's not really up to the public. If professionals decide to offer a really high-class

home-birth service, women will choose it. The home-birth rate where I worked was 10 per cent and that was in some of the most deprived communities in London. Women were choosing a home delivery and coming out of their experience feeling positive.

The other thing we have to think about in this agenda is what the midwife does. People have an image of midwives just there catching babies. But, for most women, particularly deprived women, the midwife is the first point of contact with any health professional when she's pregnant; sometimes it's her first point of contact with the health service. If the woman has a good relationship with her midwife, the midwife can deliver huge public-health benefits and can engage with the father and the granny and teach them about breastfeeding and the problems of obesity. Really we need to make sure that our midwives have enough time to do that.

The situation is crazy at the moment. I heard of a trust yesterday where the infant feeding specialist has been cut and that's in the same fortnight when there's been a huge report from UNICEF about the benefits of breast feeding and how much money that will deliver in savings as well as how much health benefit for women and babies.

I think we've really got to get hold of this agenda and work together. I really endorse what Peter said. We've got to stop individual organisations cutting services that would lead to much more sustainable health care.

BRANWEN JEFFREYS Professor Howe, GPs are very used to making every patient contact count, getting a lot of other information across to patients once they're in front of them. However, GPs are also going to have this dual role of commissioning, having a key say in designing services. Will there be an appetite to do that quite rapidly?

AMANDA HOWE A lot of GPs were working on service commissioning and developing services before the reforms. But good commissioning is only effective in the right context. Like most health – or political – interventions, they can work well in one context and not in another. Clearly there are threats in the current situation. There's a capacity challenge in general practice.

Not only in 1948, but three or four

years ago, the WHO passed the primary care for all declaration. We were delighted because that was a global recognition that, if you have good primary care services that integrate preventive, diagnostic, screening work and chronic care (end of life care even) in one place through a good team – that is a cost-effective service. The good primary care team is a microcosm of integration.

The challenge is capacity; responding to the agenda that the person has come in with as well as keeping the preventive agenda ticking over, answering their questions, encouraging them to take up interventions and self-manage. The capacity in the system to do all these things is tight. And beyond that, we need the capacity to let people go off to do commissioning, to do leadership roles, teach students, do research. We need to keep investing in the primary care workforce; we're all getting busier in primary care because there's more to do, the patients want what we can do for them in our setting. So, just because I've now got fabulous practice nurses, nurse practitioners and health-care assistants working with me, I'm not getting less busy; I'm doing more complicated stuff. There are new technologies, new drugs and things I am now able to do as a GP that the hospital has been doing until

There are new technologies, new drugs and things I am able to do as a GP that the hospital has been doing until now

Amanda Howe



now. So, if we're going to get primary care and commissioning right, we have got to have enough capacity in that system for people to translate their appetite into action.

If you are very keen on commissioning but if the practice says "We can't get a locum for tomorrow that's good enough to look after our patients", you don't get to the meeting. So there's that threat. To be able to carry through any intervention, you've got to have the right people doing the right things; enough thinking time, enough preparation time and training time – and time to communicate with the local authority, for example.

THOMAS CAWSTON Long-term health-care costs are quite interesting because the Office for Budgetary Responsibility's figures predicted they would be 1 per cent of GDP over 50 years if workforce productivity were to stay the same. However, in the alternative models they put forward, if workforce productivity were to fall, we could be looking at 25 per cent of GDP, which would have a massive impact on the economy.

So how do we improve NHS workforce productivity? I've been looking at models of innovation around the world where they've been looking at

new ways of using professionals to add value. For instance there are hospitals in India where they do massive amounts of eye care and heart care.

Consultants in these hospitals are being supported by staff, health-care assistants and health-care professionals who are less skilled and have less training and so cost less, so that consultants' time is maximised and they can get more operations done at a lower cost. For example, a hospital is able to do 60 per cent of the volume of cataract operations for 1 per cent of the costs in this way. The workforce is used differently – they specialise in one procedure. If we are going to redesign services, we need to bear in mind what that means for the workforce. The big gain is about getting professionals to work in different ways and in different places; and we need to think about how we can do that.

