INCISIVE HEALTH

Getting what we pay for

Building the long-term plan for world class health and care services

July 2018

Introduction

The NHS turns 70 this year. Public pride in – and political support for – the service remains strong, yet the challenges facing health and care services have rarely been so pressing, or so high profile. The winter of 2017/18 was one of the most challenging in the NHS' history[1] and many important indicators – including health outcomes, operational performance, finances and staff morale[2] – continue to suggest a service that is struggling.

In this context, the Prime Minister's commitment to a long-term NHS plan – supported by an enhanced funding settlement – is both welcome and necessary. The recent funding announcement for NHS England has given us a better understanding of the resources that part of the health and care system will have available in the years to come, if not yet the entirety of the system. Yet funding is only one element of what is required, and recent history shows us that bold claims about NHS funding can mean very different things to different stakeholders, with significant implications for the ability of NHS services to deliver on aspirations.

The context for the NHS is that, although the system is seen as efficient, fair and accessible by international standards, the health outcomes it delivers are poor for conditions, such as cancer. Addressing this outcomes gap must be a key challenge for the NHS, as it develops plans for the future.

In order to inform discussions about the resources required to sustain and improve health and care services, the vision that should guide the use of additional resources, as well as how this vision can be translated into reality through the long-term plan, Incisive Health brought together a range of experts from the health sector for a series of three roundtables. These included suppliers to the NHS, service providers, health charities and research organisations. A list of the organisations represented at the discussions is included in the Appendix.

Each roundtable was introduced by opening thoughts from our Senior Counsels, Richard Douglas and Professor Sir Mike Richards. This report summarises the ideas that emerged and sets out:

- The reasons why increased financial headroom is so important for creating the circumstances to build a sustainable NHS
- The key questions that are likely to be considered as part of the development of the long-term plan
- The ways in which the long-term plan could be delivered

The report is based on the discussions which took place, but it does not necessarily represent the views of any particular participant. We hope it is a useful contribution to the debate about the new plan for the NHS, as well as how it should be implemented.

Investing in improvement, not paying for failure

Recent increases in NHS spending – although higher than those experienced in many other public services – fall some way below historic rates, or indeed the rates of growth experienced in other countries.[3] Since 2010, health spending has risen at around 1.2 per cent a year in real terms, compared to an average rate of 3.7 per cent over the history of the NHS.[4] This has not been sufficient to meet the demands on the NHS, which are currently growing at around 3 per cent per year.[5]

The challenge in healthcare is that it is very difficult to reduce costs to meet constrained budgets. Many costs – staff wages and buildings – are essentially fixed and much expenditure is in response to health need, which cannot be controlled in the short-term. The result has been increasing NHS deficits, which require short-term injections of cash[6] to make the books balance.

