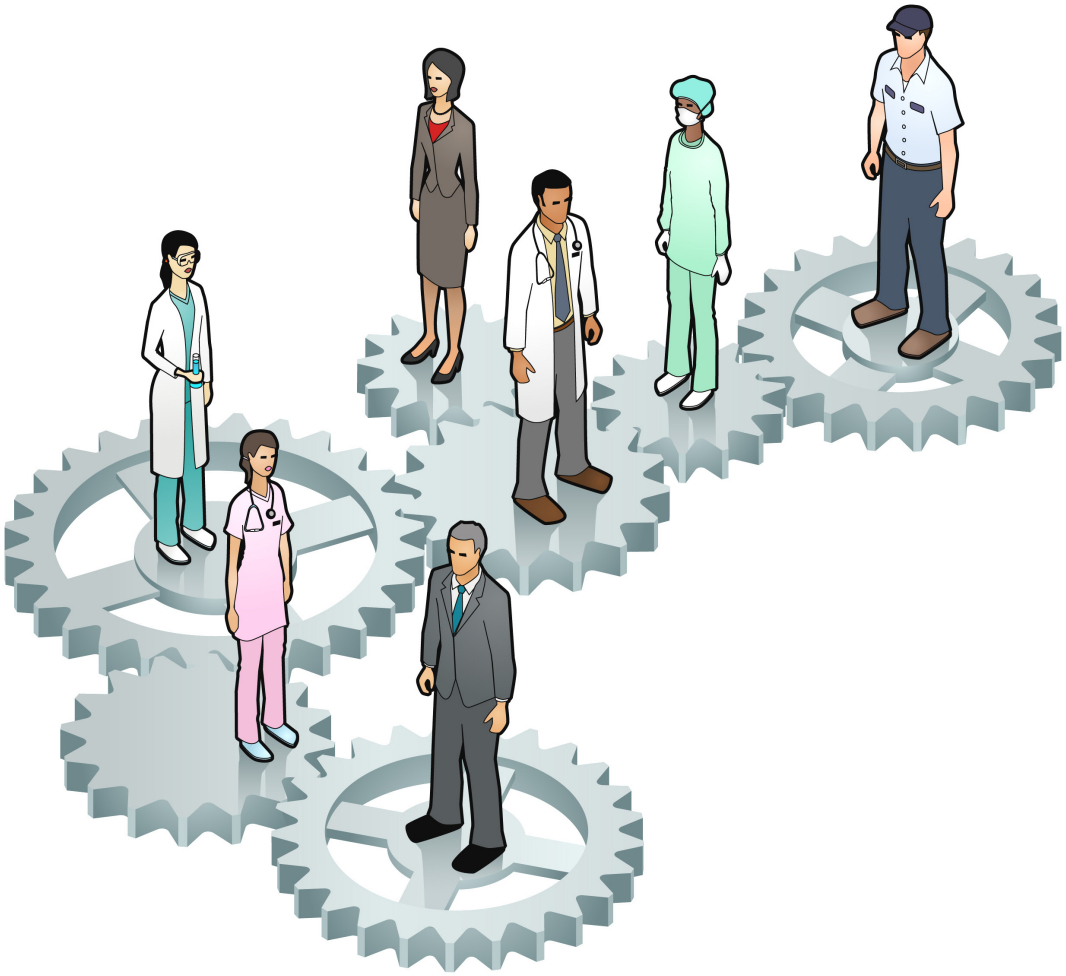

Meeting the Challenge:

Future visions of healthcare

A Localis Essay Collection

LOCALIS

Staffordshire County Council

About Localis

Who we are

Localis is an independent think-tank, dedicated to issues related to local government and localism. Since our formation we have produced influential research on a variety of issues including the reform of public services, local government finance, planning, and community empowerment. Our work has directly influenced government policy and the wider policy debate.

Our philosophy

We believe that power should be exercised as close as possible to the people it serves. We are therefore dedicated to promoting a localist agenda and challenging the existing centralisation of power and responsibility. We seek to develop new ways of delivering local services that deliver better results at lower cost, and involve local communities to a greater degree.

What we do

Localis aims to provide a link between local government and key figures in business, academia, the third sector, parliament and the media. We aim to influence the debate on localism, providing innovative and fresh thinking on all areas that local government is concerned with. We have a broad events programme, including roundtable discussions, publication launches and an extensive party conference programme.

We also offer membership to both councils and corporate partners. Our members play a central role in contributing to our work, both by feeding directly into our research projects, and by attending and speaking at our public and private events. We also provide a bespoke consultancy and support service for local authorities and businesses alike.

Find out more

Please either email info@localis.org.uk or call 0207 340 2660 and we will be pleased to tell you more about the range of services which we offer. You can also sign up for updates or register your interest on our website.

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Foreword

Alex Thomson,
Chief Executive of
Localis

No-one should doubt the scale of the challenge facing our healthcare system, or that integration must be part of the answer. The coalition government began to make some real progress in integrating health and social care, culminating in the remarkable Devo Manc announcement of an enormous £6bn budget being put under the control of Greater Manchester Combined Authority. While the detail of this deal is yet to become clear, I hope and expect that it will prove to be a giant step towards allowing other local areas to take healthcare decisions much closer to the populations they affect.