RACHEL STANCLIFFE We're talking about two things here; one is health care – the provision of services – and the other is health – the outcome that we want. So the redesign issue is about what we're aiming for. Are we aiming for better health? If so, how many years are we going to give ourselves to achieve that? A lot of the difference between sustainability in terms of financial constraints – which is what you are all talking about – and sustainability in terms of what I mean, which is long-term sustainability for the environment, is really just a matter of the timeframe.

For me, money is a thing that we use to do transactions; it's not a real resource. However, carbon is a real resource and we're running out of carbon. The health service is committed to cutting the carbon of health care by 80 per cent of 1990 levels by 2050. So that means we can either only see 20 per cent of the people we need to see or we do things incredibly differently. So, for me, the urgency with which we need to redesign services needs to be massively brought forward. If the budget is kept the same over the next 30 or 40 years, we will largely be able to carry on doing what we're doing. But we see that shaving things off, doing things differently, can not only keep the health service as we see it now but can certainly improve it.

I would argue that the health service we have now is very good but there are lots of things that we don't do right. We waste a lot, we have big inequalities, we have variation in health care – which is a way of saying that we are doing some things better in some places and we can learn from those – and also we have a lot to learn from other countries.

If you want to add value to people and to people's health care, you've got to stand back completely from what you've got now and that does mean engaging with clinicians. So the way that we work is mostly by getting people around a table. That involves not only clinicians but also patients, industry, and researchers, so we can see how what we're doing now is not working and say "how can we do that better?"

Measurement is absolutely crucial because, if we're not measuring the right things, we're not going to get the right outcomes. At the moment, I'm doing some work at the National Obesity Observatory and they've been looking at a tool that can predict savings for us. For



Shaving things off, doing things differently, can not only keep the health service as we see it now but can certainly improve it

Rachel Stancliffe

example, if we spend a certain amount on preventing obesity, what are the cost savings later on in the system? They need that information because they are fighting for the same budget that is used, say, to mend potholes in the road.

For us, in terms of sustainability, that's good but it's not enough; we're looking at the carbon as well. And that's another complication in terms of the measurement – you're looking at a triple bottom line: financial, social and carbon. So, you get some hotspots, for example, asthma inhalers, which are massive emitters of greenhouse gas equivalents – possibly 7 per cent of the whole carbon budget of the NHS. There's a lot we can do around proper use of inhalers – back to getting the patient engaged and so on. In terms of sustainable health care, we would go back to sustainable development, which is development that provides the outcomes that you want now but also provides them for the next generation and into the future – not just for the next five years, which is the political timeframe.

ANDY BURNHAM For me there's a complete alignment with the agenda Rachel's talking about between environmental sustainability and financial sustainability. I'm not thinking five

years, I'm thinking about a 21st century system because, if we're all living longer, with our needs becoming ever more complex – a mix of the social, physical and mental – I don't think we can carry on in the same way that we have been, trying to meet those needs with three different systems.

For me, the integration of these systems is what will allow us to do things differently. I was struck by what Jane and Sarah were saying about cancer care. I've got a very personal example of what I mean actually. My sister-in-law was dying of cancer in the Marsden when I was a junior health minister; she had four

children. I went to see her one night and she said to me "Can you just get me home, I want to be at home with the children".

There was me, a health minister, so I said "Of course, I'll get on the phone and sort it

out," thinking I would be able to do it. A day of phone calls later and I realised I couldn't because there wasn't the joined-up capacity between the local authority and the hospital trust. There was this problem and that problem and the pain management would be too risky and so on and so on. It was a really instructive experience for me. The system couldn't offer what she wanted from a whole-person-care point of view and yet she was there in a hospital bed that was costing tens of thousands of pounds. Marie Curie did some research which showed that, if you give people the choice to die at home, it saves the NHS a lot of money.

