

Solving the NHS care and cash crisis: Routes to health and care renewal

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Reform

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Introduction

After a difficult birth in post-war austerity and several mid-life crises, the NHS has made it to 65. It has become a national icon that makes more of us proud to be British than any other institution. A Conservative

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Chancellor described it as the nearest thing this country has to a religion. Danny Boyle’s NHS extravaganza at the 2012 Olympics captured the public mood far better than the then concurrent Francis Inquiry into poor care at

Mid Staffordshire NHS Foundation Trust. The political parties still compete to convince the voters that they love the NHS the most.

But how good is the NHS? This report suggests that the NHS has much to be proud of, particularly its universal financial coverage and many of its acute hospital services. But community services, primary care, public health and mental health continue to be patchy. Now a growing number of hospitals are struggling and social care remains a long term, and increasingly serious, problem.

More worryingly, Nye Bevan’s NHS has failed to adapt quickly enough to changing demography, lifestyles and disease profiles, as well as to technological advances and rising public expectations. We face decades of rising demand for health services from an ageing population with a mix of long term chronic conditions, many of which spring from an obesity epidemic. We cannot simply accept a system that seems incapable of either reducing health risks substantially through preventative measures or managing those conditions cost-effectively when they manifest themselves.

Some will say that the NHS represents good value for money, compared with health care systems in other advanced countries. They are right. However, these other systems are also in deep financial trouble and have to become more cost effective. Relaxing into complacency about the NHS because of its historical achievements does it no favours. Nor does the solution lie in pumping extra money into an out-of-date delivery system.

Straitened public finances are now forcing the issue – they make it virtually impossible to preserve the NHS as it is without seriously damaging other important public services or raising taxes significantly. There is a real prospect of the money running out. The NHS now represents the greatest public spending challenge for whoever is in government after 2015.

Tackling care and cost issues together

In summary, the NHS faces a combined care and cash crisis that threatens to debilitate the wider public sector and economy. The health challenge is to narrow a widening gulf between people's potential for longer, healthier lives and the disappointing reality of what too many achieve. But any solution must also be affordable and sustainable.

That's why *Solving the NHS care and cash crisis* focuses on the two problems together and on the links between them. It tackles the “care”

“Solving the NHS care and cash crisis focuses on the two problems together. It tackles the care issues in ways that will improve health but which will also bolster the financial sustainability of our NHS.”

issues in ways that will improve health and save lives but which will also bolster the financial sustainability of our NHS. Likewise, our “cash” – or funding – proposals aim not only to improve NHS finances. They also develop taxation that is better connected to NHS goals and to the beneficiaries of services. We believe that this

combined approach can curb the NHS from consuming an ever greater proportion of public expenditure at the expense of other important public services.

Our proposals set out important changes to health and care services. However, they can be achieved while preserving a key, though sometimes altered role, for virtually all current hospital sites in the new system. Nor do our proposals create a massive organisation upheaval for the NHS – they adapt the existing system that has so recently been reorganised. However, we appreciate that the proposals will

involve considerable adaptation by NHS staff, some of whom will find themselves in new roles in changed locations. Crucially, our recommendations safeguard the key principles of the NHS, while improving the quality and sustainability of services and people's access to them.

Programme for the next Parliament and beyond

Our focus for change is the next Parliament – 2015 to 2020 – but to complete the work may take longer. We have seven big messages:

1. Co-produce health A new partnership between the NHS and the individual, focussing on co-production of health. We envisage a more engaged, less episodic NHS supporting individual self-care and preventative healthcare – a system that leverages the best from the combined forces of both the individual and the NHS.

2. Build more effective community-based services and public health Rebalance the NHS so that people's health problems are tackled in the right place at the right time, both clinically and financially. That means much earlier than is often the case at the moment.

3. Merge health and social care End the artificial 65-year divide between health and social care and unify them centrally and locally in a National Health and Care Service (NHCS).

4. Strengthen specialist hospital care Consolidate specialist hospital services on fewer sites so they can afford 7-day consultant cover and, therefore, provide safer, more expert care with better outcomes.

5. Broaden the tax base Develop new funding streams to renew the impoverished parts of our care system but preserve a largely tax-funded, largely free-at-the-point-of-use NHS.

6. Diversify provision End the phoney arguments about who provides services: it is universal coverage of financial and clinical risks that is the great achievement of the NHS, not monopoly public service provision.

7. Reduce centralisation Create greater local discretion over the character of service delivery and accountability for it and reduce command and control from the centre.

As a former adviser to President Obama once said: “Why let a good crisis go to waste?” We should start the debate now and not be hidebound in our approaches, especially about where services are provided and by whom. We hope that the debate can be more constructive across the political divides than is often the case.

Executive summary

1. Why things have to change

Health and social care now cost the public purse about £130 billion a year – more than education, defence and police combined. Yet services often fail to meet health needs properly for frail elderly people, those with chronic conditions and around preventative healthcare. This reflects a failure to look after people at the right time in community health settings; a casual, long term neglect of social care funding; and half-hearted engagement with public health.

Meanwhile, hospitals are treating, in expensive settings, people who should be – or should have been – cared for in more suitable and less

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costly environments. Research studies suggest that 30 per cent or more of the patients occupying acute hospital beds – most of them frail and elderly – should not be there. We are also increasingly aware of how unsafe our hospitals have become. We know, for

example, that patients face greater risk of death if admitted at weekends because hospitals, as currently organised and funded, cannot be staffed adequately 24/7.

This inappropriate care delivery model, largely unreformed since 1948, inflates NHS costs and limits many people’s potential to live longer and healthier lives. Straitened financial circumstances are now forcing the issue. An affordability gap is opening up of at least £30 billion a year – possibly more – within a decade. The status quo is becoming economically unsustainable – given our tax base, the state of the public finances, changing population needs and the implications of scientific development. Meanwhile public expectations of services continue to rise. We face a perfect storm.

This is not simply a health and care crisis. The great unspoken truth of British politics is that the NHS, as it is run and as it is funded, risks seriously damaging other important public services. Pouring more of our limited public resources into an unreformed health and care

sector impacts hard on the budgets of other public services, already treated more harshly than an overly protected NHS.

On present plans, the NHS now takes more and more of a shrinking cake – our schools, roads, police, pensions and other benefits can expect to be cut back again and again. By 2015-16, the NHS will account for nearly a third of departmental expenditure (excluding social security). Other public services have experienced and continue to experience much greater cutbacks than the NHS. For example, there have been approaching 30 per cent cutbacks in local

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government (which impacts seriously on social care, as will be discussed) and 25 per cent in criminal justice. In contrast, the NHS has been protected so far with essentially a flat-lining budget in real terms. We risk whittling away at the intellectual, physical

and services infrastructure that underpins our economic capacity, to prop up an ailing and inappropriate sickness system that desperately needs reform. One needs only to think of early-years children’s services, social and affordable housing, education and vocational training and youth services that can expect to be hit hard. Many of these other, already financially stretched, social programmes have a major impact on the future health and wellbeing of our population and their demand for health and care services.

We have, in short, a health and care system that is both unnecessarily expensive and poorly designed to meet modern needs. If not tackled quickly and effectively, the situation will deteriorate rapidly, risking an impoverished service that provides substandard care, making it impossible to preserve the NHS as it is without sacrificing many other public services or raising taxes significantly. If we are not careful, the UK public sector could go the way of General Motors in the US – bankrupted by its own health insurance system. The NHS now represents the greatest public spending challenge for whoever is in government after 2015.

2. Today's crisis, yesterday's lessons

The last decade of financial plenty produced huge improvements in access to health services as well as reductions in avoidable adult deaths from the killer diseases of cancer, coronary heart disease and stroke. However, it was a missed opportunity because the NHS failed

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to use the extra money, staff, better equipment and buildings to fundamentally redesign its business model for the future challenges that have now arrived.

It continued with an outdated model of too many acute, district general hospitals trying to provide a wide range of specialist services – too often inadequately – that have produced dangers

that are now measurable in a higher mortality rate for patients admitted at weekends. This model has been sucking in an excessive amount of the money for inpatient care when there were cheaper and better community alternatives. Meanwhile, the social care and medical needs of an ageing population were neglected.

The NHS and other government agencies have also failed dismally to adapt to the biggest health challenge of the age – avoiding chronic disease springing from poor lifestyles. As a result, for example, a tidal wave of obesity is engulfing particularly the younger generation. Nearly 30 of every 100 adults in England are now obese and this figure is set to rise to more than 40 by 2035. Many of them can, as a result, expect to die younger than – or even before – their parents because of diabetes, stroke, heart disease, cancer and other lifestyle-related ailments. It is a dramatic failure for a system that focussed so successfully on tackling infectious disease.

We badly need new ideas. More money and organisational change have not produced the institutional change in services required. Two other big reform ideas of the past 40 years – improved management and the purchaser-provider split – have failed to shift resources into preventative healthcare, to stem the tide of lifestyle-related illness or

to rebalance services from hospital to community on the scale needed. The NHS business model has to change radically but this means winning over clinicians to convince the public and politicians of the nature and scale of change needed. A sustainable solution to the NHS challenges requires ending an historic hostility towards local government playing a bigger role in shaping health and care services.

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Local government should be seen as part of the NHS solution, not the problem.

NHS efficiency could be improved significantly but, on its own, this will not close the looming funding gap. We have to be prepared to examine a wider range of funding streams than general taxation and to see if the NHS service boundary should be changed in

relatively minor areas, without altering the fundamental principles of the NHS. We have had to tackle difficult challenges in other areas of public policy, such as pensions and welfare. There can be no escape from doing the same now for the NHS by adopting Lord Rutherford’s wartime dictum – “We’ve run out of money and now we have to think”.

3. Reimagining the NHS and social care

Our proposals for a new “National Health and Care Service” (NHCS) focus on four key areas.

3.1 New co-production partnership between the NHS and individuals (and their carers)

A new partnership would focus on co-production of health and wellbeing between the care services and individuals (and their carers) with much stronger public health services and support for people to manage their own care. This recognises and enhances the vital role

“Implementation of change should shrink the currently widening gap, for many people, between their potential to live longer, healthier lives and what they are actually likely to experience now. Our proposed system would also be more affordable without the need for another massive organisational upheaval.”

that the NHS plays in our citizenship. It also implies changing responsibilities on the part of both individuals and the State. The challenge would not be what the NHS can do *to* you, but what it can do *with* you.

Every person would gain “NHS Membership”, only open to those with residence qualifications. NHS Membership could entitle more people than now to an annual “Health MOT”, running basic health checks. It would review

progress over the previous year, agreeing individualised goals and NHS support for the coming year, with a focus on management of chronic conditions and more support for carers. Throughout the year there would be tailored flows of membership information about personal health issues, together with details of approved or kite-marked telecare and telehealth products that would help people meet their own care using their own resources.

An NHS Membership fee, for which there would be exemptions, could be collected with the council tax and used locally by Health and Wellbeing Boards (HWBs) to expand the capacity of community-based prevention services. Supporting people in the achievement of their annual health goals should become a requirement of a revised GP Contract, with performance being monitored by the new Chief

Inspector of General Practice.

On 5 July, the annual “Health and Wellbeing Day”, the new NHCS might be required to provide a “Citizens’ Audit”, offering a report to Parliament on performance and cost plus a detailed local report for each area on the development of community, primary and social care services as well as on the specialist hospital sector.

3.2 Integration of health and social care budgets and services at all levels for personalised whole-person care

We would build on the 2013 changes and gradually make Health and Wellbeing Boards the budget-holders for social care, local public health funding and community health services (including community mental health services). This would enable Boards to ensure services met the needs for their populations that they had identified in their strategic assessments and to be fully accountable publicly for doing so. Their budgets would be allocated on a new weighted capitation basis established after independent review but approved by Ministers and reported to Parliament. This new budgetary system would be operated and kept under review by NHS England which would be responsible for monitoring the performance of HWBs and for holding them to account for their use of public money.

Bringing health and social care together has to be more than the high level budget integration that we have seen, for example, in Northern Ireland. It has to mean integration of service commissioning and the delivery of those services to individuals.

The responsibility for ensuring adequate provision and supply of family doctor services to local areas would remain with NHS England so that GPs need not become employees of Health and Wellbeing Boards. It would be for Boards however to ensure that overall primary care services were appropriate for their areas. The Care Quality Commission would continue to regulate health and social care quality, whatever the setting. Monitor would ensure appropriate competition in service provision as well as continuity of care in the event of serious service failure but in association with NHS England.

Clinical Commissioning Groups (CCGs) could continue to commission

local physical and mental health services, on behalf of, and with funding from, Health and Wellbeing Boards. CCGs would be under a statutory duty to work collaboratively with social care commissioners to ensure that integrated health and care services were commissioned. CCGs could continue to play some role in commissioning some hospital services on a basis to be determined by NHS England. GPs would remain the gatekeepers for patient access to acute hospital services. Over the lifetime of a Parliament it should be possible to reduce the number of CCGs and integrate them and their administrative support units into HWBs but without a “sudden death” national reorganisation. It should also be possible for HWBs to merge where this enabled more cost-effective services to be commissioned for the populations involved.

3.3 Developing a more community-based health and care service

We would invest in more cost-effective and appropriate community-based services and public health. Far more services would be delivered closer to home and within the home, with many hospital sites converted to community hospitals acting as a hub for a wide range of community-based, integrated services. These services would be funded by an integrated budget and designed to deliver integrated services, open 24/7 but with few inpatient beds and a narrower range of diagnostic services.

These new community hospitals should include improved urgent care; physiotherapy and rehabilitation; outpatient specialist appointments, minor surgery; access to integrated health and social care; public information, advice and help; pharmacy; dentistry and optical services; palliative and end of life care including, possibly, nursing homes with access to on-site medical cover. They could also have bespoke elective day surgery centres.

These community hubs might well have enhanced ambulance and patient transport services to improve access to specialist hospitals that would provide comprehensive specialist services on fewer sites but with guaranteed seven day consultant cover, unlike now. Community hospital hubs should be required to ensure 24/7 medical support to all the nursing and residential care homes in their areas,

whether or not those homes are on-site, to stop unnecessary out-of-hours admissions to hospitals.

There would be further consolidation or federation of GP practices to develop local 24/7 health centres, funded to deliver as many services, including social care, as possible. These could be part of community hospitals or linked to those hospitals on a hub and spoke basis. We would like to see more of these local medical services led clinically by a new rank of highly qualified consultant general physicians, with particular expertise in chronic disease management and care for elderly people with multiple co-morbidities.

Consideration should be given to separating Public Health England from the Department of Health to make it more politically independent in pursuing initiatives that would benefit public health and to enable it to assure the quality of public health work done by enhanced Health and Wellbeing Boards.

3.4 Consolidation of hospital specialist services

Hospital specialist services would be consolidated on fewer sites, better staffed and better equipped for 24/7 access, with guaranteed 7-day consultant cover. This change would save lives as well as money, as has already been demonstrated, for example, by the consolidation of emergency stroke care services in London.

Consolidation across hospital specialist services should be clinically, not politically, led and should ensure higher quality of services along with enhanced safety and outcomes for patients. It would ensure more clinically and financially sustainable services over time and eliminate the mortality lottery that means patients admitted at certain times in the week are more likely to die than those treated at other times.

This change would require a major streamlining of the system for reconfiguring specialist services with greater involvement of external clinical expertise to secure local acceptance of change within the financial allocations set by elected politicians. A truly independent NHS England, under the leadership of a new Chief Executive and its Medical Director and with the strong support of the Academy of Medical Royal Colleges and clinical and political leaders, would drive the consolidation agenda for at least one Parliament and possibly

two. It would consolidate specialist services on the basis of whole health economies rather than the shortcomings of individual trusts and securing sustainable 7-day consultant cover.

3.5 These changes should make the NHS and social care feel different for the public

They would ensure that people received the right care in the right place at the right time. The programme would improve the quality of their care, save lives and the prospects for healthier lives, as well helping the NHS control costs. We appreciate this will involve changes to staffing arrangements in the NHS and the need to convince staff of the benefits both to patients and to themselves as caring individuals. Here are some of the ways that services will feel different in this more localised and more personalised health and care system.

- > **A person needing emergency specialist care** would typically receive faster, safer treatment from more expert staff 24/7, producing significant improvements in outcomes as has been achieved, for example, following the consolidation of emergency stroke care services. Clinicians consider that this move would save many lives each year, given the opportunities to staff specialist hospitals more comprehensively around the clock.
- > **The elderly person** would get much better access on a day to day basis to integrated medical and social care, including earlier diagnosis of dementia.
- > **The person with depression or anxiety** would get a speedy, expert diagnosis, immediate counselling, specialist psychiatric care and other social care supports, as well as, if needed, more personally tailored drug treatment via community-based psychiatrists rather than simply over-stretched GPs as is currently the case.
- > **A person with an unhealthy lifestyle** would be constantly encouraged with offers of help and ways to change as a consequence of shared responsibilities required by the “Health MOT” and NHS Membership, helping them to deliver a

healthier life for themselves in a non-coercive manner and so avoid the onset of many diseases from middle age.

- > **A person with a chronic condition** would have much better support managing that condition, avoiding some of the unnecessary emergencies that threaten health and disrupt life.

Maintaining NHS values

Despite these changes, clinical care would continue to be free at the point of delivery. With possibly a few exceptions, every local hospital site would be retained but, for many, there would be a different range of services. Access to care and the experience of care should become easier, better, safer and more personalised. No-one would be exposed to catastrophic financial risk. Implementation should shrink the currently widening gap, for many people, between their potential to live longer, healthier lives and what they are actually likely to experience now. Our proposed system would be more affordable without the need for another massive organisational upheaval.

4. New funding streams and stricter financial discipline

On present plans, the NHS faces a shortfall of at least £30 billion a year within a decade and possibly a deficit as high as £50 billion. It cannot rely on closing this gap through more funding from general taxation or receiving real terms increases from taxpayers at the

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historical level of over 3 per cent a year in real terms. At present, no political party has pledged significant real terms increases to the NHS. So, the NHS has to up its game significantly in terms of efficiency and productivity. However, it also needs a broader funding base than general taxation, partly for

intergenerational fairness, because the income tax element falls disproportionately on the younger working population even though the major users are the older population. Another important reason is

that income tax lacks the potential health promotion benefits offered by other, more hypothecated taxes.

4.1 Greater efficiency

Over the lifetime of the next Parliament the NHS should be required to do more for less through a major efficiency drive involving both clinical and non-clinical activities to secure savings of £15-20 billion with most of this money being used to establish a “Service Transition Fund” to fund the proposed changes in service delivery.

Clinical efficiency

The clinical programme should be focussed on consolidating specialist services, delivering more integrated care on a community basis, stopping ineffective treatments and creating greater competition and diversity of service providers, including from overseas. NHS England needs to enforce vigorously the approaches suggested by Monitor in their 2013 report *Closing the NHS funding gap*. Monitor identified scope for recurrent savings of between about £10 billion and £18 billion by 2021 from implementing their clinical proposals.

Non-clinical efficiency

Alongside these clinical shifts, there should be a major NHS efficiency programme in non-clinical areas driven independently. This should cover at least:

- A national programme to reform the NHS’s poor use of fixed assets and to secure major capital and revenue savings with annual targets and the removal of local blockages to surplus asset disposal or change of use. Monitor’s figures suggest that the NHS does not need about a quarter of its land and buildings.
- Appointment of a Board-level Commercial Director at NHS England on a five-year contract with the authority to institutionalise income-generating activities across all trusts. These could include provision of private funded services not available on the NHS, revenue-generating commercial developments on hospital sites and sale of approved healthcare products.

- Adoption of a standardised electronic health and care record for individuals within the lifetime of the Parliament.
- Monitor issuing a national minimum list of health and care services open to competitive tender by qualified providers.
- Introduction of NAO-approved performance cost standards for back office services – finance, personnel, facilities management, IT management, and procurement.

The aim should be to secure in the next Parliament at least £5 billion worth of non-clinical capital and revenue savings for placement in the Service Transition Fund to help finance the service changes we are proposing.

4.2 New sources of tax revenue

We suggest that the general tax funding of health and care should be frozen after the May 2015 Election at its then current level and only be increased in line with an agreed inflation index thereafter. Any further annual increases for health and social care should be fixed for the lifetime of the Parliament at, we would suggest, no more than 1 per cent a year in real terms. This would give emphasis to the need for improved efficiency across health and care services. Any future tax-funded increases for health and care – including the annual 1 per cent real increase – should be funded from taxes other than income tax. This would gradually broaden the tax base for health and care and open up the scope for substituting these taxes for income tax in the future. Possible sources of alternative tax revenues are:

Taxes promoting healthier living

- Inflation-proofed hypothecated taxes on alcohol and tobacco plus similar taxes on other products, such as those with excessive amounts of sugar, where scientific evidence is strong on their deleterious impact on health. Betting and gambling taxes could also be increased and used on the same basis. Inflation-proofing both the existing, under-exploited taxes and the new ones proposed would raise yield considerably over time and could help support above inflation increases for health and care funding.

