

A collection of essays published jointly by
the All-Party Parliamentary Health Group
and The King's Fund

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HEALTH POLICY PRIORITIES FOR A NEW PARLIAMENT

Health Policy Priorities for a New Parliament

July 2015

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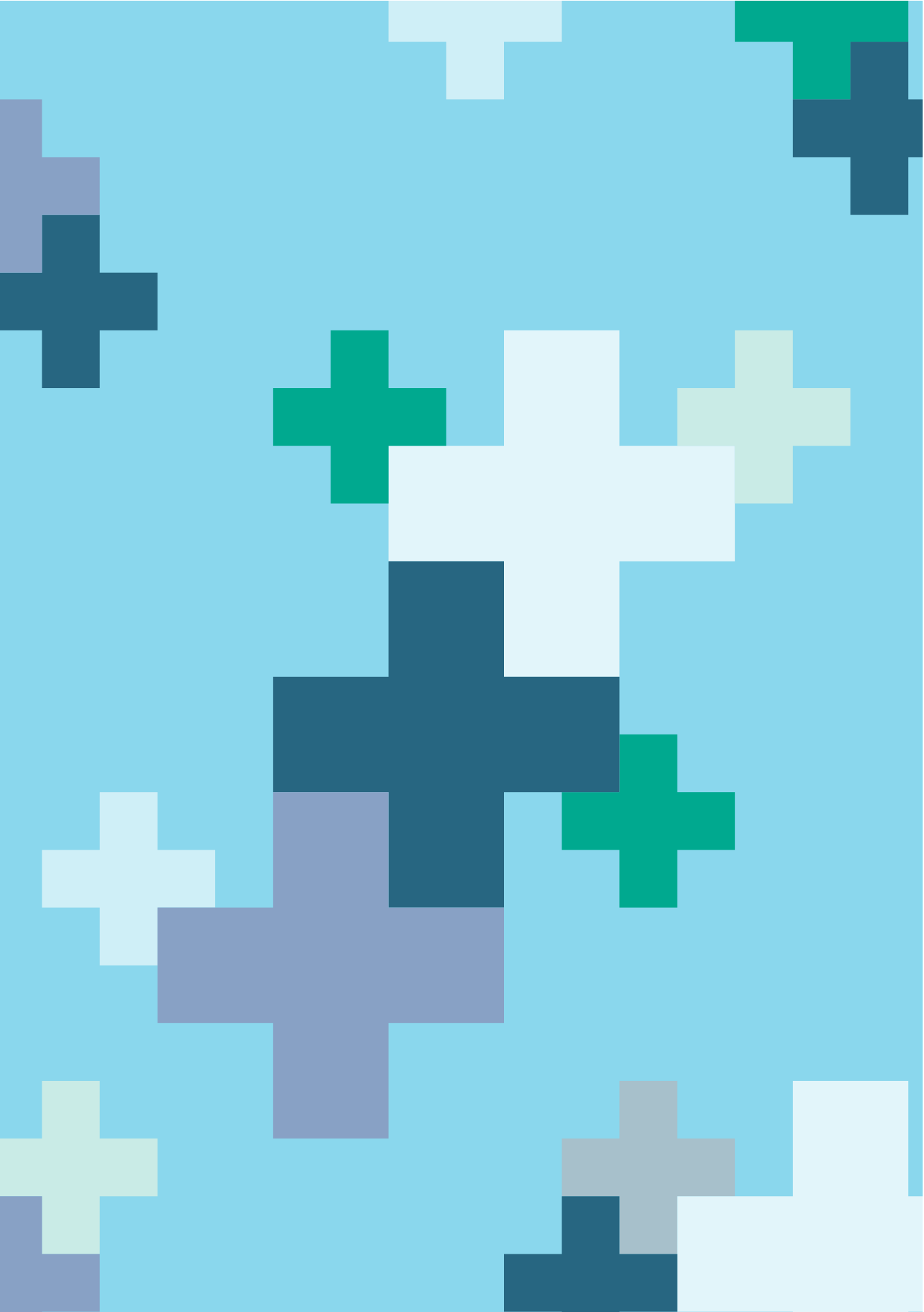


“Over the next five years, parliamentarians must continue to scrutinise how the health and social care system is working, holding the NHS to account for lapses in the quality of care, and structural and financial inefficiencies.

Parliamentarians know how the NHS is doing locally through their regular contact with constituents and healthcare providers; there is therefore no group better placed to articulate the concerns of patients and the wider public – whether at the local or national level.”

Rt. Hon. Sir Kevin Barron MP, APHG Chair

Baroness Julia Cumberlege, APHG Co-chair



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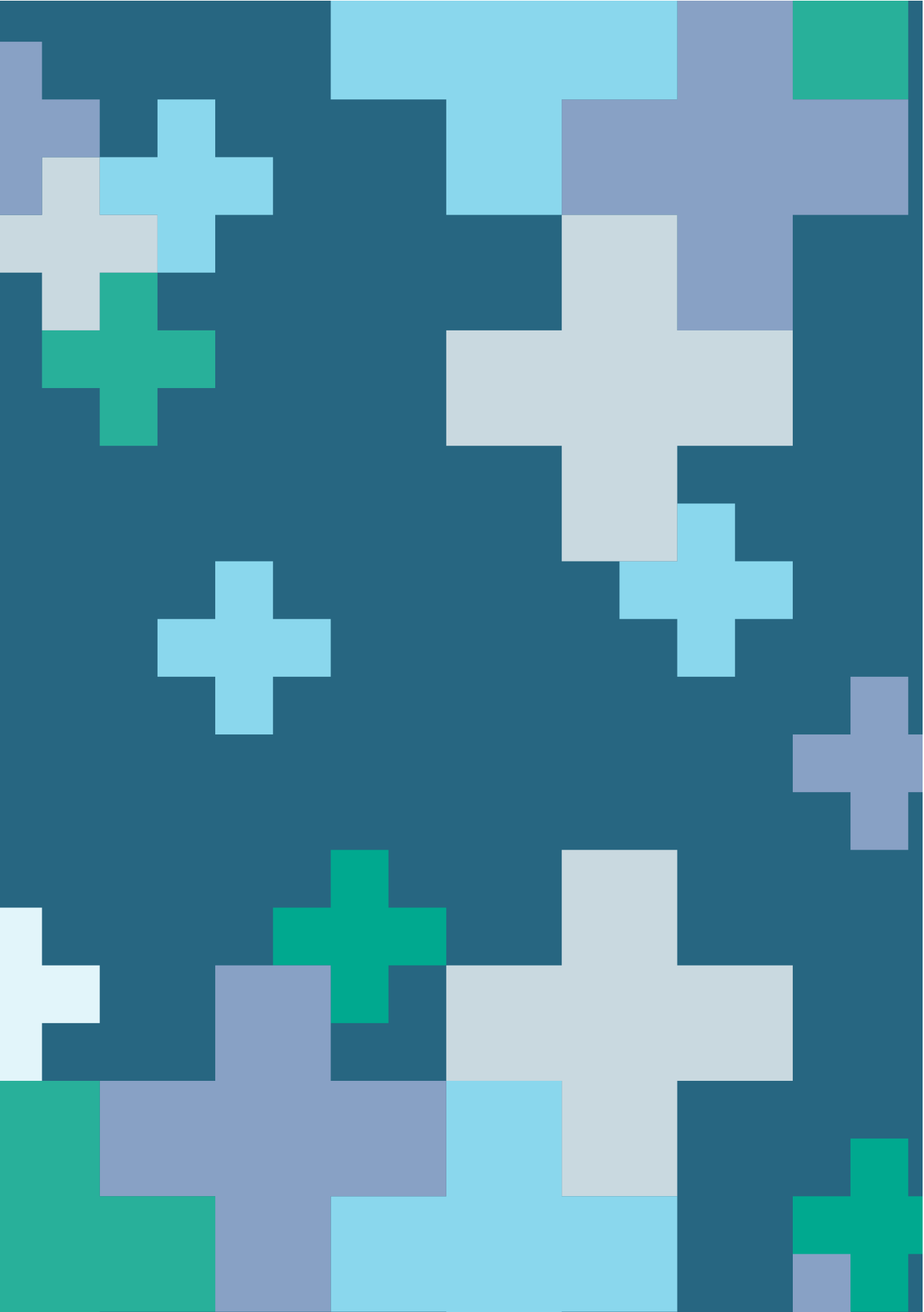
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This collection of essays, published jointly by the All-Party Parliamentary Health Group (APHG) and The King's Fund, maps out health priorities for the next Parliament, as seen from the perspective of a distinguished collection of authors, representing key stakeholders in the world of health. Never has the direction of travel for the NHS been more important – at a time when health and health care dominate public discourse and the political agenda.

We know that health and social care services face many challenges in continuing to deliver existing levels of care to patients, current constraints in NHS spending accentuated by a growing and ageing population and, in some areas, an imbalance in the healthcare workforce.

As a result, in our essay collection on health priorities for the new Parliament, certain themes emerge clearly.

Firstly, how can the financial constraints facing the health service be managed, whilst at the same time trying to improve the quality of health and social care services? It is clear that this is not just about more funding, but also about looking at ways of improving leadership in the NHS and delivering care in more appropriate and cost-effective ways – care at the right time and in the right place, using innovative technologies and cost-effective prescribing that doesn't act as a disincentive to research and development.