Against this promising backdrop of change, it seemed an excellent time for Localis to gather a range of expert views on what the future of healthcare looks like. I'm thrilled that we were able to assemble a stellar line-up of essayists for this publication, and even more pleased that there was a strong flavour of localism to all their responses.

Stephen Dorrell, former Secretary of State for Health, highlights two of the key benefits that localism can bring to the NHS: greater efficiency and accountability. For too long, he says, the voice of local representation has been ignored by the NHS as 'politics' and that this has to change. Indeed he argues that unaccountable services are bound to be inefficient services because they lose touch with the people who needs they are supposed to serve. And he concludes by arguing that it is often champions of local variation who are also the most effective champions of high national standards.

Tony Lambert, Director of Pricing at NHS Monitor, writes on the NHS Five Year Forward View and the necessity to radically redesign health and social care services in order to deal with future demand. He suggests that local government can help the NHS provide a service geared towards wellbeing and prevention through its relationship with local communities. He also argues that NHS, local and central government all have to rise above conflicting institutional interests and, by addressing public concerns in unison, make the case for change.

Cllr Philip Atkins, Leader of Staffordshire County Council, highlights the importance of effective partnerships in delivering healthcare reform, citing the example of Staffordshire which has developed a mechanism for bringing together local leaders from all parts of the county – the key city, all of the districts and county council – to speak with one voice. Through this local leaders board Staffordshire can collectively identify, agree and tackle health challenges together as a shared strategy, as part of a broader area-wide conversation about jobs, growth and housing.

Sir John Oldham, recent Chair of the Independent Commission on Whole Person Care, makes the case for multi-disciplinary integration of healthcare at the lowest level. Without such a change, he contends, the NHS and care system will remain focused on the challenges of 1945 - predominately single

diseases - rather than the very different challenges of 2015. He also calls for a National Conversation about the future funding needs of health and social care and how they might be paid for.

Dr Onkar Sahota, Chair of the GLA Health Committee, speculates on the future of General Practice. He proposes that hospital, community, GP and social service budgets should be put into a single envelope for a borough wide health population, in order to achieve the most efficient healthcare service. He points out that democratic accountability in the NHS is important and therefore suggests that for such combined budgets this could be achieved through the Health and Wellbeing Boards of local authorities. Additionally he recommends that the NHS should develop a salaried GP service, and take on responsibility for modernising GP premises.

And finally Robert Webster, Chief Executive of the NHS Confederation, writes about the sustainable future of the healthcare workforce, arguing that in order to meet the challenges ahead the existing NHS workforce will need to have a greater understanding of resources in their local community. This, he suggests, will require enhanced communication skills in order to work effectively with different sectors and professions, making the crucial observation that a large and growing proportion of healthcare is delivered by staff not employed by the NHS.

I am extremely grateful to all our authors for giving up their time to provide such fresh and optimistic ideas on the future of healthcare. And I finish by echoing their call for a healthcare system that is genuinely focused on, and accountable to, local communities – if we can achieve that, the future is bright.

Alex Thomson
Chief Executive of Localis

1

Why localism is crucial to the future of the NHS

Rt Hon Stephen Dorrell,
Former Secretary of State for Health; Senior Adviser to KPMG

Throughout the twentieth century the drive to centralize political decision making seemed inevitable.

Improving transport links combined first with printed mass media and later with electronic mass communication to make possible a centralization of power and control of which Richelieu could only dream.

Furthermore, improved communications didn't simply make stronger central control possible; they also meant that communities became more aware of local variation and challenged the central authorities to justify differences which appeared to be anomalous.

Localism too often sounded like an excuse. The challenge was insistent: variation was evidence of injustice and there was a demand for national standards to be developed and applied.

But around the turn of the 21st century something started to change.

It wasn't that people suddenly became less sensitive to principles of justice and equity. Quite the contrary. They began to notice that, however often it was repeated, the central guarantee didn't deliver.

"[People] began to notice that, however often it was repeated, the central guarantee didn't deliver. Communities began to ask whether they couldn't do better themselves"

Communities began to ask whether they couldn't do better themselves. Rather than waiting for national bureaucracies to address well documented failures and deliver the promise of uniform national standards, could the communities themselves not make quicker progress by defining the standards they sought and empowering local organizations to manage delivery?

Furthermore, as they began to explore different options for delivery, communities also began to rediscover differences between localities and the feeling began to develop that these differences should be reflected in local priorities and decision making.

The history of the National Health Service provides a perfect example of these developments. In the mid twentieth century it seemed simple; if you want to deliver equitable access to uniformly high quality healthcare you create a strong national bureaucracy, committed to deliver clearly defined national objectives.

It wasn't a matter of ideology. Enoch Powell and Sir Keith Joseph were both ideologues of the right, but both were Ministers of Health who adopted the methods of "command and control" in their attempt to deliver uniform standards.

More recently orthodoxy has changed. For 25 years successive health ministers in governments of both left and right have argued the case for more localised management, committed to delivering standards defined by national commissioners and regulators.