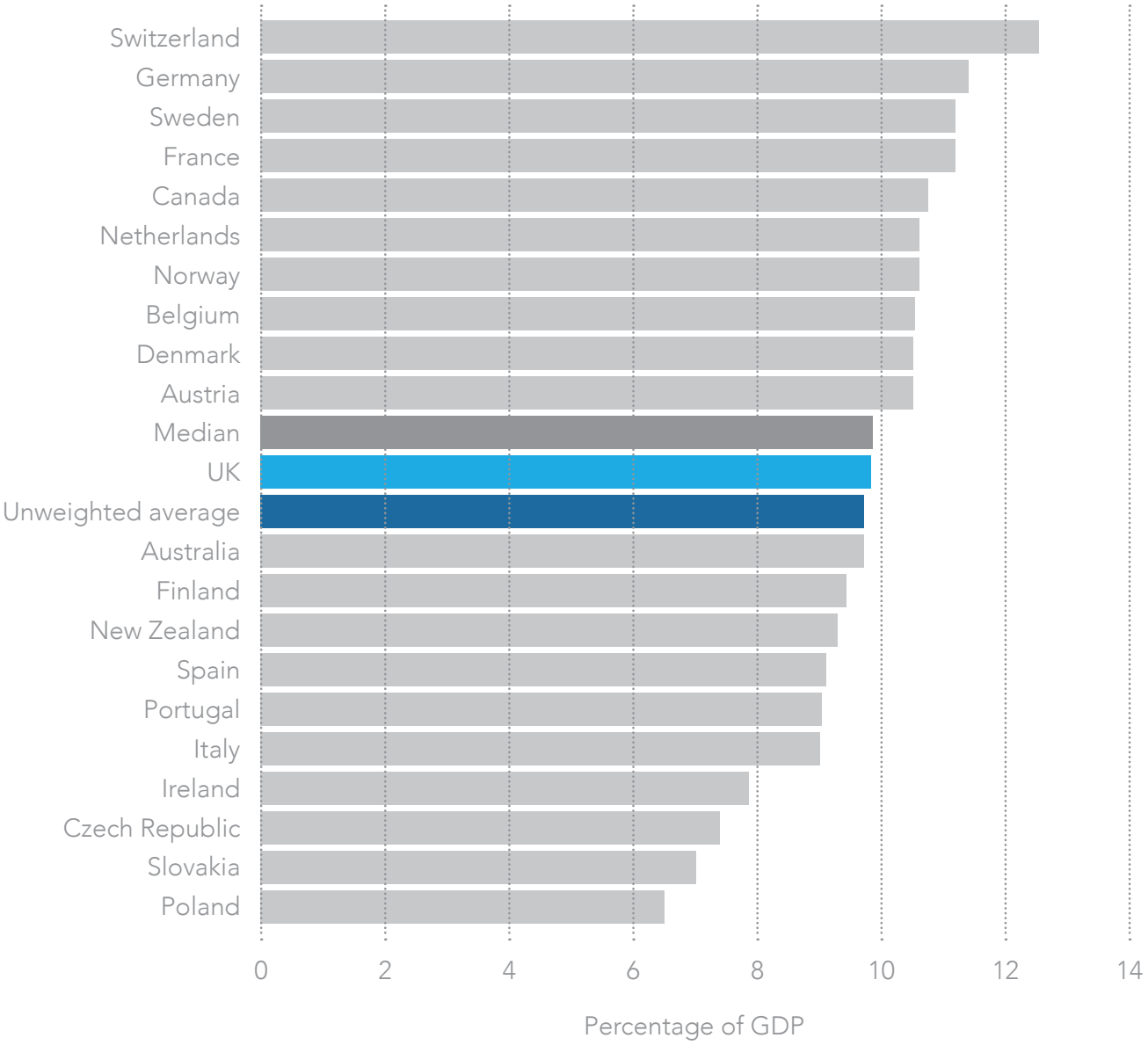
In effect, the taxpayer has ended up with the worst of both worlds: having to bail out distressed hospitals without providing health services with the financial headroom to introduce changes which might improve health outcomes and avert further financial pressures.

Participants in our discussions were unanimous that such a situation cannot continue. Instead, money needs to be made available to invest in improvements to health services and the outcomes they deliver, and not simply released to pay for the costs of failure to manage within an inadequate budget. This is a position which has now ostensibly been accepted by the Government:

> "…I do want to come forward with a long-term plan…The Government will provide a multi-year funding settlement in support of the plan, consistent with our fiscal rules and balanced approach, but ensuring that the NHS can cope with the rising demand ahead of the spending review."
>
> Theresa May, March 2018[7]

The context for reassessing health funding is that expenditure on health and care services in the UK (9.7 per cent of GDP) is some way below that in other high-income countries like Sweden, Germany and France, which spend 11 per cent or more of their GDP on health and care.

Total health spend as share of GDP 2016
Source: OECD



If the UK was to spend as much on health as Germany next year, for example, the budget would need to grow by a minimum of £30bn.[8] This discrepancy in expenditure also translates into differences in the provision of services. A recent analysis of health care spending in 21 countries[9] shows that the UK has fewer doctors and nurses per head of population than almost all the other countries, despite spending 65 per cent of its budget on staff. The UK also has fewer hospital beds per head of population than nearly every other country considered (except Denmark and Sweden) and spends considerably less on medicines.