Secondly, just how can the greater integration of health and social care be achieved? Fully integrated health and social care is now the gold standard which the NHS is striving for, involving the most effective deployment of staff, in the right

setting, but delivering this poses real challenges in practice. Patients also need to feel consulted about the healthcare decisions that affect their lives.

Thirdly, addressing the adequate funding of mental health services is going to be essential if those suffering from mental health problems are going to be diagnosed and treated before their ill-health escalates to the point where they need crisis care – costing the NHS more, and causing additional distress to already-suffering patients.

And finally, but no less important, there is prevention. When looking at how the NHS spends its resources, adequate attention needs to be given to the prevention of potentially avoidable conditions related to, for example, obesity, alcohol abuse and smoking. In the longer term, helping to reduce lifestyle-related disease and death will reduce the associated high cost to both the NHS and society as a whole. This also requires joined-up policy thinking across Government departments.

The role for parliamentarians continues to be to scrutinise how the health and social care system is working, holding the NHS to account for lapses in the quality of care and structural and financial inefficiencies.

Parliamentarians know how the NHS is doing locally through their regular contact with constituents and healthcare providers; there is therefore no group better placed to articulate the concerns of patients and the wider public – whether at the local or national level. The APHG will also continue to play its part in helping politicians to understand the many challenges facing today's NHS.



Rt. Hon. Sir Kevin Barron MP

Rt. Hon. Sir Kevin Barron MP, Member of Parliament for Rother Valley, is Chair of the All-Party Parliamentary Health Group. In 1996 he was appointed Shadow Minister for Public Health and from 2005 to 2010 he was Chair of the Parliamentary Health Select Committee.



Baroness Julia Cumberlege

Baroness Cumberlege is a Co-chair of the All-Party Parliamentary Health Group and a Conservative Peer. She was a Minister in the Department of Health from 1992-1997 and is currently leading a major review into maternity services in England.

Funding the NHS

Professor John Appleby, Chief Economist, The King's Fund

In 2015/16, the NHS in England plans to spend around £116.6 billion – just under £320 million per day. Funded mainly from general taxation, the NHS now accounts for the largest proportion of Government departmental expenditure – 32 per cent, more than three times the total spending on defence.

Despite the scale of the budget, arguably the major policy issue the NHS has had to grapple with over the past five years has not so much been the last Government's reforms, but rather its decision to restrict the growth in funding. Due to lower than forecast inflation, the planned real funding growth per year of 0.1 per cent, turned into 0.8 per cent – about five times less annually than the long term average real increase in NHS spending.

With growing demand for its services, the NHS has attempted to close the gap through greater productivity. The Department of Health's plan was mostly a top-down strategy: restricting pay rises, cutting central budgets, cutting management costs and cutting the prices hospitals charge under the national tariff system, known as 'Payment by Results' (PbR).

Evidence on whether the NHS met its productivity targets is mixed. What is clear is that while the NHS may have managed to balance its books in the last year of the last Parliament, over half of all hospitals will have overspent by over £800 million (despite a similar amount in extra funds and loans being channelled to the frontline).

While many key performance targets were met in the first half of the last Parliament, the second half saw some of the poorest performances on waiting times for a decade. The NHS has done more with less, but possibly not enough, and the easy wins seem to have already been secured, making the productivity task harder each year.

As the NHS begins a new financial year, it looks as

if it will have to do it all over again. NHS England estimates the NHS needs to grow by around four per cent a year, in real terms, up to 2020/21. With the prospect of more limited funding growth, once again, the NHS must try to fill the gap with annual productivity gains of between two and three per cent. The King's Fund's quarterly survey of NHS finance directors suggests there is a high potential risk of failure.

The pressure for the NHS is immediate. With little or no surplus in the system, many organisations are starting the year in debt (see Figure 1) and with the real increase in funding of 1.5 per cent this year more than swallowed up by transfers to the Better Care Fund (BCF), the NHS will once again struggle to make ends meet while doing more work and meeting targets.

While many agree on the need for better integration of NHS and social care services, social care has been under severe financial pressure. Following reductions in spending over the last five years and a consequent tightening of eligibility criteria, the squeeze could continue. The Local Government Association projects an adult social care funding gap of around £4.3 billion by 2020/21.

The King's Fund's survey of NHS finance directors' views about 2015/16, published in April, makes less than optimistic reading. Nearly 70 per cent of providers and 40 per cent of commissioners are concerned about staying within budget; over 90 per cent of providers and 85 per cent of commissioners are concerned about the overall financial state of their local health economies over the next twelve months.

It is hard to avoid the pessimistic view that the NHS could easily end up – in the short term at least – simply doing less with less as easier productivity gains have been made and money remains tight.

More optimistically, growth in the economy – 2.5 per cent per year real increases, as projected by the Office for Budget Responsibility between this year and 2020/21 – may allow room for a larger settlement for the NHS than pledged before the 2015 election. Nevertheless, the new Government cannot ignore the immediate financial pressures and should plan for the possibility that the NHS will struggle to meet productivity gains over the next five years.



Professor John Appleby
Chief Economist,
The King's Fund

The King's Fund

Contact details

Telephone: 020 7307 2400

Email: enquiry@kingsfund.org.uk

Website: www.kingsfund.org.uk

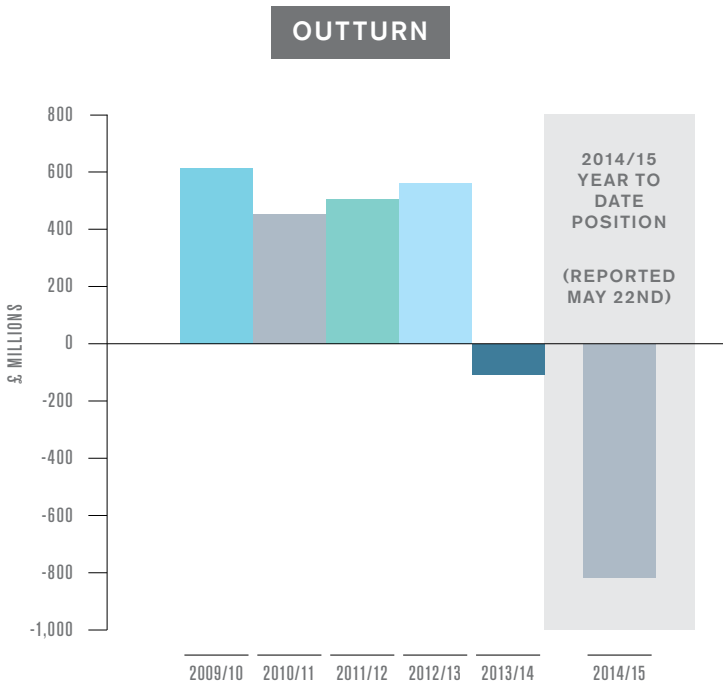


Figure 1: Outturn and forecast end of year position for Trusts and Foundation Trusts: 2009/10 - 2014/15

Delivering integrated health and social care

Professor Chris Ham, Chief Executive, The King's Fund

Differences in the funding and provision of health and social care, originating in the post-war settlement, are now widely seen to inhibit the development of the integrated services required to meet both the needs of an ageing population and the increased prevalence of long-term conditions. All of the main political parties are committed to breaking down the barriers between health and social care and a priority in the new Parliament will be to convert aspirations into action.

The starting point should be to build on the steps taken under the previous Coalition Government to integrate health and social care, including: establishing Health and Wellbeing Boards as a forum for coordinating the plans of the NHS and local authorities; launching a programme of pioneers to test out ways of integrating services in different parts of England; setting up the Better Care Fund (BCF) to pool some NHS budget and local government spending – with a particular focus on investing in services in the community and reducing emergency hospital admissions; developing new care models under the NHS Five Year Forward View; and exploring the devolution of funding and decision-making to Greater Manchester under 'Devo Manc' plans.

These initiatives are taking place in the context of cuts in local government spending, including social care, and growing financial pressures in the NHS. Whilst they demonstrate a welcome commitment to integrated care, there is a risk that the BCF will add to NHS pressures by transferring funding from health care to social care in order to ameliorate the pressures facing local government. There is also much more to be done to remove the policy barriers that inhibit integrated care, such as how care is paid for and how providers are regulated.

A major challenge for the new Government will be to review the adequacy of funding for services in 2015/16 as well as plans for future

years. Commitments made by the main parties during the general election to increase NHS funding were welcome, but it is now essential to ensure additional funding is provided early in the Parliament to prevent deficits among NHS providers from ballooning out of control. This ought to include a 'transformation fund' that can be drawn on to support new care models that bring health and social care together. A transformation fund could be a first step towards a new health and social care settlement in which entitlements to social care are aligned with entitlements to health care, as set out by the Barker Commission.

With increasing emphasis on the joint commissioning of health and social care services, it is likely that the role of Health and Wellbeing Boards will come under the spotlight. These boards are in many ways the obvious candidates to take on more responsibility for joint commissioning, but our work at The King's Fund suggests they are not yet in a position to do so. This reflects the limited time they have had to develop their role, membership and powers, and the complex environment in which they operate. We have suggested that joint commissioning is made a requirement, but that local areas should be able to decide on the approach that best meets their needs.

