

Spotlight

HEALTHCARE: PLANNING FOR THE FUTURE OF THE NHS

Jeremy Hunt / Jonathan Ashworth / Dr Philippa Whitford



Spotlight



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Is there danger in our devotion to the NHS?



Last month, YouGov asked 1,716 people to identify the areas of policy that matter most. While it revealed a chasm of opinion between young and old, one area united the generations, and it was the top priority across all age groups: to increase spending on the NHS.

But the definition of what constitutes the NHS has changed in recent years. No government can be seen taking a hatchet to this most treasured national entity and expect to remain electable, but by altering or narrowing the definition of what constitutes the health service, governments have been able to claim that they are increasing spending on “the NHS” while the less clearly defined social care and public health services, now defined as something else, became safely defundable.

This balancing act has not been healthy. The failure to sustain cheap, preventative solutions against problems such as obesity and depression turns into the vastly more expensive treatment of cancer, heart disease, diabetes and serious mental illness.

The complex truth, not suited to manifesto promises, is that any cut to public spending becomes, eventually, a cut to the NHS. Every pound diverted from trains worsens the air pollution crisis, which is killing 40,000 people a year. Every school football field that is sold grows the childhood obesity time-bomb. Every local government asset – every park, swimming pool and library – that is closed or sold makes the population fatter, more depressed and less health-literate. The stresses of a broken housing market and nearly two million zero-hours contracts will translate, in the decades to come, into devastating demand on the country’s hospitals. By simplifying the NHS into a brand, the boundaries of which are at the mercy of politicians, that symbolic acronym could distract us from the state of a healthcare system that permeates our entire society.

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Planning for a new mental health paradigm

The NHS is undertaking an ambitious effort to achieve “parity of esteem” between mental and physical health, says **Jeremy Hunt**, Secretary of State for Health

It is a little over half a century since the American physician Thomas Kuhn first popularised the term “paradigm shift” as a way of describing a revolutionary break in the ideas, practices and protocols governing scientific endeavour. Five years ago, when the government first legislated for “parity of esteem” between mental and physical health services across the NHS, we were reflecting a similar need to cast aside old assumptions and reimagine the way we plan for and prioritise mental health.

Since then, the NHS has embarked on one of the most ambitious plans for transforming and expanding access to mental health services anywhere in Europe, driven by a £1.4bn real-terms rise in funding compared to three years ago.

Of course, there remain many challenges in the delivery of mental health services and the services available to young people in particular are in need of major reform. But any fair assessment would also recognise today there are 120,000 more people receiving specialist care every year compared to just three years ago, including over 20,000 more

children and young people.

At the heart of our strategy is to reduce the long waits for care which perhaps more than anything symbolise that there is still a way to go before we can truly claim “parity of esteem.” So two years ago we became the first country in the world to introduce waiting time standards for talking therapies and early intervention in psychosis.

And last year’s introduction of a new waiting time standard for eating disorders means that two thirds of children with anorexia or bulimia are now starting urgent treatment within a week – an achievement that has been described by the Royal College of Psychiatrists as “phenomenal”.

Others have started noticing. In July, the *New York Times* described our plans as “the world’s most ambitious effort to treat depression, anxiety and other common mental illnesses”.

Our flagship Improving Access to Psychological Therapies (IAPT) programme has inspired a similar initiative in Sweden. And suicide rates in England remain low by European standards as well as being the lowest





£12.6bn is set to be invested in improving mental health

in the UK.

So why, given all of this progress, does it still feel like mental health is continuing to fall behind? Why, in many commentators' eyes, does the song remain the same? The answer is that the positive changes have to be set against the extraordinary rises in demand for mental health services. Every day there are 1,400 more people accessing mental health services today compared to 2010 – but the growth in supply has still struggled to match the growth in demand.

This extra demand is being met by services that continue to bear the effects of decades of underinvestment, with a clinical workforce that hasn't been granted the same prestige and profile as those in other medical disciplines. Which means, in short, there is an enormous amount of work still to deliver the step change in service provision that we all want to see.

You need to start with workforce requirements. So over the summer, we set out a new workforce plan to create 21,000 new posts across the NHS. This amounts to one of the biggest expansions of mental health workforce across Europe – and an essential pre-condition for meeting the increased demand for mental health support.

There will be significant rises in the number of therapists, nurses and consultants working across child and adolescent mental health, adult talking therapies and crisis care settings, in particular – and key to this will be transforming the image of mental health as a profession, so that we can encourage more doctors, nurses and other health professionals to join.

Later this year, meanwhile, there will be a major Green Paper setting out how we will transform the quality of mental health support available to children and young people by strengthening the links between school, community and clinical-based services.

And a historic review of the Mental Health Act, led by the respected psychiatrist Professor Sir Simon Wessely, will reconfigure how we treat people

with acute psychiatric disorders, and begin a much-needed public debate about issues such as detention and over-representation of certain groups in in-patient care.

At the heart of all this is a commitment to maintain a healthy flow of investment into mental health services. Last year, a record £11.6bn was spent on mental health, and by 2020 there will be an additional £1bn a year on top of that.

But not all of the answers come from government. If we want to build a more mentally resilient society, then there is only so much that can be achieved by public services.

Good mental health depends upon what happens in the wider community and particularly the workplace – which is why we have asked Mind's CEO Paul Farmer and the ex-HBOS chair Dennis Stevenson to lead a review of employer mental health.

It also depends upon the media and advertising industries operating with restraint and sensitivity in how they portray mental illness and related issues around body image, for example – and it is particularly important that major social media providers step up their efforts to confront the ambiguous role that technology plays in shaping the nation's mental health.

