

# Redefining the UK's Health Services

Monday, 30<sup>th</sup> November –  
Tuesday, 1<sup>st</sup> December 2015

REPORT



*The state of man does change and vary,  
Now sound, now sick, now blyth, now sary,  
Now dansand mirry, now like to die:-  
Timor mortis conturbat me.<sup>1</sup>*

## Introduction

In intensive care, neonatal care, oncology, and other areas of the NHS, professionals are having similar grim conversations: **the system is not delivering best value for good population health outcomes**, at the same time that funding, amid contrary reports, is dwindling in relation to need.

It is not so much about waste and efficiency, though these are continually important, as about intelligently allocating limited resources for best *health* outcomes across the nation.

**'Health' is not 'survival'**. Up to half of babies born extremely preterm will die after prolonged intensive care. A significant proportion of the remainder live their lives with severe mental and physical impairment – at great emotional cost to families, and fiscal and other costs to society. Paediatric intensive care is generating an increasing population of technology-dependent children with no prospect of independent living or quality of life. Many late-stage cancer patients suffer extraordinary torment – the right word – for a few more weeks precariously alive. The frail elderly, often with multiple disease states, are routinely sent to Intensive Care Units (ICUs) – the majority of those admitted as an emergency remaining physically incapacitated, and the minority returning to independent life at home. Such care can itself involve physical and mental suffering, as well as great cost. Much of this disease burden is entirely preventable, yet preventive and public health measures which would make a real difference to quality of life are not seen as a priority for investment. The same is true of palliative care. True, medicine achieves rising survival rates and individual miracles. Overall, though, it is not so clear that our health service delivers as much better 'health' as it could and should on its limited resources.

If money were no object, some ethical decisions could be made differently. But resources are not only limited – in the face of rapidly increasing need in the UK, they appear less than necessary even to maintain the status quo. So must we now do less activity, but of higher value? If so, how do we make the inevitable hard decisions about what such 'value' is?

We do have a good health system by global standards. The NHS is widely and justly admired for its professionalism, dedication, and grit. The UK's NHS was deemed 'the best healthcare system in the world' by the 2014 Commonwealth Fund report on health services,<sup>2</sup> coming first in many areas (especially those related to primary care). But we ranked poorly in issues of 'healthy lives', and the scale of debt and threat of unsustainability now faced by the NHS are new.<sup>3</sup>

<sup>1</sup> William Dunbar (Scots poet, 1460-1520), 'Lament for the Makaris' (Lament for the Makers), ll. 9-12; *Timor mortis conturbat me* translates as 'Fear of death deeply troubles me'.

<sup>2</sup> Karen Davis, K. Stremikis, D. Squires and C. Schoen, 'Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally', June 2014; [http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755\\_davis\\_mirror\\_mirror\\_2014.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf).

<sup>3</sup> The recent government spending round announced a 'sustainability and transformation fund' of £1.8bn which aims to eliminate most (if not all) of the NHS's debt. This is in addition to the £8bn extra funding mentioned above. So although it is true to say that the scale of NHS debt is new, it is also true to say that new approaches are being taken to reduce that debt.



We want a mandate for change; it must be a public mandate that is well informed by a clear, coherent, apolitical, professional voice; and it should be taken *from* professionals, professional bodies and the public *to* politicians (not *vice versa*). Professionals therefore now have a vital duty to converse with the public to drive demand for a political mandate for good change.

Wrong choices will surely still be made in future, but the way we make the choices can be much more right, and that will make an enormous difference to the individual as well as the greatest number of people.

### **What is the 'NHS'?**

We currently seem to have 'some national health services' rather than 'an NHS'. Power is devolved and decentralised, the structure is complicated, and there is no clear hierarchy.<sup>4</sup> Primary care, secondary care, social care and public health are ill-aligned with each other, and the ways in which we measure outcomes and develop protocols tend to encourage a focus on technological and pharmaceutical interventions against disease, while neglecting public health and prevention of sickness, the benefits of which are harder to count.