The non-partisan nature of these developments has been further reinforced by recent developments in Greater Manchester where local authorities led from the left have joined forces with a right of centre Chancellor to develop a programme of enhanced local decision making – with both sides recognising that localism offers opportunities for both greater efficiency and greater accountability.

"Both sides recogn[ise] that localism offers opportunities for both greater efficiency and greater accountability"

It is these qualities of efficiency and accountability which are the twin pillars of localism, but which are often misrepresented as two unrelated concepts. That is completely to miss the point.

It is certainly true that – in any organization – empowered local management is best placed to identify opportunities to improve workflow and reduce unit cost, but that is not the whole story. Efficiency in public service delivery is not simply a matter of minimizing cost.

Decisions which affect the shape of public services are seldom taken by individual members of the public or service users; they are taken by commissioners or service planners on behalf of the public.

Any proper understanding of the efficiency of those services must therefore include an understanding of the efficiency of the commissioning process. Do the commissioners and service planners really understand the needs and wishes of the public on whose behalf they act?

Or are they commissioning a service which they think the community ought to want?

Worse still, are they commissioning the service the community has always had, without challenging providers to match their service to the needs and aspirations of the communities they are there to serve?

True efficiency of a public service requires effective alignment of the planning process with public needs and aspirations as well as operational efficiency – which is why improved accountability of public services is a vital element in a true definition of efficiency and why localism is an important contributor to efficiency.

Does the commissioner really understand the wishes of service users – or of the local community? Or is the commissioning process the prisoner of yesterday's orthodoxy? Or of producer interest?

Once again the National Health Service provides a useful illustration.

Health services were once the responsibility of local organizations and elected local authorities. The foundation of the NHS introduced the concept of national entitlement and the voice of local representation was progressively reduced and finally abolished in 1990.

Local management came to mean management by experts – because it was believed that empowered local management would achieve greater operational

efficiency.

But excessive focus on operational issues led to a diminished understanding of the concept of efficiency in a public service. Accountability to local communities was dismissed as "politics" – and thought to stand in the way of true efficiency.

In fact, unaccountable services are bound to be inefficient services because they lose touch with the people who needs they are supposed to serve.

"Unaccountable services are bound to be inefficient services because they lose touch with the people whose needs they are supposed to serve"

Worse than that, the track record in fact shows that – for all their undoubted imperfections – accountable local authorities are actually also better at finding operational efficiencies than their counterparts in the NHS who are not required periodically to justify their track record at the ballot box.

So the case for localism is based on two propositions. Firstly effective local management is best placed to deliver operational efficiency; and, secondly, accountable local commissioners are best placed to test local management against both defined national standards and alternative local providers.

As ever when ideas when become fashionable, there is a risk that advocates get ahead of themselves. What had previously been dismissed as dark obscurantism suddenly becomes the new revealed truth.

In such an atmosphere it is healthy to be sceptical. We should remember that local interests can be over-powerful and majorities can abuse their power.

There is an important space for national standards, in particular with respect to transparency. It is one thing for a local community to choose a different path; it is another thing entirely for it to be taken on a different path by powerful interests who are not required to explain themselves in public.

But history demonstrates repeatedly that national bureaucracies will tolerate such abuses despite repeated protestations of their commitment to high and uniform standards.

So, it is ironic, but true, that it is often the champions of local variation who are also the most effective champions of high national standards.

Rt Hon Stephen Dorrell
Former Secretary of State for Health and Senior Adviser to KPMG

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Delivering the Five Year Forward View

Toby Lambert,
Director of Pricing,
NHS Monitor

Health and social care services must be radically redesigned if they are to cope with the impending surge in demand and the looming financial shortfall they both face – a task the NHS can only accomplish in partnership with local government. Adopting new care models based on integrated services will be crucial, and we can improve how the payment system supports this. Ensuring health and social care services are sustainable will therefore depend on developing a new approach to pricing and payment – in which local government has a role to play.

"Ensuring health and social care services are sustainable will therefore depend on developing a new approach to pricing and payment - in which local government has a role to play"

The challenge

The population is predicted to grow by 5 million from 2011 to 2020 and life expectancy by five years in the next 25 years, according to the Office for National Statistics. As a result, the Department of Health predicts a rise in the number of people with three or more long-term conditions from 19 million in 2008 to 29 million in 2018. In addition, the NHS will face a £30 billion funding gap by 2020.

Monitor, like every other health system leader, is absolutely committed to preserving the NHS as a free at the point of access, tax-funded universal service. We do not believe the current system needs fixing - it is not broken - but it does need significant innovation and development as well as maintenance. Although it must improve quality and efficiency in some areas, most international studies reveal the NHS to be the most equitable in the world, with efficiency standards that compare well with nations that spend a higher proportion of GDP than we do. And it retains overwhelming public support.

Yet it is inconceivable that existing arrangements can come close to providing the safe, fair and good quality services people expect without a closer union between health and social care services. Such integration could bring enormous benefits: more single pathways from home and community to hospitals and a far greater emphasis on public health and prevention.

The national NHS leadership and patient groups, clinicians, local communities and frontline NHS leaders agreed the NHS Five Year Forward View in 2014. This is a vision of how the NHS should change over this Parliament to meet the challenges the health and social care sectors are facing. It outlines new models of care that could meet the needs of today's population more effectively and efficiently.