Although it may be unrealistic to bridge the spending gap with countries such as Germany in the short-term, think tanks and other informed commentators have suggested that an increase of 3.3 per cent is required over each of the next 15 years simply to maintain standards at current levels.[10] An increase of over 4 per cent would be required to modernise and improve services.

The Government's funding announcement goes some way towards providing the increased funding and the longer term certainty that experts believe is required. The headline announcement was of a 3.4 per cent real terms increase per year for NHS England until 2023-24, frontloaded to 3.6 per cent in 2019-20 and 2020-2021.

Politically, this has two important benefits for the Government:

- Enabling it to claim that it is going beyond the 'Brexit dividend' promised during the referendum campaign
- Bringing NHS funding virtually into line with the long-term average increases in expenditure

However, there are still significant areas of uncertainty:

- The announcement only relates to NHS England revenue spending. As yet, there is no clarity on what will happen to other aspects of health spending, including capital expenditure, funding for medical training, public health, research and development and other activities funded by the Department of Health and Social Care. The Department of Health and Social Care has indicated[11] that these will be 'protected,' but whether this extends beyond a real terms freeze has yet to be determined
- The settlement for social care has not yet been made, but the quality of social care provision clearly impacts upon the need for healthcare
- The fiscal measures to pay for increased NHS expenditure have yet to be agreed and could have an impact on NHS costs, making the settlement less generous in practice

The funding settlement clearly represents a substantial increase on the funding provided in recent years. Whether it delivers the magnitude of increase deemed necessary by experts or falls some way below this will in large part depend upon how the uncertainties set out above are dealt with.

Clarity is unlikely to be provided on these issues until the 2018 Budget at the earliest and some aspects of health expenditure may need to wait until the Spending Review before budgets are confirmed.

Importantly, the settlement announced for NHS England is provisional and is contingent on the NHS developing a long-term plan which attracts the confidence of HM Treasury.

Creating the new long-term plan

The commitment by the Prime Minister to bring forward a new plan and funding settlement for the NHS presents an opportunity to create a long-term vision for health and care which will excite politicians, policymakers and the public.

In developing this vision, it is important to consider what different decision-makers will want to see. From the perspective of HM Treasury, it will be important to demonstrate:

- Evidence that the NHS will live within its means and that any longer term settlement will not unravel
- A firm commitment to meet operational standards and deliver on the rights and pledges within the *NHS Constitution*
- A plan to deliver on commitments, with much greater emphasis on the 'how' than at the time the *Five Year Forward View* was agreed

From the perspective of health ministers, it will be important to demonstrate:

- Evidence to underpin new policies
- A coalition of support among key stakeholders, which will ease the political path to implementation
- A focus on the future, with a clear analysis of how the health needs and expectations of the population will change, as well as how the NHS should respond
- New thinking, with clear and compelling responses to the big challenges facing the NHS, as well as the opportunities identified to improve quality and efficiency

Creating a single united vision for the future of the health and care system as part of the long-term plan which meets all of these expectations is challenging. Our discussions identified a number of elements that could be considered as part of the process of its development, including:

- Efficiency
- Technology
- Innovation
- Workforce
- Data
- Primary care
- Social care
- Late diagnosis

These are explored below in turn.

Efficiency

Ministers will expect to see further action on efficiency and releasing cost savings. However, there is recognition that many of the incremental efficiencies have already been found. Instead it will be important to look at:

- Efficiencies at the boundaries of organisations – improving the way in which different institutions transact and ensuring that patients are able to move between organisations in a streamlined manner
- Strategic relationships – moving beyond transactional relationships with suppliers to enable greater partnership working to address shared challenges
- Encouraging devolution of responsibility within and between professions, where this can be clinically justified

Through our roundtable discussions it was agreed that clinical conservatism can sometimes prevent the NHS from decommissioning services which have been rendered obsolete or which are not delivering good value. In order to address this, it will be important to bring clinicians into the compact supporting a new vision. This means showing how:

- Services will directly benefit from changes
- Investment in new treatments, technologies or staff are linked to decisions to save elsewhere
- Improvement in outcomes rather than just changes in activity will be rewarded

In addition to fostering consensus, there will be times where disruption is required. The use of independent sector treatment centres in tackling long waits in the 2000s was cited as an example.