Taxes more related to healthcare consumption and ability to pay

- More widespread payment of inheritance tax. This tax has the advantage of targeting more health revenue-raising on the greatest consumers of health and social care, namely older people, many of whom have benefited from a long-running housing boom, and reducing the burden on younger people. We recognise that this will be controversial. Although this tax currently raises about £3 billion a year, it is worth reflecting that currently only 3.5 per cent of the 500,000 deaths each year lead to payment of inheritance tax. In straitened times this seems an area for urgent examination.
- Some form of social care tax might be introduced in middle age. Japan introduced such a tax on a compulsory basis in 2000 and this has helped considerably to fund the care costs of their ageing population.

Changes in entitlements

Public expenditure on health and care could be reduced by relatively minor changes to entitlements for free care, as has been done in the past. The main areas we have suggested for consideration are:

- Rethinking Continuing Care as an NHS entitlement, recognising that it is really a form of social care which should, likewise, be means-tested. Continuing care would operate within the new system, set out in the Care Bill, that caps the costs of social care for any individual to avoid catastrophic risk for any individual. The cap might be lower for sufferers with dementia.
- Full-cost charging for the administration of vaccinations for overseas travel plus more rigorous inflation proofing prescription charges and possibly reducing exemption categories.
- Co-payments for the hotel costs of some inpatient hospital care.
- An NHS Membership fee for all non-exempt individuals, gathered with the Council Tax.
- Reviewing Attendance Allowance and better integrating its

annual £6 billion budget into the new care funding arrangements set out in the Care Bill.

By the end of the next Parliament, providing there was the political will, it is possible to envisage these changes in entitlements yielding over £6 billion a year. A revamped system for prescription charges and other co-payments such as hospital hotel charges could raise over £1 billion a year. A £10 a month fee for a membership scheme with free membership for those exempted from prescription charges might well produce over £2 billion a year for use in local preventative initiatives.

Paying for change

In summary, we envisage that the costs of transition to a more community-based health and care delivery system (£15-20 billion) would be met from the clinical and non-clinical efficiency savings described above. The inflation-proofed post-2015 budget would continue to be funded from general taxation. However, the 1 per cent real terms annual increase that we envisage – about £1.5 billion per year – would be met from the alternative taxes and co-payments outlined. By 2025, we would expect that this additional income relating to the 1 per cent annual increase would amount cumulatively to £15 billion a year.

One source for this extra revenue could be the inflation-proofed hypothecated taxes on alcohol, tobacco and gambling and introduction of new taxes on health-damaging foods such as those with high sugar content. Other sources could include: restructured inheritance tax (extra £3-4 billion), changed entitlements to “free care” by adjusting the NHS boundary for these entitlements (saving £3-4 billion a year); revamping the system for medicines/dental charges and introducing hotel charges in hospitals (£1 billion a year); introducing a fee-paying NHS Membership scheme that would provide additional funding (£2 billion a year) for local preventative services; integration of Attendance Allowance into the health and care budget (£6 billion).

5. Making change happen 2015 -2020

The guiding principle of the new National Health and Care Service should be “to promote and secure the health and wellbeing of the population, and individuals within it, by securing best value from the resources available.” That purpose should shape the way that all organisations work. We also need a better framework of rules

“We need a ‘Big Conversation’ with the public about the changes that need to be made in order to help increase understanding of the case for radical change and to build cross-party support for sustainable change.”

identifying the responsibilities that remain with the centre and those which are in the hands of local people. These rules should ensure that minimum standards prevail everywhere. In our view, as long as local people adhere to the requirements of the national framework, they should be left alone to sort matters out within their local communities, unless

there is a major breakdown in services that requires external intervention. This means a more locally diverse set of health and care services under the control of locally accountable bodies.

We need a “Big Conversation” with the public about the changes that need to be made in order to help increase understanding of the case for radical change and to build cross-party support for sustainable change. Five big questions require debate and some kind of public and political settlement to make progress on change:

1. Integration How can we move rapidly to a fully integrated model for health and social care at the national and local levels covering funding and delivery of community-based services, with an enhanced role for local government?

2. Rebalancing towards community-based services Can we agree to rebalance whatever we choose as a nation to spend on health and social care so that a higher proportion goes on community based services (including mental and public health) and support for self-care (including carers) rather than inpatient hospital care?

3. Consolidation of specialist hospital services Can we agree, in principle, that patient safety and outcomes are likely to improve

considerably if 24/7 hospital specialist services are consolidated on fewer sites with 7-day consultant cover after an agreed time-limited statutory process of clinical review and local public consultation?

4. Funding options Can we agree to explore a wider range of funding options for health and social care to secure greater financial sustainability, rather than continuing to rely so much on general taxation?

5. Avoiding another “reorganisation” Can we agree to make the changes required gradually over a five to ten year period using, wherever possible, existing legislation and bodies without significant organisational and legislative disruption?

Five General Election Manifesto Pledges

Implementation of our proposals will require underpinning by much technical expertise including drawing on knowledge and skills from outside the NHS as we outline later but the critical ingredients for success are public, professional and political commitment to radical change. To this end, we challenge politicians of all parties is to ensure that, in their General Election manifestos, they are frank with voters about the seriousness of the situation. We suggest adoption of five manifesto pledges, committing the next Government to:

1. Intervene earlier and more effectively to prevent and manage conditions that are blighting lives and consuming too many NHS and care resources.

2. Move more health and care resources to community-based facilities, to deliver better patient care 24/7 and improve value for taxpayers. This could involve converting many existing hospitals into community hospitals with a different, wider range of services better suited to local needs (especially for the frail elderly).

3. Merge health and social care budgets and service delivery at a pace best suited to local needs.

4. Consolidate specialist services on fewer acute hospital sites (most of the remainder becoming community hospitals as above). These, often enlarged, specialist hospitals would have the professional expertise, equipment and facilities to provide safer emergency

services that would save more lives and produce better patient outcomes in a truly 24/7 NHS.

5. Contain NHS spending with little more than inflation-proofed annual increases apart from some extra one-off funding for the shift to more community-based services. Meanwhile, find new ways, other than income tax, to fund increases beyond inflation to protect other public services from being drained by the NHS and social care.

1

Why things have to change

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The challenges that the NHS now faces are formidable and represent a perfect storm. They comprise major funding problems; changing demography and disease profiles which mean that the NHS model no longer matches people's needs; scientific and technology advances plus rising public expectations; and the knock-on effects of a social care crisis. In its present state the NHS is poorly placed to handle these challenges.

1.1 Funding and fiscal issues

There is nothing new about NHS funding crises. Demand and public expectations have often outstripped government's ability or

“The NHS now represents the greatest public spending challenge for whoever is in government after 2015.”

willingness to meet them from taxation. Some politicians would say, with some justification, that the public often wills the NHS ends but not the financial means of achieving them and then punishes electorally those who

point this out. However the next decade's likely economic and fiscal situation presents funding challenges that are likely to be unprecedented in their depth, duration and visibility.

Of course, the issues of the size of our national debt, how quickly it needs to be reduced and the likely scale and pace of economic growth are hotly debated political issues that will influence the result of the 2015 general election. But some things are reasonably clear. The Office for Budget Responsibility predicts a budget deficit (the public sector borrowing requirement) for 2014-15 of over £100 billion. Our total public sector net debt (excluding support for the banking system) stands at nearly £1,250 billion or approaching 75 per cent of our GDP. It is still rising. This compares with a level of about 30 per cent of GDP a decade ago. At best, it will not start to diminish until 2016-17.

The Coalition has been unable to achieve the reductions in national debt and annual borrowing promised in 2010. As a consequence, government borrowing will be much higher than expected at the time of the 2015 election and throughout the next Parliament. How quickly

debt and borrowing can be reduced thereafter depends on the rate and consistency of economic growth about which we could speculate endlessly. It is clear, however, that the Chancellor has promised further years of austerity before he expects to balance the books. So, even without any further global economic disasters, money for UK public services is going to be very tight, whoever governs. This is accepted by all political parties, although whether they are willing to explain the implications for the NHS is another matter.

The total health and care budget currently (2014-15) is about £130 billion a year – more than education, defence and police combined.

“We need new sources of funding for the NHS that create greater financial sustainability; support service delivery systems for health and care that today’s and tomorrow’s societies need; and which preserve much of Beveridge’s pooled risk model.”

By 2015-16 this budget will account for nearly a third of departmental expenditure (excluding social security).

Other public services have experienced and continue to experience much greater cutbacks than the NHS. For example, there have been approaching 30 per cent cutbacks in local government

(which impacts seriously on social care, as will be discussed) and 25 per cent in criminal justice. In contrast, the NHS has been protected so far with essentially a flat-lining budget in real terms.

Yet this protection or “ring-fencing”, as it has been called, is seen by many as a serious cutback because, over the last 65 years, the NHS has averaged 3 per cent real terms growth annually. In the decade to 2010, this increased to 5-6 per cent a year. This could not continue and in 2009 the NHS was set a challenge by its Chief Executive to achieve £20 billion of real terms and sustainable efficiency savings or 4 per cent a year for four years. This was a level of efficiency improvement it had never achieved in one year, let alone four on the trot. Predictably, this level of efficiency gain has not been achieved on a sustainable basis. Much of the savings made have been achieved by pay restraint and one-off cuts rather than sustainable system reforms.

The NHS now represents the greatest public spending challenge for whoever is in government after 2015. This was graphically brought

out in a report by the highly respected independent Nuffield Trust in December 2012. The report stated that the NHS faced a decade of austerity with a £44-54 billion funding gap by 2021-22 unless it delivered unprecedented productivity gains or the public finances improved so much that NHS funding could return to increasing faster than inflation. It is difficult to see either of these conditions being met. More recently, NHS England has suggested a funding gap of £30 billion by the end of the decade.

Given the spending cuts being made to other public services, it is also difficult to see the NHS receiving from the public purse even the same protection it has had since 2010, let alone historically, without either significant tax increases or sustained economic growth at pre-2008 levels. The Nuffield Trust has told the Health Select Committee that one in three hospitals could end up soon in major financial difficulties; and the current system of bailing out those which go into the red cannot deal with the scale of the problem the NHS now faces. Although many people would like the government of the day to spend more public money on the NHS, they little realise what the implication of this is likely to be for taxation.

The financial room for manoeuvre on the NHS for any future government has become very restricted indeed. The developing funding gap is becoming too large to cope with by increased funding from general taxation unless one fantasises about economic growth, tax hikes or draconian cuts in other public services. We need to contemplate new sources of funding for the NHS that create greater financial sustainability; support radical changes to service delivery systems for health and care that better meet the needs of today's and tomorrow's societies; and which preserve much of Beveridge's pooled risk model. As society has aged, we have had to reform pensions and the retirement age, so why not the NHS? However, just plugging the NHS funding gap will not, on its own, deal with all the other challenges the NHS faces.

1.2 Demography and disease issues

When the NHS was founded, Britain was a very different place. A welfare state was being invented to make post-war Britain a better

place to live for the many, compared with what had existed before the war. In the world of healthcare, infectious diseases were still major killers, especially among children. There was a legacy of ill-health produced by hazardous industrial workplaces. Access to affordable healthcare for many people was difficult and the cost of serious acute episodes could have a catastrophic impact on a family's finances. On average, men died within about three years of retirement, so care of

“The changing demographic and disease profile has not produced the necessary re-appraisal of public policies and the business models for delivering health and care services.”

older people was a less significant issue six decades ago. Moreover, families lived closer together, relatively few women worked and family care was more readily available for older and disabled people.

There was also an implicit assumption in the Beveridge proposals that, if the backlog of ill-health could be treated, then, after an initial surge, the costs of the new system would somehow stabilise. The NHS was meant to deliver more peace of mind and better access to care with a price tag of about 3 per cent of GDP. Right from the start, as the appendix shows, there were concerns about the affordability of the NHS, given the demand for services. But there was less appreciation of how demography and disease profiles could change dramatically and what would be the impact of scientific advances, family changes and rising public expectations. These have destroyed the prospects of a tax-funded universal healthcare system costing 3 per cent of GDP and have raised serious questions about its affordability even at three to four times that proportion.

A century ago, there were 60,000 people in the UK aged over 85. Now there are 1.5 million and this figure will at least double by 2030. The latest Office for National Statistics data shows that, by 2037, about 6 million people will be aged over 80. Since 1981, average life expectancy has increased from 71 to 79 years for men and from 77 to 83 years for women. By 2032, it is forecast to rise to 83 for men and 87 for women. Although this is a cause for celebration, it also presents major challenges because this older age group consumes a very large share of our publicly-funded health and social care

budgets. Moreover, the capacity of working age people to pay the bills is threatened over the next 25 years. According to the Office for National Statistics, in 2012 there were 3.21 people of working age for every person of state pension age and that is projected to fall to 2.74 by 2037.

Not only are we living longer, we are doing so with greater ill-health: the number of people in England with three or more long term conditions is expected to rise from 1.9 million in 2008 to 2.9 million in 2018. So the complexity and cost of treatments and care for this ageing population has increased and continues to do so. Compared with other advanced countries such as France and Spain, our longer lives have fewer healthy years, according to a 2013 OECD study.

We have increased our health problems through our lifestyle choices as we have become wealthier than we were during austerity years of post-war Britain. We eat more – and less healthily. We continue smoking, although less so than in war-time Britain. Our love affairs with the car and television mean we take less exercise. Easier and cheaper access to alcohol has driven up alcohol-related disease.

The rise in obesity demonstrates the impact of lifestyle changes on our health profiles. Today, nearly 30 of every 100 adults in England are obese; and by 2035 this is set to rise to more than 40. Alongside this, our children are becoming more obese – we have even seen obesity as the reason cited, for the first time, for taking a child into public care.

Obesity can give rise to many of the chronic conditions such as diabetes, which, alone, now accounts for 10 per cent of NHS expenditure. Obesity also increases the risk of a wide range of cancers. Meanwhile, although we smoke less than in the past, smoking is still driving up the budget for dealing with cancer and coronary heart disease. The number of people diagnosed with cancer increased by 50,000 annually over the past decade to over 330,000 a year. Macmillan Cancer Support has warned that the number of people living longer with cancer or its after effects is expected to rise from 2 million to 4 million by 2030, as more people survive. New diseases have also become more prevalent, reflecting Britain's ageing population: the rise in dementia is the condition of greatest public concern.

This changing demographic and disease profile has not produced the necessary re-appraisal of public policies and the business models for delivering health and care services. There has not been the investment of money and intellectual effort into public health strategies that would counter commercial pressures and help us enjoy not only longer but healthier lives. The core business of the NHS has shifted over time from acute hospital episodes to management of chronic conditions which requires a rebalancing of our services away from hospitals to community-based healthcare. Yet our investment of resources – money and people – has discriminated too much in favour of hospitals at the expense of community services. It is the acute hospitals that have attracted all the professional, public and political attention and glamour as science has advanced and public expectations have risen.

1.3 The social care crisis

If things look bad for the NHS, they look worse for social care and for the people who use it. The problems of funding social care are long-standing. The Dilnot Commission's report in 2011 made this clear: "We know that the funding of social care for older people has not kept pace with that of the NHS. In the 15 years from 1994-95 to 2009-10, real spending on adult social care increased by around 70 per cent for older people while, over the same period, real spending in the NHS has risen by almost 110 per cent."

Before the Coalition, pay and prices in social care rose more quickly than general inflation; there was, and continues to be, rising demand as the number of older people and younger adults with care needs has increased; and social care budgets rose about 1 per cent a year in real terms in the three years to 2010 compared with 5-6 per cent for the NHS. The Dilnot Commission showed that, in the four years to 2010, demand outstripped expenditure by about 9 per cent. On a conservative estimate, by 2010, the social care funding deficit was at least £1 billion a year. The Dilnot report said this approach to funding social care needed to change. It has. It's got worse.

It is estimated that, just keeping up with demographic demand, publicly-funded adult social care requires annual increases, in real terms,

of about £0.5 billion a year. So, to put right the deficit and stop it getting worse, the base budget for adult social care should be about £2.5 billion higher in 2014-15 than it was in 2010. The reality is very different. A survey by Directors of Adult Social Services states that, by April 2014, local councils will have stripped £2.7 billion out of their

“Casual neglect of social care has had major consequences for the NHS. Preventative social care services are among the first to go, so elderly people need NHS services sooner.”

adult social care budgets since 2010. Despite political claims that this has been done by efficiency measures, in practice it has been done by imposing tougher eligibility criteria on people for receiving services and by cutting pay and payments to service

providers. Some of this financial pain has been offset by transfers of cash from the NHS but, even on the most generous interpretation of this shift, adult social care budgets look to be underfunded by about £3 billion a year or roughly 20 per cent of their budget.

This casual neglect of social care has had major consequences for the NHS. Preventative social care services are among the first to go, so elderly people need NHS services sooner. More end up in acute hospital beds after being taken to A&E departments by ambulance. They then stay there longer because they cannot easily be returned home because the care and support services are not available. Research studies vary in their estimates of the number of people occupying acute hospital beds who should not be there – from 25 per cent to 40 per cent. Most of these people are frail and elderly, trapped in expensive and inappropriate acute hospitals.

1.4 Scientific advances and rising public expectations

The advances in the life sciences and medical technology since the days of Beveridge have been phenomenal. New medicines, new devices and new clinical procedures have proliferated at a bewildering rate. Modern communications make public knowledge of these advances instantly available. There is a public expectation that these advances should be available as soon as possible in the “people’s

NHS". But few of these innovations come without a price tag, however beneficial they may be to patients.

Many of these scientific and technological advances have their origins within the NHS itself, and their development offers benefits to UK plc as well as to NHS patients if they can be exploited commercially. However, too often, we have lacked the commercial nous to translate

“The public will expect the NHS and its clinicians to use these high tech services but they may not appreciate the cost implications.”

a British discovery into an economic benefit either to the NHS or the country more widely. Instead, the taxpayer has typically picked up the tab for both the research and the adoption of the discovery

within the NHS, without receiving the wider economic benefits. There are some formidable investment and professional challenges ahead for the NHS if one just thinks about genomics and digitalisation. There is an ambitious target for the NHS to go digital by 2018.

The “100,000 Genome” Project offers great potential for improved diagnosis and treatment as genomes are sequenced. However, it also presents considerable challenges of professional and public education; investment in IT and equipment; and changes in working practices. Clinical genetics requires more digital services, cross-referencing between different databases and creates the opportunity for molecular biology laboratories to offer more diagnostic services. As we learn more about genomics, these services will have to be mainstreamed across medical specialties and patients. This will make patient genetic testing and personalised medicine the order of the day in healthcare, killing off the pharmaceutical industry’s reliance on blockbuster drugs. But at what cost to the NHS?

The public will expect the NHS and its clinicians to use these high tech services but they may not appreciate the cost implications. Many doctors will, themselves, want to practice medicine using the latest tools and not leave their patients in the clinical “dark ages”. But changes of this kind have a price implication, sometimes considerable, and often stretching over many years.

Even outside the rarefied area of genomics, the public will expect the NHS to improve its use of technology, especially to speed up access

to help and services. In the preventive area, alongside DNA sequencing, there are a growing number of health and wellbeing products and apps and pieces of screening and monitoring kit. In diagnostics, there is more scope for home-based testing; point of care diagnostics and *in situ* pathology testing as well as technology-driven improvements to management and treatment. These developments and other telehealth and telecare innovations have the potential to respond positively and cost-effectively to public healthcare expectations and to increased self-care of conditions; but they require both an investment strategy and massive change of approach by staff and organisations if the NHS is to embrace them. These represent formidable internal challenges for an NHS that has struggled with change in the past.

1.5 The NHS and the rest of public services

The great unspoken truth of British politics is that the NHS, as it is run and as it is funded, threatens to seriously damage other important public services. Year by year, as the NHS takes more and more of a shrinking cake, our schools, roads, police, social housing, early years and youth services, pensions and disability services can all be expected to be cut back again and again to fund it. By failing to radically reform the NHS and how it is funded, we risk slowly destroying other parts of our economic and social infrastructure to prop up an ailing and inappropriate sickness – not health – system.

The squeeze can only get worse as austerity carries on into the next decade and the NHS limps along, providing care at the wrong time in the wrong places. Other public services will experience further cutbacks but health and care services will still not meet the nation's needs. On present plans, we can expect all the main political parties to pledge their continued protection of the NHS budget. Locally Parliamentary candidates will fall over themselves to protest their support for their local hospitals, irrespective of whether these units really are fit for purpose and in the best interests of their constituents. Few MPs are brave enough to confront the frightening consequences for the rest of the public sector as well as for patients of blindly pumping more taxpayers' money into a health and care system as broken as our present one.