Monitor is now working with the health and social care sector to design the best payment and regulatory system for encouraging development of integrated services

while improving performance and longer-term sustainability across traditional institutional boundaries. It is a massive task to continue to improve quality, meet access targets and drive up productivity. We think all of this is achievable, but not by continuing with business as usual. So far, neither NHS providers nor commissioners have responded anywhere near enough.

The opportunity

We have to work across traditional sector boundaries, within the NHS and with local government. The Five Year Forward View provides an ambitious vision for a service which is more integrated and geared towards wellbeing and prevention, not just treatment. Local government can help the NHS with this because of its distinct culture and relationship with local communities. The health sector must acknowledge that local government handles some health-related issues differently - and in some respects better.

With the Local Government Association's help, Monitor recently talked to health and wellbeing board networks about integrating services. This highlighted important cultural factors we need to take into account. In some aspects, local government puts more emphasis on the longer-term health of populations than NHS management, which is focused on shorter-term demand and capacity controls. Local government, and particularly HWBs, take account of a range of factors, including health inequalities, housing and employment, in their health strategies. The NHS is less well equipped to look beyond access and treatment issues.

"Local government puts more emphasis on the longer-term health of populations than NHS management"

Democratic accountability also divides us. The NHS is attuned to a centrally driven culture, while local government is accountable to its electorate through its councillors, direct elections and the broader range of issues it is responsible for. Intense national media and political exposure implant a different culture of accountability at all levels of the NHS.

So how do we best move forward?

Monitor is supporting the localities already delivering integrated care by providing practical help and advice to local health economies, including the Integrated Care Pioneers and Five Year Forward View Vanguards. Our role is to use our powers to encourage new care models which move beyond traditional institutional boundaries. If a provider obstructs efforts to integrate care we can step in and put things right. For example, we are ensuring that the sector does not block efforts to integrate care by including a specific requirement in our licence, the main tool with which we regulate providers.

But we need to go further and break down barriers between NHS and social care. One important tool is strategic regulation of the NHS payment system. This can help the NHS achieve the kind of new models described in the Five Year Forward View while staying true to its principles. We are seeking to reward outcomes, not volume, and encourage better co-operation, not inadvertently offer disincentives to closer working.

We have started to reform the existing pricing system so that the system better supports clinical services which span care settings, enabling integrated care. It cannot solve all the problems but used well it can facilitate new care models and high quality, more efficient services because it governs the payment terms and prices commissioners write into NHS contracts.

Regulating the payment system is not just a method for allocating funds but for influencing how commissioners and providers behave. For commissioners - of most interest to local government - our objective is to encourage quality improvement, sustainable service delivery, allocation and management of risk.

One of the main integrated care models we are working on is the multispecialty community provider (MCP), a model that incorporates groups of GPs combining with nurses, other community health services, hospital specialists, mental health and social care to create integrated out of hospital care services.

I believe that a payment model that incentivises keeping higher risk patient groups well is the best approach and this could build on a capitation payment model. It will take time to get to where we want to be but we are working closely with the LGA, mainly through its Integrated Care and Support Working Group, to engage more with local government.

Making the case for change

Working closely with local government requires a leap of faith from both sectors, with greater understanding of each other's cultural and financial pressures. We understand the frustration that the social care sector feels with the funding position, and we will continue to work with other system leaders and the LGA to make sure that funding arrangements for better integration work for social care.

An important role we can all play is in helping make that case the change. The best laid plans in health and social care often fail because of conflicting institutional interests or because they ignore public concerns, with the consequences of both leading to insurmountable political barriers. Plans are often resurrected later and given a different name, but they look and feel the same to the public. No matter how good the plan may be, repackaging it fuels further cynicism and opposition. Even if it gets through at a second attempt, years of drift have occurred in the meantime. We all share blame for this - politicians, the health sector and local government.

"Working closely with local government requires a leap of faith from both sectors, with greater understanding of each other's cultural and financial pressures"

No one is kidding themselves that the consensus around the Forward View means the job is done. Agreeing principles is relatively easy; implementation will inevitably challenge the interests of institutions and arouse the suspicions of public, patients, clinicians and politicians. Their support must be earned, not assumed. All of all us at a national level must support local communities and stakeholders to make their own case and decisions for change with the clinical and patient-focused case at the forefront of the argument.

Better co-ordinated services, if designed well, should be good for patients, with fewer (or single) pathways eliminating duplication and complexity. The language we use and our technocratic approach, particularly prevalent in the health sector, do us few favours. But we can make a strong case for change: poorly organised services in any sector mean fewer resources for the front line. Closer working relationships between the health and social care sectors improve discharge arrangements. Working together we can ensure for the public a co-ordinated service with fewer entry points and a more seamless transition from community, primary, social and secondary care.

Toby Lambert
Director of Pricing at NHS Monitor

3
What will the future of health partnerships look like?

Cllr Philip Atkins,
(Cons) Leader,
Staffordshire County
Council

With a new Government in place and the first Queen's Speech delivered, right across local government leaders are poring over the possibilities, and setting their strategies, at the start of a new era of devolution and decentralisation. While not every area is necessarily looking for new powers or even ready to seize upon them, in the shadow of Manchester, local areas must be primed to respond to the emerging opportunities.