It's the same as Cathy was saying: these systems are sometimes designed without truly thinking about what's best for the person.

If I look back to our time in government, we were offering people choice of providers that meant nothing to them in a way. True choice would have been "can you choose to die at home?" "Can you have your baby at home?" Dialysis is a really good example, where people are trekking into hospital three times a week. What an intrusion into their life! Home dialysis is only about 10 per cent. If you open up those types of services and take a vested interest in the

professions, and say “look, you’re going to have to do things fundamentally differently”, I am certain you can get much better results from people and you can spend the budget better. But it does mean proper integration of health and social care. Without that, you couldn’t provide the choice to die at home. Yes, it does come with big changes to the way people do things, but that’s where my thinking takes me.

I’m not talking about picking a fight with professionals for the sake of it. What I’m saying is that I think it’s clear to anybody who works in health care that the district general hospital model, particularly outside of the big teaching hospitals, in the smaller town, is not sustainable in its current form. My argument to clinicians who work in those hospitals is that it needs to evolve into something different and I would say it needs to evolve into an integrated care provider, providing whole-person care in their locality; physical, social and mental.

It’s quite exciting if you think about it in those terms because it can become a body that is much more about health promotion rather than picking up the pieces in an acute setting. I’m not saying this in a very confrontational way. That’s why I brought through the policy called NHS preferred provider because I wanted to give some firm ground for the NHS on which it could embrace change, moving into different settings but with certainty that they’re still going to be within the NHS. If you try to do this saying we’re going to tender for everything, you won’t get change. I think it’s all about hearts and minds, how you do it. Whole-person care sounds a bit like jargon but I haven’t come up with a better phrase to describe the simplicity of what I’m trying to do. Hopefully clinicians will say “we understand that vision, we know it makes sense for people and that speaks to our sense of vocation, and we can work with that.”

AMANDA HOWE I support a lot of what’s just been said. The point I want to pick up goes back to the health in policies issue. Julian Tudor-Hart, a GP in Wales was one of the first to point out the “inverse care law”, where the people who most need help with their health are the people least likely to access health care. So the test of any changes we make will be how we intervene in the communities where those challenges are greatest.

It’s clear to anybody who works in health care that the district general hospital model is not sustainable in its current form

Andy Burnham



Again, there are some workforce issues for most of the services; it’s hard to get people to go and work in some of the most testing areas, especially in the model where you’ve got to invest in premises and invest in team development. I think there’s also some questions about incentivising those areas.

I would recommend the work of the GPs at the Deep End project in Glasgow if you haven’t already read it. That was about what it takes to change and improve general practice in one of the most deprived areas of the United Kingdom. We know it can be done but it’s got to have the right levers and that also takes in where you train people and how you train people.

This has made a difference in Yarmouth – students are now on the vocational training scheme because they know Yarmouth is quite a good place to work, rather than thinking “Why would we?” So there’s a lot there about how we can encourage people into parts of the workforce that we’re going to need if we’re really going to take up this whole-system prevention.

One more point: I was glad Andy Burnham just said the whole of the 21st century because Cathy referred to the damage of the negative outcome in

childbirth that people live with for the rest of their life. I’ve got lots of patients where the preventive agenda will almost be too late – we’re still having the conversation about

smoking and weight, and self-empowerment. But frankly they’re the victims of a system – they’re often the people with the poorest lives and so on. I’m not going to be excessively heavy with them about the fact that they’re still smoking and a bit overweight unless they want to change. I’m going to work with them but we’re also going to have to look after them with the consequences and illnesses. So what we can prevent upstream, the health service mustn’t victim-blame downstream. One of our worries is that the person may be told that they cannot have care because there are cuts, when yes, their lifestyles might not be the best but that might be society’s fault.

BRANWEN JEFFREYS I can see David Buck wants to come in...