The new Government should signal its continued support for these developments and be realistic about the time and effort it will take to see positive results. Too often in the past, worthwhile initiatives have been terminated early and frontline staff have not been given enough time to develop new ways of working to provide care that is truly joined-up and patient-centred.

Bold plans to devolve funding and decision-making to Greater Manchester deserve support, despite many questions remaining about how this will work in practice. The ambition behind

these plans encompasses health and social care integration, but goes much further, to focus on improvements to the health and wellbeing of local populations. The prize on offer is to use funding for public services flexibly, not just to integrate care, but to strengthen communities and tackle underlying health inequalities. The history of joint working between local authorities in Greater Manchester means that it is well placed to take forward this agenda as part of a decisive break with established, and often ineffective, silo working.



**Professor
Chris Ham**
Chief Executive,
The King's Fund

The King's Fund

Contact details

Telephone: 020 7307 2400

Email: enquiry@kingsfund.org.uk

Website: www.kingsfund.org.uk

A new settlement for health and social care

Dame Kate Barker, Chair, Commission on the Future of Health and Social Care in England

The post-war settlement for healthcare was a great step forward, but left social care out in the cold. Healthcare has ring-fenced funding and is free at the point of need, but social care is funded out of local authority expenditure, is heavily means-tested, and has increasingly stringent tests for funding eligibility. Health spending has been relatively protected in recent years, but local authorities have had to make significant savings. In 2012/13, 26 per cent fewer people over 65 were receiving local authority care than five years earlier, and 24 per cent fewer young disabled people.

The number of people over 80 in England is projected to double by 2037. This means that more older people will require health or social care. Evidence given to the Commission on the Future of Health and Social Care indicated that recent changes in entitlements, the overall funding shortage, and the lack of coordination between health and social care, leads to much distress and confusion for patients and carers.

The view of the Commission was that the reforms in the Care Act 2014 did not go far enough in dealing with the issues around funding and eligibility. The present situation is that far more care costs are borne by a patient and their family if they have dementia than if they have cancer; there seems to be a basic injustice here. Furthermore, not investing more in social care tends to add to NHS costs by failing to prevent unnecessary hospital admissions and appropriate discharge from hospital; in January 2014 there were 3,000 people in hospital beds who were fit to leave, but awaiting arrangements for discharge.

There is much debate about how health and social care can best be coordinated. The Commission argued that the system would be simpler and easier to access with a single commissioner of health and social care services, managing a single budget. Only

in this way are wasteful arguments about who pays for what, and who does what, eliminated.

A new settlement would require changes in eligibility for funding. The Commission proposed that, as a first step, care should be fully funded for those with the highest levels of needs – that is those with needs currently defined as critical. This would be a larger group than those who presently qualify for NHS Continuing Health Care (CHC) which is already fully-funded. So instead of the funding cliff-edge created by CHC, there should be a funding structure which starts from a low level, non-means-tested, care and support allowance and as need increases, steps through a series of personal budgets which retain some element of means-testing and is free to those with the highest needs.

The Commission recognised that this more generous and fairer system would bring with it a funding challenge, at a time when the public finances remain unfavourable. It is estimated that making care for older people with critical needs free at the point of use would cost an extra £3 billion a year by 2025, compared with present spending plans. These are large sums, but the UK as a whole is underfunding social care relative to the spending levels in most, but not all, other countries of comparable income levels.

As the economy returns to a better rate of growth, the Commission's strong belief is that a civilised society should be prepared to devote more resources to this particularly vulnerable section of the population. The view that people should save for social care in old age is never expressed with regard to healthcare – a remarkable dichotomy of attitude. The fact is, the costs of caring have to be met, either publicly or privately: they cannot simply be avoided.

The Commission proposed a range of measures to raise additional funding: better targeting of winter

fuel payments and free TV licences; a radical overhaul of prescription charges; increasing National Insurance (NI) for those over 40; and introducing a reduced rate of NI for those working past retirement. This would effectively spread the cost of social care across the older population, just as we already spread the cost of healthcare over the whole population.

Such a package may not be popular. But as more and more families find themselves grappling with an incomprehensible and ungenerous social care regime, it will become apparent to all that we should simply talk about CARE and ensure that all in need of it can access it with dignity.



Dame Kate Barker,
Chair, Commission on
the Future of Health and
Social Care in England

c/o The King's Fund

Contact details

Telephone: 020 7307 2400

Email: enquiry@kingsfund.org.uk

Website: www.kingsfund.org.uk

More sustainable funding of social care: a key priority

Ray James, President, Association of Directors of Adult Social Services (ADASS)

Adult social care responds to a wide range of needs. It provides care, support and safeguards for people in our communities who have the highest level of need. It also helps many others to live as independently as possible through joined-up, universal wellbeing services that encourage personal responsibility and community resilience.

Over time care has shifted from remote, long stay institutions towards community and home-based services, with a strong focus on supporting carers. At the same time there has been a revolution in values, based on human rights and the promotion of independence, dignity and choice – offering people increasingly personalised, outcome-based services and support.

Social care has a long history of joint working with the NHS in areas such as coordinating patient discharge from hospital, and much of the care previously provided by the NHS is now delivered through the social care system.

One fifth of the population of England has experience of social care – as part of the paid workforce, as unpaid informal carers or as a recipient of services. As a sector it contributes as much as £43 billion to the national economy and supports 1.5 million jobs, as well as meeting social needs.

However, adult social care is in a period of significant change and challenge. The service is implementing a major set of reforms as set out in the Care Act 2014 and is committed to shifting its focus towards prevention and early intervention, but major problems persist in terms of the adequacy of the current system and how it faces up to new needs and challenges. These revolve around money, how care is delivered and joined up with other services, the quality of care, and the workforce that provides it.

In recent years spending on social care has gone

down significantly, with £3.5 billion less in social care budgets since 2010, despite costs having increased over the same period by 3% per cent annually owing to changes in demography. Ninety per cent of councils are now only able to respond to people with critical and substantial needs – in 2005 that figure was 47 per cent. At least 400,000 fewer people are getting publicly-funded help and by 2020 it is predicted the system will be face a funding gap of at least £4.3 billion.

The extent of knowledge regarding the growing numbers of people not entitled to publicly-funded care is limited, but it seems inevitable that their unmet needs will be displaced to other places and people, such as unpaid carers and hospitals.

Accordingly, the need to place the funding of social care on a more sustainable basis is pressing. The inter-dependency of NHS and social care resources means that the protection of the NHS from real term reductions, whilst leaving social care exposed to deep and significant reductions in local government spending, makes no sense. The NHS can only be protected properly if social care is protected too. The case for a single, shared funding settlement, that covers social care as well as the NHS, is overwhelming.

We want to see a system that is protected, aligned, and redesigned. To achieve this there are some immediate priorities that need to be addressed: ensuring that social care funding is protected and aligned with the NHS (including making provision for the £4.3 billion gap by 2020); focussing on ensuring quality is high and that no services cause harm; and heightening efforts to build a sustainable social care workforce, both now and in the future.

There is also the matter of developing new social and health care delivery models that are based on good information and advice to help people self-manage their health; which recognise that we are

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all interdependent and need to build supportive relationships and resilient communities; which provide services that help us to get back on track after illness; and which support disabled people to be independent.

Above all, when we do need care and support, we need services that are joined up around individual needs, including those of carers. Personal budgets are central to this approach.

ADASS welcomes the opportunity to work with the new Government and parliamentarians to both sustain momentum and accelerate social care reforms so that the mutual goals of improved health and wellbeing can be realised for all local people and communities across the country.

Association of Directors of Adult Social Services (ADASS)

- ADASS is a charity and a membership association which aims to further the interests of people in need of social care by promoting high standards of social care services.
- ADASS is focused on being positive about health and wellbeing by furthering opportunities for joint working and integration, in order to help support people to live well.
- ADASS works to influence the development of social care legislation and policy, including promoting good practice, and research and innovation aimed at improving health and wellbeing.



Ray James
President, Association of
Directors of Adult Social
Services (ADASS)

ADASS

Contact details

Telephone: 020 7072 7433

Email: team@adass.org.uk

Website: <http://www.adass.org.uk>

NHS spending on medicines

David Taylor, Emeritus Professor of Pharmaceutical and Public Health Policy, UCL School of Pharmacy

The central challenge facing the NHS with regard to medicines purchasing and use is to ensure that patients have good access to established and new treatments at an affordable cost, while also ensuring that enough is spent to protect public interests in ongoing investment in pharmaceutical innovation and industrial development.

Recent figures suggest that, for the first time since 1948, the UK trade balance in pharmaceuticals is in danger of becoming negative. But the long-term record of the health service in using its drug-purchasing powers in ways which do not reduce the country's capacity to attract research and manufacturing investment has, if not as good as that of the US and Switzerland, not been as bad as is sometimes feared.

In 2015/16 the NHS will spend about £15 billion on medicines and other pharmaceutical items. This represents 10 per cent of the total cost of the health service and one per cent of UK GDP. Almost a third of this spending is related to purchasing off-patent generic drugs, mainly produced in countries like India. The remaining outlays are mostly on innovative medicines with active intellectual property rights (IPRs). Similarly, about a third of all NHS pharmaceutical costs are today accounted for by items supplied in hospital; the remainder are mainly provided through community pharmacies.