The NHS has leadership training, but we no longer have one leader or source of leadership. (Benign tyranny can be good, but the NHS as a complex system does not work like that).<sup>5</sup> Nor is leadership synonymous with management/administration. In governance, there is a large gap between decisions and consequences which we would like to shrink, so that those who will live with the consequences of decisions have some say in how they are made.

We want the UK to develop an **integrated national health system** in which the right outcomes are well incentivised. The precise 'how' can be anything to deliver the fundamental 'what': the idea that, in the UK, **good healthcare is determined by need, not ability to pay more than others**. (Here, growing inequality and inequity sound a loud warning bell; the gap between 'care needed' and 'care received' gets worse for lower incomes; each stop east of Westminster represents a year's less life).

Crucially, **'health' should not be falsely isolated**; the nation's health, as the undergirding of life, ought naturally to be a primary consideration in policy for agriculture, transport, city planning, regional development, etc. Health, in turn, is influenced by much more than health services. Many health issues can be perceived and dealt with as naturally joined-up issues at a local or city level, making for better health *and* greater efficiency.

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<sup>4</sup> The 2012 HSC Act made changes to the NHS that might be reversed through the NHS Reinstatement Bill (the NHS Bill) now being discussed – e.g., the primary responsibility of the Secretary of State for the health of the population and duty to provide care to *all* residents.

<sup>5</sup> Healthcare organisations (as professional organisations) are found not to work like machine bureaucracies such as factories in which control devolves clearly through formal hierarchies, partly because individual professionals such as doctors, lawyers, and accountants bear dual responsibility: to the immediate hiring organisation but also outside to their professional accrediting body. (Arguably, since 2012 the NHS has functioned more as a market than an organisation.) Technical or process efficiency in a professional organisation plateaus lower than in a 'machine bureaucracy'. See Henry Mintzberg, 'The Structuring of Organizations: A Synthesis of the Research', McGill University: Desautels Faculty of Management (1979).



Thirdly, related to the above, we need to be more supportive of **promoting and funding public health and prevention of disease**, rather than diverting more money to treatment.

The **Five-Year Forward View** makes it clear that the NHS is expected to be better than cost-neutral. Individual providers have to do things differently, and the system watchdogs who are signatories to the View will check that they do. It is not all stick and no carrot; and, with the creation in April 2016 of a new watchdog, NHS Improvement, it seems there is an explicit move towards more support as well as regulatory action. But it is still an eyebrow-raising ask – and the ownership of the View, and the consequences of *not* managing to do more with less money while lacking the mechanisms of how to implement the View, are unclear.

### **Intensive care and palliative care**

Admission to ICUs highlight many of the broader issues at stake across the health services, especially around surrogate decision making:

- The legal framework is changing, subtly; physicians can no longer make paternalistic decisions around end of life; the judgement in the Tracey case<sup>6</sup> has emphasised the obligation to discuss resuscitation status with patients or, if not possible, their families.
- People from different religious backgrounds have very different attitudes about dying and life after death, which can put families and doctors/consultants in awkward and occasionally conflicting positions.
- Expectations about survival are high, and biased upwards by misleading media coverage (including television drama).
- Diseases, such as some cancers which formerly had very poor prognoses, are now managed outside critical care in ways that are associated with much better outcomes for some – this creates genuine uncertainty about immediate success or otherwise of critical care, while the prospects of success or even what success means remain very uncertain.
- Such care may come with a burden of physical and mental suffering which may outlast ICU admission by a long time and possibly the remains of the patient's life.
- Few leave intensive care with better background health and functional capacity than they had before.
- Much of the burden of ill health managed expensively on ICU may be avoided or moderated through social and public health measures (reduced salt, trans-fat and sugar intake; reduced consumption of alcohol; less smoking; greater active transport; reduced road use and air pollution; reduced energy poverty; increased social equity); and palliative care can make a real difference where death is inevitable.

These issues reflect broader concerns about health. It is a first priority somehow to identify early the patients who *will* benefit from ICU admission.<sup>7</sup> Since money is tight, maximising the common good has to be a significant factor in decision-making. (An Indian Medical Research Council strategy document is explicit about not doing research into making people live longer, but into helping them live better.<sup>8</sup> Perhaps this should be part of the debate in the UK). We need to be less clever, more kind – but not just 'tea and sympathy' kind. Judgment and



<sup>6</sup> See <https://www.judiciary.gov.uk/wp-content/uploads/2014/06/tracey-approved.pdf>.