In Staffordshire our response has not just sought to create something new but instead reflected on how we build on what we already have. Alongside devolution the closer integration of health and social care, also set out in the Queen's Speech, promises to radically transform the scope and scale of local government throughout the new parliament. Indeed these two themes could redefine the very essence of councils across the country. The strength and effectiveness of health partnerships are therefore fundamental to how and what we deliver in future.

Context

Staffordshire is not alone in looking at this issue, or in undertaking significant work and engaging with numerous organisations over the last five years. However, before turning to that, and remembering it is worth looking back in time, the following passage helps encapsulate the challenge:

"The answer is not to go back to an old model of councils trying to plan and run most services. Instead councils should focus on their role as leaders of local communities by developing a clear vision for their locality, organising and supporting partnerships and guaranteeing quality services for all"

Sound about right? This is the role of a local council at a critical juncture, a means of supporting delivery across a local area to provide better outcomes. The author was Tony Blair, in the opening to a publication by IPPR in 1998 entitled 'Leading the Way: A New Vision for Local Government' and would lead to the Local Government Acts 1999 and 2000.

Now I'm not often one for quoting Mr Blair, but the fact that a quote about the challenge ahead for local government in 1998 still rings true 16 years later is pretty stark. In 1998, the focus was to clarify the separation between leadership and accountability in local councils, finding a means to get effective local delivery whilst preserving the need for proper accountability. It also recognised that councils were a crucial delivery partner of central government, but beset by problems: lacking a clear sense of direction, lacking coherence and cohesion in delivery, and the quality of local services was too variable.

The diagnosis of issues and the role of local government in 1998 remains a useful

framework for how we develop local partnerships to meet our shared health challenges. We need effective local delivery around the unified issues of health and care; the answer is not to go back to a system which relies upon the NHS to deliver everything nor assumes that care can only be done by a council. Likewise. recent evidence from the Baker Commission and others shows that there is still huge variation in services and a lack of cohesion.

An additional point is that there is a need for change; the Government through the Better Care Fund, the Care Act, and the NHS through its Five Year Forward View are making the progress towards creating a better aligned and a more integrated system, which meets the needs of our ageing population.

However, as with devolution, there is no one size fits all solution here as demographics and geographies differ so widely. Local areas need effective and functional partnerships to create a unified sense of direction for their own distinct health economies and to provide the coherence and integration that will deliver services on the ground and remain accountable to their people.

Staffordshire Partnerships

All areas have their Health and Wellbeing Boards - but there is also a need to identify and exploit those wider operational partnerships which affect the array of issues which we face strategically.

Staffordshire was not amongst the last government's Community Budget pilot areas but as a commissioning council our focus on outcomes naturally drew us towards the development of effective solutions demonstrated by similar approaches. Examples of our outcomes focused programmes include:

"However, as with devolution, there is no one size fits all solution. Local areas need effective and functional partnerships to create a unified sense of direction for their own distinct health economies"

- Families First, Independent Futures –new, integrated models of supporting families and people with disabilities to access support and preventative services

- The Multi Agency Safeguarding Hub (MASH) – bringing council, police and health professionals together in one office to share information and work more closely to keep children and vulnerable adults safe.

- The Staffordshire and Stoke-on-Trent Partnership NHS Trust – a partnership arrangement that has allowed the council to merge social care and health functions and staff into a single body, the largest of its kind in the UK.

- City Deal – through the LEP and with Stoke-on-Trent City Council, securing City Deal with benefits for our shire area, securing investment to unlock a further £100m of private sector investment and transform the local economy.

These examples are not exhaustive but do demonstrate how the Community Budget ethos is helping us to address local demands. While each has its own characteristics, what the examples share is a focus on leadership, the effective use of insight, and marshalling joint resources to develop new ideas and methods of delivery.

What we have also experienced is the improvement in our relationships with partners, with new approaches in discrete areas are making a difference on the ground. The situation remains far from perfect, particularly in relation to Staffordshire's health economy, but from operational approaches to our strategic partnerships, we understand each other better than we did and we can approach

issues and problems with a common purpose.

Through these partnerships, the various public sector organisations across Staffordshire are better aligning strategies, identifying opportunities and improving the way they deliver against their priorities. However, while this works well in some areas, this may not prove effective enough for dealing with the challenges around our health economy.

Staffordshire Partnerships now

Across Staffordshire, like most other areas, we have a series of crucial strategic partnerships from the Local Enterprise Partnership, a Safer Staffordshire Strategic Board and two Health and Wellbeing Boards. These strategic boards are focused on their particular remits.

Alongside this we have our own pan-Staffordshire partnerships. We have the Staffordshire Hundred which is a group of the key people in the County who meet to look at particular issues, sharing ideas and insights which has proven invaluable in developing our partnership approach. We have also evolved and adapted the myriad of area partnerships – we have a Staffordshire Strategic Partnership Board, a Staffordshire and Stoke-on-Trent Strategic Consortium and a Staffordshire Chief Executive Officers Group.