If we are not careful, the UK public sector could go the way of General Motors in the US – bankrupted by its own health insurance system. This is not inevitable if we are collectively prepared to face up to the radical changes required to our iconic but seriously ailing NHS. In making change, we have to understand the true lessons from the past as we discuss in the next Section, but with more detail in our annex. However, simply trying more of what has already been tried will not do the trick. We will have to contemplate more comprehensive and radical changes as we suggest in Sections 3, 4 and 5.

2

Today's crisis, yesterday's lessons

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Today's crisis in the NHS was unfolding years before austerity hit the public sector. Patients have long struggled to secure integrated care both within the NHS and across the health and social care divide. Their care has been fragmented even between hospital and GP. Despite a number of high profile, disruptive reorganisations, as well as changing needs, the care and treatment silos that were in place in 1948 have changed little.

The NHS and other government agencies have also failed dismally to adapt to the biggest health challenge of the age – avoiding chronic disease springing from poor lifestyles. As a result, for example, a tidal wave of obesity is engulfing particularly the younger generation. Nearly 30 out of every 100 adults in England are now obese and this figure is set to rise to more than 40 by 2035. Many of them can, as a result, expect to die younger than – or even before – their parents because of diabetes, stroke, heart disease, cancer and other lifestyle-related ailments. It is a dramatic failure for a system that focussed so successfully on tackling infectious disease.

2.1 Poor productivity growth

The picture on productivity in the NHS has been worrying. The cruder input/output productivity analysis of the Office for National Statistics shows rather disappointing NHS productivity for the level of increased investment in the last decade, with a slow burn and most of the

“The decade of plenty was a missed opportunity for the NHS to use the extra money and staff and the better equipment and buildings to redesign its business model for the future challenges that have now arrived.”

improvement coming in the second five years. A more sophisticated analysis by the Centre for Health Economics (CHE) at York University shows the NHS producing an 8 per cent productivity improvement between 2004 and 2010. But this is far from earth-shattering given that the annual

investment was going up by 5-6 per cent a year. It also conceals huge regional variations in NHS productivity; for example CHE's work suggests that, if all parts of the country were as productive as the South West, the NHS could cut expenditure by over £3 billion a year,

without reducing the number of patients treated.

The decade of financial plenty certainly produced huge improvements in access to services and reductions in avoidable adult deaths from the killer diseases of cancer, coronary heart disease and stroke. All this was also helped by a centrally-driven targets regime and more competition and patient choice. However, too much of the money

“We keep open acute hospital beds to care for thousands of elderly patients inappropriately at three times the cost of a good nursing home bed or decent home care, simply because we treat health care and social care as two separately organised and funded systems.”

was spent on simply recruiting more staff and increasing their pay. Wage drift was high through the national pay bargaining system which failed to incentivise robust productivity improvement. The extra money spent on pay did little to secure different skill mixes among NHS staff that would enable more care to be delivered

outside hospital in the community. The decade of plenty was a missed opportunity for the NHS to use the extra money and staff and the better equipment and buildings to fundamentally drive improved efficiency by redesigning its business model for the future challenges that have now arrived.

Historically, demand for healthcare has increased on average by about 4 per cent a year, with funding increasing by about 3 per cent. So there was a productivity gain of 1 per cent a year to be made by the NHS. Since 2010, that productivity requirement has leapt to 4 per cent and that higher level of productivity improvement is now likely to be necessary throughout the next Parliament, under existing plans. There is no credible plan to deliver this level of productivity gain.

2.2 Service delivery is inappropriate and slow to change

Almost without anybody noticing, the NHS core business has become the management of long term chronic conditions of an ageing population, with a specialist medical adjunct for serious acute

conditions. Yet we have retained, for the most part, an expensive hospital-dominated service delivery model spread around too many sites but with insufficient good-quality, community-based services for the core business. Our funding system incentivises hospital care so, unsurprisingly, medical wards of acute hospitals are frequently full of people who should not be there.

Study after study suggests that 25-40 per cent of people in medical wards should not be in hospital. The great majority of these people are frail, elderly patients being failed by the inadequacies of the community based services. At the end of their lives, the majority of people die in hospital even though they want to die at home (or the care home they regard as home) and, with better support, they could do so.

Most of our current problems with over-crowded and over-used Accident and Emergency Departments have their root cause in the failure to restructure services and shift investment to more and better quality community health and social care services. Far too many

“The politics of hospital services reconfiguration is toxic. MPs – particularly those in marginal constituencies – can lose their seats if they appear to agree to local hospital services going off-site.”

people are brought to A&E Departments unnecessarily. They then wait a long time there, or in ambulances, for medical attention. Many are admitted eventually – especially out-of-hours – because of the absence of an alternative to hospital. Then, they often cannot be discharged because the community support is not

available. Recent research has shown that some of these people are turning up in A&E Departments 50 to 100 times a year rather than being dealt with by primary care and community services. The answer is not more A&E Departments, but services outside hospital to offer much better alternative services that keep people out of hospital.

Many of the acute hospitals receiving all these patients are poorly equipped to cope with the volume and range of conditions being presented but they soldier on in the absence of an alternative game plan. Many of them are financially unsustainable in their present form. A report published in March 2013 by the Public Accounts Committee

– with a Labour Chair – concluded that NHS organisations will have to make significant changes to patient services to become financially sustainable.

We know that at least 20-30 hospitals are clinically and financially unviable in their present form. Some of these low-performing trusts are on “special measures” because of concerns about their quality of care. The Francis Report on poor and dangerous care at Mid Staffordshire NHS Foundation Trust was not a one-off example of such care. Over time, these hospitals find it more difficult to recruit good doctors and managers. We know that all hospitals have problems at certain times of the week – death rates for patients are higher when they are admitted at the weekend rather than during the week. The risk for over-stressed hospitals is a slide to mediocrity or worse. Many of the more specialist services need to be moved off site and consolidated elsewhere in the best interests of patient safety.

NHS professional and managerial leadership know the problem and the solution, even if they tend not to talk about it too loudly. That is because the politics of hospital services reconfiguration is toxic. MPs – particularly those in marginal constituencies – can lose their seats if they appear to agree to local hospital services going off-site. Yet the present arrangements for reconfiguration of hospital services place most of the onus for doing so on local personnel building the case to an audience that doesn't want to hear it. The result is growing numbers of acute hospital sites with clinically and financially unsustainable services that threaten patient safety, but no credible system for achieving change.

Meanwhile, many doctors have opposed initiatives such as Ara Darzi's 2008 alternative model of polyclinics which aimed to strengthen community services as an alternative to hospitals. There has been a total failure to go to scale on local initiatives showing the benefits of integrating health and social care. As the funding pressures increase, there is beginning, belatedly, to be a realisation that rebalancing the delivery system from hospital to community, and reducing the number of specialist sites, is the right way forward. However, progress is painfully slow and politically fraught.

The factors preventing service delivery change have made it difficult

for the NHS in its present form – despite endless reorganisations – to respond effectively to budgetary austerity. We now have a growing body of evidence indicating how the NHS is currently coping – or more accurately not coping – with three years of flat-lining budgets. The emerging picture is not reassuring on issues such as speedy access to services, quality of care and being treated with compassion and dignity. At the core of this problem is a failure to redirect care, staff, effort and money around people in or close to their own homes, rather than in hospitals.

2.3 Care scandals

NHS belt-tightening has seen a flurry of care scandals and concerns in acute hospitals and care homes. The Francis Inquiry exposed poor care and a lack of dignity for vulnerable elderly patients in the Mid Staffordshire Foundation Trust that was considered to be more widespread than just a single hospital. The Medical Director of NHS England investigated unusual mortality rates in 14 acute hospitals and required special measures to be taken. Winterbourne View and Orchid View are just two of the care homes that have hit the headlines for totally unacceptable care of vulnerable people.

At the heart of these scandals has been a culture of indifference, on the part of some staff and organisations, to the dignity and discomfort of patients. Much of the care is provided by unqualified care assistants, too often badly paid, poorly trained and inadequately supervised. Doctors and nurses have, in some instances, been reluctant to blow the whistle on poor practice; and the system has been slow to pin accountability for poor care and neglect on individuals or organisations. Financial stringency has also played its part, especially in care homes and domiciliary care where local authority funding cuts have reduced expenditure on social care significantly. This has led to difficulties in filling managerial posts, with many care homes lacking approved managers; big cuts in prices paid to care homes making services unsafe; and care providers being paid for fleeting 15-minute home visits to frail elderly people.

The result of these scandals has been an overhaul of the regulatory system, including a revamping of the Care Quality Commission and a

new system of monitoring and visiting hospitals and care homes to ensure that they are safe, caring, effective, responsive and well-led. Using a new set of over 150 indicators and more expert inspectors, the Commission will have inspected all NHS hospitals under the new system by December 2015. But, as it has already shown, this new approach is throwing up groups of trusts about which there are concerns, some of which were not even on anybody's radar previously. Welcome though these new regulatory arrangements are, it would be surprising if they did not reveal significant concerns over quality of care in additional hospitals, care homes and GP practices.

2.4 Barriers between health and social care

These problems around care standards, patient dignity, speed of access and seven-day working would be big challenges for the NHS at a time of plenty. In period of austerity, they look like a substantial mountain to climb in terms of the improvements in staff training and

“Neither the NHS nor social care is equipped to meet the financial and care challenges of the next decade. The gulf between what we should expect and what we get from our health and care services is rapidly widening.”

attitudes required, as well as the major overhaul of organisational culture and governance needed. The NHS culture seems inward-looking, suspicious of outsiders and new ways of working and is reluctant to change direction quickly. It is a provider-dominated service that prefers retaining its silos in most cases to sharing sovereignty with others. Nowhere

is this more apparent than in the barriers between health and social care that many elderly people and their carers struggle with day in, day out. Across that boundary, adult social care now faces a care and funding challenge that is even more daunting than the NHS's but which has serious consequences for the NHS's own ability to cope.

We now face a future where, each winter, the situation will worsen further in A&E Departments and acute hospital wards with TV coverage revealing an NHS crisis that is largely of our own making. We keep open acute hospital beds to care for thousands of elderly patients inappropriately at three times the cost of a good nursing

home bed or decent home care simply because we treat health care and social care as two separately organised and funded systems.

Parliament will pass a new Care Bill reforming the law and approach to adult social care and putting in place a new funding architecture on the basis of the Dilnot Commission's recommendations. However, this will work only if the new system is adequately funded and fully integrated with the NHS. The Coalition is experimenting with about 14 pioneer pilot sites using integrated budgets and services for health and social care. The big question remains whether properly funded integrated health and care services will happen at the pace and scale required.

In their present form, neither the NHS nor social care is equipped to meet the financial and care challenges of the decade. The gulf between what we should expect and what we get from our health and social care services is rapidly widening. We have now to contemplate a major overhaul of both the way we deliver services and their funding.

2.5 Lessons from previous NHS crises

Given these long term imperatives for change plus the immediate crisis, what can policies employed during previous NHS crises tell us about managing this one? The Annex carries a full chronology of NHS change since 1948. But, here, we draw out the key lessons for issues we face today.

We would contend that the NHS should be wary of pursuing some of its traditional responses: they look unlikely to deliver the changes needed. The barriers to change evident over time also tell us how difficult real reform is and the importance of leadership. We highlight some important alliances, particularly with clinicians, that have been required in the past to implement serious change.

To achieve successful change, the NHS will need to resolve its historic ambivalence about the role of local government. It should build on its record of rethinking financial solutions during difficult times, in particular to broaden the healthcare tax base.

Traditional strategies may not work

So, first, here are a few warnings against traditional responses. In difficult times, the NHS has frequently relied on economic growth to free up funds to fix problems. Elsewhere in this report, we suggest that, this time around, economic growth is unlikely to provide sufficient finance. But, even if the money could suddenly be found, it would be unlikely to solve fundamental problems around service delivery. Periods of economic growth, as explained earlier in this Section, have not delivered significant NHS service change. Money has tended to go on extra staff and existing delivery arrangements rather than system reform.

The expensive hospital sector, rather than primary and community-based healthcare, has typically soaked up the benefits of growth, notably with the hospital-building programme of the 1960s and 1970s

“We have yet to find a commissioning structure strong enough to curb the resource consumption of powerful acute hospitals. And the purchaser-provider split has, so far, done little to integrate health and social care. We need fresh ideas to tackle key issues that have bedevilled the NHS since 1948.”

and, later, in the 2000s, during the major development of hospital capital infrastructure. That recent “decade of plenty” did feature attempts to shift the agenda away from hospitals to care closer to home, more public health and integration of health and social care. However, the payment system remained skewed to activity in the more expensive acute hospitals which continued to dominate NHS budgets. Ara

Darzi’s 2008 report called for community-based polyclinics but NHS vested interests seriously limited implementation.

Another tried and tested NHS response to crisis has been rationing – denying access to services, especially elective surgery. This strategy is once again emerging in the cash-strapped NHS. But, historically, it has been a short term salve – resulting in hold-ups at the NHS bottlenecks, such as A&E, forcing governments once more to pour money in. Today’s problems are more long term and profound, unsuitable for the temporary ration-then-fund fix.

Management reorganisation and the purchaser-provider split

Occasionally, political leaders have opted for major reforms. The NHS has, over the last 40 years, had five major reorganisations – 1974, 1983, 1991, 2003 and 2012. These all featured either – or both – of two main reform ideas. The first was that the NHS needed to find the right system of management and governance and organisation: so area health boards, hospital trusts, foundation trusts and general management have all had their day in the sun. The 2012-13 reorganisation has produced a massive organisational upheaval costing some £3 billion that has caused both confusion among NHS staff and a lack of clarity over public accountability. Although the jury is very much out as to the lasting benefits of this reorganisation, it is clear that the NHS cannot be expected to cope with another reorganisation on this scale. The effort must now be made to make it work more effectively with the minimum amount of re-engineering.

The second, more profound, reform has been to split the commissioning of services from their provision – the so-called purchaser-provider split. This change in 1991 has shaped all subsequent organisational changes. The idea has been that separate commissioners holding a budget would better focus services on the needs of users, so they got the right care in the right place at the right time at the best value. It was hoped that this would produce a more patient-centred, efficient NHS. However, more than 20 years later, we have yet to find a commissioning structure strong enough to curb the resource consumption of powerful acute hospitals where most of the top NHS managers have built their reputations. Moreover, the purchaser-provider split has, so far, done little to integrate health and social care in a cost-effective way for patients and funders. The commissioners of services have so far never been powerful enough on their own to use their budgets to drive the new patterns of service delivery required.

Major successful change has required strong political leadership.

History warns us never to under-estimate the political commitment required to achieve change in a sector that is remarkably resistant to deep-seated reform. Despite all that has happened around it, the

NHS business model has barely altered since 1948. In very few areas has it been possible to reconfigure local services in the way needed without defeat, major uproar or significant unjustified compromise. Few, if any, of the local “victories” have been in the best long term interests of patients.

Nevertheless, the radical shift from Victorian asylums to community care improved the lives of many people immeasurably by the development of very different service models. More recently, after 2000, lives were saved from killer diseases by using central targets and new providers as well as by investing more money. Many of these changes were opposed, but they show that strong political leadership can produce change that benefits the public. There is also growing political agreement that a move towards more integrated health and social care is essential. We need now to build on these areas of political agreement.

Clinical champions are vital to convince public and politicians

Experience suggests that the success of reform will rely on winning over clinicians, some of whom have been a block on change. Opposition from general practitioners is generally remembered as the chief obstacle to founding the NHS – overcome by the then Health Secretary, Aneurin Bevan, “stuffing their mouths with gold”. Vested clinical interests were, however, central to halting plans for locally based medical hubs – polyclinics – in 2008. Hospital staff have also played an important role in rallying opposition among both the public and politicians to the reconfiguration of health services.

There are, however, encouraging signs that some doctors today recognise that the shifts we are proposing are vital, if professional reputations are to be maintained and the NHS is to survive.

Clinicians are important not only because they are at the heart of delivery. They also provide the public and politicians with the confidence to support change. Public and political debate – often reflecting the views of hospital-based clinicians – has focussed too much on maintaining large numbers of local acute hospitals. Too little of the public debate has been related to building up health and care services in the community. This has to change.

Local government is part of the solution

If real reform is to take place, there will need to be a major shift around local government. It should be seen as a big part of the NHS solution, rather than part of the problem. Historically, the role of local authorities in health and social services has been deeply confused, holding up integration of health and social care, which could offer a better way for people to get the care they need in the appropriate place at an affordable cost.

Back in 1948, local authorities, through their medical officer for health, had responsibility for whole population health and running health centres and district nursing. But, in 1974, local government was removed from the NHS.

“We are dealing with challenges in other policy areas as a result of rapid global, financial and demographic change. There can be no escape from doing this for the NHS. Will the NHS and politicians follow Rutherford’s wartime dictum – ‘We’ve run out of money and now we have to think’?”

Margaret Thatcher was deeply opposed in 1991 to allowing local government to run community care, only backing down at the last moment in the face of opposition from her Health Secretary, Kenneth Clarke. The 2013 reforms have now brought local government back into the NHS fold through Health and Wellbeing Boards, but have given them no budgetary responsibility.

These changes have also split public health responsibilities between central and local government in a way that has produced a good deal of confusion on accountability.

Over the years, funding of social care through local government has been far less favourable than that for the NHS, thereby reducing services at a time of rising demand, with knock-on effects for the NHS.

In spite of this political ambivalence displayed towards local government, councils have arguably performed better than many of the other actors in the health and social care saga. Unlike the NHS, they balance their budgets annually. They are also democratically accountable at a local level, in contrast with the NHS. The personalisation of social care is way ahead of the personalisation of

healthcare. Though starved of funding and less trusted than the NHS, local authorities could be the “White Knight” for an NHS in crisis if they were given a wider role and the funding to discharge it.

Bringing health and social care together has to be more than the high level budget integration that we have seen, for example, in Northern Ireland. It has to mean integration of service commissioning and the delivery of those services to individuals.

A financial crisis could drive service change

We know that a financial crisis can be a spur to major reform, as in 1951 when it produced co-payments in the form of prescription charges. General management and improved efficiency sprang from the recession of the early 1980s; while the internal market developed out of the 1987 NHS financial crisis. Poor access to healthcare can also drive fundamental change. The founding of the NHS in 1948 was based on Beveridge's central argument that the existing health insurance systems did not cater adequately for large swathes of the population. Likewise, it was the deteriorating access to services in the late 1990s – especially to GPs and for cancer – that forced change and increased investment in the NHS after 2000.

There are now large groups losing out under the NHS as it stands - the frail elderly, large numbers of people with moderate mental health problems plus millions of people with chronic conditions or whose lifestyles are likely to generate major health problems for the future. They are paying a price in terms of care, longevity and quality of life that has parallels with pre-1948 Britain as the gap widens for many people between the potential for healthy lives and the actuality. These groups could provide the political constituency to drive real service change.

Rethink NHS boundaries and financing

In strengthening the funding of health and social care, we should also understand the history of the shifting boundaries between NHS and means-tested care, and the role of co-payments, as well as ways to make the best of under-utilised capital assets to fund major change. The boundary of the NHS has been redrawn periodically in the areas of geriatric care, learning disability, dentistry, optical services and

prescription medicines. Has the time come to consider further redrawing? We already have co-payments, such as prescription and optometry charges in primary care, but should they be extended to the hospital sector for hotel costs?

The sale of the Victorian asylums freed up money to fund alternative community care services. Should we now be rethinking how to make better use of other parts of the NHS estate to finance other service improvements? And what should we do about general taxation?

“Can taxation to fund the NHS be developed more creatively to incentivise healthier living?”

The past shows us that it is a very efficient way for collecting money to pay for the NHS. However, we have yet to find the best way to

distribute that money to achieve a cost-effective and adaptive NHS. Can taxation to fund the NHS be developed more creatively to incentivise healthier living?

The time is approaching for a wider public debate on how we raise the money for our health and care system and how we distribute it. As a country, we are dealing with difficult challenges in other areas of public policy as a result of rapid global, financial and demographic change. There can be no escape from doing this for the NHS. Will the NHS and politicians follow Rutherford's wartime dictum – “We've run out of money and now we have to think”?

There are useful lessons from the past but they are inadequate on their own for the scale of change needed now. More creativity and ambition is required to produce good quality health and care for the population as a whole. Patching things up isn't good enough. We have to start re-imagining our health and care system and its funding.

3

Reimagining the NHS and social care

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Everyone knows that the NHS is at its best when you really need it in emergency, when you are really ill. It's there for you and for your fellow citizens, whoever they may be, and can be excellent, particularly in the acute sector. However, we need a system that offers more than just heroic care during difficult moments in our lives. It must also stand alongside us more consistently on a day-to-day basis, helping people achieve good health and a higher quality of life into a longer old age.