<sup>7</sup> <http://www.ics.ac.uk/icf/james-lind-alliance/intensive-care-research-top-priorities/>

<sup>8</sup> See at <http://icmr.nic.in/guide/nhrp.pdf>, Annexure 1

personal humanity temper protocol, while getting fixated on checklists and tickboxes is unhelpful.

Possibly, an observable convergence between intensive care and palliative care (including 'end-of-life care') should be more openly acknowledged and worked with – as has begun to happen in Australia and some centres in the US. An ICU bed may cost £3000/day but can be 'a good place to die' if this is the recognised endpoint, while dying at home is not necessarily cheaper if quality is to be preserved. Occasionally intensive care does deliver palliative care – either for people at the end of long active treatment, or for people admitted and for whom it has become rapidly apparent that survival is not possible. As professionals, we need to be able to say, 'Your mum is dying; would you like a cup of tea and to sit by her?', rather than being driven to intensive intervention through family expectation, threat of litigation, or through 'choosing the easy route'.

The metrics for success in palliative care are hard: they are not 'survival'. 'Quality of remaining life' is important, as are 'the extent to which people feel involved in decisions and care' and 'how many people are cared for and/or die where they want to'. (NB: asking 'the public' where they would prefer to die gives a higher 'at home' response than asking *patients* where they want to die). Choice is about personal choice and control, not about selecting from a predetermined menu, and palliative care is necessarily highly individual because standard protocols and approaches do not work across many highly personal preferences and circumstances. There is a mixture of settings for providing palliative care, with mixed funding streams. Many agents need to be involved: regulatory, charity, social care, patients and families.

The recently published 'Ambitions for Palliative and End of Life Care' is a national framework for local action, and explicitly recognises the role and importance of the wider community in achieving these ambitions.

### **Cancer**

Though oncology today can shift survival of some late-presenting cancers by months or years, the best 'cure' for most cancer remains prevention, through regular physical activity, a healthy diet, not smoking, and avoiding obesity, excess alcohol, air pollution and excessive UV exposure. Preventive and public health measures are thus very important – but so too is action in areas traditionally outside health regulatory frameworks (taxation, urban and transport planning, agricultural policy and so forth).

We can and should also discuss details of pathways, GP roles and instincts, difficulties in accessing GPs, red flag symptoms (or lack of), false-positive costs and the reticence and 'probably not urgent' attitude of the British public – but we still know that early diagnosis is much, much cheaper than treatment, and therefore we simply need to invest in early diagnosis. The UK diagnoses late compared with other EU countries, with many patients presenting at an emergency stage when the cancer is already heterogeneous and there is little hope of cure. We should consider more palliative care. A multimodal approach is necessary, and must include more screening facilities.

In advanced cases, all tumours are inherently resistant. Many oncologists would themselves refuse the treatments given because the side-effects are so ghastly. Real-life prescription does not work out like clinical trials; treatment can leave someone utterly unable to function, or in intensive care.

Cancer treatment costs can be very high indeed, driven by the US market, and rising – but cost is not at all proportional to efficacy. It is not simple to balance futility (or not) against affordability (or not), whether as an individual practitioner or across society. In the Netherlands, cancer drugs deemed too expensive by



the state were reintroduced eccentrically into the system at the behest of patient groups funded by pharmaceutical companies. In the UK, NICE was established to indicate best use of resources, but (in the case of oncology) is undermined by the Cancer Drugs Fund.<sup>9</sup>

### **Polypharmacy**

With increasing numbers of people living with multiple morbidities, members of the public have become unwitting *in vivo* experiments for unresearched combinations of multiple drugs. Only 3% of patients with heart failure in a recent analysis in Scotland only had heart failure, while 74% also had three or more other conditions. We do not actually know whether statins work when taken in combination with (for example) ten or fifteen other drugs, and we are unlikely to find out because clinical trials of such polypharmacy would be expensive and too hard to perform. Over-administered antibiotics add the further grave problem of increasing antibiotic resistance around the world.