We must also look at our own ability as individuals to change the story. One of the great advances of the decade is that people from all backgrounds – from establishment figures such as Prince Harry, to sporting icons such as Dame Kelly Holmes – are speaking out about their own experience of mental illness.

We must capitalise on this to give more people the skills throughout their lives to cope better with personal adversity and crucially, to recognise the signs of mental illness in others and help them through it.

Mental health has become one of the defining social issues of our time. And even as the NHS embarks on a huge expansion of services, we should acknowledge that perhaps the biggest opportunity is within us all: to become more aware, more knowledgeable and more equipped to support others.

Avoiding another NHS winter of discontent

Jonathan Ashworth, Shadow Secretary of State for Health, warns that the coming months will push the NHS to the edge of a crisis without increased investment

Last winter, Theresa May's first as Prime Minister, was a terrible time for the NHS and its patients.

With the worst waiting lists on record and with patients stacked up in the corridors of overcrowded hospitals, the struggles of the NHS came to be seen as emblematic of the Prime Minister's failure to manage her domestic agenda while also juggling the huge demands of preparing for the country to leave the European Union.

This year has to be better. The government has had ample time to prepare, and there's no excuse for NHS patients and their families to suffer the same chaotic scenes as last year.

So far, the signs are not encouraging. Attendances at large A&Es were running three per cent higher this summer than last year. Overnight bed occupancy rates are at the highest level for 16 years. NHS Providers says that 92 per cent of trust leaders predict a lack of primary care capacity this coming winter and NHS England has warned of a "heavy flu

season" requiring extra preparation.

The Royal College of Emergency Medicine says "by all metrics, the months ahead... seem likely to be worse even than last year". The Royal College of Surgeons warns the NHS will face a "winter of woe" unless hospitals and local authorities tackle delayed discharges.

And it is the figures for delayed discharge that give perhaps the most cause for concern. Delayed bed days due to social care are running 11 per cent higher this July compared to last year, despite the government investing in social care with the aim of freeing up 2,000-3,000 hospital beds. Hospital bosses claim that cash-strapped local councils are failing to put the emergency funding into schemes to help patients get home quicker by improving social care support for them.

Despite all these warning signs the government have, at the time of writing, resisted calls to bring in emergency funding to help the NHS get through the winter months. This looks an





Government is resisting calls for emergency winter funding

unsustainable position.

Labour has argued for the government to put in an additional £500m of funding, focused on three areas: increasing capacity in hospitals to cope with the seasonal spike in demand; allowing hospitals to secure additional staffing without resorting to costly agency staff; and delivering effective arrangements between NHS and social care to reduce delayed transfers of care.

Up until 2014/15, dedicated additional funding of between £300m and £700m was made available nationally to support and sustain the urgent and emergency care system during winter. However, this funding was pulled into the NHS budget from 2015/16 with an instruction to CCGs to ensure it was passed to providers. Seasonal resilience funding, currently £400m, is now being swallowed by the wider financial pressures on the NHS.

The truth is that the problems over winter are only the most obvious symptom of the catastrophic financial

settlement which the Conservative government has imposed on the health service. Seven years of Tory underfunding have pushed NHS finances to the brink.

£2.8bn of capital funding has been used to plug revenue gaps over the past three years. Staffing shortages have left trusts spending more than £3bn per year on agency staff. The Capped Expenditure Process is now stripping millions more from budgets, in year, behind closed doors.

Collectively, NHS trusts ended 2016/17 with a reported deficit of £791 million and, according to NHS Improvement, were already a further £736m in the red after Q1 of this year. The provider sector is planning for a deficit of £496m by the end of 2017/18.

A long-term solution is well overdue. At the election Labour pledged to boost NHS spending, funded by raising income tax for the top five per cent of earners. Investment is essential in the workforce, in general practice, in mental health and in infrastructure. Our proposals would have raised an additional £5.4bn a year, plus £10bn capital from reversing corporation tax cuts, to protect NHS patients. Just as importantly, we had a costed plan to deliver it.

The Tories in contrast only set a vague target to increase funding by the end of the Parliament with no explanation of where the money would come from. Under Labour's plan, investment to support NHS patients would have been available now – three months on, the Tories have not even confirmed their spending plans, much less when it will be available. Their existing, pre-election spending plan will see spending per head fall over the coming years.

They can't go on like this. Most of the Conservative manifesto has already been pulped, decisively rejected by an unforgiving electorate. Now is surely the time for Theresa May to see sense on NHS funding and put in place a sustainable, long-term package of support that gives NHS staff the resources to deliver for their patients, not just during the winter, but all year round.

How can we create an ecosystem for innovation?

Improving the way we treat rare diseases depends on the strength of the life sciences sector and the infrastructure surrounding it, explains Claudia Rubin, director at Decideum

The government has confirmed that it is committed to ensuring patients get fast access to life-changing and cost-effective medicines. It has also recognised the massive contribution of the life sciences industry, not only to our understanding of diseases and the best way to treat them, but also the £56bn and tens of thousands of jobs it brings to the UK economy every year. The ambition is clear, but the accelerating pace of innovation in science brings with it opportunities and budget pressures for the NHS in equal measure.

There is some evidence that speed of access to new medicines is improving, for example in oncology. However, progress is lacking in other areas. Of particular concern are challenges that patients with rare or so-called “orphan” diseases face in accessing medicines. A recent report by the UK’s Office for Health Economics makes for uncomfortable reading, showing the UK falling behind comparator European countries in speed of access to “orphan drugs”. Of the medicines licensed to treat rare diseases by the European Medicines Agency between 2001 and 2016, time to reimbursement was an average of 19 months in France and Italy, almost immediate in Germany, and 28 months in England. Moreover, access itself is comparably low too; the same report finds that less than 50 per cent of “orphan drugs” are routinely funded by the NHS.