NHS hospital pharmaceutical spending has risen relatively rapidly since the start of the 1990s because of the growing use of high cost, yet comparatively low volume, medicines used in areas such as oncology. However, as a proportion of all NHS outlays, total pharmaceutical costs have stayed broadly constant for almost half a century. As new and expensive medicines have been introduced, established treatments have become generically available at lower prices. This is possible because, with the loss of IPRs, products usually cease to make R&D and allied cost contributions.

New medicines and allied health technologies have helped to improve health outcomes. In oncology,

for instance, they are now reducing age-specific death rates. Despite controversies about anti-cancer drug costs, they account for little more than 0.1 per cent of GDP. Nevertheless, sometimes exaggerated fears (including those relating to new treatments for Hepatitis C, which are already available for considerably less than the published launch price) have led to an increased focus on controlling individual product costs.

The NHS's long-established Pharmaceutical Price Regulation Scheme (PPRS) seeks to control returns on capital and overall outlays. In its current format it imposes a cap on total NHS spending on branded/IPR protected medicines. Expenditure above an agreed ceiling is returned to the Treasury. Yet on top of this, NICE and its partners conduct assessments which may or may not find given medicines 'affordable' in incremental Quality Adjusted Life Year (QALY) terms. Bodies like NHS England and local Clinical Commissioning Groups (CCGs) are also seeking to establish their own rules as to when treatments are affordable.

For some it may be reassuring that there are multiple controls on pharmaceutical pricing and costs. However, there is a danger of unduly complex and restrictive bureaucratic interventions. These could harm patient interests and make the UK less attractive to private investors. Public spending on resources such as Academic Health Science Centres (AHSCs) and initiatives like the 1000 Genomes Project will be of limited value to the country unless positively linked to income-generating industry.

This reality cautions against over-elaborate approaches to controlling individual medicine prices. Theoretically, the fact that the fixed costs of drug development are usually very high as against the marginal costs of pharmaceutical production means that, once licensed, effective new treatments could be made affordably available to all whom they may benefit, should a sufficiently sophisticated incentive and compensation system exist.

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This is not to suggest that public spending on medicines ought not to be controlled. It is rather to emphasise the potential value of overall cost-capping measures as opposed to attempts to set the unit prices of individual treatments.

Notwithstanding problems linked to 'postcode prescribing', the NHS has had a relatively good record of limiting medicines outlays to affordable levels without unduly undermining access to cutting edge medicines. To go on prospering, the nation should seek to build on this achievement in ways that do not ever leave patients feeling they have to beg for the best treatment possible, or result in its research-based industry being further diminished.

UCL School of Pharmacy

The origins of the UCL School of Pharmacy date back to 1842 when the College of the Pharmaceutical Society was founded by the then Pharmaceutical Society of Great Britain. It was renamed The School of Pharmacy in 1949 when it became independent of the Pharmaceutical Society and was incorporated into the University of London as a constituent college. The School was granted a Royal Charter in 1952 and merged with UCL in January 2012.



David Taylor
Emeritus Professor of
Pharmaceutical and
Public Health Policy,
UCL School of Pharmacy

UCL School of Pharmacy

Contact details

Telephone: 020 7753 5800

Website: <http://www.ucl.ac.uk/pharmacy>

Making innovation everyone's business

Professor Tony Young, National Clinical Director for Innovation, NHS England

Much has been said of health care innovation over recent years. I believe innovation = invention + adoption + diffusion. An innovation may be a novel idea, product, service or care pathway that has clear benefits when compared to what we currently do. Successful innovations also have two key qualities: they are both usable and desirable.

Historically, the NHS and our academic partners have led the world in inventing and testing potential innovations. However challenges remain. How can proven innovations be quickly and effectively adopted as best practice and taken up across the whole healthcare system? How can the commercial success of our ideas be realised at home rather than abroad, as has too often been the case? The situation has to change if we want our patients to receive the first-hand benefits of innovation.

Healthcare is not unique in being slow to implement new ideas. The use of the telephone and electricity took 70 and 50 years, respectively, to be widely adopted. Other sectors have made progress, however, and the most successful companies are those that begin by asking their customers what they want – and then use this information to develop their ideas. They identify key problems and work together to solve them, moving their plan from the page to practical reality.

The frontline is the key to making innovation happen. However, all too often, as clinical demands and pressures increase, new ways of working become the first casualty. There is no penalty for following custom and practice, but if you try to make a positive change and it fails, repercussions for the individual clinician, Trust or CCG board can be considerable.

In order to change the situation, innovation needs to become everyone's business. We need to create the right economic climate for innovation to flourish and to unleash the potential of the entire

NHS workforce. We need to envisage what the landscape will look like in 2020, and beyond, and to examine the actions we need to take now in order to ensure a future, sustainable, health service which can deliver the potential of pioneering plans such as those in the NHS Five Year Forward View.

As we look forward, advanced technology, genomics and data analytics will combine to deliver a personalised medicine revolution. However these innovations will only be taken up successfully in the health system, at scale, if they are implemented in a way that increases social inclusion, rather than contributing to social isolation. Increasingly, solutions in these areas will be invented and delivered by industry. In order to transform the way it provides care, the NHS, therefore, needs to build new relationships with industry and professionals and to unify the journey from research to innovation.

Many of the building blocks which form the foundation of a more innovative culture are already in place, including best practice tariffs, Innovation Challenge Prizes, clinical excellence awards, Academic Health Science Networks (AHSNs), National Innovation Accelerator and Test Beds, to name just a few.

However we need to do more. We must accelerate the process from research to innovation, join up pockets of excellence in implementation, and promote systems-wide adoption, to make the UK the 'go to' place for medical innovation. There needs to be better clarity on intellectual property rights and an equally clear vision for economic growth, one which makes the NHS a straightforward environment in which to do business. For innovation to be viable against a backdrop of financial pressures, we need to look at not only how to achieve a good return on investment, but also at the best ways to measure the impact on patients.

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There are many ways of addressing these issues, but developing a culture of innovation is paramount. Only in this way can we recognise that failure is the 'learning' part of innovation, engage with NHS staff from the boardroom to the frontline, and provide future leaders of innovation with training and education opportunities. AHSN's have a fundamental role in helping to deliver this.

We have already started developing this culture within the NHS. As we get better at promoting innovation, the benefits will be limitless. The latest and greatest technical advances will be rapidly adopted, impacting positively on patient care, sooner. Staff will be empowered to provide innovative care and treatment for their patients at all levels. The time from invention to adoption will fall from 15 years to under five.

The new infrastructure will support quick delivery and widespread adoption to ensure that our ultimate aim is met – sustainable, high-quality care, free at the point of delivery for generations to come.

NHS England

- NHS England is an executive non-departmental public body belonging to the Department of Health, responsible for overseeing the running of the NHS.
- Grounded by the values and principles of the NHS Constitution, NHS England works hard to place patients and the public at the heart of everything it does.
- NHS England empowers and supports clinical leaders at every level of the NHS, helping them to make genuinely informed decisions, to spend taxpayers' money wisely, and provide high quality services for patients both now and in the future



Professor Tony Young
National Clinical Director
for Innovation, NHS
England

NHS England Contact details

Telephone: 0300 311 22 33

Email: england@contactus.nhs.net

Website: <http://www.england.nhs.uk>

Equipping the NHS with the staff it needs

**Candace Imison, Director of Healthcare Systems,
The Nuffield Trust**

Currently, 1.4 million people work in the NHS and a further 1.6 million in social care; together this accounts for one in ten of the working population. Staff will always be the health and social care system's most valuable resource, yet we enter the new Parliament with significant workforce challenges ahead: many feel undervalued, there is a misalignment between existing ways of working and the needs of patients, and there are problems with attracting and retaining high quality leaders¹.

Successful workforce planning should ensure that we have the right number of staff with the right skills in the right place at the right time, but this is not currently the case in the health and social care sectors. The workforce has been trained to work within a model based on acute episodes of care, yet the greatest demands on the system today come from people with multiple long-term conditions, many of whom are frail and elderly. They need care to address a multiplicity of mental and physical health challenges, as well as their social care needs. This misalignment is bad for staff – who feel poorly equipped to do the job asked of them – and bad for the people they support, who receive suboptimal care.

Developing more generalist skills in secondary care, more specialist skills in primary care and more resources in primary and community care – to support the growing burden of multiple conditions – would be an important way forward, but we have seen precisely the opposite clinical workforce trends. Between 2004 and 2014 the number of hospital doctors grew by 44 per cent² and whilst the number of GPs per 100,000 head of population in England increased from 54 in 1995 to 62 in 2009, it has now declined to 59.5³. Between 2001 and 2011 the number of community nurses also fell by 38 per cent⁴. Nursing and GP vacancy rates are rising and there is a growing dependency on agency staff⁵.

Cuts in social care also mean that the sector is

facing growing workload pressures. Poor terms and conditions, coupled with demanding yet sensitive tasks, make it difficult to retain staff⁶. In domiciliary care alone, around 30 per cent of staff leave their jobs each year⁷. By 2025 there could be a shortfall of over 600,000 care workers⁸.

Problems are not confined to the clinical and care workforce. The NHS has well-documented difficulties in recruiting and retaining good leaders. A recent study found that almost a third of hospital Trusts had at least one board-level position that was not permanently filled⁹. This may be related to the complex environment in which Trusts operate: a recent Nuffield Trust analysis on the impact of the Francis Inquiry on hospitals revealed a burdensome culture emanating from regulatory bodies¹⁰.