This system cannot be expected to do everything for us, except, perhaps, when we are very sick. Most of the time, good health is down to how we live and look after ourselves. We need to do more to

“It is a great paradox of the current system that poor access to health and social care is one of the key causes of today’s mushrooming healthcare cost crisis. Poor care is not just killing people. It’s killing the NHS.”

manage our own health. To do this, we need better support along the way, both when we stumble and when we want to take bigger strides to better health – both physical and mental. This Section is about the State providing good access to – and a good experience of – healthcare and support on a day to day basis, not

just in an emergency. But it is also about individuals, at the same time, doing a better job of stepping up to their responsibilities for improving their prospects.

Rebuilding the two pillars of the NHS and social care: Good access and good experience

What makes the NHS and social care good? Many have tended to think, since the foundation of the NHS, that the core quality is simply being “free at the point of delivery”. That is, of course, an important part of the vision. Lack of income or wealth should not prevent access to healthcare – this continues to be an important principle of the NHS, although we accept that social care remains mean-tested.

A new health and social care system needs a much bigger vision than simply being “free”. Access that is free, but largely unavailable – or achievable only via a long and tortuous pathway – is access in little

more than name. We also argue that the second key principle of a new system should be that care is a good experience. It not only makes us better, but sets us on our way to more sustainable good health and well-being.

Looking below at what these principles – good access and good experience – mean in practice highlights some of the shortcomings of today's NHS and the social care system. It helps us to understand the case for change.

Ten standards of good experience and access to the NHS and social care

Good access and experiences require care to be:

1. Fast. You don't have to wait a long time for the right intervention

2. Easy to reach. That might mean close-by or via a trouble free, quick journey.

3. Expert. Care is provided by the person who really can solve the problem.

4. Listening. It responds to your need.

5. Straightforward. Care is easy to navigate so you get what you need.

6. Enabling. The experiences also harness and enable your personal capacities to improve your own health.

7. Holistic and lifelong. It's from the cradle to the grave, engaged with the whole person over a lifetime.

8. Integrated. You don't fall between cracks in the system, for example between your GP and hospital or between hospital and care in the community.

9. Compassionate. It engages with your passion for a fulfilling life, understands your suffering in ill-health, and supports you in both.

10. Safe. It avoids doing harm.

When rated against these standards, much of today's NHS and social

care falls well short of excellent and much is not even good enough. For the most part, it is only regularly achieved in the hospital sector in emergencies – and not always then. Outside hospital, the patient often has both inadequate access and a disappointing experience. Below are three examples of patients often treated inadequately by the current NHS and social care systems:

- > **The elderly person**, poorly looked after medically and physically at home, who, as result, can find themselves acutely ill in a crowded A&E, perhaps leading to a lengthy stay in hospital where they can expect to be exposed to potential infection. Being admitted to hospital is often the last thing an elderly person needs or wants – most would prefer good alternative care coming earlier and more appropriately. Today's arrangements are often bad for them as well as damaging to others and to the NHS, causing beds to be blocked for those awaiting operations and treatment. Care in this case has failed many of the ten standards detailed above – leading to avoidable harm. It has failed to be fast, easy to reach, listening, straightforward, lifelong, holistic, integrated, compassionate or safe. The patient has been let down by an NHS which has pledged to provide them with free access to services and with a good experience.
- > **A person with depression and anxiety** may find themselves leaving a doctor's surgery after a short appointment, armed with a prescription for anti-depressants. There may be a promise of counselling possibly after a wait of several months, because the queue is so long and resources are so scarce. The counselling may never materialise because the only eventual option is during the day when the person is at work. And there will probably be no referral to a psychiatrist. If the patient fails to take the medication or seek counselling, they are unlikely to be followed up. The consequences for them and their families can be devastating in terms of lost jobs, diminished personal relationships and deepening mental health problems over time. Care in this case has failed to be expert, listening, enabling, holistic, integrated, compassionate or, arguably, safe. The patient has been let down by an NHS which is meant to provide

free access to services and a good experience.

- **A person with unhealthy lifestyles.** Largely ignored by the NHS and social care until it is too late, this person is storing up problems for the future – both theirs and that of the NHS and social care. They are gradually increasing their risks of chronic and acute disease including diabetes, heart disease, stroke and cancers. They will find that the care and support that they need early on is not easy to reach. They are unlikely to see an expert or be supported to change significantly. One sees more and more of these people every day – including some children – for whom absence of skilled intervention is likely to mean a considerably shortened and unhealthier life. Their care is not holistic, integrated nor particularly compassionate. They are not particularly “safe” in the NHS’s hands until they get really sick. They too have been let down by a service that is meant to offer free access to services and a good experience.

These typical access failures store up huge problems for individuals and can steer them eventually into the hospital system where they will be treated far too late in a more expensive environment for problems that could have been resolved much earlier with much better outcomes for the patient. So, simultaneously, these inadequacies develop long term costs for both the NHS and the citizen. It is a great paradox of the current system that untimely access to health and social care is one of the key causes of today’s mushrooming healthcare cost crisis. Poor care access is not just killing people. It’s killing the NHS. We do not protect the NHS by viewing it through rose-tinted glasses.

We need a new vision for the NHS and social care system. It is one where individuals get the care that’s right for them personally in the right place at the right time. That is what we all want and need. And it would be better for the NHS and social care system to do more to nip problems in the bud, rather than waiting for them to develop, thus creating more problems and higher costs later. The four key structural features of the changes we envisage are:

1. A shift towards co-production of health and well-being between the care services and individuals (and their carers), with much stronger public and mental health services and support for people to manage their own care.

2. Full integration of health and social care budgets and delivery of personalised whole-person care.

3. More care delivered in the community and closer to home, often using transformed existing hospital sites.

4. Consolidation of hospital specialist services on fewer sites, better staffed and better equipped for 24/7 access to save more lives and improve outcomes.

3.1 Co-production of health and well-being – a new partnership between the NHS and individuals (and their carers)

We suggest that the new NHS and social care system should focus on a fresh partnership between the State and citizens, based on co-production of both physical and mental health and well-being. This recognises and enhances the vital role that the NHS plays in our citizenship. It also implies changing responsibilities on the part of both individuals and the State.

This vision recognises that the greatest potential health and wellbeing gains today spring largely from consistent individual self-care,

“On a day to day basis, the challenge is not what the NHS can do to you, but what it can do with you.”

changed lifestyles and the State doing more to support individuals and families in these processes, rather than waiting to pick up the pieces in crises. On a day to day

basis, the challenge is not what the NHS can do *to* you, but what it can do *with* you.

The problems are clear. The era of economic growth since the Second World War has produced a rapid increase in lifestyle diseases. These are rooted mainly in smoking, alcohol consumption, poor diet and lack of exercise. Aside from ageing, these factors collectively represent the most significant risk to human health today.

We cannot do a lot about ageing. But we can do a great deal to reduce these lifestyle risks – which are costly to long term health and to the NHS.

The good news is that, even as lifestyle-based diseases are taking hold, there has also been a parallel revolution in self-care and preventative healthcare by many ordinary people. There is growing

“If the NHS is left solely responsible for individual health, then interventions are likely to be too little too late. Likewise, if individuals are solely responsible for preventative and chronic healthcare, they are unlikely to be as successful as if the NHS supported them actively.”

evidence about, and interest in, what people can contribute to their personal well-being in terms of healthy eating, reduced smoking, less drinking and taking exercise. People also increasingly give themselves self-care. They use their local chemists and the increasing knowledge they derive from the internet and from health advice services, some of them State-funded, to look after themselves. Many are also funding

themselves through counselling. They and carers are also called upon increasingly to manage their own chronic conditions. But the NHS’s engagement with this parallel revolution is often half-hearted. This reflects its reluctance to shift from a professionally-focussed, provider-dominated institution to a patient-centred organisation that works with people over time rather than doing things to them in an emergency.

Our vision is to build on this historic movement towards greater individual responsibility for health maintenance. This requires partnership – the co-production of long term health and well-being. If the NHS is left solely responsible for individual health – both physical and mental – then interventions are likely to be too little too late and too hierarchical, a failure for all concerned. Likewise, if individuals are solely responsible for preventative and chronic healthcare, they are unlikely to be as successful as they might be if the NHS supported them actively.

We know the consequences of such failure. For example, governments accepted the link between smoking and lung cancer in

the 1950s, but we are still arguing about whether the branding on killer cigarettes should be banned. Thousands of people have died unnecessarily from smoking-related diseases because of slow and poorly engaged government action. The health history with tobacco is now being replayed with alcohol and food. Despite the closure of the Victorian asylums, the stigma and discrimination around mental health remains. People with mental health problems often also have physical health issues and their care needs to be integrated. Too often they have serious difficulty in accessing services or getting them on a continuing basis and not just at times of crisis.

We suggest two new approaches and mechanisms to encourage individuals to be more active in their own health maintenance. These would be every citizen's new NHS Membership and annual Health MOT. We also suggest a number of ways in which the NHS could be become more locally democratic and accountable to its users via a Citizens' Audit, delivered annually on Health and Wellbeing Day.

NHS Membership, a Health MOT and a Citizens' Audit

At present, people know they pay their taxes for the NHS, but they know little about its costs and often do not know what services it provides. For example, the Dilnot Commission found that more than half of people thought social care was part of the NHS and "free". We

"NHS Membership could be an important part of British citizenship"

believe that people might gain a more direct personal stake in the NHS, and improved knowledge and awareness, if it became more

like a membership organisation that provided structured and regular contact between individuals and the services supporting them.

For this to happen, there would need to be enrolment processes and some discernible benefits for individuals and their families. The process would also provide an opportunity for improving the mutual knowledge of both the individual and the healthcare system as well as identifying the obligations that membership entails – for both the health professionals and those using the system. NHS membership could be an important part of British citizenship and only open to those with residence qualifications, although emergency care would continue to be available to visitors. A membership scheme of this kind, using a membership card, could be a protection against

growing public concern about “health tourism” and facilitate an individual’s access to their own electronic patient record as part of co-production of health care.

NHS Membership could entitle more people than now to an annual Health MOT. This might be available to people of working age below the age 50. The purpose would be primarily supportive, not punitive. The Health MOT would run basic health checks such as weight, BMI, blood pressure and raise lifestyle issues such as smoking, drinking, diet, exercise and stress. The latter would provide an opportunity to identify early stages of mental health problems and the scope for early access to services such as talking therapies. It might also focus on the management of chronic conditions such as diabetes and heart disease and it would do more to support those who were carers. The Health MOT would review progress over the previous year and agree individualised goals and NHS support for the coming year. It should encourage people to raise concerns about progress before the next MOT. Such arrangements would be helped enormously by a rapid move to individual integrated electronic records for health and social and the enhancement of new sources of public information on health and wellbeing issues.

We think there would be merit in introducing an annual fee for NHS Membership, although this could be waived or reduced for designated groups such as children, or the very old. Such a fee could be collected and used locally to improve local services aimed at enhancing health and wellbeing rather than being diverted into the national pot for funding of the NHS. The NHS Membership fee might be collected with council tax and be paid into a fund held by enhanced Health and Wellbeing Boards that would help to expand the capacity of community-based preventative healthcare. We discuss the revenue from a membership scheme further in Section 4. However, such a scheme could provide scope for financial and other rewards for individuals and healthcare professionals who successfully tackled locally-determined, priority health and wellbeing issues.

There would be an annual membership renewal process for everyone. This might usefully be accompanied by major health and wellbeing messages on an age-appropriate basis. These should make maximum use of new technology and messaging to keep individuals

and the NHS connected throughout the year. For those groups offered individual Health MOTs, this could be linked to renewal of their NHS Membership. No-one would lose NHS Membership if they failed to take their Health MOT after repeated reminders, but they should be confronted with the consequences and costs of their actions for the NHS in the longer term. For such a scheme to be successful, the support of GPs and the primary care system is critical. Some of the money raised from fees might be spent on incentivising general practice to be more pro-active in supporting people to improve their health and wellbeing. We would suggest that supporting people in the achievement of their annual health goals should become a requirement of a revised GP Contract, with performance being monitored by the new Chief Inspector of General Practice.

In our view, this new partnership between individuals and the State could be enhanced if there was an annual Health and Wellbeing Day when a new National Health and Care Service was required to provide a Citizens' Audit on its performance and cost. This would be a report to all of us on the progress it was making to meet the needs of NHS members. There would be a national report to Parliament plus a detailed local report for each area on the development of community, primary and social care services, as well as on the specialist hospital sector. We would suggest that it should include surveys and comments on performance and what local people thought of the services and what they wanted to see changed. The media – national and local – should be encouraged to stimulate public discussion and debate in a constructive way around these audits, with participation by MPs, professionals and the public.

The NHS was established on the 5th July 1948 so July 5 might be a good date for Health and Wellbeing Day, a regular celebration of its achievements and a reflection on where it needed to improve, replacing the existing NHS Change Day which has received little attention.

3.2 Integration of health and social services budgets and service delivery

Successive governments have toyed with the idea of integrating health and social care services. Successful schemes have been tried, most notably in Torbay, but these have been isolated cases and

invariably small scale with populations usually of 150,000 or less. There has been no expansion of these schemes on any scale and the pace of service integration has been glacial, both at the level of organisations and that of service delivery to individuals. Integration of budgets has seemed difficult because the NHS is centrally-funded and free at the point of delivery while social care is administered by local authorities and is mean-tested. This has proved both a difficult technical and political issue, not least because of the fear that more means-tested care would be shunted over the boundary to the “free” NHS. The result has been staunch defence of that boundary – the so-called Berlin Wall – and service users wrestling with two care bureaucracies rather than one.

Added to this has been a longstanding distrust by central government of local government being involved in health care. We describe in the Annex some examples of this: the removal of local government from any NHS role by in 1974; and the reluctance of Margaret Thatcher in the early 1990s to allow local authorities to administer community care. This distrust has not been helped by periodic social care scandals, often related largely to under-funding and usually no worse than their NHS equivalents.

However, there is now a wind of change blowing, with a broad cross-Party acceptance that, at least in principle, we need to move at

“We would build on the 2012 changes and make HWBs the budget-holders for social care, local public health funding and community health services (including community mental health services).”

greater pace and scale to the integration of health and social care and to break out of the separate silos that have existed since 1948. The Health and Social Care Act, 2012, provides for Health and Wellbeing Boards (HWBs), based on top-tier local government acting as assessors of overall strategic local

population health needs but without budgetary responsibility. Local authorities already have the budgets for adult social care and now new responsibilities for public health. Their responsibilities will be strengthened in the Care Bill (soon to become an Act), the thrust of which is to promote individual wellbeing through public agencies working more closely together and to introduce a new system of

funding care and support based on the Dilnot Commission recommendations. These changes will require a closer working of the NHS and social care with housing agencies to provide joined up services focussed on individual needs that facilitate people staying in their own homes as long as possible.

We think the time has come now to think more radically about integration by building on the 2012 Act changes and gradually make HWBs the budget-holders for social care, local public health funding and community health services (including community mental health services). This would reflect the growing political consensus on the need to integrate health and social care services for the benefit of individuals. It would enable implementation of the report of an independent commission chaired by Sir John Oldham, entitled *One person, one team, one system*. These integrated budgets would be a

“CCGs would continue to play some role in the commissioning of hospital services on a basis to be determined by NHS England. GPs would remain the gatekeepers for patient access to acute sector hospital services.”

step to a “whole person” concept of care, rather than the current siloed care systems that people currently experience.

HWBs would be required to use this money to commission services in an integrated way and in the best health and wellbeing interests of the population they served. The responsibility for ensuring adequate provision of GP

services would remain with NHS England – at least initially – so that GPs were not forced to become contractors/ employees of local government, a position they have always strenuously opposed. Over time, this might change if groups of practices wished to change on a voluntary basis. The Care Quality Commission would continue to perform its current regulatory role both on the quality of primary and social care and any new community-based services that emerged. Similarly, Monitor would retain its economic role of ensuring there is appropriate competition in service provision and ensuring continuity of services when serious failure occurs.

For integration to work, more money that was traditionally allocated to the NHS has to be invested in social care services. This shift would be

gradual, over at least the lifetime of a Parliament. Delivering the ideas in this report and that of the Oldham Commission requires the NHS to transfer between £2-3 billion a year for at least five years.

We see no reason to disturb the current arrangements whereby existing Clinical Commissioning Groups (CCGs) commission local physical and mental health services, except that they would receive this money from HWBs and they would also be under a statutory duty to work collaboratively with social care commissioners to ensure that integrated health and care services were commissioned. CCGs would continue to play some role in the commissioning of hospital services on a basis to be determined by NHS England. GPs would remain the gatekeepers for patient access to acute sector hospital services.

We do not favour these changes taking place with one big organisational bang. The direction of travel should be set with a completion period of a five year, whole Parliament. It would be for local areas or combinations of local areas to convince NHS England and Ministers that they had an agreed business plan and satisfactory governance and accountability arrangements to move to the new way of working. It would then be for Ministers to make local implementation orders to start the new arrangements. Artificial standardisation should be avoided and local innovation encouraged.

To give practical effect to these changes, we could encourage a new government to expand rapidly the current Better Care fund so there was a clear commitment to transfer NHS resources to social care at least over a five year period at an agreed rate. We would favour such a rate as being in the range of £2-3 billion a year, which would enable money to be used wisely and secure growing impact on delivering services outside hospitals.

These changes could be achieved without the upheaval of another major top-down re-organisation. Legislative change would be needed to enable HWBs to become budget-holders and to define precisely their remits and those of NHS England and CCGs. However we believe that many changes could be introduced without any huge organisational upheaval on a set date, in an evolutionary way through negotiation and using, wherever possible, the wide range of provisions in the 2012 Act for Secretary of State mandation, direction

and regulations.

Over the lifetime of a Parliament, it should be possible to reduce the number of CCGs and integrate them and their administrative support units into HWBs but without a “sudden death” national reorganisation. It should also be possible for HWBs to merge where this enables more cost-effective services to be commissioned for their populations.

Central government would need to change how money is distributed locally for adult social care, community health services (including mental health) and public health. The days of separate allocations to local areas by the Department of Health (DH) and the Department of Communities and Local Government (DCLG) should end. It is not good enough for central government to urge local bodies to integrate budgets and commissioning if central government is not prepared to integrate budgets itself. This will require the Treasury, DH and DCLG to re-engineer the way the government grant to local government is made each year. This poses technical problems but they are public policy problems of the kind that governments have a civil service to help them solve. It is the job of Ministers to ensure that Departments work cooperatively on changes of this kind.

In our view, the end product should be an integrated, weighted population-based, resource allocation system to HWBs for the services for which they will gradually have budgetary responsibility, combined with an appropriate accountability system for the large sums of public money involved. For this resource allocation system to be seen as fair and to retain credibility over time, there would be much merit in some form of independent scrutiny of the system's weighting and data collection elements to minimise accusations of political manipulation. This new resource allocation system would not include the funding of specialist hospital services, to whose consolidation we turn to later.

3.3 Developing a more community-based health and care service

Co-production of care requires a re-imagined health and care service. It needs greater capacity, investment and expertise in community-

based services, closer to where people live. This direction of travel was set out in a Government White Paper in early 2006 entitled: *Your health, your care, your say*. The public consultation leading up to that White Paper revealed how concerned the public were about the lack of services focussed on improving wellbeing – something that had gone largely unnoticed by professionals and politicians. Little, unfortunately, has been done to give effect to the ideas contained in the 2006 document. Instead, we have continued to favour unreformed acute hospitals with resources and to cut funding for social care – including the public funding for nursing and residential care homes, in which many frail, elderly people actually live and require support. This has to change fundamentally and quickly. Scarce specialist resources need to be concentrated on where they can provide most benefit as we discuss later. Locally we should be doing more to sustain people in their own homes or the place they regard as home. The acute hospital should be a place of last resort for frail, elderly people or those with chronic conditions, not the first port of call when something goes wrong.

So, how will this new more localised and more personalised health and care system look? With possibly a few exceptions, every local

“The goal of this change is to improve and integrate access to care locally while speeding access to specialist care, even if it may be more distant.”

hospital site would be retained but, for many, with a different range of services on it. We see these changed sites as community hospitals that are the hub for all health and social care services in the area, funded by an integrated budget and designed

to deliver integrated services. They should be open 24 hours a day, seven days a week providing a wider range of services than most GPs and community hospitals do currently. These might well include improved urgent care for both physical and mental health; physiotherapy and rehabilitation; outpatient specialist appointments; minor surgery; access to integrated health and social care – including mental health services; public information, advice and help; psychology and “talking therapies” services; pharmacy; dentistry and optical services; palliative and end of life care including possibly nursing homes with access to on-site medical cover. In some places

they could also have bespoke elective day surgery centres if this made sense, but with only a few overnight beds.