This is not a new problem, and the past few years have seen changes to the way we assess treatments for rare disease, including the advent of a

Highly Specialised Technologies assessment, and various iterations of the specialised commissioning process. Lately, however, it is as if we are building the tracks with the train already moving, and the system is still not there, especially for products that are almost, but not quite considered “ultra-orphan”. A constantly changing system for enabling access to treatments for patients with rare diseases means that an already lengthy and complicated process is that bit harder. This is true even for the largest global companies, and particularly so for the hundreds of smaller companies that have developed the science with the potential to change lives.

The Life Science Industrial Strategy published last month was commissioned to look at how to position the UK as the best place in the world to invest in life sciences. Rapid access to the benefits from this research industry, namely the healthcare technologies that patients need, is a critical part of realising this ambition. It is right that the government looks to get the best value for the NHS, and managing the size of the overall drugs budget is part of that. It is not about bringing in wide profit controls. The government wants Britain to be the pharmaceutical industry’s European centre of operations post-Brexit, and its profits are what fund the research that makes remarkable medical advances more possible.

It is vital that we create the right infrastructure that encourages companies to do their research here, but also to launch the products of this research here. It is that system, the mechanism by which complicated technologies – devices, diagnostics and drugs – secure reimbursement and reach their patients, that needs to be effective.

Now more than ever, our services are called upon to help manufacturers navigate this constantly evolving process. Gathering the evidence, building the case, crunching the numbers; our work is driven by the reward that success brings.

For more information, please visit: www.decideum.com

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Supplementing mainstream healthcare

Well-regulated and professional complementary therapies can offer benefits both to patients and health professionals, writes the CNHC's chief executive Margaret Coats

Later this month the Royal Society for Public Health will report on ways to include the UK's growing ranks of complementary therapists in the wider public health workforce. It's the outcome of a joint project with the Professional Standards Authority for Health and Social Care (PSA), which is looking not only at how complementary practitioners can help to meet the country's public health priorities, but also how their work can relieve some of the pressure on an overstretched NHS.

Complementary health therapies – distinctly different from alternative and traditional medicines – have wide acceptance in the UK. An estimated one in four of the population use these to supplement conventional medicine. Fifteen of these disciplines make up the register run by CNHC.

Government policy has focused on the need to protect the public while taking the view that, due to the low potential risk from treatment, there is no logical case for statutory regulation. From the late 1990s through the early 2000s, a lot of government funding was put toward developing standards to define what safe and competent practice looked like.

A second step toward integration included setting up the Complementary and Natural Healthcare Council in 2008 – with the support of government as well as the initial funding – as the voluntary regulator of these practitioners, with the single objective of protecting the public.

The voluntary nature of the regulator was emphasised by two Department of Health statements; in 2010 GPs were advised to recommend patients

seeking complementary therapies to consult practitioners who were CNHC registered – followed by the 2011 recommendation “that where people are looking for complementary healthcare practitioners, they use someone who is CNHC registered.”

A further step came with the Health and Social Care Act 2012, which provided for a tier of accredited registers to run in parallel with statutory regulators of mainstream healthcare. Implementation was made the responsibility of the PSA, and CNHC welcomed the opportunity for external scrutiny; it has held an accredited register since 2013. In 2015, the government recommended that people seeking a health practitioner who is not regulated by law should only consult one on an accredited register.

In April 2016 the Scottish government updated its guidance making clear accredited registers “have a number of benefits for practitioners, patients, contracting organisations and employers; providing reassurance that professionals are subject to appropriate scrutiny.”

It's a measure of the growing integration of complementary and conventional healthcare that guidance published by the National Institute for Health and Care Excellence increasingly includes reference to professions regulated by CNHC. Current NICE guidance includes:

- Complementary therapy to support palliative care for adults with cancer.
- Massage for pain management in end of life care for infants, children and young people.
- Massage therapy for low back pain and sciatica.
- Hypnotherapy for irritable bowel syndrome in adults.
- Alexander technique teaching for Parkinson's disease in adults.

In 2015, the General Medical Council also amended its guidance to doctors to confirm they are able to refer patients to practitioners on accredited registers.

The CNHC is committed to further integration of complementary and conventional healthcare – not only to benefit public health, but to enhance the NHS mainstream workforce.

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CNHC

Complementary & Natural
Healthcare Council

NHS Providers is a trade association representing over 94 per cent of all NHS trusts. Its chief executive **Chris Hopson** argues the NHS is facing collapse without a major review of funding and workforce

Back to black: acting to prevent an NHS crisis



It's like a scene from an old war movie. The National Health Service is a Royal Navy ship crashing through a stormy sea being buffeted by wave after wave of surging demand. Fuel is running low. The captain calls for more power. The needle on the engine room pressure dial goes above 100 per cent, and becomes stuck deep in the red zone. After ten minutes of running at absolute maximum power the engines falter and the ship shudders. Nervous glances cross the bridge. How much longer can the ship stay in the red zone? Can it stay afloat? When will it founder?

Excuse the dramatic license, but that's how it feels in the health service at the moment – we're trying to run the NHS permanently above its sustainable limits, well into the red zone.

Take NHS funding. We are in the middle of the longest and deepest financial squeeze in NHS history. Costs

and demand are growing by five per cent a year, but we are in the midst of a twelve year stretch where funding, on current plans, will rise by less than one per cent a year on average.