Taken together, it ensures that across our partnerships we have a common knowledge of each others problems and pressures, and the ability to develop a shared view of the challenges we face and the ability to focus and target those same groupings onto particular problems.

"By bringing together a key city, all of the districts and county council we can identify, agree and tackle our health challenges"

This is one of the reasons why we are also developing a local Leaders Board to focus our strategic discussions within a two tier area in a way that brings together local leaders to speak with one voice, firstly locally with public sector partners, but secondly forms the basis of our discussions with government. By bringing together a key city (Stoke-on-Trent), all of the districts and the county council we can identify, agree and tackle our health challenges, but in a way that makes it part of the same conversations on jobs, growth and housing.

But its not just about a strategic conversation, its also about ensuring that everything is covered and new ideas can be developed. For example the LEP is focused on economic development – but that development covers a broad area from housing to skills. We shouldn't ignore the role of the LEP in terms of health and public health issues which are related to the workforce, but also as a mechanism to ensure that around issues of mental health, work related injuries and illness remain part of the work we undertake to deliver the difference locally.

Health challenges

So how do we make that change in our health system? Local areas largely have the powers they need to create the health economies they want and can underpin the wider approach to meeting better outcomes for local people. This isn't about clarion calls to government; it's about delivering together and supporting each others priorities.

But as I suggested above there are perhaps some core issues which we are facing around health. For me one is a lack of identified leadership, across both local

government and the health system, which means that there is a gap that inhibits the ability of both sectors locally to work together on large scale strategic solutions and cut the Gordian knot.

On the one hand we are incredibly effective at addressing operational issues in a strategic way – the focus around Better Care Fund and the development of Health and Wellbeing Boards increasingly proves them to be the right approach. But there is still little in the way of a strategic forum for system leaders to develop and execute clear plans to fix local health economies at a fundamental level.

To counter this we are developing, as mentioned, a Leaders Board for local authorities, but this has limits and is only part of the solution. As highlighted in Localis' recent report, 'Unblocking: Securing a health and social care system that protects older people', the NHS and Local Government are different sides of the public sector, we have our own cultures, cultural history, financial regimes and experience of public policy.

However we are both likely to endure and experience the new government's policy in much the same way. Without a single forum for local authorities and the NHS (CCG's, Providers and Mental Health), as a means of bridging these areas there is a chance that true devolution of health services and local accountable control will remain confined.

To me a Leaders Board takes us some of the way there, at least for local authorities, but this isn't about replicating 'Manchester' solutions in every area. It is about local partnerships evolving in response to shared challenges and agreed priorities. That might see Health and Wellbeing Boards develop, it might see some other model – but it will take time.

"This isn't about replicating 'Manchester' solutions in every area. It is about local partnerships evolving in response to shared challenges and agreed priorities"

Conclusions

Faced with greater devolution not just to local government but also health, the need for effective partnerships is critical and the issue is ensuring that the partnerships currently established are able to create a shared strategy to support delivery by each local partner.

However on the horizon is the logical notion that this will need to transform to potentially a single strategy which secures the local partnership as a means of delivery.

What does this mean? We can't be exactly sure, it needs to be developed, but currently partnerships are about aligning what we are doing in terms of priorities as separate but interconnected organisations. That is fine and a critical step – but to deliver integrated health systems and truly original devolutionary offers, there is a need to go a step further than having interconnected priorities and use the partnerships as an effective means of delivery.

Cllr Philip Atkins
(Cons) Leader of Staffordshire County Council

4
What could a new care model look like?

Sir John Oldham
Adjunct Professor of Global Innovation, Imperial College London; Recent Chair Independent Commission of Whole Person Care

The challenges that faced the NHS and care system in 1945 were predominantly single diseases, usually infectious, and are not the challenges of 2015. 70% of activity and cost is generated by caring for people with multiple long term conditions or frailty. Yet the system behaves very much as it did in 1945; disease based and siloed with Monty Pythonesque queues of people outside a person's home, each responsible for a body part, when the evidence is clear that the person they are dealing with needs to be viewed as a whole; their physical, mental and social needs together. Many people will have experienced for themselves, or know someone who has experienced, the immense frustration of trying to speak to several different agencies and professionals about the same person. Even adepts cannot navigate the system.

This is illustrated by the story of an old man I came across nearly two years ago. He had long standing chest disease, heart problems and arthritis. He attended numerous outpatient clinics and yet was admitted to hospital numerous times in the previous year, often generated by him dialling 999 because of natural anxiety about breathlessness. Then locally the GPs social care and community services together with Age UK created integrated teams to co-ordinate care for this group of people. Instead of saying "what is the matter with you?", they started by asking "what matters to you?"

His answer was that he wanted to take his dog to the beach again. The team used that as their goal, and began to construct the improvements to his physical health, his understanding of his own diseases, and his care arrangements to make that happen regularly. He stood with his Zimmer frame whilst the dog chased the ball and the waves. He was admitted only once to hospital in the subsequent year. Collectively in that locality this approach reduced admissions in this vulnerable group of people by 30% as well as reducing attendance to GPs—improving the health and wellbeing of the people concerned.