Drug companies assert that they are ethical and engaged, and work in a tough environment, and that in general there is no inappropriate relationship between the pharmaceutical industry and government that might inappropriately bias drug use. To make a profit, drug companies focus on:

- economies of scale (for example, across national boundaries)
- profitable populations
- health-*product* thinking rather than health-*benefit* thinking.

Perhaps the pharmaceutical industry needs to be better at targeting unmet needs but this is not as easy as it might appear. The repurposing of drugs off-patent, researching effects of combinations of established drugs, and gathering of real-life data are all areas where partnerships are vital, and through which health can be improved.

At the moment, though, medical conditions are divided up for treatment by department and pathway, while they actually co-exist and overlap in the whole patient as an individual, who really needs treating as such. Of course we need specialists, but we also need balance; only 38% of guidelines and recommendations are based on typical patients. Should generalists not receive the longer training, specialists the shorter? We need *expert medical generalists* for a sustainable NHS.

Furthermore, we *create* 'diseases' for treatment such as 'pre-diabetes' where it is very unclear that there is real value from drug prescription. Data analysis and IT in these areas are great, but piling up information (hundreds of diagnoses from a spot of blood) is not necessarily a way forward to better health outcomes. Lack of information is usually the easier part of the problem, and what you do with the information is harder; but if IT can help with this, we should find out more.

### **Public health and prevention of disease**

It is common sense that 'public health' cannot be boxed up separately from 'health'. We can measure the good effects of prevention and public health spending; we have modelling evidence for the benefits of reducing dietary salt, trans-fatty acids and cholesterol; we *know* STDs and unwanted pregnancies are prevented effectively by targeted campaigns (why is their funding being cut?)



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<sup>9</sup> NB: a drug can be high value, yet hard to afford; it is a question of the greatest good for the greatest number (or utilitarianism) and in addition considerations of duty and virtue ethics. NICE offers a framework to judge cost-effectiveness and value.

At the moment, relatively little is spent on prevention of disease. Smoking, drinking too much alcohol, dietary neglect and failing to get enough exercise continue to hasten sickness and death and NHS costs in high numbers. So how can we get the money to prevent disease? Should it be taken away from other areas, or sought newly? Messaging is all-important. (MRSA was huge in the press during the 2005 elections, and that won the NHS a lot of money, with which we successfully tackled the issue. We achieved more with good funding in two years than we had during two decades).

There are many ways to promote public health: invest in 'Healthcare Public Health', engage patients to reduce harmful or ineffective interventions, reduce variation amongst NHS providers,<sup>10</sup> implement the Wanless Report recommendations,<sup>11</sup> consider place-based commissioning,<sup>12</sup> implement the manifesto of the Faculty of Public Health and Royal Society for Public Health,<sup>13</sup> introduce a tobacco levy, tackle the social determinants of health to tackle health inequality,<sup>14</sup> tackle the 'industrial imperative', change the political cycle on health with a seven-year plan, and make proposals overlap – for example, active travel means both less pollution and more physical activity; more efficient insulation and ventilation is good for lowering emissions and bettering health; a low-environmental-impact diet is also a fine preventive for much disease.

### Structural change

Most structural amendments towards better health outcomes fall under two headings:

- **towards greater value** (making the best of what we have); e.g., we know that the system collapses on predictable dates when staffing levels do not rise to meet need, or that having eight pathways with eight different outcomes for COPD in neighbouring CCGs in London is silly, etc.
- **transformative changes** for long-term national health benefits; these are more aspirational

Obstacles to structural change include:

- locked-in funding to 'keep the existing going', so marginal changes only are possible, unless one takes courageous and unpopular action such as closing wards, ceasing contracts, etc.
- communication difficulties: for example, working with fifteen largely uncoordinated bodies not talking to each other makes it hard even to prepare the foundations for rolling out a new model – people tend not to like other people's solutions, unless they make a *huge* difference.
- the long timeline for real change: the five-year political timeframe is very short (in artificial intelligence development, by comparison, twenty to thirty years seems reasonable)

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<sup>10</sup> The Dalton Review (2014);