DAVID BUCK We all know the NHS is full of great work but the problem is making sure it’s in the right place and spreading it. In Yorkshire and Humber we’ve got 15,000 health champions, working with GPs and working with people. What I think is important is that all that work has been being coordinated by the strategic health authority (SHA) up to now. I was in Doncaster last week and it really struck me how important those regional roles are in coordinating ground-up support from local areas. They’ve got fantastic work with lay people going into communities. So when we think about the workforce and capacity, we’re not anywhere near releasing the potential in people, in the public, in patients and in people before they become patients.

We’re doing a piece of work with people in London and Leeds and the public really are engaged in this debate. If you involve people and help them to understand some of the key issues, they really do want to get involved and help change the future of health care – and see the need to do it. So I think we’re on a good path with this, despite the financial issues.

BRANWEN JEFFREYS I was struck by what Cathy said about people knowing what a good service looks like – even in the poorest communities, they can make a different choice if they have confidence in what they’re being offered.

CATHY WARWICK Absolutely. I just wanted to pick up the issue from what Thomas said about professionals and I do totally agree that it is the professional behaviour that we’ve got to change as much as how people view their services. I think that, if the professionals get hold of what’s right and really get behind it and offer it, then the public do see something different and realise that it’s good.

The other issue I wanted to pick up on was that of using a different skills mix. I think it’s a real risk at the moment that professions won’t engage in discussions about a changing skills mix if they feel it’s all just about saving money.

In my own area, maternity, there’s a real debate going on about the role of the midwife versus the role of the support worker. There’s a real anxiety among the profession that it’s just that support workers are cheaper than midwives.

BRANWEN JEFFREYS And yet they might really change a women’s experience of labour just by being with them...

CATHY WARWICK Exactly. I think the issue is that support workers can be used incredibly well and we often don’t need a highly trained professional to do things but that discussion has got to take place in a climate of trust. It’s interesting that, in Scotland for example, there have been national discussions about what support workers can do in maternity services, and about how they should be trained; there’s a national curriculum.

In England, it’s all being left to the local economy to work that through. It’ll be delivered by provider discussions and the local education and training boards. That just leaves professionals terrified that we’re going to throw out babies with the bathwater! So I think a mature discussion in a climate of trust is necessary, rather than one of fear of being cut because you’re a professional.

BRANWEN JEFFREYS Andy Burnham, how do you get long-term decision making when you’ve got year-on-year pressures to find cheaper ways of doing things?

ANDY BURNHAM With difficulty is the answer to that. Cathy’s absolutely right and actually this is exactly what most frustrates me about what has happened in the last three years. The efficiency challenge, or QIPP in the DH jargon, should have been the only show in town. Nothing else should have been going on.

The idea was that innovation should be driving efficiency in the main and professionals should be coming forward with the ideas themselves, seeing where they could save money and taking ownership of it. Before the last election, the civil servants were saying to me: “We’re going to do nothing else apart from QIPP if you come back.” I bought that completely.

I made a change before the last election that was difficult, where PCTs directly employed community staff. We finally grasped that nettle and we wanted them, in the main, to be employed by acute trusts because we wanted acute trusts to begin to have that workforce on the ground in the community to start to take them in the direction that everybody’s talking about.

Then what happens? Everything is thrown into turmoil with the reorganisation. That was a catastrophic decision to disrupt the efficiency challenge by throwing everything up in the air, and all the costs, waste and distraction that came with it.

The NHS will pay a major price for that because it’s had two lost years on this agenda. And you can see knee-jerk

Support workers can be used incredibly well and we often don’t need a highly trained professional to do things

Cathy Warwick

reactions to the QIPP agenda because local health economies have lost control.

BRANWEN JEFFREYS Did Labour miss an opportunity to change some ways that care is delivered by focusing on investing in hospital buildings when people were already beginning to talk about looking after patients in a different way.