The individual and their needs was the starting point of the Independent Commission on Whole Person Care. Our belief was we had to get the system and organisations to work around the people, not the people have to work around the organisations. One Person helped by people acting as One Team from organisations behaving as One System. Home should become the locus of care.

We trawled the international literature and examples on how best to manage people with multiple problems and published our evidence based recommendations in 2014. I highlight some of the key features.

An integrated multidisciplinary approach involving health and social care is

what delivers the best outcomes. We recommended the establishment of integrated care teams made up of people from all the relevant disciplines at a locality level, with one person in the team acting as the main contact for each person being helped. That professional is themselves involved in the care but co-ordinates others, drawing on specialist knowledge - e.g. the pharmacist or specialist nurse - as required. For the person being assisted this means a continuous relationship with an individual who really gets to know you, and who you can call. Information is given once. An integrated team is not new people but the same people acting differently.

"We recommend the establishment of integrated teams made up of people from all the relevant discplines at a locality level"

Integrated teams don't happen by magic. Getting the right people working in the right way means changes to education and training before and after qualification in your discipline. Before qualification, learning with other disciplines helps someone start to appreciate the necessity of pooling expertise to assist complex problems. Team working needs to be worked at, especially if there has been a climate of mistrust before. But example after example shows this is eminently achievable. The whole of this facilitated by changing the leadership academy for people from health care to become a joint academy including those from local authorities, forming the mutual understanding, and relationships in management that will underpin future change.

Co-management with the citizen to the maximum possible must be the default operating model. This recognises that people have to look after their own conditions for some 8000 hours in a year, professionals intervening for an average of three to four hours. It makes sense to give people the knowledge to help in the 8000 hours.

"Co-management [of objectives] with the citizen to the maximum possible must be the default operating model"

Technology has a clear role in this, indeed a vital role. It is ever a frustration that health care is one of the last industries to embrace the digital revolution, yet one where citizens could reap so much benefit.

Indeed it is emerging countries and people themselves who are showing the way. In Mexico a mobile telecoms company has set up a "phone doctor" service. 60% of calls can be dealt with on the phone, prescriptions picked up at local pharmacies, referral to a list of connected and accredited physicians if needs be and strong clinical governance. All at a fifth of the cost to a Mexican citizen of attending a doctor. In Sichuan province in China, in the wake of the 2008 earthquake devastation, they set up 60 virtual hospitals linked to field workers who carry computer tablets with cloud access to records and with point of care diagnostics.

It is time we used technology to change the model of service delivery, not just being added on to the existing service model. It will shortly be the Facebook generation who have long term conditions. The belief that they will want to struggle to speak to numbers of people on the telephone, travel somewhere with difficulty parking, to wait in a crowded room to be seen for a short period of time by someone they may not know, is illusory. Embracing technology and the users of the system as part of the system is not only better for them, but more efficient for the system as a whole.

The principle of co-management is also why we believe the legal ownership of records should reside with the citizen, not the Secretary of State, as now. This

also helps people from different organisations to work co-operatively, ensuring the flows of information necessary for care to happen. Information governance is important but should be the servant not the master. Indeed information sharing should be a core service element.

None of this works unless the incentives for different organisations are aligned and the financial flows are addressed. For this cohort of people (with multiple morbidity and frailty) we recommended a shift from episodic payments. So called 'Payment by Results', to a Year of Care capitation tariff incorporating all activity over a year. This requires either a coalition of providers, or lead provider and subcontractors sharing the quality goals, and the financial incentives/disincentives—or an integrated provider. The Vanguard future models fall short on embracing social care.

The commissioning plan using this tariff for this cohort of the population and these arrangements we suggested should be driven by a whole system leadership invested in Health and Wellbeing Boards, or analogous arrangements in county council areas. Providers should be part of that conversation. Existing commissioners would remain the accountable organisation; but Local Authorities and CCGs would be legally obliged to enact the joint plan. Not structural change, but behavioural and relationship change. Plymouth are already showing the way. CCGs would continue to commission other things – such as elective care - as of now unless there is local agreement to pool the budgets more comprehensively. We suggested enabling legislation to permit areas to go down this route should they wish.

Finally we made necessary recommendations to address biases in the wider system that will act as a brake on the changes required. For example, let's have greater input from Local Authorities onto the Board of NHS England who should become Care England and the system leader. Let's make sure NHS England has equivalence in its professional input from pharmacists and allied professionals to social care and primary care. 18 National Clinical Directors of body parts doesn't sit easily in a multimorbid world. £1 billion of public money goes into clinical research, yet next to nothing to research how to best manage people with multiple needs and problems. Let's change that. Training boards are geared around the needs of hospitals; let's have balance.

"£1 billion of public money goes into clinical research, yet next to nothing to research how to best manage people with multiple needs and problems"

I have précised our report but I hope I have conveyed there is not one thing to do to get whole person care, but multiple things simultaneously. Everything we suggested could be done within a parliament, much without legislation and is entirely deliverable. However it is also, to some extent, academic unless the elephant in the room is also confronted. Social care deficit will be £7-10 billion by 2020. Although promises have been made about future NHS funding, there is no point refurbishing the house if you don't mend the roof (social care). That said any additional resource for NHS or social care must be in exchange for vigorous reform and rigorous action to reduce unwarranted variation. However our report called for an honest debate with the public, a National Conversation, about the future funding needs of health and social care and how that is to be paid for, or not. Fudge won't do, and the changes we proposed are as necessary as ever.