Any attempt to address recruitment and retention problems within the NHS must stem from actions that address the complex, top-down, and often blame-centred, culture within which staff work. Tackling this may mean moving away from an overreliance on targets or constant monitoring by regulators and commissioners. It will also require a more coordinated approach to fostering and nurturing talent.

The problems facing the NHS workforce will not be solved by single policy interventions. Some decisions, such as the setting of stringent and high-profile targets, like the four-hour A&E waiting time target, may actually make problems worse, in this case leading to an unhealthy and onerous reporting culture.

What's more, political pledges to recruit a specific number of doctors and nurses, whilst seemingly attractive, may do more harm than good. Unrealistic targets miss opportunities to deploy staff differently and manage gaps in the workforce in other ways. For example, in some places the gaps in the GP workforce may best be filled by

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pharmacists, nurses and health care assistants, with more active support from secondary care specialists. In others areas, where, say, there are a high number of GPs retiring, more GPs may be a critical part of the solution.

Politicians can help by setting clear strategies and supportive regulatory frameworks for developing a flexible and responsive NHS workforce, including negotiating adequate pay for staff. NHS England's Five Year Forward View set out a compelling vision for how care models will need to adapt in the future, but this requires big changes in the NHS workforce, which must be driven locally and supported nationally.

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The Nuffield Trust

- The Nuffield Trust is an authoritative and independent source of evidence-based research and analysis that aims to improve the quality of health policy and practice, and, through that, the health and health care of people in the UK.
- The Nuffield Trust aims to provide the evidence base for better health care through four key activities: conducting cutting edge research and influential analysis; informing and generating debate; supporting leaders; and examining international best practice.
- The work of the Nuffield Trusts focuses on a number of key areas in which it has expertise, including commissioning, competition, efficiency and productivity, health systems and workforce, integrated care, NHS reforms and quality of care.



Candace Imison
Director of Healthcare
Systems, The Nuffield
Trust

The Nuffield Trust Contact details

Telephone: 020 7631 8450

Email: info@nuffieldtrust.org.uk

Website: <http://www.nuffieldtrust.org.uk>

A new deal for primary care

Dr Maureen Baker, Chair, Royal College of General Practitioners

Our population is changing. Patients are living longer and routinely presenting with multiple, chronic conditions, both physical and mental. General practice is facing this challenge head-on, but is struggling to cope with increasing demand, against a backdrop of depleting resources and a severe shortage of GPs.

Due to our ageing and growing population, GPs are now seeing 370m patients a year – 70m more than five years ago. Over 90 per cent of patient contacts in the NHS are managed in general practice for just over 8 per cent of the overall budget. And while GP workload has increased and become more complex, the GP workforce remains relatively unchanged. Existing family doctors are leaving, either to retire or work elsewhere, and not enough medical students are joining the profession to replace them.

This is bad news for patients, who face longer waits for appointments, and for the wider NHS, which relies on general practice to keep patients out of hospital, where care is more expensive. Things need to change. General practice is the cornerstone of the NHS and if it is left to deteriorate further, the entire health service will be at risk. The consequences for patient safety will be disastrous.

In 2013, the Royal College of GPs launched Put Patients First: Back General Practice, along with the National Association for Patient Participation. As part of the campaign we are calling for general practice to receive an 11 per cent share of the NHS budget over the course of this Parliament to redress the funding imbalance and restore funding to at least 2010 levels. We also estimate that 8,000 more GPs are needed in England – 10,000 across the UK – to meet increasing demand. We are calling on the Government to urgently implement robust measures to build the general practice workforce.

We firmly believe that funding general practice appropriately will transform services for the benefit of patients and provide solutions to many of the problems currently besetting the NHS. The NHS England Five Year Forward View was a huge step in the right direction and we welcomed the recognition that general practice is one of the greatest strengths of the NHS.

The Royal College of General Practitioners (RCGP) has also launched a joint 10-point plan with NHS England, Health Education England, and the BMA to boost the GP workforce. This includes initiatives to recruit new GPs, incentives to retain existing ones, and plans to make it easier for trained GPs to return to practise in the UK after a career break or period working abroad. We all need to work together to do what we can to 'recruit, retain and return' as many GPs as possible and the new government must prioritise this as a matter of urgency.

I've been a GP for over 30 years and it is a fantastic, diverse and rewarding profession, but the last few years have been tough – some of the toughest in my career. All too often we see GPs vilified in the media or by politicians who tell us that we are not working hard enough, or not doing things as we should. This needs to stop.

GPs are 'expert medical generalists' on the frontline, dealing with some of the most difficult challenges facing the NHS, such as the rising number of people living with multiple, long-term conditions. We have the privilege of building relationships with our patients over time, and are performing procedures in our surgeries that just a decade ago would have been referred to hospital.

General practice also matters to patients. Family doctors are consistently rated the most trusted healthcare professionals and, leading up to the general election, a ComRes poll of people in

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marginal constituencies, revealed that 90 per cent of potential voters said protecting local GP services should be a top priority for the next Government. These are the messages we need to get across.

General practice is the cornerstone of the NHS, keeping the rest of the health service sustainable by delivering care to patients out of hospital and closer to home. More resources and 8,000 more GPs are needed to enable us to continue to offer first class services to patients; and it is critical that our call for general practice to receive 11 per cent of the NHS budget is met so that our patients can see their family doctor when they need to and be guaranteed the safe care they deserve.

Royal College of General Practitioners

- The RCGP is the professional membership body and guardian of standards for family doctors in the UK, working to promote excellence in primary health care.
- The RCGP also acts as a strong voice for high quality patient care and undertakes in depth research and analysis of some of the biggest challenges facing the NHS, proposing solutions that will improve patient care.
- The RCGP works hard to help shape the health care agenda through its policy function, which identifies emerging issues for the profession and seeks to inform and influence decision makers and stakeholders on the latest developments in the rapidly changing political and healthcare environments.



Dr Maureen Baker,
Chair, Royal College of
General Practitioners

Royal College of General Practitioners Contact details

Telephone: 020 3188 7400

Email: chair@rcgp.org.uk

Website: <http://www.rcgp.org.uk>

Public health and primary care – the way forward

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

If you use the term ‘the NHS’, most people will immediately think of their hospital or their GP, but our NHS is so much more. It is a wide-ranging set of services, covering primary, community and mental healthcare, that touches the lives of us all, regardless of where we live or the services we need to stay healthy and well. It is only by looking at the NHS in this broad sense that we can even begin to adequately plan for the future.

The population of the UK is changing and so are its health needs. Although we are living longer, we are not all living healthy lives. At the moment our healthcare system cares for people when they become ill, but it doesn't do enough to prevent people from becoming ill. Demand for health services is therefore rising, much of this increase caused by lifestyle-induced conditions. Obesity alone causes a myriad of health problems and it can lead to hospital admissions for conditions such as heart disease and osteoporosis. By preventing obesity we can relieve a great deal of the strain placed on the NHS.

When we use the NHS it is often nurses who are our first, and most frequent, point of contact. They are instrumental in coordinating care between different services and are therefore excellently placed to play a central role in keeping people out of hospital. Throughout the country, nurses working in public health, in the community and in schools, do vital work in health education and prevention. When people have long-term conditions, nurses can also work with them to manage their health at home. Avoiding unnecessary hospital visits is not only good for the NHS – it's good for patients as well.

Recently, mental health services have risen up the public and political agenda, and they are another excellent example of where investing in prevention can have long-term benefits for patients and the health service alike. Too often, far too often, people with mental health problems cannot get the

help and support they need until their condition escalates; by then it can only be treated at a far higher cost – both financial and personal. This trade-off between saving money in the short-term by cutting resources, and spending even more in the long term, is indicative of the challenges facing the NHS as a whole.

There will be a lot of talk in years to come about the importance of treating people in the community rather than in hospital. The current watchword for delivering improved models of care is ‘integration’ – making health and social care work together for the benefit of patients. However the success of care should not only be measured by how quickly patients can be treated in hospital, but by ensuring that everyone, both in and out of hospital, can lead as fulfilling and healthy a life as possible. This spotlight on integration complements the need for a greater focus on prevention within the health service. However we must not put the cart before the horse by removing services from hospitals without first ensuring that services elsewhere in the system have the capacity to take up the slack, which includes having enough staff with the necessary experience and expertise.

For the move from acute to community care to be completely and successfully made, there is an urgent need for more nurses with the right skills in the right place. There is an equal imperative to look after staff already working for the NHS: a healthy and happy workforce is much better for patients. Politicians must recognise this and become nursing advocates themselves in order to ensure the very best for the NHS.

When we think about ‘future hospitals’ we need to stop thinking of hospitals purely as buildings and start to think of what services these hospitals provide and of what care can be delivered closer to home. There will always be a need for hospitals, but it should not be the default care position.

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An ageing population and the increasing complexity of conditions means that we need to modernise and energise our thinking. A greater focus on the patient as a person, and making it easier for them to access care outside hospital walls, would be a good place to start.

Royal College of Nursing (RCN)

- The RCN is a membership organisation which works to represent the interests of nurses and nursing, and to be their voice locally, nationally and internationally.
- The RCN supports and protects nurses through leadership development and education, advocating the value of nurses and nursing staff in all their diversity and promoting excellence in the science and art of nursing and its professional practice.
- The RCN also works to help shape health policy by lobbying governments and others to develop and implement changes that improve the quality of patient care, and build on the importance of nurses, health care assistants and nursing students for health outcomes.