These new community hospital hubs might well have enhanced ambulance and patient transport services to improve access to specialist hospitals, with comprehensive specialist services on fewer sites. These new community hospitals should be required to provide 24/7 medical support to all the nursing and residential care homes in their areas whether on-site or not. (Most of these homes have a very weak out-of-hours service at present leading to many unnecessary admissions to hospitals.) We would also like to see these hubs taking responsibility for improving the quality of support for carers – whose health is too often neglected – and a site on which health and social care can be more integrated than at present.

The goal of this change is to improve and integrate access to care locally while improving access to specialist care when it is really needed, even if it is more distant.

“We would like to see more of these local medical services led clinically by a new rank of highly qualified consultant general physicians... This would provide some career progression for those GPs willing to undertake further training.”

People needing chronic disease management would have much better care and support locally, and out-of-hours services and advice would be better than now. Those with very acute illness would see their needs also better catered for, as we describe below. It should be for local people and their agencies to use the resources available to decide the

most appropriate configuration of services on these community hospital sites to meet their community’s needs, rather than having standardised solutions imposed upon them externally. This would enable more experimentation and innovation to occur and create more local ownership of services by staff and public.

As part of these changes, we envisage further consolidation or federation of GP practices to develop local 24/7 health centres, funded to deliver as many services, including social care and mental health, as possible. These could be on community hospital sites with practices or linked to those hospitals on a hub and spoke basis. We

would like to see more of these local medical services led clinically by a new rank of highly qualified consultant general physicians, with particular expertise in chronic disease management and care for elderly people with multiple co-morbidities. This would provide some career progression for those GPs willing to undertake further training.

GPs would be a crucial part of the shift to more community-based health and care services but they would need to accept more varied ways of providing services to their patients and agree to a reward system that reflected those changes. The future structure of general practice must inevitably change to reflect the changing profile of GPs, with more wishing to work part-time and more preferring a salaried position rather than taking on the responsibilities of being business partners. We recognise the importance of retaining both the key role of GPs and their relationship to individual patients. However general practice has to move on from the older, largely outdated model of small premises with limited on-site services which restricts what they can offer their patients and is not fit for the 21st century. This change of direction for general practice will require an investment strategy that does not simply rely on the current small-business model of general practice raising the money but accepts the need for both public and private investment in a regenerated and stronger primary care sector which also provides more satisfying careers for those who choose general practice.

We recognise that changes of this kind will take time and will not suit all localities – particularly sparsely populated rural areas, for which the smaller GP practice may continue to be an effective vehicle for healthcare delivery. But, even in these areas, GPs can only do the best for their patients if they are well integrated into other services. Our proposals seek to avoid a “one size fits all” approach and should be the subject of local decision-making rather than imposed by the centre.

Many of these changes were envisaged by Lord Darzi's polyclinic model some years ago, but were never pursued very enthusiastically, possibly because the name did not convey the range of services likely to be available. In taking forward these changes, the maximum use should be made of existing hospital sites and, in planning redevelopment, people should be ambitious in the range of services

provided and not opt for the bare minimum. For example, it might well be sensible, where there are locations with good road and rail communication, to place elective day surgery centres on these sites and nursing homes. However, it is not the purpose of these changes to retain large numbers of acute hospital inpatient beds and complex equipment and services at community hospitals because of the problems of ensuring the safe specialist medical cover required.

It is not difficult to see how care closer to home can be transformed. Here are a few examples of innovations from abroad:

Kaiser Permanente, a US insurance plan with nine million members, has spent years pioneering the treatment and care of people with chronic conditions outside hospital. It makes sure that, if you have diabetes – as millions of people in the UK do – your GP will be a specialist in that condition; and that, at any time of the day and night, you can go into a pharmacy and have a test done. The computer will analyse the data and, if there is a problem, a red risk flag comes up. Your doctor will be sent an email and then give you a call to check whether you are, for instance, taking your drugs. This real-time tracking has made Kaiser a world leader in preventing unnecessary and expensive visits to hospital, doing much better than the NHS on value for money.

In Mexico, Pedro Yrigoyen has founded MedicallHome, using the humble telephone to bring medical cover to five million people in Mexico. This is a subscription-based, medical hotline and health discount network covering 1.2 million households. Users pay £3 a month, which gives them access to a call centre staffed by doctors ready to assess their concern and, should further attention be needed, discounts at a range of healthcare providers. They take over 100,000 medical calls a month, with 62 per cent resolved there and then. These numbers suggest that, even in a free healthcare system, two-thirds of all initial physical encounters could be avoided with an effective medical telephone triage system. MedicallHome has now started operating in Peru and Columbia.

In this new, community-oriented health and care system, there needs to be a stronger role for public health to support an environment in

which it is easier to stay healthy. It is 60 years since the government accepted the link between smoking and cancer, yet the current administration remains uncomfortable about banning cigarettes' seductive branding. We need to shift this culture of reluctance to act. The rise in alcohol-related disease requires stronger action on pricing.

“The public may be more ready to see government step up to the plate with tougher tax regimes for products that harm health.”

Much more action is required on what the Victorians would have recognised as the adulteration of a wide-range of foods, particularly for children, with sugars and other substances that are demonstrably harmful to health and impose a

huge bill on the tax-funded NHS. We believe that the public may be more ready to see government step up to the plate to support consumers in making healthier choices with better labelling and tougher tax regimes for products that harm health: we discuss tax issues further in Section 4. We also believe there should be more encouragement of local public health initiatives, as for example those of the former Mayor of New York, and the use of innovative approaches such as Nudge techniques and reward systems.

Professional treatment and care in the community should cease to be episodic and reactive. Nowhere is this more apparent than in mental health, where too often the early warning signs are ignored until matters become serious. At least a third of lengthier absences from work are thought to be stress-related. The longer these are not dealt with effectively the greater the damage to individuals and the economy. A strengthened community-based system must have professionals who are more engaged with people's daily living and wellbeing and can anticipate needs and support healthier behaviour. Just as the successful retailers of today anticipate and encourage consumer need, so the community-based system should be encouraging demand for – and support for – its preventative services and healthy behaviours. It is the demand for expensive and often inappropriate acute hospital care that we want to choke off – not demand for community and primary care that reduces demand for those expensive services.

Nye Bevan's NHS saw the GP-led primary healthcare system as the

gatekeeper to the hospital system, restricting access to it and therefore controlling costs. Today, so much more treatment and care could be better delivered at a community level, without in-patient hospital beds. The primary healthcare system still needs to be a gatekeeper but, with its social care partners, the gatekeeper to a much wider range of services delivered in the community, rather than in traditional general hospitals. With GP-led commissioning groups, nobody is better placed to deliver this vision than the over 35,000 family doctors who command high levels of public trust.

Consideration should be given to separating Public Health England from the Department of Health to make it more politically independent in pursuing initiatives that would benefit public health and to enable it to assure the quality of public health work done by enhanced Health and Wellbeing Boards.

Building remote care

If we, as the public, want it, there is nothing – apart from political and professional apathy - to prevent substitution of community-based care for much of our acute hospital care. Much of this new care and support could be inside our own homes within a decade. Soon, we

“Stronger community services would not be at the price of reduced access to specialist hospital expertise and equipment”

could have access to electronic individual records, with our unique NHS number providing information about individuals for all publicly-funded health and social care services. These records are our records. There is

no reason why they cannot be accessed through our phones and tablets to find out about our symptoms, diagnoses, prescriptions and treatments in real time. Indeed, it will seem quite natural to the Facebook generation. All of this will change how we interact with doctors, nurses and other professionals. This fundamentally alters the balance of power between individuals and professional services. In doing so, it increases the scope for self-care through the growing expertise of patients and peer support, using websites such as Dipex and PatientsLikeMe that are already available.

To date, there has been a reluctance to adopt remote care – telecare

and telehealth – especially in the NHS. In part, this has been because of an unwillingness to change working practices, especially if new technologies reduced jobs, as has happened with technology in other industries like banking and the motor industry. This has made it difficult to show that remote care can save money by replacing traditional models of care. Often an insistence on double-running old and new systems has suggested that savings may be illusory, particularly in the short run. Secondly, telecare – generally a feature of means-tested social care, particularly for elderly people - has operated under different systems - and to different standards - than telehealth, which is run out of a medically-based, NHS, free-at-the-point-of-delivery system. This has made comparisons difficult. Third, the fragmentation and uncertainty of demand among multiple, poorly coordinated purchasers has made industry reluctant to invest and to deliver at a scale that would reduce substantially the unit price and running of kit.

These issues could largely be resolved by a shift to community-based care with real public and political commitment. The economic case against remote care dissolves if it becomes a major plank in a reformed and integrated health and care system in which community-based services and self-care expands. The integration of health and social care delivery systems should also help tackle problems of building telecare and telehealth together, establishing joint operating systems and standards. These changes would increase demand and so reduce unit costs, as would a stronger self-funding market for care, as described in Section 4. A clear government commitment to the widespread adoption of remote care across health and social care would send the crucial signal to industry to expand and establish interoperable systems; and create the imperative for public services to develop the skills and capacity to purchase new systems and make the staffing changes required. The convenience of effective and cheaper remote care technologies would also create a private market for these products that might well reduce demand on publicly-funded services as has happened with many aids and off-prescription medicines.

Stronger community services would not be at the price of reduced access to high quality, specialist hospital expertise and equipment. However, it is in the interests of people's own safety that much more

of this expertise is concentrated on fewer specialist sites, as we describe later. Those sites would have an improved capability to reach out into communities to deliver the diagnoses and interventions required, as we discuss below. We recognise that people need to be convinced that we will be moving along a path to improving the access to and quality of services. We set out the case for consolidation in the next Section.

3.4 Consolidating hospital specialist services

As we have already said in Section 2, many of the acute hospitals receiving patients are not well-equipped in terms of skills or equipment to cope with the range of conditions being presented. Yet they soldier on, too often relying on locum doctors to plug increasing

“A truly independent NHS England under the leadership of a new Chief Executive and with the strong support of the Academy of Medical Royal Colleges and political leaders needs to drive the consolidation agenda for at least one Parliament and possibly two.”

medical staffing gaps, in the absence of any alternative publicly acceptable game plan. Many of them are not only financially unsustainable in their present form but clinically unsustainable as well, given the requirements of top quality modern medicine. Simply giving them more money, as local activists often call for, will not deliver the clinical competence required for high quality services and will be effectively wasted.

Many hospitals that are both clinically and financially unviable in their present form, not least because they are trying to offer more service lines than they really capable of providing. Gradually, these hospitals find it more and more difficult to recruit good doctors, good nurses and good managers and they slide to mediocrity and then to serious failure. At which point regulators are required to intervene. Across the key agencies – NHS England, CQC, Monitor and the NHS Trust Development Agency – well-qualified people know that many of the more specialist services need to be moved from their current sites and consolidated elsewhere in the best interests of patient safety. But they are hamstrung by a political and public reluctance to face up to

what has to be done in the best interests of patients. Put bluntly, much NHS professional and managerial leadership is reluctant to talk openly about the problem because the politics of hospital services reconfiguration is so toxic. MPs can lose their seats if they appear to agree to local hospital services going off-site. Yet the current arrangements for reconfiguring hospital services places most of the onus for doing so on local personnel building the case for an audience that doesn't want to hear it.

More positively, a few medical leaders have set out the diagnosis clearly in public. Professor Terence Stephenson, the Chairman of the Academy of Medical Royal Colleges, put things very succinctly when, in 2012, he said: "I don't think it's possible in quite a small country of 60 million people to have 200 to 300 24/7 acute centres offering every single discipline." He went on to say: "Modelling we did in paediatrics showed that we're running 220 24/7 centres across four countries and we thought it should come down to 170. Broadly we need to move to a smaller number of bigger centres giving treatment that's hi-tech, risky and rare." More recently, NHS England, with its role for commissioning specialist services, has suggested, in planning guidance, that it may be necessary to concentrate these services on fewer sites. It ventured the view that 15-30 hospitals may be involved. So, some tentative toes are starting to be dipped in the consolidation water.

However, reductions on this scale may be too modest in some specialties. As the hours that doctors work have been reduced under the European Working Time Directive, it has become more difficult to provide specialist consultant cover for a safe 24/7 service. Yet we know that death rates are worse at weekends and for out-of-hours admissions to hospitals – the patient's best interest is served by concentrating expertise and the most up-to-date equipment on fewer acute specialist hospital sites. So there are clear trade-offs for patients between safer more distant specialist services and less good services closer to home. We know what we would plump for if it was our own family's safety and we think most people would, if it was explained to them properly.

In March 2012, the advantages of the concentration of specialist services grabbed the headlines with the example of the footballer, Fabrice Muamba, who collapsed in a game in front of 35,000 people.

An off-duty cardiologist had him rushed to a specialist hospital, ignoring two nearer hospitals, because this was his best chance of survival. This is an individual example of why it makes sense to bring together the best doctors in particular specialisms with the most up-to-date kit and training to deal with a higher volume of cases, 24 hours a day. Despite strong opposition, London has done just this by cutting the number of hospitals providing specialist stroke services from 31 to 8, saving an estimated 400 lives within two years. If the London system was applied nationally, research suggests that 2,100 lives a year could be saved. And it would save money – despite the extra costs involved in setting up the new stroke care system, the NHS saved over £800 per patient because they recovered more quickly.

Although a more robust approach with strong clinical leadership has shown that consolidation of specialist services can be achieved with clear benefits for patients, these are relatively rare examples. More typically, there are long drawn-out local battles to achieve change even when it is in the best interests of patient safety and outcomes to do so. Not untypical is the decade or longer of struggles to reshape specialist hospital services in South East London or in North London with Barnet and Chase Farm Hospitals. These long-running disputes not only damage patient safety, they can end up with Health Secretaries being taken to the High Court at considerable cost to taxpayers and sometimes losing on technicalities. Consolidating specialist hospital services has become a war of attrition for politicians, professionals and managers with a resentful public too often lining up against their own best clinical interests.

In the UK, things have to change on consolidation of specialist services if patient outcomes are to improve and services are to become financially sustainable. Two examples from overseas show what can be achieved:

- **Narayana Hrudayalaya** The quest in surgery is to make operations resemble industrial production lines because, as in other walks of life, practice makes perfect. Surgeons achieve higher levels of perfection when they do several operations daily rather than monthly. As volume and quality rise, costs fall. The idea of what have been called “focused factories” is not new – there are many of them around the world – but they are

controversial, especially in the UK. This is because specialisation means reorganising the location of services and this can upset doctors and others. But we should consider the emerging evidence. At the Narayana Hrudayalaya cardiac centre, founded by Dr Devi Shetty, surgeons only deal with hearts and their surgical outcomes are world class yet cheap (about a tenth of the UK price). The 42 surgeons perform nearly 9,000 heart operations a year.

- **Coxa hospital** Alternatively, consider Coxa, which is a celebrated joint replacement unit in Finland. It has been so successful that it does all the joint replacements for a region and all of the revisions for the country. This has caused at least five other units in the region to close but has produced better outcomes for patients.

Both of these examples challenge our idea of the local general hospital trying to provide too wide a range of specialist services. They bring in new entrants to the system and can cause old, less efficient, organisations to go bust and close down. We may not be ready for such a brutal approach, but these examples show the path that we need to tread if we are to have a clinically credible and financially viable specialist hospital sector. This means revamping the system for reconfiguring specialist services, with less reliance on local change agents and greater involvement of external expertise to secure local acceptance of change within the financial envelope set by elected government Ministers. This was the model used by Canadians in Ontario in the 1990s when their healthcare system went bust.

A truly independent NHS England under the leadership of a new Chief Executive and with the strong support of the Academy of Medical Royal Colleges and political leaders needs to drive the consolidation agenda for at least one Parliament and possibly two, and not simply rely on the failure regime vested in Monitor. We consider that NHS England should be mandated for the lifetime of a Parliament to start the process of reconfiguring hospitals specialist services to make them sustainable. Using its mandate and its existing specialist commissioning functions, it should be empowered to reconfigure specialist services on fewer sites but related to defined health economies rather than the sustainability of individual hospitals.

We think this process would be helped by the appointment of an independent small commission to devise, within 6-12 months, a new system for reconfiguring specialist services in defined health economies. This system would need to operate on a timetabled basis, be led by experts but involve time-limited local consultation within a financial envelope proposed by NHS England for each health economy and approved by Ministers. The final decision could be taken by Ministers but without any change in the financial envelope already approved by them. For these arrangements to work, we believe this process would have to be fixed on some form of statutory basis to prevent manipulation and variable application across the country. Once a Ministerial decision was taken on a health economy, it would be the responsibility of NHS England to implement the changes through its commissioning responsibilities, without political interference.

3.5 These changes should make the NHS and social care feel different for the public

How would these changes deliver better services to those we earlier identified as being let down currently by the NHS service organisation? It would ensure that, far more than presently, they received the right care in the right place at the right time. So it would improve the quality of their care, improve outcomes as well as saving the NHS money. Here are some examples:

- > **The person needing emergency specialist care** would typically receive faster, safer treatment from more expert staff 24/7, producing significant improvements in outcomes as has been achieved, for example, following the consolidation of emergency stroke care services. Clinicians consider that this move would save many lives each year, given the opportunities to staff specialist hospitals more comprehensively around the clock.
- > **The elderly person** would get much better access to integrated medical and social care, including earlier diagnosis of dementia. Better care would allow them to remain longer in their own homes or receive higher quality medical care than at

present in residential and nursing care homes. In comparison with the present – and in keeping with our ten standards of good access and experience – care would be fast, easy to reach, listening, straightforward, lifelong, holistic, integrated, compassionate and safe. As a result, far fewer frail, elderly people would be seeking help at A&E and many would avoid lengthy and potentially dangerous stays in hospital for conditions that could have been managed better closer to home. The change would reduce the number of elderly people who currently die in hospital yet would prefer to spend their last days at home or in the residential home they regard as home.

- > **The person with depression or anxiety** would get a speedy, expert diagnosis, immediate counselling, specialist psychiatric care and other social care supports, as well as, if needed, more

“The essential values of Beveridge’s and Bevan’s NHS would remain but be updated to cope with today’s and tomorrow’s challenges.”

personally tailored drug treatment via community-based psychiatrists rather than simply over-stretched GPs as is currently the case. They would be supported through to recovery by an integrated health and social care service, so protecting their mental and

physical health, their families, their jobs and their long term well-being. They could expect much better outcomes and the NHS would not find itself picking up the pieces later in life of more serious mental illness.

- > **A person with an unhealthy lifestyle** would be constantly encouraged with offers of help and ways to change as a consequence of shared responsibilities required by the Health MOT and NHS Membership. A good analogy is for this style of engaged care would be that which a pregnant woman currently receives. A pregnant woman is not sick. But she is at risk if she does not receive the care and support she needs to live and stay well during her pregnancy and beyond. It is not a perfect system – as demonstrated by continuing high levels of undiagnosed post-natal depression. However, it does involve serious ante-natal engagement by professionals, which is

enabling, rather than coercive, helping mothers to do the best for their child and themselves in a difficult time. The results, in terms of successful pregnancies, are impressive. It may also help explain why mothers are, long term, more proactive in making use of what the NHS can offer than are other groups. This analogy shows the type of expert, enabling engagement that is needed for people with unhealthy lifestyles or chronic disease, helping them to deliver a healthier life for themselves in a non-coercive manner and so avoid the onset of many diseases from middle age.

- **The person with a chronic condition** would have much better support managing that condition, avoiding some of the unnecessary emergencies that threaten health and disrupt life.

3.6 Conclusions

The NHS feels uncomfortably like the British car industry in the 1970s – financially unviable in the longer term and with the wrong business model for its core customers. We have suggested a major reimagining of health and care so that self-care is more strongly emphasised and supported. Health and social care should be fully integrated, nationally, locally and individually, with a stronger planning and funding role for Health and Wellbeing Boards. Far more services would be delivered closer to home and within the home, with local community hospitals acting as a hub for a wide range of community-based services. GPs would retain a strong role as commissioners of local services and probably in larger groups playing a bigger role in proactively helping people to manage their own health and care.

It is only by making these changes that we will both improve access to the care people need in a timely fashion and help them take more personal responsibility for their health. The new National Health and Care Service we envisage would represent a new partnership between the State and individuals. This invigorated relationship would be reflected in a new membership scheme for the new service and a membership obligation for many to undertake a simple annual health check-up and act on its findings with the support of professionals. The essential values of Beveridge's and Bevan's NHS would remain

but be updated to cope with today's and tomorrow's challenges.

The changes we have proposed leave much more to local discretion and variation. However there will need to be some agreed national architecture with a framework of standards based on outcomes and some national guarantees on user access to services. In addition, there will be requirements on accounting and performance reporting as part of the good governance and public accountability of public bodies spending large sums of public money. But these national requirements should not become an excuse for the traditional command and control too often exercised from Whitehall.