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/384126/Dalton\\_Review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf)

<sup>11</sup> Derek Wanless, 'Securing Good Health for the Whole Population' (2004):

[http://webarchive.nationalarchives.gov.uk/http://www.hm-treasury.gov.uk/media/D/3/Wanless04\\_summary.pdf](http://webarchive.nationalarchives.gov.uk/http://www.hm-treasury.gov.uk/media/D/3/Wanless04_summary.pdf)

<sup>12</sup> The King's Fund, 'Place-based systems of care: A way forward for the NHS in England' (2015): [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Place-based-systems-of-care-Kings-Fund-Nov-2015\\_0.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf)

<sup>13</sup> [http://www.fph.org.uk/uploads/manifesto\\_public\\_health.pdf](http://www.fph.org.uk/uploads/manifesto_public_health.pdf)

<sup>14</sup> Michael Marmot, 'Social Determinants of Health Inequalities' (*Lancet* 365, 2005):

[http://www.who.int/social\\_determinants/strategy/Marmot-Social%20determinants%20of%20health%20inqualities.pdf](http://www.who.int/social_determinants/strategy/Marmot-Social%20determinants%20of%20health%20inqualities.pdf)



We tend to stop while a system is very complex and describe it, rather than moving through to the 'simplicity the other side of complexity'. **Inefficiency can be good** if engineered for the desired result. Engineers can develop ways to make people, for example, want to be more active. In Detroit and Riyadh there are great results from city developments for green transit spaces and family activity areas outdoors. (The New York Highline is so successful that there are suggestions that a train line needs to be re-established alongside..) An eight-mile distance between linked hospitals can become a cycle route and even a walking corridor – 'inefficient' at one level, but hugely beneficial at another.

Fifty **Vanguard projects** are testing new models around the country to rapidly develop new models of care that can easily be replicated in later years. In five years, results will begin to show, and real benefit in ten to fifteen. Inherent in this rapid progress is the idea that some Vanguards will fail but others will succeed. Those that succeed can be rolled out to other suitable local health economies. The risk to this strategy is a possible increase by the system watchdogs in their aversion to the failure of Vanguards. If *all* Vanguards are expected to succeed, then progress is less likely to be as rapid as foreshadowed in the Five-Year Forward View.

**Gamification** is underused for better health outcomes. The 'speed camera lottery' frames good behaviour in terms of potential reward (the number plates of those who go at the desired speed are recognised, and the drivers entered into a lottery for financial gain). So why have we not put the NHS model online for people to play with, to crowdsource efficiencies and solutions, educate generally, and open up the many desired conversations? Briefly, for change: never criticise; only applaud; use the internet; be feted.

#### **Measurements and more**

To intervene and support meaningfully, you need **good metrics**. It may seem too much to say that 'if it moves, it should be measured' but more should be done to measure and analyse people, assets, data, tests, results, etc. – rather than the present situation of legally liable medical directors taking decisions according to diverse protocols inside black boxes.

Already, the **NHS sits on a hugely useful and transformative mass of information**. Can we not propose a partnership for a small practical analytical experiment which could be done immediately to measure the implementation of a protocol, evaluate it, and show areas to make it more effective? Data analysts could work with Trusts that have risk-tolerant and media-robust leadership, not on the basis of Trusts partnering with a monolithic provider, but in a decentralised, bilateral relationship – and using only non-sensitive, back-end database material, such as lab data, subject to restrictions on its use.

#### **Our message**

We have no one voice (although the Academy of Medical Royal Colleges may offer one possibility). Our message must convey our desire to **work out what is appropriate care and good use of resources and data, and make more intelligent use of information and communications**. We also need the public and patients to say what they need to know.



Our voices as healthcare **professionals** and members of professional groups are powerful in the public ear because we are regarded as experts, we have duty to our patients and populations, and we can act as advocates for them. A leading oncologist saying 'we need early diagnosis' can have more impact than a public health representative saying the same. We need charismatic spokespeople, not faceless organisations, to convey issues. But the voice of 'a professional' (who stays within profession guidelines) is different from that of 'the profession'. So

we also need to speak together with a collective, clear, coherent voice. We are important in this respect also because we are health spenders. We *can* challenge the narrative of where efforts should go.