ANDY BURNHAM Maybe we did but we were responding to the issues at the time.

People couldn’t get into hospitals to get their care; they were waiting two years for a heart bypass. We had to get hospitals working more efficiently, get waiting lists down. In the end, the tariff, while it might have helped hospitals work more efficiently, it might have encouraged this somewhat episodic approach to health care, and didn’t encourage the system to look at the whole person. I can see that we really have to turn everything on its head now and face up to the ageing population in different ways.

What I hear is recurrent stories of older people on hospital wards, dehydrated, disorientated because there isn’t the social care on those wards to help them get to the toilet, get dressed, or help them eat their food. Nor is there proper mental-health support on that ward because that’s in a different system and in different buildings. The cracks between these different systems are now becoming a massive problem and that’s why the move has got to be decisively towards integration. And it’s why I reject the market-based reforms that have come in because they’re a path to fragmentation. Arguably, they will make it much harder to deliver these efficiencies and deliver the whole-person care we need, rather than easier.

I think there’s a big philosophical divide coming in health and social care policy and it’ll be a massive choice come the next election.

BRANWEN JEFFREYS I think that’s quite a good place to wrap up our discussion. Some optimism from David Buck which is very nice, that there are younger people coming through who are engaging

more with public-health messages. We’ve heard about willingness to work differently from some health-care professionals as well as the anxieties about the financial challenges. And we’ve had quite a lot of agreement with the idea of taking the patient as the starting point, making their journey through the health-care system as the point at which we should begin to think about how things work in the future. Thank you very much. ●

Change in the NHS has come more slowly than we have seen in other industries

Keeping pace

By Anna Dixon

The mantra that rising expectations, new technologies and an ageing population will render the health-care system unsustainable is not new. Similar arguments were made in the 1970s. Yet here we are, more than 40 years later, spending around 8 per cent of GDP on health care. The basic tenets of the NHS – that it is universal, comprehensive and largely free at the point of use – remain intact. However, the world has changed.

Dramatic shifts

There have been radical shifts in disease profiles, with many more people surviving conditions that were previously fatal. Increasingly, people are living with multiple chronic conditions. While life expectancy continues to rise and more people are living longer, conditions such as dementia are set to increase. Changes in medical technologies have made it possible to treat more people and more diseases. Information technology makes it possible for huge amounts of data to be processed and made available almost anywhere in the world; it has transformed how we communicate and do business. Has the NHS changed to reflect these ongoing dramatic shifts in society?

Successive governments have made repeated attempts to change the NHS but, nearly always, they have focused on re-forming the super-structure, changing organisational and administrative arrangements in the NHS. Constant restructuring by focusing on organisational changes not only misses the point that improvements in services are what matters, but also makes it difficult for those working in the system to deliver high-quality care

in line with their training and values.

While health- and social-care services have evolved since the NHS was established, change has been much slower than in some other industries, where the use of technology has transformed the relationship between service providers and their customers. The current delivery model in all providers (hospitals, primary care, community services, social care and mental health) is based on outdated ways of working that result in poor value for money and lack of user responsiveness. We need different and more fundamental changes to provide health and social care services that are fit for the future.

Evidence of gaps in quality and safety in the NHS underscore the urgent need to develop new models of care. The increasing complexity of health and social needs put the current system under strain. The

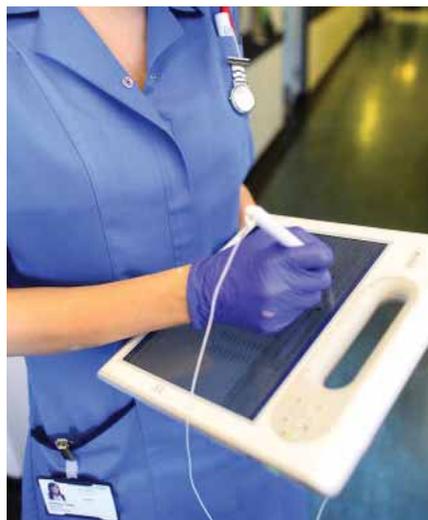
majority of patient contact with the NHS happens in general practice and in the community; patients often want more proactive support to remain at home. But too many people, particularly frail older people and those nearing the end of their lives, find themselves in hospitals and residential-care settings. Traditional relationships between health- and social-care professionals and service users are rightly coming under question. Patients want and can play a much more active role in their own care. For many people with chronic conditions, it is no longer about treatments and cures but about how to maintain a decent quality of life.