Although NHS trust finances have started to stabilise, there is still an underlying deficit of at least £3.5bn. We are only balancing the books by robbing capital budgets, selling off land and making one-off, nonrecurrent accounting adjustments or savings. The consequences are increasingly obvious; for example, the safety-critical NHS maintenance backlog has more than doubled in just two years from £458m to a whopping £947m. As the National Audit Office has pointed out, the health service at a local level remains under considerable financial pressure and the NHS still has a long way to go before we can regard it as being once again on a sustainable footing.



The workforce pressure dial is firmly in the red too. We have widespread staff shortages. There are growing recruitment and retention problems due to Brexit and ongoing NHS pay restraint. Many staff argue they can't provide the safe, high-quality care that patients deserve, despite routinely working longer than recommended or paid hours.

I was particularly struck by a

The NHS is running above its limits, into the red zone

SHUTTERSTOCK / IMRAN'S PHOTOGRAPHY

conversation I recently had with a nurse who, after building her experience and expertise for 12 years, had decided to leave the profession because she had woken up too many times at three in the morning worrying about whether she had been able to do her job safely. That is what trying to run the NHS permanently in the red zone looks like from a staff point of view.

It is the same situation with NHS performance. We have now reached a point where the health service is no longer able to deliver all that is being asked of it. Mental health bed occupancy rates regularly reach 100 per cent. District nurses are run ragged, trying to cover an impossibly large number of patients. Despite best efforts, for the first time ever last year, all four key NHS hospital performance targets were missed. Waiting lists for routine surgery are the longest for a decade. And

only a handful of trusts are consistently meeting the four hour target in A&E.

Last winter provided graphic evidence of what running in the red zone looks like for patients. Far too many mental health and community services stretched to capacity. Far too many patients stranded in ambulances queuing outside overcrowded A&E departments. Far too many twelve-hour trolley waits in busy corridors. Too often, patient safety is being put at risk.

The trust leaders we represent – the people who are responsible for providing frontline care to a million people every 36 hours – are clear what they need to offer the safe, high-quality care we all want the NHS to provide.

Firstly, honesty and realism about what can be delivered with the funding available. Trusts want to deliver the performance standards set out in the NHS Constitution, but they can only



The November Budget needs to set a clear plan for NHS delivery

do this if they are properly funded to meet those targets. Their leaders are not magicians; they cannot deliver the impossible. So the November Budget needs to set a clear plan for the rest of this Parliament which matches NHS delivery expectations to the money available.

We must also, as a matter of urgency, come up with a clear strategy to address the workforce challenges that trust leaders now say are their biggest problem. That includes a plan to end pay restraint, and much-needed reassurance and clarity for the current and potential future NHS workforce on what happens after Brexit. Above all we need urgent steps to fill gaps in the current workforce and an affordable long-term strategy that sustainably matches workforce supply to likely future demand.

Finally, we should support the NHS to deliver the transformation in care

that is required to meet the growing and changing needs of our society. That means putting greater emphasis on preventing ill health and ensuring wellbeing. It also means delivering much more care closer to home so hospitals are used only for those who require acute care. We need a better integrated health and care system where different elements – community, mental health, ambulance and hospital services, GPs and social care – come together to serve the needs of the population.

It is painfully clear that the NHS is now running in the red zone. We need national NHS leaders to acknowledge this is simply unsustainable. As the health service nears its 70th birthday, now is an opportune moment to make the big decisions which are urgently required to reach calmer waters, and bring that pressure dial round to “safe”.

A long-term vision for life sciences

Developing the synergy between the government and the life sciences industry is crucial to maintaining a world-class NHS, according to Erik Nordkamp, managing director of Pfizer UK

Our National Health Service is 70 years old next year. For all but five of those early years, Pfizer has been an active partner to the NHS, developing new medicines and working collaboratively to ensure patients have access to some of the very best treatments in the world. By working together on a new sector deal between the government and life sciences industry we are confident we can continue to deliver for Britain over the next 70 years as well.

In our near seven-decade relationship together, we have discovered, developed and delivered medicines here which have improved and saved the lives of millions of people around the world. To put it into context, nine million patients across the NHS now take a Pfizer medicine every year. That's equivalent to the entire population of London. Working in collaboration with both UK universities and the NHS, our scientists have achieved transformational outcomes; including mass-producing penicillin in the 1950s.

American life sciences companies like ours invest £1.2bn in Britain each year, employing more than 14,000 highly skilled workers at more than 40 manufacturing, research, packaging and commercial sites across the country. We need to be honest, though, about the challenges the NHS faces and how we address them. The NHS is a very different organisation to the one imagined by Aneurin Bevan in 1948, and so too is the way the life sciences industry makes medicines. The NHS is bigger, handles an increasingly more

complex workload and is much more reliant on technology than ever before. It is also facing an unprecedented squeeze on its finances, as leaders figure out how to deliver universal health care to an ageing population. Global innovators like Pfizer are increasingly developing personalised medicines for individuals or smaller groups that tackle specific subsets of disease, using science and data unimaginable to our forebears in the 1950s. This dichotomy in priority and process means patients risk not having access to the very best medicines in the world, with the NHS more unlikely to adopt the next generation of medicines on the grounds of cost effectiveness.

Analysis commissioned by Pfizer carried out by management consultants PwC Strategy& shows that UK patients are prescribed up to 75 per cent less new medicines by volume per capita in their first year of launch compared to those in France, Germany, Japan, Switzerland and the United States. We believe Britain can reverse this trend by capitalising on a precious opportunity to put patients first and make the UK first for life sciences post-Brexit. This can only be achieved, though, if we reset the relationship between the pharmaceutical industry and government; a relationship that enables a sustainable, world-class NHS, and supports a vision of Britain as a global leader in life sciences.

Through commitment to the NHS and industry partnerships, we would be able to transform care and patient outcomes, improve patient access to medicines and ensure a sustainable and controlled NHS medicines budget.