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

Royal College of Nursing (RCN)

Contact details

Telephone: 020 7409 3333

Contact email: press.office@rcn.org.uk

Website: <http://www.rcn.org.uk>

No matter what: 'Quality should drive the bus'

Dr Jennifer Dixon CBE, Chief Executive, The Health Foundation

Post election, the task for politicians should be to focus their efforts on two things: maintaining the quality of care provided by the NHS and addressing the £30 billion funding gap by 2020/21 – the difference between the funds the NHS estimates it will need relative to flat real growth in spending.

High quality healthcare is safe, effective, timely, person-centred, equitable and efficient. Across a range of national metrics, the quality of NHS care is generally good (relative to international standards) and improving over time¹. In the past the NHS has responded to budget constraints, in part by holding wages and prices down, and in part by cutting back on goods and services, in particular staffing – all of which have an impact on the quality of care.

But the NHS may be close to the limit of achieving further financial efficiencies as the room for manoeuvre has been restricted because of increased scrutiny and transparency of the quality of care. Trusts would rather be faulted for overspending than skimping on quality, not least because of increased attention from CQC inspections and subsequent public ratings of quality. Nevertheless, quality has slipped in some areas as our QualityWatch work with the Nuffield Trust shows², notably on waiting times and access to mental health care services. Many areas of care also go unexamined because of poor or absent data – care provided outside hospitals and for some vulnerable groups being a case in point.

Given all these challenges what might be an intelligent way forward and what does this mean for politicians? The bottom line must be to use quality as the lodestar for change over the coming years, not finance or productivity. This mission unites all working in the NHS, particularly clinicians who, more than any other staff group, will need to make and lead change if the NHS is

to progress. As they say at the Mayo Clinic – one of the world's highest performing health systems: 'Quality drives the bus'.

In the short term we need a coherent strategy to improve technical efficiency in the NHS, one to make operational processes less disordered and to reduce waste, particularly in hospitals, a key area of public concern³. Dig deeper and much waste is to do with basic operational processes – poor communication, time wasted waiting, qualified staff doing low-level tasks, activities that lack coordination, avoidable delays to discharge, etc. Tackling this will involve clinicians, on an unprecedented scale, doing detailed teamwork to map care pathways for patients and using basic quality improvement techniques to make changes. The Health Foundation has shown how this can be done in some of its projects to improve safety⁴.

The medium-term strategy will be to transform the NHS through using new models of care to boost prevention and self-management, more and better integrated out-of-hospital care, and reconfigured acute care designed to improve outcomes for patients. This was clearly set out in October 2014 in NHS England's Five Year Forward View⁵ – the nearest thing to the NHS's own manifesto. To work, it will require a shift of resources from acute hospitals to other areas of care, including social care – painful but true.

What does this mean for politicians? Firstly, not another rearrangement of administrative structures of any sort. Secondly, not an overriding pursuit of personal agendas or a set of Government priorities at odds with the challenges outlined above. Thirdly, strong and public support for the national 'system stewards' – those leading the key arms-length bodies – and NHS and other public sector leaders (e.g. local government) who need trust and space to make the necessary changes. Fourthly, a good understanding of public opinion,

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but also bravery when difficult choices must be made in reconfiguring services or trying to improve public health.

The Government should be prepared to take risks and tolerate failures (particularly in the first two years post election) and be open and honest with the public about this. Easily said, but not usually translated into action. Finally, keep quality of care at the centre of all initiatives and monitor it rigorously. By following these key principles, the future of the NHS could be assured: there is plenty of talent and motivation in the NHS to do so.

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The Health Foundation

- The Health Foundation is an independent charity working to improve the quality of health care in the UK; it exists to support people working in health care practice and policy to make lasting improvements to health services.
- The Health Foundation carries out research and in-depth policy analysis and runs improvement programmes to put ideas into practice in the NHS, support and develop leaders, and share evidence to encourage wider change.
- Each year The Health Foundation gives out grants in the region of £18m to fund health care research, fellowships and improvement projects across the UK, all with the aim of improving health care quality.



Dr Jennifer Dixon CBE
Chief Executive,
The Health Foundation

The Health Foundation Contact details

Telephone: 020 7257 8000

Email: info@health.org.uk

Website: <http://www.health.org.uk>

From awareness to action – priorities for mental health

Paul Farmer, Chief Executive, Mind

In April 2015, I was invited to act as independent chair of an NHS taskforce on mental health.

The purpose of the taskforce was to set out how services should improve over the next five years to give mental health 'parity of esteem'. This has been an aspiration of the NHS since the introduction of the Health and Social Care Act 2012; the challenge now is to make it happen after years of neglect, and at a time when services are struggling.

That such a taskforce even exists is a sign that mental health is higher up the political agenda than ever before. Under the last Government we saw really positive and important developments – from the Crisis Care Concordat, which aims to ensure people get the help they need when in crisis, to the first ever waiting times and access standards for mental health services. The Coalition also introduced a two-year programme to reduce physical restraint in mental health hospitals, and was committed to eliminating the use of police cells for children in crisis.

Yet it has been difficult to celebrate these successes when the reality is that, in recent years, life has become significantly more difficult for many people with mental health problems. Austerity has taken its toll on the mental health of the nation, whilst cuts to NHS mental health services mean that people across the country are being failed when they are at their most unwell. People tell us every day that it's becoming harder and harder to get the help they need.

In March, the All-Party Parliamentary Group (APPG) on Mental Health launched the findings of a year-long inquiry into parity of esteem, which looked at three key areas: premature death, crisis care and public health. It is a disgrace that people with severe mental illnesses, such as schizophrenia, can expect to die 20 years earlier than the rest of the population. It is unacceptable that most local authorities do little about mental

wellbeing as part of their remit to prevent ill health. We should be appalled that our NHS fails to treat mental health crises with anything like the same sense of urgency as it treats physical health emergencies. The APPG concluded that the next Government has to go much further, much faster, in making parity a reality.

Whichever way you look at it, this comes down to funding. Some might say it's naïve to ask for more money in the current climate, but there's no way around it; years of chronic under-investment, compounded by cuts over the last few years, mean that our new Government has no option but to put things right.

An investigation by the BBC and Community Care found that mental health services have been cut by eight per cent in the last five years. We have lost 3,300 mental health nursing posts and bed numbers have dropped by 2,100. Meanwhile we are starting to see the scale of unmet need and we know that around 75 per cent of people with depression and anxiety get no help at all. Things cannot continue as they are. We need to see an increase in NHS funding for mental health to the tune of at least 10 per cent over the next five years if we are to begin to bring mental health services up to scratch.

The introduction of the first ever waiting times, and access standards, for mental health services represents a huge landmark and a significant step towards parity, but, if these targets are to be meaningful, investment will be needed quickly. There are many pilots happening in A&E, in police forces and in children and adolescent mental health services that have the potential to transform the care people receive, but only with the right resources behind them. We also need to see a substantial slice of the public health pie given to preventative initiatives so that fewer people need NHS services in the first place.

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If the last five years have been about having the right conversation about mental health, then the next five have to be about the right action. It's clear that we have a consensus about the need to make mental health a greater priority, but it's now time to stop talking and to start doing. Our new Government must maintain the momentum for change and, above all, finally give mental health what it needs to improve the lives of all of us who live with mental health problems.

Mind

- Mind is a mental health charity that, for more than 65 years, has been committed to trying to ensure that everyone experiencing a mental health problem can access the support they need and is treated with the respect they deserve.
- Mind's mission is to provide advice and support to help empower anyone experiencing a mental health problem; it also campaigns to improve services, raise awareness and promote understanding.
- Mind has a network of over 180 local associations across England and Wales that respond to mental health issues within their communities and provide services including supported housing, care homes, drop-in centres and self-help support groups.



Paul Farmer,
Chief Executive, Mind

Mind

Contact details

Telephone: 020 8519 2122

Email: contact@mind.org.uk

Website: <http://www.mind.org.uk>

Transforming services for older people

Professor David Oliver, President, British Geriatrics Society

When the NHS was founded in 1948, 48 per cent of the population died before they reached 65; this figure is now around 13 per cent, with people over 80 now the fastest-growing age demographic. By 2030, 65 year-old men will live to an average age of 88 and women to an average age of 91; one in five people will be over 65. Currently there are around six million unpaid carers in the UK, many looking after older relatives, which means that the demand for carers is likely to outstrip the supply.

This challenge raises questions around retirement, pensions, the health and social care workforce, recruitment of migrants and support for carers. However an ageist narrative of a 'grey tsunami' is not only unhelpful, but it also ignores the positive aspects of an ageing population. Death rates from common causes of death have fallen consistently for decades and ageing no longer inevitably reduces our chance of living a long and flourishing life.

Government-funded national censuses, surveys and ageing studies show that, despite some media depictions of older people as vulnerable, isolated and in poor health, many rate their health as good or very good. They also report levels of happiness higher than in mid-life, and most remain independent, while contributing to society and the economy through work, volunteering, caregiving and grand-parenting.