Members of the **public** are capable of making good decisions on the basis of good data – possibly with less beating about the bush than professionals. A 'Daily Mail' fear *can* be controverted by good sense when the message is accessible and debatable. There is no point then in our being defensive or haranguing about problems (criticism) if we can offer the means to develop solutions (help). For example, the public hated the idea of linked health records, but the defence was merely 'er, really, there is no risk' rather than showing benefits – for example, 'by linking more data, we can beat Ebola'.

**Politicians** are easy to blame, but they understand public opinion very well, and they do have to show results within a five-year term of office. In political opinion, the NHS is a sacred cow, and one cannot close hospitals or there will be marches in the street. How can we as medical and healthcare professionals work with and influence political leadership? More and better communications, with respect for the political point of view, are needed. (The Chancellor of the Exchequer and other ministers now do want to be informed by a wider group than previously; our voice may be heard there too).

**Partnerships** which show apolitical commitment to health will strengthen credibility (though all health messages will tend to be interpreted locally as politicised). Partnerships with, for example, patient groups or specific disease groups, able to see the broader issues, can counteract criticisms made on the basis that narrow professional interests are being pursued. Persistence, effectiveness, and sharing data and tools can make one *de facto* into a leader.

The Health Foundation, Nuffield and the King's Fund do a lot of work to present consistent messages; more work needs to be done if the messages are not getting out there. The Five-Year Forward View offers opportunities to push key messages about public health, and a public voice about health.

### **The Conversation**<sup>15</sup>

As HC professionals, we regularly tell patients that they have incurable diseases, and they often ask how long they have to live. However, as members of the UK public, **we generally do not discuss how we want to die.**<sup>16</sup> In our health services, and as (ageing) carers, we will soon deal with more drawn-out ends of life than ever before. Advance decisions and advance care planning are clear ways of enabling individuals to discuss some of the most difficult decisions that could be made about their care and treatment. At the moment, though, they are too often disregarded, inaccessible, unclear, or lacking due process. Clearer communications and better mechanics of making wishes known will improve the quality of death for millions annually.

Decisions about preserving life are often made under stressful, last-minute conditions (in labour, when a relative has just collapsed), and based on risk, not certainty, about survival and disability. Consultants frequently ask patients and

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<sup>15</sup> See <http://theconversationproject.org/>.

<sup>16</sup> Discussion during the pre-launch consultation of the Assisted Dying (No. 2) Bill 2015-16 suggests a legal and administrative framework for social decisions around death. This interesting departure highlighted that beyond diagnosis and prognosis physicians have no unique competence around end of life issues and that perhaps wider society might take a greater role in determining policy. The Bill did not proceed past its second reading in the House of Commons (11 September, 2015) but can be read at: <http://www.publications.parliament.uk/pa/bills/cbill/2015-2016/0007/16007.pdf>.



families what they want, only to be asked 'What would you do?' But our prediction is poor, and practice variation is wide. **Professionals cannot supply the mandate**: there has to be a public discussion for public mandate to do things differently and better.

Obviously, **individuals differ** about what is 'a good death'. Arguably death is never desired. But its perceived aptness relates in large part to the quantity and quality of life that realistically remains each time death is forestalled – if only we had the essential, flawless foresight to know ...

So, **we must discuss principles of decision-making** in these areas to make decisions with at least *more* understanding, agreement, and certainty, and develop agreements on how to use resources better. When, with whom, and how often, should 'The Conversation' be scheduled?

### **Moving forward**

This meeting is the start of our own conversation. As health professionals, we need to acknowledge and share the truths of our experience. We all agree that, for better health as a nation, we should seek agreement across sectors about what outcomes we want to deliver, and how to incentivise these, which we can only define in partnership. To do so, we must speak up, as individual professionals and members of professional groups, to:

- **create ongoing partnerships and conversations** between public and professionals
- **broaden 'health'** in the public consciousness to include larger social goals
- **define value well**, and agree on an overall vision of 'good' and 'right' health outcomes
- **stimulate societal debate** about best use of resources
- **re-examine the budget, allocation of resources, and structure** of the NHS
- examine the **measurement of outcomes** in extreme health cases
- **align and integrate services** and areas of concern

How shall we move forward? We might suggest a Commission. We surely should reconvene.