A new deal focused on innovation will give the industry the confidence to keep investing here, supporting tens of thousands of jobs, as well as continuing to help universities, smaller innovators and start-ups. Pfizer and the international life sciences industry are embedded in the history of the NHS. By working together we can continue to deliver for patients, the NHS and Britain for the next 70 years and beyond.

For more information, please visit: www.pfizer.co.uk

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New Zealand and the Netherlands have lessons for the NHS

Dr Stephen Dunn, chief executive of West Suffolk NHS Foundation Trust, has found valuable lessons in other nations' approaches to healthcare planning

Three years ago Chris Ham from the health policy think tank, the King's Fund, came to Bury St Edmunds to discuss West Suffolk's strategy for the future. I had just been appointed as chief executive of the West Suffolk NHS Foundation Trust, and at the time we were unclear whether we needed to evolve into a hospital chain or pursue a strategy of community integration. The diagnosis then, as it is now, was that our problem was not quality or efficiency, but our ability to effectively meet the rising demand of a largely ageing and affluent population. Chris urged us to take action and to learn the lessons of integration from around the world, particularly the experiences of Canterbury, New Zealand.

The King's Fund has recently published an update on the health system in Canterbury, following on from an initial review written in 2013, which reflects on the implications for the new models of care being developed across England and for sustainability and transformation partnerships (STPs). This report gives me hope for five reasons. First, because it is realistic. The

Canterbury system has slowed the demand for acute hospital care; it has not reversed it. We can't bury our heads in the sand believing that we can reverse the rising tide of an ageing population with multiple long-term conditions. What is more, the transformation doesn't happen overnight; the NHS five-year forward view might need a contract extension!

The experience from New Zealand also makes clear that we shouldn't divest away from acute hospitals but rather work differently in an alliance with health and care community and primary care services. We are working to develop an alliance to run community services on a locality basis, partnering with the county council, the GP federation and a provider of mental health service. This is a new form of contracting that parallels the Canterbury experience.

Second, the report emphasises the importance of shared goals and aligned incentives. In Canterbury they unified behind the "one system, one budget" mantra. For the last couple of years we have had a block contract with West Suffolk Clinical Commissioning Group (CCG) with an agreed health and care





This is a new form of contracting

vision that has been endorsed by our health and wellbeing board.

Sometimes our regulator wonders whether we are trying to buy integration by putting ourselves on a block contract. But there is only a finite amount of money for our local population and we might as well work with the CCG and other local providers to make the Suffolk pound go that little bit further. This is a key lesson from Canterbury. And it would help if the regulators came to a common agreement on how to establish and police a one-system budget.

Third, the report highlights the need to invest in leadership and in improvement science and new technologies across health and care. In Canterbury, 80 senior staff participated in the Xceler8 programme, which embedded management techniques such as Lean and Six Sigma across the health economy. We are beginning to do something similar in West Suffolk. We have begun our first system leadership days and have a focus on becoming a health and care digital exemplar on the back of the successful launch of our new electronic patient record, e-Care.

Our objectives are to become (as far as possible) a paperless hospital, a paperless health and care system, to upgrade our hardware and to share our experiences with the NHS. This summer we have been connecting our e-Care system to primary care as well as getting our different electronic health systems to communicate with each other. This is only a start to sharing information and developing a population health focus. But it's clear from Canterbury that this investment should pay dividends.

Fourth, the report showcases new models of care, especially around community rehabilitation and enablement. In Canterbury, the community rehabilitation enablement and support team offers community-based rehab to older people to avoid admissions or get people home more quickly. The report seems to suggest that these teams are made up of nurses, occupational therapists and physios.

On the face of it, I think we are going

further. We have set up an early intervention team (EIT) which has nurses, occupational therapists and physios, social workers, third sector volunteers – such as Age UK – paramedics and care workers. This is making a huge difference and helping us manage demand. This multidisciplinary focus on doing what is needed to get people back on their feet and in their homes or in their community has to be the way forward.

The experience of Canterbury also emphasises the importance of pathway experimentation. Together with partners across West Suffolk, we are recruiting one of the country's first "Buurtzorg" teams to test a Dutch model of integrated health and personal care. *Buurtzorg*, which in English means "neighbourhood care", advocates the use of highly qualified nurses to deliver dedicated personal and health care to patients in a neighbourhood. The nurses work in small, self-managed teams to deliver holistic care, working alongside their formal and informal networks to allow individuals to stay in their homes and communities for as long as possible.

In the Netherlands, the *Buurtzorg* model has led both to higher levels of satisfaction and significant reductions in the cost of care provision by providing early detection of problems, increasing quality of life, reducing longer term care needs and reducing hospital admissions. To me, this report says the NHS five-year forward view and what we are doing locally are the right sort of things. Aligned incentives, investing in leadership, new pathways and new technologies result in marginal improvements and marginal gains that will help slow the growth in the demand for health and care services. But, and this is my fifth takeaway: without strong relationships and strong staff engagement, none of this is possible.

Another version of this article was written in response to a report published by the King's Fund in August 2017. It can be found at: www.kingsfund.org.uk/publications/developing-accountable-care-systems

Patients, not profit, must be the priority



Local health services and treatments must not be viewed as simply numbers on a spreadsheet, argues

Layla Moran, Member of Parliament for Oxford West and Abingdon

In my nearly four months in Parliament, I've realised that throwing accusations about which party has allowed the private sector to encroach more on the NHS is a weekly staple of Prime Minister's Questions. But grandstanding and political posturing in Westminster aside, it is the real-life impact on patients and staff that I want to understand. People in my constituency are currently feeling the impact of our local physiotherapy and orthopaedic triage services moving from a public to a private provider. The company that has taken up this contract argues it will be able to offer a more patient-centred service. That remains to be seen. My concern is the terms of their new contract will see the number of sites where the services will be provided cut from 13 to nine, including the discontinuation of the treatment at Abingdon Community Hospital in my constituency. Furthermore, the transition has been botched with appointments being cancelled at the last minute and people

not having the continuity of care they were expecting.