In addition, there are two important issues relating to service providers that need attention: payment methods and a wider range of new entrants to the health and care market. The tariff system for reimbursing hospitals based on activity is now past its sell-by date and needs to be replaced by reimbursement systems that are more likely to reward value and outcomes. This means moving to payments for periods of care for particular conditions or groups of conditions in which one provider takes responsibility for coordinating care, possibly receiving a premium for doing so but accepting a penalty for failing to do so.

The second issue is making it easier for a wider range of providers from the public, voluntary, social enterprise and private sectors to enter the health and care market. This means debunking the myths that, somehow, competition is incompatible with integration and that public provision is always superior to private. Health and care systems need all the help they can get, not turning their backs on outsiders who are qualified to help. We need to return to any willing and qualified service provider being able to compete in the health and care market if they meet the regulator's standards. A new National Health and Care Service should not begin by shutting the door in the face of new entrants simply to protect incumbent providers. It should be helped to keep the door open by Monitor providing a list of service areas where qualified providers could benefit patients by their entry to the market.

For the last five years the NHS budget has been protected – some would say over-protected – at the expense of other important public services, not least social care, as we have demonstrated. This cannot

go on. We can see no escape from the NHS learning to do much more for more patients without the financial cushion it has had. It has to start planning, in our view, to cope for the indefinite future on the basis of no real terms growth and then be pleased if the economy or some new revenue streams produce a nice surprise. This means pushing on with changes of the kind that we have outlined in this Section. Only in that way will the health and care system be able to deliver speedy access to good outcomes for a growing number of patients with complex needs.

None of this will be easy and will require strong political and clinical leadership, nationally and locally, and a public willing to face up to the inevitability of radical change. As a country, we can correct the current skewed and close-to-bankrupt system of health and care if we collectively want to. But even with radical system change, we may have to pay more ourselves and reduce our reliance on funding through general taxation. We discuss new funding approaches in the next Section.

4

New funding streams and stricter financial discipline

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So far, we have been reimagining a new national health and care service more suited to the demographic and disease challenges ahead. This would integrate health and social care, provide more services in the community and rebalance expenditure between hospital and community services. All this would help people to take more responsibility for managing their own health and care. We have also argued that the current system of funding the NHS and social care is unsustainable in its present form, with its historical reliance on tax-funded annual increases of over 3 per cent in real terms.

The NHS could do much to help balance its books by improving its efficiency but its track record on innovation and increased productivity has not been encouraging. On past form, we cannot rely on NHS efficiency gains to balance the books. Nevertheless, there is need for a more robust attempt to change the NHS's ways and deliver better value for tax-payers' money. So, before setting out our ideas on new funding approaches, we outline how the NHS could get more for less.

4.1 Getting more for less

Unless the rising annual costs of care are indeed absorbed by greater efficiency until at least end of the decade, then the NHS in England is likely to experience a huge funding gap. NHS England suggests a £30

“QIPP and the current levels of productivity improvement of about 2 per cent a year will not fill the funding gap we face. Pay restraint is not a card that any government can go on playing for a decade.”

billion gap but the respected and independent Nuffield Trust has suggested that it could be between £44 and £54 billion by the early 2020s. Whichever figure one prefers, unprecedented levels of efficiency gains are required by the NHS to maintain current care services without draconian cuts in other public services or significant

increases in general taxation – or some combination of the two. So how is the NHS doing on efficiency improvements and what more could it do?

The Government claims that, under its Quality, Innovation, Productivity and Prevention programme (QIPP), it made efficiency

savings of £5.8 billion in 2011-12, £5 billion in 2012-13 and is forecast to make £4 billion of savings in 2013-14. The Public Accounts Committee report of March 2013 on NHS efficiency could only substantiate 60 per cent of the Department of Health savings for 2011-12. The Government estimates that about 25 per cent of these savings are a consequence of pay restraint but the Nuffield Trust suggests that figure is nearer 40 per cent. Moreover, many of these savings are “one-off” savings that do not get carried through year on year; and, on the Government’s own figures, the trend line on savings is dropping. It is difficult to find any independent commentator suggesting that QIPP is producing transformational service changes that deliver sustainable annual efficiency gains over a decade. A fairer judgement would be that most of the QIPP savings have come from picking low-hanging efficiency fruit, securing one-off economies, cutting vacant posts and ensuring pay restraint.

QIPP and the current levels of productivity improvement of about 2 per cent a year will not fill the funding gap we face. Pay restraint is not a card that any government can go on playing for a decade. By the 2015 election, this device will have been used for five years and it cannot be used much longer, particularly in a more demanding work environment. Doctors are an international resource operating in a global market: it costs the NHS £600,000 to train each doctor and, to retain them, it has to pay competitive rates. There is a similar situation with nurses and professions supplementary to medicine. In addition, we cannot expect to have good quality care services provided by poorly trained people paid at, or below, the minimum wage on zero-hours contracts. Already, the impact of pay restraint is being felt in health and care recruitment. This will worsen as the economy improves.

This does not mean that the rigidities of our long-established systems of national pay and conditions of service should be retained. Many more regional and local flexibilities, particularly if performance-related, would be beneficial to service providers, individual staff and service users. Although these are contentious issues, they do need to be considered. This will take time and any set of new flexibilities on terms and conditions of service will not solve our care funding problems.

A different approach to efficiency gain

Over the lifetime of the next Parliament the NHS should be required to adopt a major efficiency drive involving both clinical and non-clinical activities to secure saving of between £15-20 billion, with most of this being used to establish a Service Transition Fund to pay for the proposed changes in service delivery.

Clinical efficiency

For a start, NHS England should ensure that the QIPP productivity improvements and high impact changes adopted in the most efficient areas are adopted everywhere. Bringing the productivity gains of all areas up to that of the best would also be worthwhile. According to the University of York's Centre for Health Economics, the NHS could save £3 billion a year if all parts of the country performed as well as the South West. In addition, full implementation of the 2006 Carter reports on reform of pathology services, including greater competition, should also be pursued more vigorously. This would produce better performance and efficiency savings of at least 20 per cent of the £3 billion a year spent on NHS pathology services.

NHS England needs to enforce vigorously the approaches suggested by Monitor in their 2013 report *Closing the NHS funding gap*. This report identified a range of measures the NHS could take to improve the productivity of existing services, mainly through clinical staff working differently by implementing the current QIPP and established cost improvement programmes but also by using ideas from overseas. Some of these proposals chime with ideas in this report. Monitor estimated that there was scope for recurrent savings of between about £10 and £18 billion by 2021 from implementing their clinical proposals. But, even achieving the top of their range of estimated savings (which would largely incorporate the York University figures) would fall well short of the funding gaps predicted by NHS England and Nuffield Trust. So can a greater effort be made to plug the gap by securing big efficiency gains in non-clinical areas?

Non-clinical efficiency

There are other – too often neglected – ways that the NHS could improve its efficiency. Many of its business processes and administrative systems are poor and often a source of frustration to patients. The NHS has been reluctant to learn from other service

areas – public and private – on how to interact with those who use its services and to adopt new technology and more business-like approaches. Too many trust boards and senior management do not robustly challenge the internal workings of their organisations to seek better value for money and improved customer service. There needs to be a major improvement in the rather complacent approach that the NHS adopts to running organisations, using public fixed assets and managing finances.

We do not have the resources to do an exhaustive study of all the business efficiency improvements that the NHS could make. Instead we have identified, as exemplars, a few areas for change that would

“There needs to be a major improvement in the rather complacent approach the NHS adopts to running organisations, using public fixed assets and managing finances.”

produce better value for public money, if only the NHS as a whole was required to pay attention to these neglected and politically unsexy areas. Real effort in these areas would increase substantially the funding available for patient care as well as improving the

customer experience. In a time of austerity, much greater political and public pressure should be exerted on the NHS to secure rapid change in areas such as these.

Our illustrative suggestions are as follows:

Improved use of fixed assets

The 2013 Monitor report stated that the current total value of the NHS estate is £31.2 billion. It suggested that the underused acute and mental health estates could be sold for a one-off gain of up to £7.5 billion. We suspect that this is based on figures relating to current use of the land rather than true market value with change of use – a very important consideration in high land value areas like London and the South East. Moreover, some independent commercial experts have suggested that surplus NHS land should not always be sold but developed with commercial partners to secure recurrent revenue returns from change of use. But the Monitor figures do suggest that the NHS doesn't need about quarter of its land and buildings. This is consistent with detailed work done in the former London SHA in 2008. This revealed in one quadrant of London that only 18 per cent

of NHS-owned land was built on; within that, another 18 per cent was underutilised; and 25 per cent of its buildings were functionally unsuitable.

We consider that there is a longstanding problem of NHS mismanagement of fixed assets. This now needs to be tackled vigorously by measures more ambitious than the new NHS Property Services company that came into operation in April 2013 to manage all the properties of the abolished Strategic Health Authorities and Primary Care Trusts. In our view, the NHS needs a major injection of professional facilities management and land use to release both capital and revenue to fund the redesign of services and better patient care. This will require the commercial expertise and financial capability only available in the private sector. It will also involve a reduction in local control over high value, fixed assets in the wider national interest, even if held by foundation trusts; as well as financial penalties for persistent poor use of fixed assets. A focussed programme lasting at least a full Parliament is now required to maximise capital and revenue for better patient care through the optimal use of NHS fixed assets.

A new Commercial Director to drive wider income-generating activities

A Board-level Commercial Director at NHS England should be appointed on a five year contract with the authority to institutionalise income-generating activities across all NHS trusts. These activities could include services not available on the NHS; revenue-generating commercial developments on hospital sites (including different uses of fixed assets); and the sale of approved health products that assisted patient self-care.

Standardised electronic health and care record

A national programme, locally administered, to introduce within three years a standardised summary electronic health and care record (with a unique identifier), controlled by adult service users with space for their own comments; and a similar system for children. This should be funded from within existing budgets in order to give patients more control over their treatment and care, as well as to drive NHS efficiency.

List of health and care services for competitive tender

Monitor (in consultation with the Care Quality Commission and the Office of Fair Trading) to issue a national minimum list of health and care services that should be open to competition from any qualified provider registered with the Care Quality Commission, including international healthcare providers. Academic studies have shown that, used carefully and selectively, competition can improve services to patients and achieve better value for public money. This need not lead to fragmentation of care because contracts could be let for integrated services in a geographical area for particular groups of conditions.

Cost standards for back office services

The NHS could introduce National Audit Office approved performance cost standards for back office services – finance, personnel, facilities management, IT management, and procurement – and require competition in and combination of these services across public bodies where standards are shown by auditors not to be met.

It is difficult for us to quantify how much would be produced by a sustained national effort in areas such as these. Real commitment by Ministers would be required to drive change in these areas and overcome NHS inertia; but the financial situation is serious enough to justify a concentrated effort politically and managerially. The Thatcher governments used private business people reporting direct to Ministers to drive public sector efficiency, with some success. We suggest that the NHS should be subjected to a similar programme lasting at least a full Parliament. The aim should be to secure in the next Parliament at least £5 billion worth of capital and revenue savings that would be placed in the Service Transition Fund to finance the service changes we are proposing.

Even with the most favourable improvements in NHS efficiency and commercial acumen, the next Parliament's funding gap will not be filled and that gap will continue to grow during the following decade. More immediately, health and social care services could well experience a financial firestorm well before the end of the next Parliament. We consider that it is now irresponsible to pretend to the public that we can go on indefinitely providing a good quality health and care system funded from general taxation, as we have done for 65 years. It is time to consider alternatives that are consistent with a

new service delivery system; can be introduced without another costly and distracting top-down reorganisation; and that do not require expensive new administrative collection systems. This is the topic of the rest of this Section.

4.2 Social insurance and taxation

Beveridge's healthcare model was, in essence, a pooled risk insurance scheme with national coverage, protection against catastrophic risk for all, and access to a range of services free at the point of clinical need. The health services themselves were to be provided by a range of agencies – including private providers like GPs – and not necessarily by public bodies. (Indeed, GPs were themselves – and continue to be – private partnerships, with profit and loss accounts, contracted to provide NHS services.) Social care was always intended to be means-tested. There is much public and political support for Beveridge's pooled risk principle, and it has stood the test of time

“A shift to a social insurance model for funding health and care would be a major and costly administrative upheaval that would be unlikely to produce financial relief for the NHS in the timescales now required.”

reasonably well. It is worth trying to preserve the principle in any future funding system.

During the 65 years of the NHS, there have been periodic debates about the merits, or otherwise, of funding health and care through private payments, insurance and taxation. The UK is the only advanced country to have plumped general taxation which,

is easy to collect and has low administrative costs. This approach has had strong public support on grounds of social cohesion. However, this system has always co-existed with substantial elements of private payments and private insurance, which we discuss below. Despite these periodic debates, the British public and the political class have shown little interest in following mainland Europe down the route of funding health and care through social insurance.

UK supporters of social insurance have usually argued that it would provide more buoyant revenues, increase consumer choice, reduce

inefficiency, and even curb a “something for nothing culture”. However, opponents see it as a payroll tax that would adversely affect jobs and put providers in the driving seat, and which has a poor track record elsewhere in checking healthcare cost inflation. Whatever the

“We favour serious consideration of using sales taxes on products that tend to increase demand for health services and of taxing windfall wealth more effectively.”

balance of advantage, the shift of the UK to a social insurance model for funding health and care would be a major and costly administrative upheaval that would take time and would be unlikely to produce financial relief for the NHS in the timescales now

required. Any change of this kind would require a major appraisal beyond our resources plus a full-scale public debate. We have declined to be tempted down this road, but others may wish to explore it as a longer term solution.

Unless we are willing to contemplate improbable levels of economic growth and income tax, thought should be given to alternative ways of raising tax revenues that are better aligned with health objectives, have reliable buoyancy and may be more acceptable to the public than higher income tax. Here, we would acknowledge that consideration could be given to a national insurance contribution levy for the NHS – as Gordon Brown did in the 2000s. However, this would look to the public much like income tax, could be seen as a tax on jobs and does not relate payment to use or demand. A levy of this kind is something you can do once, but it does not provide buoyancy over time. Instead, we favour serious consideration given to making greater use of taxes that promote healthier living and are more related to healthcare consumption and ability to pay. We also favour taxes that over time may be more buoyant than income tax.

Top of our list of health taxes would be tobacco and alcohol. Revenue from tobacco duty in 2011-12 was £9.55 billion, up from £8.09 billion in 2007-8. The equivalent figures for alcohol duty are £10.04 billion and £8.3 billion. The Treasury estimate these taxes each to represent 9-10 per cent of NHS spending for those years. Buoyancy is not too bad at present levels and the public are more likely to see the raising of taxes on these products in line with health inflation – or possibly

higher – as fairer than increasing income tax. It would be well worth testing that theory with public polling.

At the same time, examination should be made of the scope for imposing taxes on other products where scientific evidence was strong on the damage they do to health. Here sugar, particularly in relation to confectionery and fizzy drinks would be a strong contender, as possibly would be products with high salt content. For example, a 20 per cent tax on sugary drinks has the potential to raise about £270 million a year but, clearly, a more detailed study of international evidence on taxing unhealthy food and drink products is needed.

We are not equipped to produce a detailed analysis in this area but, from these figures, it is clear that taxes on tobacco, alcohol and selected unhealthy food and drink could deliver over £20 billion of revenue by the end of this decade. If various forms of betting and gambling, with their addictive qualities, were added to the menu then the revenue take would be higher still, as tax revenue from these sources is now over £6 billion a year. In total, one could envisage hypothecated taxes from all these sources producing more than £25 billion a year by 2020. Some of this revenue, from new taxes in particular, would be additional to current planned tax take, and the extra could begin to replace some funding of health and care from general taxation.

Tax collection of this revenue would be no more difficult than income tax. It should be possible to ensure that revenue is inflation-proofed and even kept pace with health inflation. A change of this kind would require the Treasury to abandon their longstanding opposition to hypothecated taxes. However, it seems worth abandoning this theology in exchange for the political prize of more publicly acceptable and buoyant taxes to fund health and care.

Given how much the public values the NHS, it seems worth also considering taxes on what amounts to windfall profits from property sales. In practice, this would mean higher taxes than present on property either before death or after death through inheritance tax. Before death, money could be raised through toughening up transaction taxes such as stamp duty or higher banded council tax,

both likely to be politically unattractive. But so also would be raising income tax. Collecting revenue after death through inheritance tax would have the advantage of targeting revenue-raising on the greatest consumers of health and social care – the current generation of older people – rather than hard-pressed working younger people who will be part of a smaller working population in the future.

At present, only about 20,000 people (2011-12 figures) pay inheritance tax a year. This is just 3.5 per cent of the deaths each year. The threshold for inheritance tax has been frozen at £325,000 since 2009 and is due to stay frozen until 2018. The tax rate drops if assets are divested before death; and, if the divestment takes place seven years before death, no tax is paid at all. The result is that inheritance tax produces only about £3 billion a year. Given the rising cost of care in old age to the public purse, there seems to us a case for a review of the takings from inheritance tax to see if substantially increased revenue could be obtained to fund care paid for the public purse. This would be likely to increase taxes from those most able to pay them.

In considering these issues it seems to us that, whoever is in government, Ministers need to take account of the inter-generational fairness aspects of different taxing strategies. This operates in several ways. First, at present, the NHS is largely funded from income tax which is inevitably paid by younger working people rather than the older people consuming most of the NHS services. This has always been the case but the disconnection between payment and usage is becoming ever more acute as the number of older people goes on growing in proportion to the shrinking cohort of younger taxpayers. This is particularly a problem if the public services that younger people use are being significantly cutback to fund NHS services for older people.

This analysis suggests to us that, for the future, we should look where possible to replace some of the income tax funding of the NHS with taxes that are more aligned with demands made on the health and care system; and to tap into the wealth – much of it windfall profits from property – accumulated from those in the population making the greatest demands on the care system. However, we should also look at other new funding streams for health and social care. We turn now

to a part of the present arrangements that, in our view, have been too little discussed – private payments and private insurance.

4.3 Private payments and private insurance

Private payments and private insurance have always played a bigger role in funding care than is often recognised. Indeed, they were the means of payment that preceded the NHS. They have often had a bad press as public affection for the NHS has increased, partly under the illusion that it is “free”. Too often they have become an ideological battleground between political left and right, particularly when tax incentives or quicker treatment has been involved in the discussion. We believe that it is almost inevitable that they will play an increasing role in the future and that it would be timely to unpick some of the issues and have a wider, better-informed debate about what is involved.

Private payments are often equated with one form of payment – private medical insurance. But they include health care plans, annuities, dental benefit plans, critical illness insurance, income protection, long term care insurance, direct payments (self-funding) and co-payments (charges). We assume that no-one would seriously dispute that, in a democracy, people should be able to spend their own money on health and social care in any way they wish, within the law. If people want to save money for such events, through whatever savings mechanism they choose, that is their affair. New systems of direct payments and individual budgets in social care encourage citizens to add their own resources to what the State will pay, in order to design service provision that best suits their personal needs. If a person chooses to use their own resources to get private treatment faster than the NHS can provide, they are perfectly entitled to do so.

None of this is to argue that the State should provide subsidies in the form of tax incentives to encourage private payment for care, although some may argue that it should. Such subsidies have high “dead weight” costs because they provide incentives to people who would have gone private any way without the subsidy. So we do not favour this approach.

At present, all forms of private insurance are voluntary. The Dilnot Commission proposals for capping individual care costs, with the

State picking up the catastrophic care costs, was intended to identify a clear set of risks for which the financial services sector could price and offer new insurance products. It remains to be seen how many new products emerge and how much public enthusiasm there is for them. At present, the financial services sector has been reluctant to create new products, which is very disappointing.

The public and political debate in this area has shown little support for compulsory insurance for care costs. However, in 2000, the Japanese Government introduced compulsory insurance for care costs when people reached the age of 40 – the monthly premium is now believed

“There is nothing new about changing what is provided free under the NHS.”

to raise about 50 per cent of the costs of social care. If there is to be a wider public debate about the future funding of health and care, it might be worth testing the

political appetite and public support for some form of compulsory insurance for care costs and its likely effectiveness in generating new products.

However, if we do nothing to clarify what funding arrangements people should make, then we encourage the public to expect more and more from a tax-funded health and care system that is already financially unsustainable. This is likely to mean that we have to start examining what should remain the State’s NHS offer – that is to say what services are within the NHS boundary and what could be shifted to the areas of mean-testing and private payment or private insurance.