Meanwhile, please write, discuss, and publicise.



## **Annexe 1: Leadership and influence pertaining to the national health services**

### Political leadership

The democratically elected Secretary of State of Health (see below), Chancellor of the Exchequer and Prime Minister are responsible for broad policy, and for what they believe to be the political mandate based on public opinion and (perhaps not identically) media views (the 'Daily Mail test').

### Devolved leadership: NHS Executive

Simon Stevens leads NHS England, which oversees the CCGs (see below) while Monitor and the TDA (soon to be NHS Improvement) are led by Jim Mackey and oversee providers.<sup>17</sup> The leaders can influence, but not control, health services, in that they do not have a direct managerial role; his responsibility is to account for what the national health service is doing (books balanced, waiting times met).

### Devolved leadership: Trusts

Foundation Trusts have autonomy from the Department of Health (and are regulated by Monitor), while NHS trusts do not. These bodies constitute a fragmented assembly in terms of the *running* of national health services.

### Private sector organisations with public responsibility

May use public money to provide certain health services.

### Local Authorities

LAs have an explicit role in spending money on, e.g., social health services, obesity, etc.

### Medical Director of NHS Executive (Sir Bruce Keogh)

Offers medical advice, represents clinicians at a high level, and communicates about health issues, but *not* a manager; there are also Medical Directors of Monitor (Hugo Mascie-Taylor) and the TDA (Mike Durkin).

### Chief Medical Officer (Sally Davies)

The CMO is a highly respected and influential advisor to government (not just Dept of Health) on all things health. Davies has powers and responsibilities as the head of her profession to speak out on broad health-domain issues. She jealously guards her political and organisational independence so that she can speak out credibly; she will not intrude on NHSE 'territory'.

### Secretary of State

The Secretary of State is a political role, responsible to his colleagues for the gamut of health and social issues in the UK: the NHS, social care, and public health. He asks each Monday about productivity, accessibility, etc., and is *politically* accountable for those.

### Civil servants

Civil servants can be very talented in negotiating the political system, and know a lot; they are trained to listen, think, negotiate and manage the political landscape.

### NICE

NICE does a good job of providing an independent view of specific medical questions, and should be supported.



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<sup>17</sup> NHS England, Monitor and the TDA are known together as the 'tripartite authorities'.

### Health and Wellbeing Boards

These sit within local government authorities (LGAs), can make a difference at local levels, and comprise:<sup>18</sup>

- Clinical Commissioning Groups (211 CCGs were introduced April 2013 by the Health and Social Care Act 2012 to replace PCTs)
- Healthwatch units (nationally, Healthwatch England; independent consumer champion organisations also established by HSCA 2012)
- LGAs

Leaders are created through a mixture of political and clinical discussion between civil servants, national clinical directors, influencers in the NHSE, etc.



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<sup>18</sup> See 'Structure of the NHS in England', <https://www.england.nhs.uk/wp-content/uploads/2014/06/simple-nhs-guide.pdf>, pp. 8-9.

## Annexe 2: Discussions around the NHS budget

What does it mean to say that the NHS is 'protected', with 'increased spend year on year'? The government says it, the public hears it, and the Five-Year Forward View indeed describes £8bn made available for NHS England, front-loaded. The full story appears gloomier and more complicated. The NHS as a whole requires more than £8bn (although the NHS asked for only £8bn); trusts are already spending from surplus to maintain services, with 90% of trusts forecast to be in debt by the end of the year; population growth will take up much of the £8bn straight away, while the increasing age of the population adds further pressure; health spend is actually *falling* as a percentage of the overall UK economy; we are spending substantially less than comparable countries.

NHS England says £30bn more is needed to treat the population in five years if there are no productivity savings. If there are savings, it will need £22bn. If there is a 1.5% rise in productivity, £16bn extra will be enough. This is all evidence-based.