There is plenty we can, and should, do to optimise health in older age and to reduce the major inequalities between different groups in society. Around half of the ill health experienced by people over 60 could be prevented by them making changes to their diet, exercise, drinking and smoking. We can also do more to enable older people to remain well and active. Factors including adequate housing, heating, preventing isolation, and transportation, can have a major impact on older peoples' wellbeing. For these reasons policy

thinking at both the national and local government level must focus on prevention and reducing inequalities.

For all this good news, a higher number of older people inevitably means more people living with health problems and using multiple health and care services. With increasing age, people also often live with more than one long-term condition, leading to multiple (often clashing or harmful) medications being prescribed. To avoid this, training, skills and system incentives need to move away from a 'single disease' focus.

Dementia affects around 800,000 people in the UK with projections showing this figure is set to double in the next 20 years. Staff working in health and social care must be attuned to this as already one in four hospital beds and 70 per cent of nursing and residential care places are occupied by people with dementia. The Dementia Strategy, and spin-offs such as the Dementia Action Alliance and the PM's Dementia Challenge, are generally regarded as a force for good with tangible benefits, although critics will point to the lack of hard cash going towards memory clinics, long-term social care or support for carers.

Older people, especially those with long-term conditions and complex needs, account for the biggest proportion of spending across health and social care services, as well as the largest amount of activity, variation in care and service inefficiencies. The challenges of rising demand, growing costs and restricted funding cannot be met without making our services more accepting of the needs of older people. Despite using multiple services and seeing a variety of healthcare professionals, both older people and their carers describe fragmented and poorly-coordinated services. There are still too many instances of care which is undignified, depersonalising or characterised by age-related discrimination.

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The big policy challenges, and ones which the new Government must heed, include: greater focus on prevention and wellbeing; a large enough workforce with the right skills and training; a better balance in primary, community and home-based services in order to help people live comfortably at home; proper acknowledgement of the impact of social care funding on older people and other health services; and an approach that makes more use of non-clinical support, such as carers and the community and voluntary sectors.

Above all, better care planning and integration across health and social care are needed to help deliver what National Voices have rightly termed ‘person-centred, coordinated care’. People have a right to services that fit around their particular requirements, including their age, so we can move away from stories of inadequate and suboptimal care.

British Geriatrics Society

- The British Geriatrics Society (BGS) was founded in 1947 for “the relief of suffering and distress amongst the aged and infirm by the improvement of standards of medical care for such persons, the holding of meetings and the publication and distribution of the results of research”.
- Today, the BGS is a professional association of doctors practising geriatric medicine, old age psychiatrists, general practitioners, nurses, therapists, scientists and others with a particular interest in the medical care of older people and in promoting better health in old age.
- The BGS is an advocate of equal access to health care treatment. It believes that all older people should be entitled to a comprehensive assessment, a proper diagnosis and a treatment plan, regardless of their age.



Professor David Oliver
President, British
Geriatrics Society

British Geriatrics Society

Contact details

Telephone: 020 7608 1369

Email: committees@bgs.org.uk

Website: <http://www.bgs.org.uk/>

Patients and communities: a new relationship?

Jeremy Taylor, Chief Executive, National Voices

At the outset of the new Parliament in 2015, money is the factor most obviously dominating health policy and politics. In the past five years, demand for health and social care grew, but funding did not keep pace. Services were under increasing pressure, waiting times increased, a growing number of NHS bodies were in deficit and access to social care declined. This framed the debate about health during the election campaign and parties competed to reassure voters about the extra money they would spend, the new doctors they would train, and how much more quickly patients would be seen.

Important as these things are, they are not the whole story. There was less focus on what any additional funding would be spent on, what an increased workforce would actually do, and whether the care received by patients would not only be timely, but also appropriate and effective.

Nevertheless, a cross-party consensus is emerging, as politicians increasingly recognise that the growing number of people living with, and at risk of, chronic illness requires new responses. There is now broad agreement that we need a greater emphasis on prevention; to move from a purely medical, to a more holistic, model of care; services which are personal, coordinated and close to home; and people and communities actively involved in decisions about their healthcare – not just because it is right in principle, but because it results in better decisions.

This consensus is well articulated in the NHS Confederation's 2015 Challenge and in the NHS Five Year Forward View¹, which highlights the need for "a new relationship with patients and communities". It is broadly reflected in the health announcements so far made by the new Government.

For National Voices, our members, partners and friends, this consensus could be summarised

as "making person-centred care happen". It is a change of mind-set which means professionals do not just ask "What is the matter with you?" but also "What matters to you?"

This is not about paying lip service to putting patients first and then carrying on as before. It means implementing a number of well-evidenced approaches that lead to better decisions, improved quality and a more rational allocation of resources. These include: shared decision-making; care and support planning; care coordination; and education and support for self-management.

They also include different ways of working with communities and the voluntary sector, unlocking wider societal resources to promote wellbeing and support people. Social prescribing is one good example. At a time when money is tight and demand is rising, engaging people differently has to be reframed not as an optional extra, but as the way that health and care systems need to do business.

As National Voices argued in our pre-election position statement², person-centred care has become an established policy goal, but it is not yet a policy priority. Nor, despite great examples across the country, is it mainstream practice. Only five percent of people with long-term conditions have a care and support plan and only a little more than half of hospital inpatients feel involved enough in crucial decisions about their care. Many people experience disjointed services and feel that they are battling the system. Too many disabled people do not get the support they need to participate in society.

NHS leaders are still measured and held to account against narrow criteria such as managing budgets, meeting waiting time targets and reducing hospital admissions. However these are, at best, only proxies for high quality, person-centred care and support.

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Under the new administration, resources for the NHS, and even more so for social care, will continue to be highly constrained. Those designing and delivering services will be expected to do more for less, while transforming what they are doing: it's a tall order. Meanwhile changes elsewhere in public policy and services will have an impact on people's health. Parliamentarians can help by providing support where possible, and by critically challenging new health and social care models. It is good to ask: "Are these services meeting everyone's needs or are some people being overlooked or excluded? How are patients and citizens involved in decisions about their care? Are these changes making things better for patients and families? Are these policies creating or undermining health?" These are some of the questions I hope you will ask, and continue to ask, during the new Parliament.

1. NHS England (2014), Five Year Forward View. Also available at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
2. National Voices (2015) Person Centred Care 2020: Calls and Contributions from Health and Social Care Charities. Also available at: <http://www.nationalvoices.org.uk/person-centred-care-2020>

National Voices

- National Voices is an umbrella group for national health and social care voluntary organisations working together to strengthen the voice of patients, service users and those who represent them.
- National Voices works to place people at the heart of national policy-making by involving the organisations that represent them in the policy-making process, ensuring that their diverse needs and preferences are genuinely placed at the heart of policy development.
- National Voices represents all service users, including those with long-term conditions, young people, older people, people with disabilities, carers, and minority and ethnic groups, to bring their voices together to ensure they can be heard, and their opinions used to shape services according to their needs.



Jeremy Taylor
Chief Executive,
National Voices

National Voices Contact details

Telephone: 020 3176 0738

Email: info@nationalvoices.org.uk

Website: <http://www.nationalvoices.org.uk>

UK high streets: an untapped resource for promoting health

Shirley Cramer CBE, Chief Executive, Royal Society for Public Health

The 20th century witnessed some of the greatest achievements in public health, including the introduction of universal healthcare, huge reductions in mortality from infectious diseases, and a decrease in infant mortality rates.

These achievements, however, belie the major challenges that remain. The 'big killers' of the 21st century, including heart disease, stroke and some cancers, are no longer the result of poor hygiene or a lack of access to health services, but are instead often attributable to unhealthy lifestyle choices. It is estimated that a staggering one in four deaths in 2012 could have been prevented¹.

These avoidable illnesses are not distributed evenly throughout society. Despite improvements in health care and living standards, society continues to be characterised by stark health inequalities. The Marmot Review found that those in the most deprived groups can expect to live, on average, seven years less than those in the least deprived groups. This figure rises to 17 years when considering disability-free life expectancy². This is not only detrimental to social justice, but also places a huge financial burden on healthcare services, the welfare system and employers, through productivity losses³.

To effectively tackle these issues, we must look beyond solely medical interventions. It is vital that we take a whole-system approach, mobilising community assets and utilising the wider public health workforce, consisting of any individual who is not a specialist or practitioner in public health, but who has the ability or opportunity to improve the public's health. In our daily lives, we are faced with many health pitfalls alongside confusing and often contradictory advice. We must therefore look to embed healthy lifestyles throughout communities, in the settings where people eat, work and socialise, thus empowering them to make healthy choices. Nowhere is this more important than on our high streets.

The high street, as the heart of a local community, offers the ideal location for health promotion, with real potential to reach those most in need of support. In recent years, however, we have seen a proliferation of high street outlets with potentially damaging consequences for public health.

Evidence indicates that the clustering of businesses such as fast food outlets, betting shops and payday loan shops increases their usage, contributing to obesity and problems with gambling and debt⁴.

Recent Royal Society for Public Health research found that these businesses are particularly prevalent in areas of high deprivation and poorer health outcomes. In a league table of 70 towns and cities, ranked according to the number of healthy and unhealthy businesses in their core retail boundaries, the top 10 unhealthiest locations all featured in the bottom 40 per cent for premature mortality in the UK, and four of them were in the bottom five per cent.