Technology

The greater use of technology to deliver healthcare and to streamline clinical processes will be a theme of any future vision. However, it will be important that there is a genuine strategy – rather than just a shopping list – to guide action on technology. This should seek to answer the following questions:

- What changes would benefit patients and, given changes in other areas of society, what changes will they expect?
- How can technology help us deliver more timely services to more people at a time of workforce scarcity?
- Where can technology free-up skilled professionals to focus on the more complex and relational aspects of care?
- Are there particular groups who could benefit more from technological solutions and, if so, can we create a specific offer for them?

Encouraging innovation and enabling its uptake

It will be important that a future vision for the NHS is carefully linked with the *Life Sciences Industrial Strategy*, and that it:

- Embeds research and development within the NHS
- Identifies the most significant innovations and ensures that NHS patients receive the earliest appropriate access to them
- Enables the rapid adoption of new technologies where these can benefit patients and / or improve services

The timelines for negotiating the next medicines pricing agreement – the Pharmaceutical Price Regulation Scheme (PPRS) – align with those for delivering a longer-term funding settlement. It will be important that discussions on both align and that the next PPRS is seen as an instrument for delivering high quality treatments which improve outcomes within an affordable and predictable budget.

Workforce

Many of the workforce challenges facing health and care services cannot be addressed in the short-term, based on the existing model of care. As set out above, technology and devolving responsibility within and between professions could offer partial solutions to this challenge. However, it will be important that this process is clinically-led wherever possible. We need to ask the following questions:

- What workforce will we need in 5-10 years' time? How will this differ from now and why?
- What aspects of their jobs would different groups of professionals be happy to devolve or stop and how can we facilitate this?

Data

The potential of NHS data to improve research, service delivery and efficiency has been much discussed. However, the barriers to access and usage remain. A new vision should set out how data will be better used and by who, as well as how privacy and confidentiality will be maintained. In doing so, it will be important to articulate the anticipated benefits for:

- **Patients** – how will the sharing of data deliver practical benefits for the people who provide it?
- **Clinicians** – how will the collection of data improve the quality of treatment both now and in the future, and how will it not get in the way of everyday care?
- **Society** – how can we show how health data is being put to good use, improving care and saving money?

Rethinking primary care

A new offer for primary care may be needed to overcome some of the extreme workforce challenges facing the sector. Opportunities to consider include:

- **Self-care** – more can be done to encourage people to self-care for minor ailments, whilst being careful not to erect barriers for those who do require medical assistance. Community pharmacy could play a greater role in encouraging self-care
- **Disruption** – the example of community pharmacy shows how delivery models can be changed to better support people with repeat prescriptions while taking costs out of the system and potentially free-up skilled professionals to work in different settings
- **Devolution of professional responsibilities** – nurses, pharmacists and social prescribers could be empowered to take on some responsibilities from GPs, freeing-up GP time to focus on patients with more complex clinical needs
- **Technology** – remote care could be used to increase the accessibility of primary care services for some groups in society

Social care

Any strategy for the NHS which ignores social care will fail. There are two key challenges to developing an integrated strategy:

- The social care green paper development process is currently separate from the Prime Minister's pledge to bring forward a new plan for the NHS
- Much of social care policy and delivery remains the responsibility of local authorities, which are separate from the NHS

Given the legislative pressures created by Brexit, the Government is unlikely to contemplate a radical change to this divide. Ministers will, however, be looking for ideas to join up, or at least align the incentives for, delivery and funding.

Late diagnosis

Issues with late diagnosis seem to be endemic across many different conditions. For example:

- Approximately 40 per cent of HIV patients are diagnosed late, when their disease has already progressed[12]
- Approximately 30 per cent of dementia patients remain undiagnosed[13]
- Approximately 24 per cent of cancer patients are only diagnosed after an emergency presentation,[14] when their disease is more likely to have spread and outcomes are poorer

Late diagnosis is bad for patient outcomes and costly for the NHS, often requiring more intensive and expensive interventions than would otherwise be the case. Many participants in our discussions believe that late diagnosis – which often prevents patients from accessing the best treatments – are major explanation for comparatively poor outcomes.