The primary motivation to privatise is usually to save money, and private companies must therefore bid lower than the existing provider to secure contracts. However, these companies also have a duty to return profits to their investors and the resulting squeeze exerts a downwards pressure on accessibility and quality of care. Wouldn't we be better off keeping the expertise in the NHS while allowing innovation, instead of allowing public money to be creamed off by shareholders?

Which brings us to the thorny issue of money. It is no secret that Clinical Commissioning Groups across the country are facing massive deficits and Oxfordshire is no exception; last year the local overspend was £24m. Various cost-cutting measures have already been put in place including closure of beds in acute wards at the John Radcliffe in Oxford. I'm worried beds at my local community hospital in Abingdon will



“The NHS is one of the jewels in the British crown”

be next to go.

In response to a letter I wrote during the election querying changes occurring as part of the local Sustainability and Transformation Plan, the chief executive of one of our local NHS trusts confirmed to me that cost saving was certainly one goal. He then went on to say another was innovation and that all changes will protect patient safety and quality of care.

Clearly, there is pressure to reduce spending; whether this can be done on the scale planned without adversely affecting quality and safety is the key question for my constituents. The answer, we are told, is to shift resources from hospital care to primary care; and from treatment of patients when they are ill into disease prevention. To achieve this, we must change our hospital services, reducing the reliance on bed-based care and treating more patients on an outpatient and day care basis.

Great idea! But hold on, we seem to have already started the hospital closures and service cuts before building capacity

in the community to provide this care. The idea is sound, but without the necessary investment in the community, it is leading to patients being stuck in the remaining beds and cancellations of elective procedures leaving many in chronic pain for much longer than is humane. And while I am all for new ways of doing things, and even better if they cost less for the same quality, I am now increasingly convinced that there will not be a way to maintain safety, quality but also, crucially, accessibility.

So, what should we do? I freely admit that I do not have the whole answer but I'm not sure that anyone does, and I'm certain that Mr Hunt doesn't. What I do know is that I am sick of successive governments blaming the last. And I know from the thousands I spoke to in the election and see in my surgery that I'm not the only one.

That's why the Liberal Democrats are calling for all parties to come together and agree a long-term settlement for the NHS and social care that puts patient care, not political point-scoring, first. We were honest in the election that to fix the immediate issues, we'd propose a penny on income tax to fill the financial shortfall. But we also propose a cross-party commission to devise a long-term vision that looks beyond the electoral cycle. This would be combined with an arm's length body, such as the Office of Budget Responsibility to be honest about the financing of that vision. Would that include rolling back on the scale of privatisation? I bet it would, because it's a waste of money. And tax rises? Probably. But the point is it would stop the NHS from being used as a political football by all parties and do what needs to happen most: that we agree a tangible solution to how we protect one of the jewels in the British crown.

We face huge challenges ahead. An increasingly elderly population, more expensive lifesaving drugs, a stagnating economy and the Brexit bombshell ticking away in the background like Captain Hook's crocodile. But our NHS is the envy of the world and despite the challenges it is worth protecting.

Generic medicines and the invaluable role they play

Generic medicines provide better value to taxpayers and better outcomes for patients, writes executive vice president of Accord Healthcare Europe and MENA, James Burt

You may have heard of Pfizer and Roche, but it might surprise you that more UK prescriptions are filled by medicines from Accord Healthcare than by either of those companies. Accord has long been a core contributor to the NHS, supplying high quality generic products at a fraction of the price of branded competitors.

The NHS is facing major funding challenges due to ever increasing demands from an ageing population and rising costs of new technologies.

Generic competition – when a branded product loses patent protection – reduces prices paid by the taxpayer by up to 90 per cent. The British Generic Manufacturers Association (BGMA) estimates that generics save c. £13.5bn per year in England and Wales. The average price to the NHS for a pack of medicine from Accord is under £1.50, meaning access to life-changing drugs for less than a cup of coffee per day.

In 2016, the OECD reported that generics accounted for 84 per cent of the volume of pharmaceuticals in the UK (the highest among EU countries) but that this represented only a third of the total value of those prescriptions. Making more of the most expensive medicines affordable to the NHS by fostering and promoting the launch of new generic medicines should be a key pillar of the government's healthcare strategy. Per wholesaler data, hospital orders for generic medicines are met at a vastly superior rate than branded medicines, where drug shortages are more likely. Increasing the share of generic medicines within the NHS' overall budget not only

saves money, but provides more patients with access to treatment, thereby improving overall chances of recovery.

Accord offers a broad range of over 1,000 different medicines in the UK, to treat a vast array of conditions including cancer, neurological disorders, heart problems and viral infections. Over 230 million packs, one in six of all generic medicines supplied in the UK, are provided by Accord.

Accord has been investing in the UK for over 14 years. In 2016, a large site was acquired in Fawdon, Tyne & Wear which was ear-marked for closure by Sanofi, which Accord renovated and invested in. Partnering with local universities, skilled jobs are being created in Tyne & Wear by introducing new technologies, like effervescent granulation.

Despite the uncertainty around how new generics will be approved and regulated in the UK after Brexit, just this year Accord acquired Actavis UK & Ireland. This c. £600m investment included a manufacturing site in Barnstaple, Devon, securing over 600 jobs in an economically disadvantaged region. Barnstaple is a key component not only in the NHS' supply chain but also in the UK's broader pandemic readiness system, ready to supply emergency drugs at short notice.