New skills mix

We need to think differently about how we organise and provide care, including the role of patients and service users in the care team, the mix of skills and staff that are needed to deliver care, where care is provided and, finally, how care is supported through harnessing the potential of information technologies.

There have been real improvements in the last decade – to waiting times, to the information available about services' performance and in improved life expectancy. However, we believe there remains a strong case for fundamental change. This fundamental change is necessary to protect the core principles of the NHS, specifically the commitment to universal access to care, the provision of a comprehensive range of services, and the ability to focus on the needs of the whole population. ●

Anna Dixon is Director of Policy at the Kings Fund



NHS needs fundamental change

FACTS AND FIGURES

The NHS carbon footprint:

20m

tonnes of carbon dioxide
equivalents (2010)

Emissions
broken down:

procurement
59%

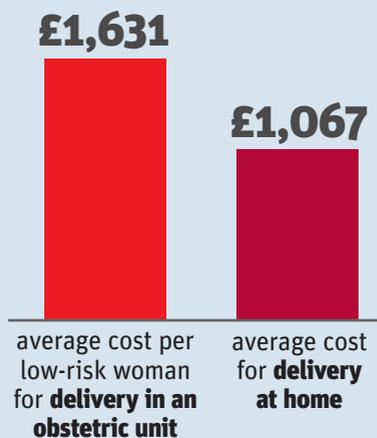
travel
17%

**building
energy**
24%

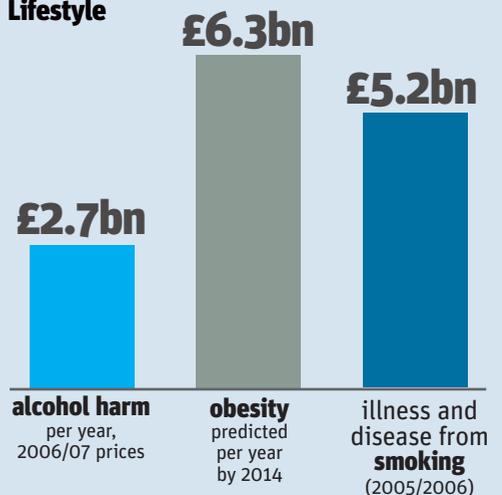
Current trajectory shows that, by **2020**, the NHS will only have managed to achieve a **9.8%** drop in emissions. A further 24.2% reduction is required to meet the **34%** reduction stipulated in law

Costs to the NHS

Giving birth



Lifestyle



NewStatesman

7th Floor
John Carpenter House
John Carpenter Street
London EC4Y 0AN
Tel 020 7936 6400
Fax 020 7936 6501
Email: events@newstatesman.co.uk

This round-table report forms part of the
New Statesman & Pfizer Policy Forum,
a programme of events and publications launched
in April 2005.

It aims to bring together leading opinion-formers
to explore a range of health issues relevant to
policymakers and the electorate alike.

Pfizer sponsors these events and collaborates
with the *New Statesman* to determine
the discussion topics.

The *New Statesman* selects participants
and manages the event, and has sole
editorial responsibility for the content of
the supplement and the text that appears
on the website.

Previous reports can be accessed via the website:
policyforum.co.uk

The logo for the Policy Forum website, featuring the text "www.policyforum.co.uk" in white, centered within a horizontal oval that has a red-to-purple gradient background.

www.policyforum.co.uk