Challenging a 'culture of late diagnosis' could be an ambitious but inspiring goal for a future vision for the NHS, encompassing many of the issues discussed in this paper, including:

- **Data** – using intelligence gathered from NHS patients to target early diagnosis interventions
- **Technology** – applying new technologies to increase the accessibility of primary care services and to better identify potential signs and symptoms of ill health
- **Workforce** – addressing capacity shortages by devolving some tasks to other health professionals
- **Primary care** – rethinking how people can access primary care services when they have symptoms they are concerned about

There are clearly links between many, if not all, of these areas. A key challenge for the Government, NHS and other stakeholders will therefore be to create a vision that speaks to the shared opportunities and addresses the common challenges in these areas.

Delivering the new long-term plan

If a compelling vision is required to appeal to the public, mobilise stakeholders and reassure the Government that the NHS is an 'investable proposition,' then it will be equally important to have a clear process for delivering on the vision as part of the long-term plan.

The first task for delivering the new plan will be to demonstrate that the NHS is back on track. This means being clear about the steps to:

- Eliminate overall deficits, ensuring that the NHS will not require further bailouts
- Deliver on the core performance targets, notably for A&E attendances, cancer waiting times and elective treatment
- Improve outcomes for key diseases, so that they are comparable with the best in the world

It will also be important to ensure that focus and momentum are not lost once the strategy is set. Participants argued that *Delivering the NHS Plan* was more significant than *The NHS Plan* itself in that it created the structures and mechanisms, as well as introducing the disruption, required to enable delivery of the shared vision set out in *The NHS Plan*.

Given the legislative constraints created by the hung Parliament and Brexit, it would be challenging to introduce new legislation to underpin delivery mechanisms but, nonetheless, it will be important to set out in some detail how local areas will be expected to work together to deliver the plan.

Beyond 'rewiring' the system to deliver the intended changes, there will be a number of important enablers for delivery, including:

- Building capability and capacity for transformation
- Encouraging collaboration to enable disruption
- Creating broad support for change
- Using a disease-specific focus to drive system-wide change

Below we set out the importance of these enablers in more detail.

Building capability and capacity for transformation

Transforming services requires particular skills, as well as capacity. Unfortunately, financial pressures have eroded these. A key question for the NHS is whether, in its current form, it has the capability and capacity to deliver transformation of its services.

Restoring this capability and, crucially, building capacity for the NHS to transform is vital. To do so, it will be important to:

- Improve how we recognise and spread good practice across the system
- Encourage a culture of learning, improvement and spread of good ideas amongst clinical teams
- Recognise the value delivered by non-clinical NHS roles, including by investing in back office functions and systems that can deliver more efficient processes and free-up clinical time
- Instill a system-wide focus on outcomes improvement – informed by an ambition to make NHS outcomes the best in the world
- Create and invest in clinical networks to plan services across larger populations, encourage collaboration and integration, and identify and act where improvements are required

Encouraging collaboration to enable disruption

Change can occur through a combination of collaboration (encouraging people to work together to introduce changes) and disruption (introducing changes which challenge the status quo).

Transforming services in a sustainable way is difficult even with the support of the workforce. Without support it can be impossible. Yet, in many NHS organisations, there is a sense of 'transformation fatigue'.

The proposed 'NHS Assembly' has the potential to help address this transformation fatigue, ensuring NHS staff feel a sense of engagement in, and ownership of, planned changes. However, it will be important that the very real need for collaboration does not lead to complacency and the rejection of disruption. Instead, an approach of 'collaborative disruption' should be adopted. This will mean:

- Agreeing the areas of health and care where services are not currently working or where staff shortages are creating unsustainable pressures
- Identifying the areas of the service where staff feel they can make the biggest contribution
- Developing disruptive interventions or technologies to fill the gaps

This approach could avoid some of the destructive stand-offs that have inhibited service change in recent years, where staff have felt that changes have been imposed against their will rather than in response to their concerns.