The jobs Accord creates and secures are highly skilled in nature. Its manufacturing and research facilities are training graduates and employees in a wide range of technical transferable skills. Engineering UK estimates that for every new job created by STEM companies such as Accord, two more jobs are created elsewhere in the UK.

Accord is working to launch new generic and novel medicines that are not already available in the UK. With the support of a favourable regulatory environment for generics, Accord is committed to not only being at the cutting edge of developing more effective and cheaper treatments for cancer and other chronic diseases, but also turning these innovative treatments into products that can be delivered to patients.

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 The Evolution of Generics

Digital health: Wild West or a new frontier?

Digitalisation of services has the potential to slash costs for the healthcare industry and improve access for patients, writes Julie Bretland, founder and CEO of Our Mobile Health

The UK digital health sector is experiencing a 21st century Gold Rush. In a period of unprecedented growth it is expected to reach £2.9bn by 2018. This growth is predominantly driven by mHealth apps; more than 259,000 health and medical apps are available today. The promise of this new frontier is appealing. In the UK, the NHS' Five Year Forward View anticipates the benefits of digital and mobile health to address the funding gap, and these were recently highlighted in speeches by Jeremy Hunt and NHS leaders during the NHS Innovation EXPO. With the mounting pressure on health systems, apps offer a valuable, patient-centric intervention that brings tremendous potential benefits for us as individuals and for the healthcare system in terms of improved health outcomes and cost savings. mHealth could save €99bn in healthcare costs across Europe by 2017. For patients and health professionals, quality digital health apps are convenient, accessible and patient-centric interventions that can be used alongside or in some instances even instead of medicines or other therapies.

As app developers rush to create new and innovative ways to help people to lead healthier lives, there is a danger that the digital health space becomes like the Wild West. With so many apps available and new ones coming to market all the time, healthcare providers (HCPs) and patients face the challenge of finding quality interventions in amongst the hundreds of thousands of apps available.

Our Mobile Health has created an assessment framework to evaluate digital

health apps so that HCPs and patients can use them with confidence. Our process ensures they are safe, effective, engaging interventions. Our framework combines expertise from the digital world and peer review, and goes beyond a regulatory review to also look at best practice and indicators of effectiveness. We work in partnership with app developers and health organisations within and outside of the NHS to assess and curate digital health apps, so healthcare providers can confidently recommend, deploy and socially prescribe digital apps.

Law and order is one thing but how does digital health go from being the new frontier to an established part of today's healthcare ecosystem? Today, 90 per cent of the UK population report using the internet and 80 per cent using a smartphone, with 60 per cent using online banking apps, but less than 10 per cent report have any digital interaction with the NHS. To realise the potential of digital health as a sustainable model of care, it must be integrated into health practice at scale, not simply one app at a time. This requires system-level changes to remove practical and perceived barriers.

To promote adoption of digital health interventions on the scale required, building on the trusted relationship between patients and HCPs is crucial. Research has shown that patients are much more likely to use a health app when it has been recommended by an HCP. For digital health interventions to become commonplace they need to be integrated into the current workflow. As pioneers in the world of digital health, our vision is for all HCPs to be able to access a formulary of quality-assured apps that can be prescribed alongside or instead of more conventional treatments. Though our rigorous app assessment framework, and our partnerships with healthcare providers to develop curated app libraries, Our Mobile Health is creating a path to help make digital health a reality in the UK.

For more information, please visit: www.ourmobilehealth.com

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Dr Philippa Whitford, practicing surgeon and SNP Westminster spokesperson for health, talks about health inequality in Scotland, and why devolution is key to reducing poverty and improving health

More devolution would improve Scotland's health



Good health is not something created by the NHS, which is more about treating and managing illness, but comes from what were described in Professor Marmot's famous report as the "social determinants of health" – a decent start in life, good quality housing, education, a satisfying job and being socially included.

The Scottish government is working to ensure children get a good start in life through various Early Years projects, including the Baby Box which provides every baby with the necessary essentials. The Childsmile dental program has helped tackle Scotland's notoriously bad teeth – reducing children with caries by 24 per cent and bringing the worst area of Glasgow into line with the rest of Scotland; it has even saved £5m in dental treatments. This contrasts with the lack of a preventative dental contract in England, where children are

struggling to access NHS dentists and multiple extractions are increasing.

Housing costs are the biggest financial burden on any family which is why the Scottish Government has invested more in affordable housing than other UK nation; building 33,000 new homes over the last parliament and committing £3bn to build 50,000 during this session. While the SNP Scottish government stopped the sale of council houses in 2016, the UK Conservative government is actually accelerating the process, making it harder for the next generation to even get on the rental ladder, never mind the property one, and increasing the incidence of homelessness.

Often described as the 'sick man of Europe', Scotland has traditionally had higher death rates from conditions such as heart disease, addiction, suicide and cancer. Indeed, cardiovascular disease



causes more than a quarter of all deaths in Scotland and mortality of lung cancer in women has been either the highest or second highest in Western Europe for the past 50 years. This has been attributed to the greater prevalence of smoking and high alcohol intake. But, while we have recently seen increased deaths among older citizens affected by addiction, combined with chronic illness, fewer young people are taking

Scottish life expectancy is two years below the UK

up smoking, heavy drinking or illicit drugs. The public smoking ban in 2006 (the first in the UK) helped get smoking rates below 20 per cent but the Scottish government has been fighting the drinks lobby since 2012 to introduce a minimum unit price for alcohol, which is proven to help tackle alcohol abuse.