Without greater powers to curb the rise in unhealthy businesses, the excellent work being undertaken locally to improve health, risks being undermined. Local authorities must be given greater planning controls; this could include setting health as a condition for the licensing of all types of businesses, removing betting shops and payday lenders from the A2 use class (permission is not needed for conversion of many business types to A2 class), and allowing councils to set differential business rates. We also call for a limit of five per cent to be placed on the number of unhealthy businesses allowed to open in a given area. This limit would maintain consumer choice, but restrict clustering and encourage greater diversity on the high street.

Alongside this, there is huge potential for high street outlets to promote healthy choices within their stores. It is vital that we make healthy choices the easy option and we call on the new Government to introduce mandatory calorie

Factsheet

labelling in food outlets, the mandatory removal of unhealthy items from checkout and queuing areas, and mandatory health warnings in stores. There is also a huge untapped resource of high street staff, who, if trained as health champions, could deliver brief health advice to a large number of people.

Over the past century, the nature of the public health challenges we face has changed, and so too must our approach to tackling them. We must create communities in which public health is everybody's business, and the high street could be an integral part of this.

1. Office for National Statistics (2014) Avoidable Mortality in England and Wales 2012. Also available at: <http://www.ons.gov.uk/ons/rel/subnational-health4/avoidable-mortality-in-england-and-wales/2012/stb-avoidable-mortality--2012.html>
2. UCL Institute of Health Equity (2010), Fair Society, Healthy Lives. The Marmot Review, Executive Summary. Also available at: <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>
3. Frontier Economics Ltd (2010), Estimating the Costs of Health Inequalities: A Report Prepared for the Marmot Review. Also available at: <http://www.cawt.com/Site/11/Documents/Publications/Population%20Health/Economics%20of%20Health%20Improvement/Estimating%20the%20costs%20of%20health%20inequalities.pdf>
4. Royal Society for Public Health (2015), Health on the High Street. Also available at: <https://www.rsph.org.uk/en/policy-and-projects/campaigns/health-on-the-high-street/index.cfm>

Royal Society for Public Health (RSPH)

- The RSPH is an independent, multi-disciplinary charity dedicated to the improvement of the public's health and wellbeing.
- Formed in October 2008, the RSPH helps inform policy and practice, working to educate, empower and support communities and individuals to live healthily.
- The RSPH has a membership of over 6,000 public health professionals, encompassing a wide range of sectors and roles, including health promotion, medicine, environmental health and food safety.



Shirley Cramer CBE
Chief Executive, Royal
Society for Public Health

Royal Society for Public Health Contact details

Telephone: 020 7265 7300

Email: ksanger@rsph.org.uk (press office)

Website: <https://www.rsph.org.uk>

Contributors



Professor
John Appleby
The King's Fund



Baroness Julia
Cumberlege
APHG



Professor
David Oliver
British
Geriatrics
Society



Dr Maureen
Baker
Royal College
of General
Practitioners



Dr Jennifer
Dixon CBE
Health
Foundation



David Taylor
UCL School
of Pharmacy



Dame Kate
Barker
Commission
on the Future
of Health and
Social Care
in England



Paul Farmer
Mind



Jeremy Taylor
National Voices



Rt. Hon. Sir
Kevin Barron
MP
APHG



Professor
Chris Ham
The King's Fund



Professor
Tony Young
NHS England



Dr Peter Carter
Royal College
of Nursing



Candace Imison
The Nuffield
Trust



Shirley
Cramer CBE
RSPH



Ray James
ADASS

About The King's Fund

The King's Fund is an independent charity working to improve health and health 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.

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About the All-Party Parliamentary Health Group

The All-Party Parliamentary Health Group (APHG) was launched in November 2001 and is a group dedicated to disseminating knowledge, generating debate and facilitating engagement with health issues amongst Members of both Houses of Parliament.

The APHG comprises parliamentarians of all political parties and its remit is to provide parliamentarians with high quality and impartial information about the key health issues of the day, both at the local and national level. We are recognised as one of the preferred sources of information on health in Parliament.

The APHG is very grateful to be able to draw on the invaluable expertise of senior figures from both Houses of Parliament, the NHS, and the public, private and voluntary sectors.

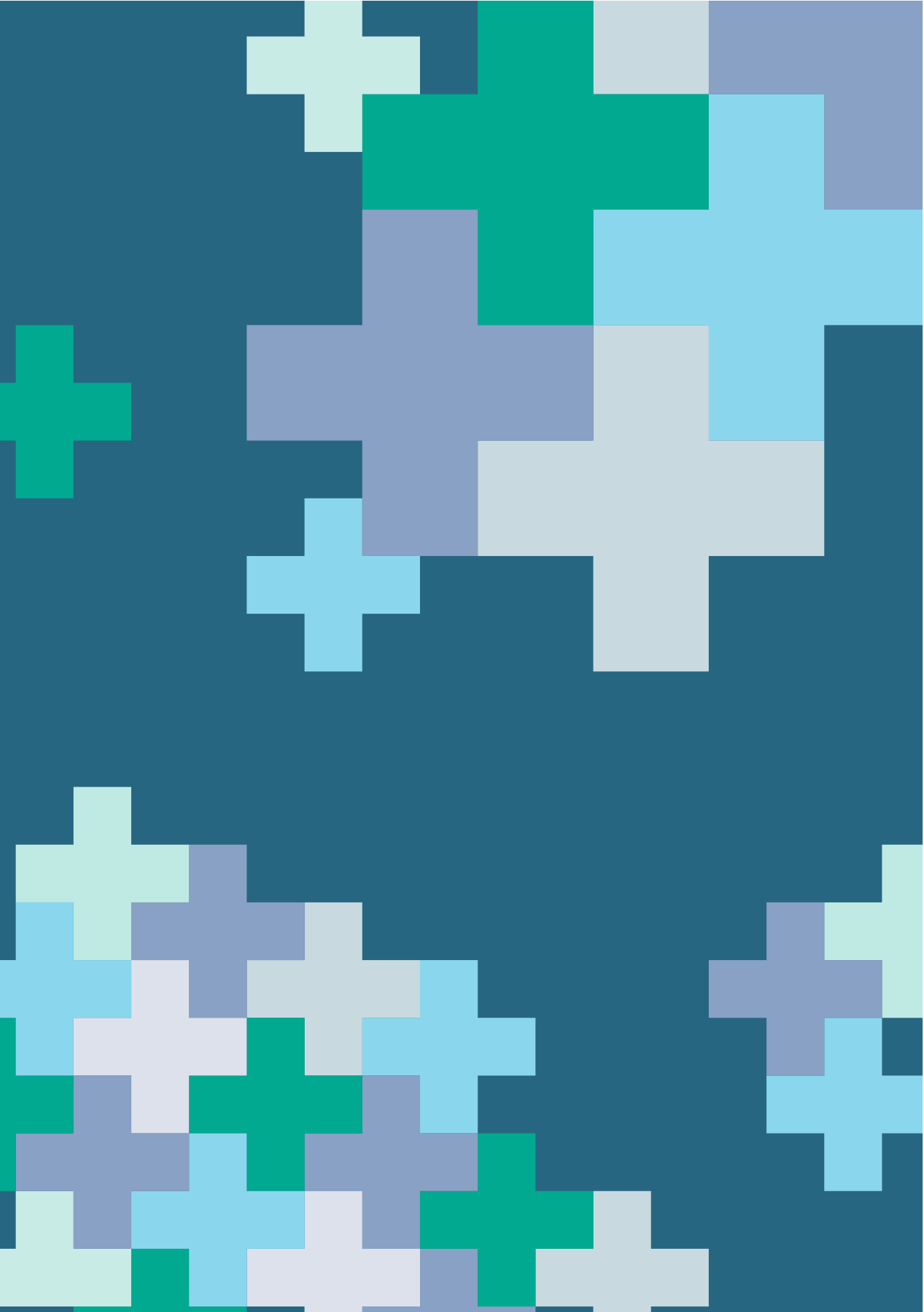
We inform and engage parliamentarians through the organisation of seminars and conferences during the year, conducted under Chatham House Rule, and also provide parliamentarians with daily media briefings and a comprehensive weekly parliamentary bulletin on health policy developments in Whitehall, Westminster and the wider health sector.

The APHG's agenda is set by our all-party team of elected Parliamentary Officers, in consultation with our distinguished Advisory Panel, and our work is delivered by a small, dedicated secretariat.

The Group is financially supported by an Associate Membership of 16 of the UK's leading companies working in the health sector, who, as well as providing an independent source of funding, offer a valued insight into developments occurring within the wider healthcare community in the UK.

Acknowledgements

The All-Party Parliamentary Health Group would like to thank all the individual authors and organisations that contributed to the production and publication of this Essay collection.



For further information, please contact:

Judith Abel, Group Manager

All-Party Parliamentary Health Group
c/o Policy Connect
CAN Mezzanine
32-36 Loman Street
London SE1 0EH
judith.abel@healthinparliament.org.uk

APHG Secretariat

Tel (020) 7202 8577
Email: aphg@healthinparliament.org.uk
Website: www.healthinparliament.org.uk



@HealthAPPG

For further information about The King's Fund,
please contact:

The King's Fund

11-13 Cavendish Square
London W1G 0AN
Telephone: 020 7307 2400
Email: enquiry@kingsfund.org.uk
Website: www.kingsfund.org.uk



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The APHG is very grateful for the financial support provided by the King's Fund for the publication of this essay collection. The content has been produced independently by the APHG and the contributing authors.

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