It is proposed that the NHS should become more efficient, with savings of 2-3% pa. This would be higher efficiency than that of the economy as a whole, though it is debatable how significant that is. Increases in productivity must plateau, because the NHS is service-led. (NB: management in the NHS is a relatively small cost, so saving money by reducing managers is (a) a negligible gain (b) leaves doctors doing administrative and managerial work.) What does 'more efficient' mean for units that already have 100% ward occupancy? Number of people through the system? Savings?

Treasury are probably thinking that they have given what the NHS asked for: £8bn, front-loaded. There were seven signatories to the Five-Year Forward View, including Public Health.<sup>19</sup> Budget details could be argued indefinitely so perhaps it should simply be borne in mind that there is a Treasury point of view.

Any way you cut it, there is less and less money. (NHS England will soon publish its plans for maintaining the status quo on less resource; which promises interesting reading). But it would be false, and dangerous, to infer that 'we cannot afford the NHS'. Unsustainability is far from unaffordability. We *can* afford it, but it will take some brave changes. As a nation, we may have to be realistic about having a very good, but more limited, national health service.

We are not in fact very inefficient with our 'least worst' tax model (although there is wastefulness in replicating initiatives). By contrast, social insurance brings high transaction costs for claims. The USA spends more on the public health system as a percentage of the GDP, adds private healthcare, and is still less efficient (and not universal). This is not to say that we would not benefit from a system to share gains and losses more equitably, to save money. Various suggestions:

- The UK has had some good success using personal health budgets (PHBs) rather than capitated health budgets in many cases where there is continuing health care.<sup>20</sup> Still, PHBs are not the answer for everyone, especially not in a hierarchy as diffuse as ours.



<sup>19</sup> Full list here: <https://www.gov.uk/government/publications/five-year-forward-view-time-to-deliver>

<sup>20</sup> See, e.g., 'Personal Health Budgets: a revolution in personalisation', by Gail Beer, Jon Paxman, Charlotte Morris (July 2013) [pdf available online].

- The Barker Commission suggests a wealth tax (inheritance) and increased NI payments for the over-40s who will benefit most from healthcare, among other possibilities.<sup>21</sup>
- Prescription charges could be reworked.
- Probably we can learn from funding models abroad, though it is hard to establish the efficiency of mixed funding models. But Cuba and Costa Rica in particular have developed interesting answers to problems of universal primary care coverage and the proportions spent on 'non-curative' (social and palliative) care.
- We could, contentiously, consider possibilities such as cutting the Cancer Drugs Fund, locums, internal market costs,<sup>22</sup> private finance and for-profit independent providers. (Private providers claim to offer better quality, but do not submit the same data that NHS providers do; should they, if they are going to make a profit?).
- 'Innovation' for value sounds attractive but in practical terms 'innovation' in the NHS is necessarily restricted and usually signifies higher (technological, drug) costs, not lower. A strong academic base used to be a source of new practice, but it is being managed out of the system; innovation (as we usually understand it in a business sense) does not scale well inside the NHS.
- Centralised data would be simpler to manage; proper handling of big data would reduce bureaucracy and administration. Reducing variations of primary care spends would make savings, and good measurement and use of data would make this possible and useful.

If the NHS did get more money, would spending continue to outstrip increased funding? People will continue to get ill and die, and efforts will continue expensively to push the boundaries further back in survival's favour.

On the other hand, we are *good* at value judgments and need not accept ideological rhetoric. We can be sensible, and make the NHS affordable. But we do need enough to keep going.

The overall view is that there is no one overarching solution to the budget problem, and pursuing several difficult partial solutions is necessary, demanding courage, consensus, political will, energy, vocal and visible championship, and a clear public mandate.



<sup>21</sup> A useful outline by the King's Fund of the findings of the Commission on the Future of Health and Social Care in England (led by Kate Barker) is viewable at <http://www.kingsfund.org.uk/projects/commission-future-health-and-social-care-england/summary>.

<sup>22</sup> The NHS internal market, set up in 1992 under Ken Clarke, has been described by the Select Commission as twenty years of expensive failure. However, the internal market post HSC Act 2012 is different from the internal market that preceded it and evidence suggests this new internal market is delivering better value.

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