4.4 Changing the NHS boundary

Public expenditure on health and care could be reduced by changes to entitlements for free care. Changes to the NHS boundary have already occurred since 1948 with charges for spectacles, dentistry and prescription medicines. In the late 1980s and early 1990s, much geriatric care was quietly transferred out of the NHS to privately-run, nursing homes with their residents means-tested by local authorities as to whether their care costs should be met from the public purse. Many services for people with learning difficulties have been transferred

from the NHS. So there is nothing new about changing what is provided free under the NHS. Shifting this boundary can take a number of forms: removing some services from the NHS altogether; means-testing some services; and, thirdly, requiring co-payments.

In the first category – removing services from the NHS altogether – there are several possible candidates. IVF/fertility services could be one, though it would be heavily contested. Removal of tattoos or cosmetic surgery mistakes might be another. Asking NICE to identify poor value medical procedures and banning these from the NHS might also be considered. More controversial would be denying transplants or surgical procedures to people who refuse to change unhealthy lifestyles despite repeated medical advice. This is a highly controversial area. Ministers could consider drawing up a list of procedures and treatments that would no longer be available under the NHS and test public and clinical opinion, rather than simply assert that this is a no-go area. However, it is difficult to see this as an area securing large or quick financial returns for a strapped NHS budget.

Some will see any extension of means-testing to current NHS services as equally controversial. But it is worth reflecting on the fact that, since 1948, we have had means-testing for much of our care provided by local authorities. Today, self-funding of adult social care already accounts for about 40 per cent of the people in nursing and residential care homes. An even higher proportion of care in the home is paid for by people and their families from their own pockets. As the population lives longer, it is not unreasonable that more of those who can afford it should fund their own care, rather than let the cost burden fall on tax-paying working younger people. It certainly seems to us worth having a wider public debate over this issue, given the parlous state of the NHS finances.

Currently, we have a very opaque and disputed boundary between NHS and social care, whereby endless individual disputes and costly administrative systems are devoted to assessing whether people should get free NHS continuing care or means-tested adult social care. For example, there are disputes as to whether help with bathing an elderly person in their own home amounts to a free NHS bath, or whether it should be a means-tested social care bath. If we are to integrate health and social care, it might be worth exploring moving

Continuing Care out of the NHS. This would make it part of the new capped-risk system of means-tested adult social care that is to be introduced in 2015 under the new Care Bill once it completes its parliamentary passage.

Continuing Care costs the NHS £2.8 billion in 2011-12, according to the Department of Health, plus further administrative costs. That figure had risen by over £700 million since 2009-10, when it was £400 million more than the previous year. At its present rate of growth, Continuing Care will be costing the NHS about £4 billion a year by 2015-16, with the prospect of further increases for the rest of the decade. We suggest serious consideration be given to removing continuing care from NHS entitlement and regarding it as means-tested care, operating within the new capped care system.

If this was done, care would continue to be free for people with incomes below the new higher means-test threshold; Those required to pay for their care would have their financial liability limited by the new cap on social care costs under the Care Bill, soon to become an Act. The new system of deferring payments for care until after death, provided for under that Act, could be adapted to cover continuing care. This change would also significantly simplify administration and save those costs, as well as providing greater clarity to the public about their responsibilities for funding care. Under this system, it would be possible for governments, over time, to adjust entitlements to free care and liabilities under the cap, if economic circumstances allowed. For example, there might be a lower cap for dementia sufferers in a nursing home.

4.5 Co-payments

Another way of effectively shifting the NHS boundary further is through the introduction of more co-payments by individual NHS service users. Since 1951, people have paid NHS dental charges and prescription charges for medicines, unless they were in exempt categories – mainly pensioners and children. In 2011-12 these charges raised £1.06 billion. This would have been higher if the charges had been consistently increased in line with inflation (as measured by the rate of price inflation): some £87 million more if

charges had kept pace with the RPI just between 2006-7 and 2011-12. For the future, these charges should be increased annually in line with inflation. In addition, many older people who are now in the exempt categories could afford to pay for their own medicines and dental charges. So we suggest the exempt categories should be reviewed to produce a higher yield from charges.

Currently, four travel vaccines – polio, typhoid, hepatitis A and cholera – are routinely available free of charge on the NHS. GPs are funded to provide these under the capitation payments made to them. The Department of Health is unable to identify the costs of vaccines for

“Any review of prescription and dental charges should consider introducing full-cost charging for the administration of vaccinations for overseas travel.”

travel purposes. However, with the exception of the polio vaccine (provided under the childhood immunisation programme), most of the other vaccines are highly likely to be provided for holiday or business travel. It is difficult to justify this as a free NHS service at a time of financial stringency.

We would suggest that any review of prescription and dental charges should consider introducing full-cost charging for the administration of vaccinations for overseas travel and inflation-proofing such charges.

Some, including GPs, have argued for charges for GP consultations, of the order of £10 a visit. This would be partly to raise money and partly to deter unnecessary visits to the doctor. Other countries, for example France, have introduced such payments – sometimes linked to the number of visits in a given period – as the cost of healthcare has risen. We are sceptical about the value of doing this in the UK, particularly if we want earlier diagnosis for some of the killer diseases such as cancers for which we know our performance often lags behind other countries. Many GPs would be reluctant to administer such a scheme for understandable reasons and any such scheme might well have a large class of exemptions, similar to that for prescription charges. We suspect that the actual financial returns from any such scheme might well be modest relative to the clinical and political downsides but some may want to take another look at this “old chestnut”.

More attractive might be the whole area of co-payments for the hotel

costs of inpatient hospital care, both to deter unnecessary stays in high cost care and to raise revenue. Germany, France and Sweden make a charge for inpatient hospital stays; and, in the UK, at present, people receiving nursing home or residential care – even those below the means-test threshold – are required to pay for their hotel costs on a standardised basis. There is a case for some form of contribution being made to the board and lodging costs of hospital care because it might incentivise better use of expensive acute hospital beds, with patients pressing for early discharge.

People could be charged a flat rate of, say, £20 a night, possibly with a higher rate for those whose length of stay was longer than the average for the age group – for example under 65, 65-85 and over 85. To get the incentives right for hospitals as well, they might be reimbursed at a much lower rate, akin to hotel charges, when lengths of stay were longer than the average for an age group. This would chime with initiatives being taken by more innovative hospitals like University Hospital in Tampere in Finland which transfer patients to medically supervised hotels when patients are in recovery. This innovation provides the added advantage that relatives can book rooms in the same hotel to be nearby. We believe these ideas deserve urgent study on both care and cost grounds.

By the end of the next Parliament, with sufficient political will, it is possible to envisage these options yielding over £4 billion a year, most of it coming from changing the NHS boundary on Continuing Care.

4.6 Other sources of revenue

We return to the idea of a membership scheme discussed in Section 3. We believe this is worth developing in its own right as a way of regularly securing individual continuing commitment to the collectivism of the NHS; reinforcing the message that healthcare is not a free good; combating ‘health tourism’; and encouraging personal responsibility for people’s own health. It could also be a useful source of local health revenue for preventative and public health programmes that benefit local people.

A membership fee of £10 a month for all adults, with similar

exemptions to those for prescription charges, would leave about 23 million people paying an annual fee. This would raise over £2 billion a year for local programmes. We think that such a scheme might be popular, if the money went directly to local programmes rather than into central government coffers. This local dimension could be retained by collection of the membership subscriptions through the council tax. Its public acceptability might be enhanced if some of this money could be used to attract matching money for healthy living projects from the National Lottery which has been used already to fund projects for health benefits. These jointly funded projects might be run by voluntary organisations to deliver on high profile local priorities such as obesity, dementia or diabetes. We consider that there would be merit in piloting the membership scheme in a large area to test the public appetite for such a scheme and to demonstrate the benefits it could bring.

Finally we would mention Attendance Allowance (AA). At present, Government spends about £6 billion a year on AA. The cost has been rising sharply over the past decade. AA is not means-tested and is administered by the Department for Work and Pensions. It is theoretically unconnected with the care system, although it is used by older and disabled people for purposes that most would see as a part of social care. The Dilnot Commission on the Funding of Care and Support had this to say on AA: “The Government should clarify the role of AA by re-branding the benefit. People do not understand the term Attendance Allowance or the purpose of the benefit.” The Commission also suggested improving AA’s alignment – and indeed that of other benefits paid to disabled people and carers – with the new care funding system now to come into being under the forthcoming Care Act. In these straitened times, we consider that it is time to take up the Dilnot Commission’s recommendation and look at the effectiveness of AA and how it could be better integrated into new care funding arrangements.

4.7 A new financial regime for health and care

This analysis shows there is an alternative to continuously finding extra money for health and care from general taxation. With committed leadership, it is possible to drive NHS efficiency

improvement and get more for less, just as it is possible to tap into a wider range of funding streams to general taxation. With consistent political support it would be possible by the end of the next Parliament to place the NHS on a firmer financial footing with a more robust financial regime that relies less on moving resources from other public services.

The key features of such a regime would be:

- More efficient NHS service delivery and administration producing £15-20 billion in recurrent savings. This, we suggest, should form the basis of the Service Transition Fund we have proposed.
- Developing hypothecated health and care taxes as alternatives to some general taxation. If these taxes, many of them currently existing but under-exploited, were inflation-proofed they could be more buoyant than at present. The extra sums raised could supplement and/or partially replace some general taxation, particularly income tax.
- Restructuring inheritance tax to produce at least an additional £3-4 billion a year for health and care than is currently raised by the tax.
- Changing entitlements to free care by adjusting the NHS boundary for these entitlements in order to save £3-4 billion a year.
- Revamping the system for medicines/dental charges and introducing hotel charges in order to increase income by £1 billion plus in recurrent income.
- Introducing a fee-paying NHS membership scheme which could leverage national lottery money and could provide additional funding of £2 billion plus for local preventative services.
- Integration of the £6 billion a year spent on Attendance Allowance into the health and care budget.

Most of these changes represent the prospect of new money for health and care during the lifetime of the next Parliament that would continue on a recurrent and inflation-proofed way in later Parliaments. They would be linked to a more efficient care system of higher quality.

It would be for the Government of the day to determine the speed and scale of replacement of general taxation by these funding changes as the basis for funding health and care. We believe that these funding changes would be easier to sustain over time and more buoyant in revenue terms than the existing funding arrangements, as well as causing less damage to other public services.

Our analysis shows that, with sufficient political will, it is possible to break out of the current service and funding straitjackets but, in doing so, there needs to be greater financial discipline over the health and care budget. Our vision is that the costs of service transition to a more community-based health and care delivery system would be met from the efficiency savings we have indicated, via the mechanism of a Service Transition Fund. But this would require a laser-like focus on driving NHS efficiency and productivity improvement in a sustained way. This would be encouraged by the Treasury keeping a tight control on the allocation of public funds for health and care while the structural debt and deficit were being reduced.

In our view the 2015-16 budget should be inflation-proofed for the life of the next Parliament for both health and care but with no increase beyond that coming from general taxation. Any increases beyond that might be limited to 1 per cent real terms increase a year – about £1.5 billion – but financed from the alternative taxes and co-payments we have suggested. This would begin the process of reducing reliance on general taxation for funding health and care services. If such arrangements continued to 2025 this would mean levying about £15 billion from these alternative funding sources, more if the annual increase was more than 1 per cent or the government chose to replace general taxation faster as the basis for funding health and care. Over time, the aim would be that increases in public funding for health and care came increasingly from sources other than general taxation, especially income tax.

Clearly, more detailed work on these ideas is needed but we hope we have provided some new thinking for people to consider alongside our ideas for making change happen in the lifetime of the next Parliament, set out in the final Section.

5

Making change happen 2015-2020

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5.1 The need for a road map

We have argued that the NHS and social care have to change radically and quickly to deal with the accelerating demographic, disease and financial challenges. We have proposed moving to an integrated National Health and Care Service (NHCS) based on a new partnership between State and citizen, with more integrated services available locally in the community and consolidation of hospital specialist services on fewer sites of higher quality. We have also outlined possible options for new funding streams instead of relying on a remorseless, and probably unachievable, rise in general taxation. We have set out some ideas for a major change of direction for both health and social care, but not provided a complete blueprint for service overhaul. For change to happen, a lot more detailed work is required, much of it technical and well beyond our expertise. However, before that technical work can start, some big questions have to be tackled in the public and political arenas. So we have sketched out a road map to start us on a journey of change. It needs to begin now and continue through the next Parliament.

5.2 Public understanding and a Big Conversation

The starting point for a road map is the public. There is little public understanding about how serious matters are and why radical and rapid change is needed. Most of the debate on these issues has

“We have to open up a ‘Big Conversation’ publicly to discuss difficult issues in a grown-up way without beating up politicians who raise them in public.”

taken place among those in the know but there has been a reluctance to engage with the public about the scale of change that is needed and what is likely to happen after the 2015 Election. There is an urgent need to open up a public debate on the way we

provide and pay for health and social care and the changes that are necessary to tackle the looming crisis. We have to find a way to open up a “Big Conversation” publicly about how we move forward and to start discussing difficult issues in a grown-up way without beating up politicians who raise them in public.

This public discourse must embrace the public, professionals and politicians. Indeed politicians should be leading the debate among their constituents, rather than trying to defend unsatisfactory and unsustainable local services. But they find this electorally difficult to do. They need help from clinical leaders, voluntary organisations, local government, the media and professional bodies to get some of the issues and ideas out in the open. The role of social media could prove vital, along with local events such as citizens' juries. But the conversation has to be about change, not the preservation of the status quo.

This has been done in recent times. In 2005, Ministers organised a wide-ranging set of local events and consultations to explore public views on community-based service changes, culminating in a whole-day event with nearly 1,000 people in Birmingham discussing, with Ministers, their preferences and voting on them. The outcome was reflected in a January 2006 White Paper on bringing services closer to home. Too few of the policies arising from that public engagement have been implemented in practice. Nevertheless, this is the kind of initiative that should now be attempted. Perhaps the broadcast media, given their public broadcasting responsibilities, might venture a lead.

A major player in facilitating public debate of change both nationally and locally should be Healthwatch England and the new local Healthwatch organisations. Given modest extra funding, they could help the public understand the need for radical change if the essential characteristics of NHS care are to be preserved. Much could be achieved by increasing funding for Healthwatch England to lead a public debate.

5.3 Engaging staff in change

The NHS is one the biggest employers in the world with over 1.5 million staff. Only the People's Liberation Army in China, the Wal-Mart supermarket chain and the Indian railways employ more people. These staff need to be fully engaged in the debate on radical change so that they can contribute their ideas and not see change as something being done to them. We would like to see the

encouragement of local workplace forums in which staff could develop their ideas for change and become involved in changing service delivery locally.

To aid this process, we suggest that NHS England appoints a board-level Director of Transformational Change to lead a work programme developed with staff and employer representatives to engage staff in transformational change. This work should be done in conjunction with Health Education England, which should be required to direct more of its existing resource to developing training and education programmes that help the workforce to re-skill themselves for a more community-based and integrated way of working.

Alongside this, the new Director should examine the scope for strengthening existing arrangements for the development of mutuals so that staff could, where they wish, come together and collectively own parts of the new National Health and Care Service. This could increase staff commitment to change as the Circle group has shown when replacing traditional NHS management arrangements. We consider that the John Lewis-like mutual model of running organisations may have much to offer in securing health and care staff commitment to radical change in the delivery of services.

5.4 The big questions for debate

What are the main questions for a Big Conversation? Our analysis suggests that five key questions require debate and a public and political settlement for change:

1. Integration How can we move rapidly to a fully integrated and personalised model for health and social care at the national and local levels covering funding and delivery of community-based services with an enhanced role for local government?

2. Rebalancing towards community-based services Can we agree to rebalance whatever we choose as a nation to rebalance the health and social care budgets so that a higher proportion is spent on community-based services (including mental and public health) and support for self-care (including carers) rather than inpatient hospital care?

3. Consolidation of specialist hospital services Can we agree, in principle, that patient safety and outcomes are likely to improve considerably if 24/7 hospital specialist services are consolidated on fewer sites with seven day consultant cover after an agreed time-limited statutory process of clinical review and local public consultation?

4. Funding options Can we agree to explore a wider range of funding options for health and social care to secure greater financial sustainability, rather than continuing to rely essentially on general taxation?

5. Avoiding another reorganisation Can we agree to make the changes required gradually over a five to ten year period using, wherever possible, existing legislation and bodies without significant organisational and legislative disruption?

Of course, people want information about what change will mean for their local services and them personally, so we need more transparency about what is involved. Local MPs could play an important role in facilitating an honest debate, and could even secure some credit for facing up to the changes needed to secure better and affordable health and care services. They need to help local communities play a constructive role in transforming local services.

5.5 Building political consensus

We recognise that none of this will be easy. The NHS rouses much public and political passion that all too often turns into party-political claim and counter-claim. It will be very difficult to debate publicly the ideas we have set out without the political temperature rising, especially in the run-up to a General Election. Despite this, there is some mutual self-interest across the political spectrum in starting the debate now because whoever is in government after 2015 will have to deal with the issues we have raised. We hope it is possible to channel the energy of public and political debate towards a political understanding of the changes that must be contemplated.

There is an emerging political agreement over the need to integrate health and social care. In private, politicians across the Parties acknowledge that modern medicine and patient safety mean that consolidation of specialist services on fewer 24/7 hospital sites is

necessary in the next Parliament. There may be sufficient underlying agreement for cross-party talks to take place before the 2015 Election to at least settle the questions to be tackled, even if the answers await the outcome of the Election.

5.6 Key operational characteristics of a changed system

In thinking about a new National Health and Care Service, it is important to consider how we want the new system to work differently from the old order, for the benefit of users. That is an important part of a public debate and vital to the more than 1.5 million

“The NHS should define its purpose clearly: ‘To promote and secure the health and wellbeing of the population, and individuals within it, by securing best value from the resources available’.”

staff involved. If a transition to a new NHCS is to be successful, people working in it will – along with the public – need to believe things will be better but different. Some key characteristics of the new system will have to be very different to now, if it is truly to change user experience. We will

mention just five: purpose; partnerships; payment; population health and commissioning; and political accountability.

Purpose The guiding principles of current services lack clarity. There are lots of organisational objectives, lists of functions and accountabilities, and even vision statements, as well as an NHS constitution. Nevertheless, there has been a failure to articulate a simple overarching core objective that, day in day out, guides health and care organisations and those who work in them. We suggest that this guiding purpose is: “To promote and secure the health and wellbeing of the population, and individuals within it, by securing best value and outcomes for people from the resources available.” That purpose should shape and guide the way that health and care organisations work in the future, and should underpin any new legislation that may be required.

Partnerships Silos, both organisational and professional, have bedevilled the NHS. They seriously damage people’s relationships with the health and care system. They mean that even a person who

is the responsibility of a single hospital cannot depend on receiving integrated care from trust hospitals. The problem of silos has become worse for an ageing population with multiple conditions, not all of which can be dealt with in one place. Professor Michael Porter of Harvard has suggested a solution – the Integrated Professional Unit at the level of the patient. The GP, in theory, is a coordinator of care, as are the care managers in social care but, too often, integration does not work in practice. Professional and organisational partnerships, with a guide/broker for the individual, have to become the new normal in a National Health and Care Service, if integration of services is to become a reality and truly benefit service users.

Payment We must move away from paying service providers for activity and towards paying them for outcomes for individuals. That means shifting from paying for episodes of care under the payment by results (PbR) system to paying for a period or cycle of care for all the needs of an individual. These are major changes requiring a lot of technical work and can only happen through phased implementation. We must begin the process quickly. Otherwise, activity-based tariffs for hospitals will bankrupt the NHS as well as damage quality of patient care. Changing reimbursement in this way would improve partnership working.

Population health and commissioning Individual health is likely to improve more if we improve our focus on population health. There needs to be a new system of resource allocation with a greater focus on securing better population health, based on a strategic assessment of the health and wellbeing needs of particular populations. We have suggested that the best way to secure this change would be to strengthen the role of Health and Wellbeing Boards (HWBs) to allocate resources locally, since they already have the responsibility for making these strategic assessments. Change of this kind need not affect Clinical Commissioning Groups discharging their current functions in integrated commissioning partnerships with HWBs. These more integrated groups should consider a shift to commissioning services on the basis of segments of their patient population with particular conditions (e.g. diabetes) or groups of conditions, and for particular providers to be responsible and paid for integrating services for individuals over a period of time. Nothing in

these changes needs to alter patient rights to choose their own general practice as they do now, although many of these practices will need to transform the ways they work.

Political accountability Over the years, there have been endless discussions about the Health Secretary's accountability for the NHS. Typically, this has ended up with the NHS being run on the basis of top-down central control. This has stultified local autonomy, creativity and experimentation. Too often, local bodies look upwards to the centre rather than outwards to their populations. A top-down, centralised command and control approach to running a new National Health and Care Service, even in a time of austerity, will be a disaster. After 65 years, there is little evidence that it works well over time and a fair amount of evidence that it works badly. Political accountability, in our view, needs to be shared more between the centre and localities with, we suggest, more local democratic accountability by those planning and commissioning services locally.