Creating broad support for change

Of course, support for change must go beyond NHS staff. The public and patients must not perceive changes as being imposed on them because of financial pressures, but as a considered response to meaningful engagement which has identified priority areas for action.

Stakeholders such as charities, providers of health services, researchers and life sciences companies can all play an important role in helping design the changes that are required and then communicating the benefits that they will bring.

Using a disease-specific focus to drive system-wide change

The lens through which change is communicated can also have an impact on how it is received. Too often the health service has communicated change using an abstract 'system' language which has little meaning or relevance to people's own experience of health.

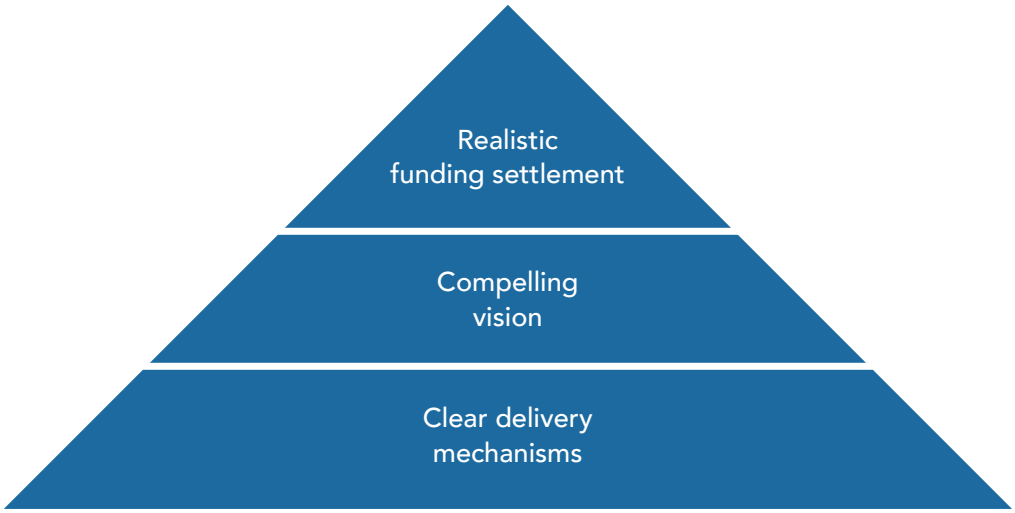
People – patients, the public and clinicians – often relate to a service for a specific disease or medical condition. If this is the case, then it may be important to articulate and deliver change in that context, even if the ultimate objective is to deliver system-wide change. So, for example, change may be delivered through exemplars of improved outcomes in cancer, mental health, stroke or dementia services and then applied more broadly.

Conclusions

A successful plan for the future of the NHS in England will require a realistic funding settlement, a compelling vision for how additional resources will be used, as well as clear mechanisms to ensure delivery.

The new funding settlement for the NHS is therefore extremely welcome. Whilst it may not deliver in entirety the increase which many experts believe the NHS will require, it does represent a material improvement on the previous settlement.

The task now is to use this funding to create and deliver a vision for health and care in England that will be both financially sustainable and achieve the world class outcomes that politicians and the public rightly want to see. Our roundtable discussions were an attempt to stimulate new thinking and collect ideas on what that vision should be, as well as how it should be delivered. This report shows that there is no shortage of ideas or enthusiasm. If these can be captured and applied, then the future of the NHS will be bright.



Appendix

Organisations represented at roundtable events:

- AbbVie
- The Association of the British Pharmaceutical Industry (ABPI)
- Allocate
- Alzheimer's Society
- Bayer
- Breast Cancer Now
- Cancer Research UK
- Gilead
- General Medical Council
- Incisive Health
- MSD
- Novartis
- PAGB (Proprietary Association of Great Britain)
- Pfizer
- Pharmacy2U
- Roche
- Shire
- Stroke Association
- Vertex

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