While there have been substantial increases in both Life Expectancy (LE) and Healthy Life Expectancy (HLE) for both men and women across the whole UK, marked inequalities remain. With average household wealth in the south-east of England twice that of Scotland there is a ten-year difference in life expectancy between a man from a rich London borough and a man from the poorest area of Glasgow. However, figures published by the National Records of Scotland show life expectancy has improved over the last three decades, increasing by eight years

for men and 5.9 years for women. It is still, however, 2.1 years less than the UK as a whole. From my work on the APPG on Health in All Policies and our inquiry into the impact of welfare cuts, the correlation between poverty and poor life expectancy is clear, and poverty remains the biggest driver of both mental and physical ill health. Indeed, academics estimate that we lose 1,400 children each year as a direct result of poverty due to premature birth, low birth weight, hunger, malnutrition, chronic illnesses, road accidents, house fires, violence, suicide and addiction.

Child poverty has been rising since the Tory government's first welfare cuts of 2012 and stands now at approximately four million. It is expected to reach five million by the end of this decade due to the housing benefit cuts within universal credit, the benefit freeze and the limiting of tax credits to just the

The levers to combat poverty are held by Westminster



first two children in any family. As I highlighted during the Welfare Debate in Parliament, the cynical Tory approach to tackling child poverty is simply to try and redefine it out of existence.

While, disappointingly, the Labour party failed to fight the benefit freeze or welfare cuts in Westminster, the SNP has opposed this Tory government's austerity agenda at every turn. Seven years of austerity have failed to clear the deficit on schedule due to reduced tax take, and cuts to welfare spending have taken money out of local economies. The £1bn of welfare cuts in Scotland persistently hamper the Scottish government's efforts to reduce poverty, as it has spent over £400m since 2013 just to alleviate Tory cuts, including £125m to mitigate the unjust "bedroom tax". Devolution should allow us to enhance our country, not simply clean up the mess made by Westminster.

Newly acquired social security powers allow the Scottish Government to give greater dignity to those in need of support and their child poverty bill is currently making its way through Holyrood. Although 14 per cent of

social security powers and 29 per cent of tax is now devolved to the Scottish Parliament, the Joseph Rowntree Foundation recently commented that, while it is clear devolved policies have gone some way to mitigate certain impacts of welfare reform, there is a strong case for giving devolved nations further tools to address rising poverty. The main economic levers to combat poverty, such as the minimum wage, national insurance, corporation tax and VAT are still controlled by Westminster, which is why the SNP sought to have greater powers devolved to the Scottish Parliament in the last Scotland bill. Sadly, this was opposed not just by the Tory government but also by the Labour opposition.

Poverty is the root of inequality. It is crucial that we see a shift in focus away from dealing with the health and social consequences and aftermath, to tackling the underlying cause. I believe the opportunity to achieve this will only present itself when the Scottish government has full control of fiscal as well as social policy, and can set its own priorities.

Communities can help bridge the social care gap

Social care needs new ideas, writes [Abbie Rumbold](#), head of public services at Bates Wells Braithwaite, and the best of those ideas could come from looking at where, how and with whom people live

This summer's election and the "dementia tax" debacle taught a sharp lesson that meddling with the status quo, despite wide acceptance that status quo is unsustainable, is politically extremely risky. Yet the traditional model of social care provision in this country continues to be under extreme financial pressure from a combination of falling local authority funding, rising wages, reduced labour supply and increased regulation.

So, if paying for care is a problem, politically and practically, we need to look more widely for solutions.

I recently spoke to Neil Woodbridge at Thurrock Lifestyle Solutions CIC, which provides services for adults with disabilities. Quizzed on how he was able to deliver impressive and much-needed savings while still providing exemplary support, he said: "We use community networks." Woodbridge says TLS CIC is founded on the concept of community solutions, using disabled people as experts by experience, and has developed ways of supporting people in lifestyles of choice in their own communities. They refer to interdependent, not independent, living – recognising that the word "independent" is often misunderstood when talking about disabled people living in communities. The TLS CIC team works with individuals to map out those interdependencies and so provide support that harnesses the power of communities.

Brendoncare, a national care provider, is moving in the same direction. It is developing a shared care project which will allow couples where one partner has dementia to live together in a supported

community. By doing so, it will support the huge contribution made by unpaid carers and importantly make such arrangements more sustainable. It also means that as needs rise, the care package can seamlessly change without the often distressing need to relocate.

Both these models aim to support existing community – and family-led models of care, and as a result are financially sustainable. Most importantly they are, surely, what all of us would want if we were the recipients of care.

But if we are really to tackle the conundrum of delivering health and wellbeing in these financially constrained times, we need to look at a much wider portfolio of services.

As they struggle to make ends meet, councillors and senior council executives begin to wonder how necessary it is to invest in "other services" – libraries, parks, theatres, museums, galleries and leisure centres. Do such services really meet the needs of the community or are they, in these difficult times, a luxury? Evidence shows that it is precisely these sorts of services that can make a significant and financially sustainable contribution to our health and wellbeing. There are countless "non-health" organisations that deliver health services whether they are garden nurseries providing therapeutic employment, heritage organisations providing dementia-friendly trails or leisure centres providing stroke rehabilitation.

Such services should be at the heart of our communities, working with residents and organisations to deliver co-ordinated, financially sustainable solutions. We know people thrive when they are part of their communities and communities thrive when they care for the vulnerable. Discussions of the challenges faced by the NHS should look at how we harness the power of communities and the resources local authorities can bring to bear, beyond the adult social care budget. As Wendell Berry – a poet, not a lawyer – said: "The community... is the smallest unit of health... to speak of the health of an isolated individual is a contradiction in terms."

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