However, on this last point, we recognise that a service spending some £130 billion of taxpayers' money each year requires political accountability to Parliament. The 2012 Health and Social Care Act starts to put a bit of day-to-day distance between the Health Secretary and the NHS. This needs to be built on with a better framework of rules identifying the responsibilities that remain with the centre and those which are to be left in the hands of local people. In our view, as long as local organisations adhere to the requirements of the national framework, they should be left alone to sort matters out within their local communities, unless there is a major breakdown in services that requires external intervention. The more political agreement there is on the rules in a national framework, the more effective and consistent a new national service is likely to be, and the less likely it is to be buffeted by changes of Government or Ministers.

Legislation, processes and timescales

We suspect that, in due course, a new legislative framework will be required if there is to be a new NHCS in order to consolidate and amend the Health and Social Care Act and the current Care Bill, which is shortly to complete its Parliamentary passage. However, there is plenty of scope for moving along the path we are suggesting

within the current primary legislation, if there is the necessary political will and public support. The 2012 Act provides the Health Secretary with wide powers of direction, as well as many regulation-making powers. Nevertheless, implementation of our proposals will require underpinning by much technical work, including data collection and analysis, robust policy development and option appraisals plus a full assessment of the legislative, financial and operational implementation issues, including modelling change.

We see five main work streams for this technical preparation:

- > **Unification of resource allocation** Analysis of the implications for central and local government of unifying the resource allocation from the centre for health and social care; the implications for the budgets of the organisations affected; and the likely timescales for transition.
- > **Unifying community-based health and care services** Assessment of the operational and personnel implications of the main options for unifying community-based health and care services.
- > **Reconfiguring specialist services** Designing, for public consultation, more effective and speedier statutory processes for reconfiguration of hospital specialist services on a clinical and financially sustainable basis. These could operate across the whole of England but with scope for operation on a regional basis.
- > **New funding streams** An option appraisal (with defined criteria) of alternative funding streams to pay for health and social care in place of, or alongside, general taxation and current private payments.
- > **Efficiency programme** Development of an ambitious five year programme of NHS efficiency and innovation gains, including use of all its fixed assets and commercial opportunities, led by people with expertise from outside Government and the NHS.

The issue then arises as to who should do this work. We recognise that Civil Service resources are limited but some of this thinking is similar to the usual preparation that the Civil Service does for any change of Government at the time of General Elections. However, the

whole burden of this work need not fall on the civil service. It would be desirable to secure as much external expertise as possible – especially on the last two work streams and to undertake this work in a transparent way to increase the prospect of wider support for change. For example, work on new funding streams could be done by a commission along the lines of the Turner Commission on Pensions or the Dilnot Commission on Funding Care and Support, working to a defined brief and timescale. NHS England could drive NHS efficiency and innovation with another independent body, charged with taking a hard look at the use of NHS fixed assets, facilities management, administrative processes and use of technology. It is clear to us that the serious crisis looming on the delivery and funding of health and social care for the next government makes it imperative to undertake some contingency planning as soon as possible. It should not neglect understanding and facilitating the development needs of those who work in the NHS and social care, as we have suggested.

Conclusions

We have no doubt that there will many different views on how to take forward a change agenda. Our purpose in providing this road map is to illustrate the kind of issues that have to be addressed, some processes that could be used, the actors that have to be engaged and the timescales likely to be required. Our suggestions are illustrative only and are not a blueprint. They are designed to get people thinking. We are, however, clear about three key issues:

- **Agenda** We urgently need a change agenda and road map for changing our health and care systems.
- **Debate** There has to be a wide public, professional and political debate about the need for change and what it involves.
- **Leadership** Our politicians need to help lead that debate and use Election Manifestos to say where they stand on the change agenda.

Five pledges for the 2015 General Election

There is no escaping the urgency of bringing the serious problems facing the NHS and social care to the electorate's attention in 2015.

Voters need to be engaged with the need for major change and what would be involved. Many voters suspect that we cannot go on as we are on health and care. In the 2012 British Social Attitudes Survey, 44 per cent of people thought that the NHS would not, in ten years time, still be paid for by taxes and be free for all at the point of use. Voters may even reward those who are straight with them and strive for consensus rather than point-scoring on something as totemic as the NHS.

Five manifesto pledges

Our challenge to politicians of all parties is to ensure that, in their General Election manifestos, they are frank with voters about the seriousness of the situation and make five pledges, committing the next Government to:

- 1. Intervene** earlier and more effectively to prevent and manage conditions that are blighting lives and consuming too many NHS and care resources.

- 2. Move** more health and care resources to community-based facilities to deliver better patient care 24/7 and improve value for taxpayers. This could involve converting many existing hospitals into community hospitals with a different, wider range of services better suited to local needs (especially for the frail elderly).

- 3. Merge** health and social care budgets and service delivery at a pace suited to local needs.

- 4. Consolidate** specialist services on fewer acute hospital sites (most of the remainder becoming community hospitals as above). These, often enlarged, specialist hospitals would have the professional expertise, equipment and facilities to provide safer emergency services that would save more lives and produce better patient outcomes in a truly 24/7 NHS.

- 5. Contain** NHS spending with little more than inflation-protected annual increases apart from some extra one-off funding for the shift to more community-based services. Meanwhile, find new ways, other than income tax, to fund increases beyond inflation to protect other public services from being drained by the NHS and social care.

Annex 1: How did we get where we are?

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The first 50 years – Bevan to Thatcher

The idea of an NHS started during the Second World War with the 1942 Beveridge Report and the five giants that he wanted to slay, one of which was disease. Beveridge's central idea was that to have a satisfactory post-war social security system you needed "a national health service for prevention and comprehensive treatment available to all members of the community". This idea has dominated public and political thinking on UK health policy ever since. It is highly doubtful if we have delivered the prevention bit. Moreover, the seeds of excess demand for healthcare were sown at the outset because when the report was written most people lived only a few years after retirement.

Bevan, the architect of the NHS, put in place to run it a tripartite system of hospitals; GPs and primary care; and local authority public health and community services. Hospitals were run by a triumvirate of medical director, matron and hospital secretary, with doctors very much in charge. Many doctors were reluctant to participate in this new State service but Bevan "stuffed their mouths with gold". GPs insisted on retaining their small businessman model rather than being salaried and this model remains a problem today. Local authorities, through their medical officer of health, had a responsibility for whole population health – something that has been lost along the way. From the outset, social care was means-tested and run by local authorities separately from the NHS. These separate silos have caused problems ever since and are a major issue for today.

Finance and its control was always a problem. In 1949, Bevan said to *The Times*: "I shudder to think of the ceaseless cascade of medicine which is pouring down British throats at the present time." In 1951, the Attlee Government introduced prescription and other charges, leading to the resignation of Bevan, Harold Wilson and John Freeman from the Cabinet. Treasury concern about NHS costs led to the 1956 Guillebaud Report. This was surprisingly reassuring on NHS running costs but identified problems with capital that have continued to dog the NHS.

By the 1960s, a Tory Health Minister (Iain Macleod) had rather optimistically declared that the NHS was "out of party politics". The

majority of doctors had accepted the NHS; but GPs wanted better pay and more money for premises and threatened the Health Minister Kenneth Robinson with mass resignations from the NHS. There remained problems with the NHS fabric. Enoch Powell wanted to replace the Victorian asylums with community care and produced the first hospital building plan. This was to establish a network of district general hospitals providing a range of specialist services on a 24/7 basis. But money was tight and the pace of building slow – the Liverpool Teaching Hospital took 25 years to produce an out-of-date hospital. The 24/7 district hospital model now poses its own problems of sustainability. The longstanding lack of public capital investment in the NHS was to lead 30 years later to the controversial PFI schemes for providing new buildings and equipment on a “have now, pay later” basis.

The 1970s saw political attention turn to two topics that have dominated reform thinking for 40 years – management and reorganisation. The Salmon Report in the mid-1960s created a new senior management structure for nurses with significant long term consequences. The Heath Government removed local government from the NHS – a serious mistake that is now being remedied to some extent in the 2012 Health and Social Care Act. In the early 1970s, Keith Joseph, as Health Secretary, brought in McKinsey to review the Department of Health; and hired a professor of management at Brunel University to create new structures of professional and lay management for new area health authorities. These reforms were introduced reluctantly in April 1974 by a Labour Government and were extremely bureaucratic.

Hostilities with the doctors resumed with Barbara Castle as Secretary of State over pay and consultants private practice in NHS hospitals. Strikes and threats of resignations dominated the agenda. For the first time, two new issues were raised: whether money was allocated fairly within the NHS, which resulted in the Resource Allocation Working Party that shifted money away from London and the South East; and the related issue of health inequalities, which led to the Black Report published after the 1979 election. Money remained a problem. The IMF was called in and cash limits were introduced into the NHS. Waiting times lengthened and for the first time a patient sued the

Health Secretary over the refusal of a hip replacement.

The arrival of Margaret Thatcher in 1979 brought a new emphasis on management and efficiency across the whole public sector with gurus drawn from retail – Derek Rayner from Marks & Spencer and Sir Roy Griffiths from Sainsbury's. The Rayner efficiency programme was spread across all Whitehall Departments and compulsory competitive tendering was introduced into local authorities who increasingly became commissioners of services rather than providers. The NHS was initially exempt from competition. Norman Fowler's review of NHS management, by Roy Griffiths, led after 1983 to the introduction of general management in the NHS and a new NHS Management Board. These changes have significantly influenced how the NHS has operated ever since and probably led to many doctors opting out of NHS management even though they were committing most of the resources.

Despite the emphasis on better management, money got tighter and in 1987, after Thatcher's re-election, the NHS had its worst financial crisis in its history, with its Finance Director, Ian Mills, telling Ministers that the NHS was "technically bankrupt". Thousands of beds were closed in attempts to balance the books; doctors marched on Downing Street; the Presidents of the medical Royal Colleges appealed publicly to the Government to "save our NHS". In 1988, out of the blue, Thatcher announced on the Panorama programme an NHS review. This led to the NHS internal market which was not what the Royal College Presidents had in mind.

In 1985 a US professor, Alain Enthoven, published a pamphlet on the management of the NHS suggesting the creation of an internal market in which health authorities would be able to buy and sell services from each other and from the private sector. Little noticed before the 1987 election, this became a basic element in Thatcher's secretive review which progressed little until the arrival of Ken Clarke as Health Secretary in June 1988. On holiday in Galicia he came up with the idea of GP fund-holders using budgets to purchase services for their patients. Clarke, transported by riverboat to Limehouse, launched his White Paper *Working for Patients*. This totally transformed the NHS with a purchaser/provider split: health authorities and GP fund-holders were to do the commissioning of

services and hospitals (public or private) were to provide services.

These changes produced as big a row with the doctors as Bevan's in 1948. Thatcher got cold feet even after the legislation was passed and tried to stop Clarke going ahead with the changes on D-day, April 1991. Clarke wouldn't back down and the most fundamental changes were made to the NHS since 1948. The Clarke reforms have shaped all the organisational changes since – both Labour's and the Coalition's.

Not satisfied with NHS revolution, Clarke pushed on with reform of means-tested social care where a whole private care homes sector was being created and funded through a loop hole in the social security system. Reports by the Audit Commission and Sir Roy Griffiths proposed more emphasis on people being cared for in the community rather than in care homes or hospitals. For social care Griffiths proposed a purchaser/provider split and a mixed economy of service providers, not public provider monopolies. Service users would have a care manager to help them assemble individualised care packages. These ideas survive to today but have gained little traction in the NHS. A political dispute arose over whether to give the NHS or local government responsibility for community care (including nursing homes). Only last minute efforts by Griffiths persuaded Thatcher to opt for local government before she was deposed.

From rags to riches

Labour had supported Griffiths on community care but attacked Clarke's NHS changes. This remained their position up to the 1997 election. Major and his Health Secretaries tried to soften the language on the NHS but were forced to pump more money into London's hospitals as the NHS struggled financially and waiting times lengthened. To their credit the Tories committed themselves to tackling health inequalities, ten years after the Black Report. They produced a *Health of the Nation* White Paper and set targets to cut smoking and heart disease by a third by 2000, along with premature deaths from breast cancer and suicides. It was Major not Blair who invented targets, rightly. Labour approached the 1997 Election with a health policy that did little more than promise to cut waiting times and the number of "men in grey suits" who were expected to do the cutting.

When Tony Blair arrived, the NHS was essentially bankrupt with a 1.5 per cent budget deficit, bills unpaid and 12-hour waits on trolleys in A&E. Bits of the NHS like optical services had fallen off the edge but most of Bevan's architecture had survived, but in a crumbling state. The most dramatic reduction in NHS scope had been in long term care, particularly of the elderly. As the ageing population increased, long term care for the elderly was now firmly entrenched in means-tested social care. There had been growth in people who paid for their own care rather than the state paying; a rapid increase in private nursing homes; and the disappearance of NHS geriatric hospitals.

To win the 1997 election Labour tried to shake off its "tax and spend" reputation and promised to keep to Conservative expenditure plans for two years. This meant little extra NHS expenditure despite its problems. Waiting times were lengthening and the NHS hospital estate had 100 year-old hospitals, out of date equipment and virtually no IT (no confidential email even). The NHS was a 1940s service at the end of the 20th century. The UK was spending about 6 per cent of its GDP on health when most of Europe was spending about 8-9 per cent and the US double or more. Blair's growing confidence and the arrival of Alan Milburn as Health Secretary in 1999 changed this. The 2000 NHS plan promised within a decade 7,000 more hospital beds, modernisation of 3,000 GP premises, 10,000 more doctors, 20,000 more nurses, over 100 new hospitals, a modern IT system and much else, with shorter waiting times for treatment, especially of the killer diseases. In the 2000 Budget, the Chancellor announced that the NHS budget would grow by over 50 per cent in cash terms and a third in real terms.

The price for this largesse was the introduction of central targets for things like shorter waits in A&E, for GP appointments and for cancer treatment. Targets were to convince the public they would see improvements for the extra money but NHS professionals disliked being held to account in this way. Targets and the extra money/staff drove down premature deaths from heart disease, stroke and cancer significantly as well as reducing deaths from healthcare-acquired infections. These successes have been lost sight of in a rush to appease NHS professionals and blamed for deaths which in reality were caused by poor professional practice. But Labour fell into a trap

from the past with an ill-judged reorganisation in 2002 that lacked sufficient competent staff for the 300 new PCTs and 28 SHAs established. These organisations were reduced by over 50 per cent in 2006, but the damage was done.

Frustrated with the slow pace of change, Blair pursued Ken Clarke's idea of competition, with private providers offering NHS services like elective surgery and imaging; and enabling patients to choose public or private providers for their NHS treatment. GP fund-holding was reinvented as practice-based commissioning. The unions resisted these changes: warning patients of the privatisation of their NHS. But patients liked choice and seemed to care little about who provided their NHS care.

In the first decade of the new millennium, the NHS was set new standards; it replaced X-rays with digital imaging and introduced a networked IT system, but failed to implement an electronic patient record. For the first time there was a system of NHS regulation for identifying failing hospitals and the most successful could become self-governing Foundation Trusts. The Private Finance Initiative – invented under Major – was used to give over a hundred communities new or extensively modernised hospitals and better community premises. But in this flurry of modernisation and extra money NHS financial management proved inadequate and 2005-6 saw another financial crisis. Some PFI schemes were too grandiose and the annual repayments (for 30 years) could not be met from annual budgets. The extra doctors and nurses improved quality in many places but overall productivity declined. New regulators exposed failings in both the NHS and social care as they struggled to cope with an ageing population and its long term conditions, including dementia.

An era of economic growth produced a rapid increase in lifestyle diseases – obesity, diabetes, alcohol-related conditions and from smoking – and a population that took insufficient exercise. Social care moved into crisis as local authority budgets – less generously funded than the NHS – could not cope. Legislation was passed to ban smoking in workplaces and public places. In 2006, there was an attempt, after a major public consultation, to shift the agenda away from hospitals to care closer to home, public health and integration of health and social care. In the policy lexicon “wellbeing” was added to

“health.” But the payment system remained skewed to activity in the more expensive acute hospitals which remained the focus of public affection and dominated NHS budgets.

In 2007, Gordon Brown replaced Blair and ordered an NHS review for its 60th birthday by a surgeon/ Minister, Ara Darzi. This produced a 2008 report emphasising quality but in practice led to little change in priorities away from hospitals as vested interests declined to implement Darzi’s new idea of polyclinics. Despite the fiscal problems caused by failing UK banks and a global financial crisis, Brown still increased NHS funding further. This extra money went mainly on extra staff rather than system reform. Social care continued to be the poor relation of the NHS, despite the demographic pressures. Brown showed little interest in the Blair agenda of more competition and patient choice; and in his Health Secretary announced a policy of NHS preferred provider. Work was begun belatedly on an unaffordable idea of a tax-funded national care service to replace social care and run alongside the NHS, but the legislation for this was defeated in the House of Lords in 2010. An election then intervened and the departing Labour Chief Secretary accurately but perhaps unwisely warned his Coalition successor that there “was no money left”.

The road to austerity

Prior to the Election the Coalition’s Health Secretary, Andrew Lansley, had promised no top-down reorganisation. Despite this the new Government embarked on a major NHS reorganisation that probably cost some £2 billion and disrupted management from concentrating on the £20 billion of efficiency savings over four years that the NHS Chief Executive had said were required in the straitened fiscal climate. After a bruising political battle that did little credit to anybody, the Coalition’s 2012 Health and Social Care Act was finally passed. In April 2013 the managerial pack of cards was reshuffled again so that 10 SHAs and 150 PCTs were replaced by 200 clinical commissioning groups led by GPs and about 40 new Health and Wellbeing Boards were established based on top-tier local authorities but without any budgetary responsibilities. Looming over them is a huge quango, NHS England, responsible for most of the NHS budget and two regulators: the Care Quality Commission (for quality) and Monitor

(economic). Responsibility for public health is split between central and local government and there are two other new smaller quangos responsible for health research and for training staff. The public are entitled to feel thoroughly confused as to who is really running the NHS.

While these organisational changes have been going on, another political battle has been in progress for the public's affections. This has been about who would do the most to protect funding of the NHS at a time of fiscal constraint and public expenditure cuts to reduce the nation's debt. Historically the NHS has been used to more than 3 per cent annual growth in real terms to cope with the costs of inflation, demography and medical advances. The Government has claimed that it ring-fenced the NHS budget. In practice, this increasingly means, at best, the NHS can expect a flat-lining budget in real terms, although this is better than the 20-30 per cent real terms cuts some other public services. Adult social care has been treated much less generously, although in desperation hand-outs of about £1 billion a year are being slipped across the border from the NHS. Most of the £20 billion NHS efficiency gains have been achieved by pay restraint and one-off cuts rather than fundamental system reform. The political claims of ring-fencing the NHS budget look increasingly unreal. They are also counter-productive in that they reinforce the view that in the NHS that major system change is not required.

Greater competition has been abandoned under pressure from Labour and the Liberal Democrats. The need for major service reconfiguration is being left largely to local decision unless a Trust's deficit and debt is so large that it is finally recognised as bust. Then the Health Secretary or Monitor has to appoint a Trust Special Administrator but so far this has happened only twice. No MP wants to tell the local electorate that their local A&E Department or maternity services are financially and clinically unsustainable. There is much talk about integrating health and social care but few examples of this on any scale or much evidence it will save money. Social care budgets, already tight, are being cut by over 30 per cent in four years with serious consequences for the NHS. Unplanned hospital admissions are at an all-time high with mainly elderly people staying longer

because of social care shortages. Study after study shows 25 to 40 per cent of those in acute hospital medical wards should not be there – at two to three times the cost of a decent nursing home with medical cover.

The NHS now faces a period to 2030 when demography, science and public expectations will produce cost pushes that the country's fiscal circumstances are unlikely to be able to meet without radical changes to the way the NHS uses resources and delivers services. The Francis Reports on the failures at Mid Staffordshire NHS Foundation Trust exposed the shortcomings of organisational cultures in some parts of the NHS and the inability to handle change effectively. Change is now inevitable, as this pamphlet demonstrates but, in making these changes, the lessons of history should be absorbed and the mistakes of the past avoided.

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We have drawn on material from a wide range of sources including websites, magazines, press articles and conferences. While writing this document there has been an outpouring of papers, reports and speeches expressing concern about the state of health and care services, and we have tried to capture a sense of this rising concern. Below are the main sources we can recall using, arranged under themes and in chronological order. We have no doubt failed to acknowledge some documents. We beg forgiveness. We have not included Parliamentary answers too numerous to record in detail. In borrowing or adapting ideas from the many sources drawn upon we hope we will be forgiven any inadvertent errors, which are all our own.

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