Sir John Oldham
Adjunct Professor of Global Innovation at Imperial College London; Recent Chair of the Independent Commission on Whole Person Care

5
What will the future of General Practice look like?

Dr Onkar Sahota
Chair
GLA Health
Committee

Before the NHS was established in 1948 GPs ran their own practices as independent practitioners and often operated from their own houses with their wife or housekeeper acting as the telephone receptionist.

When the NHS was established GPs were reluctant to give up their independent status. Therefore the new NHS allowed them to practice as Independent Contractors delivering services defined by the 1948 NHS General Medical Services Contract. The key features of which included:

- That the patient was registered with a named GP;
- That the GP was the gatekeeper to secondary care;
- That the GP had 24 hour, 365 days a year responsibility for providing or arranging care for his patients.

In 1994 this 24 hour commitment became a national issue when GPs were buckling under the demand, leading to low morale and a recruitment crisis. In 1996 the Government allowed willing GPs to set up Co-operatives which could provide Out of Hours (OOH) on behalf of other GPs. This relieved some of the pressure but did not remove the burden of being responsible 24 hours a day, every day of the year.

In 2004 the Government responded further to the recruitment and retention crisis in General Practice by introducing the 2004 GP contract. This made two significant changes:

- The patient will be registered with the practice and not a specific GP,
- Established GP core hours of service would be from 8 am – 6.30 pm Monday - Friday with the responsibility for arranging OOH Service being passed on to the Primary Care Trusts.

Two core principles of General Practice in the UK have thus remained broadly unchanged since 1948:

- Practice based registered patient populations,
- GPs acting as gatekeepers to hospital and other specialised services.

Challenges

Since 1950 with the introduction of the welfare state, childhood immunisations, revolutions in hospital care, public health initiatives and better understanding of the

disease processes, life expectancy has risen sharply. Today life expectancy is 79 years for men and 83 for women across the UK (compared to 63 in men and 69 in women in 1948).[1] We have a growing elderly population, often living alone in the community, with more complex needs[2] such as multiple chronic illnesses including cancers, cardiovascular disease or diabetes.[3]

Due to advances in medical technology, specialisation, therapeutics and the creation of the NHS Internal Market, hospitals have taken the lion's share of the NHS Budget. The focus of the NHS has been on treating sick patients rather than investing in illness prevention and promoting wellbeing. Public Health, Social Care and Primary Care have therefore been starved of investment. This has caused a lopsided health service which does not meet the needs of today's patients; today General Practice receives 8.4% of the £100bn budget despite providing 90% of patient contacts.[4] In their 'Put Patients First' campaign the Royal College of General Practitioners have asked for 11% of the NHS Budget to be spent in General Practice. In real terms spending on GP services fell by 3% from 2009/10 to 2013/14 whilst spending in secondary services has risen significantly.

"The focus of the NHS has been on treating sick patients rather than investing in illness prevention and promoting wellbeing"

We are now beginning to realise that if we are to get more "fizz for our bucks spent" then we must re-focus the NHS to invest in primary care and create the capacity to manage complex patients in the community and improve on the wider social determinants of health. We need to stop seeing patients as simple machines to mend, but as complex social beings who need integrated treatment.[5]

This all is best delivered in General Practice. However the consequences of under investment in General Practice, shifting under resourced care out of the hospital and increasing public demand has led to increased pressure on GPs. In a recent GP survey, 54% of the respondents felt that their workload was unmanageable or unsustainable.[6] This has led to fewer doctors wanting to train as GPs. 12% of training posts were unfilled in 2013/14 (an increase of 2.7% on the previous year) and 700 practices are currently under threat of closure as GPs take early retirement as the vacancy rate has increased by 50% in the last year.[7]

The Future of General Practice

Primary care is the bedrock of the NHS for solving the challenges that face health care in the UK. General Practice can integrate social, mental and health services and work with the local authorities to deliver public health and the address the wider social determinants of health. The 'Five Year Forward' plan released last year by the NHS England Chief Executive Simon Stevens takes on board the overwhelming body of opinion that if we are to address the challenges facing the NHS then we must make more investment in General Practices and community care.[8]

Building on this and to secure a General Practise fit for the 21st century we need to:

1. Deliver Public Health and address inequalities

We simply cannot afford to continue with this high level of preventable illness. Seriously addressing public health must be the number one priority for anyone who wishes to keep the NHS free at the point of delivery. The levels of unnecessary illness because of lack of exercise, poor diet, poor access or awareness to mental health services is unacceptable. We need to model ourselves as a healthy society.

1 The Office for National Statistics
2 The King's Fund, The Care of Frail Older People with Complex Needs (March 2012)
3 Journal of Public Health, The Economic Burden of Ill Health Due to Diet, Physical Inactivity, Smoking, Alcohol and Obesity in the UK (May 2011)
4 Royal College of GPs, Put Patients First
5 The American Journal of Bioethics, Treating Patients as Persons (2013)
6 The British Medical Association
7 Sofia Lind, "GP Vacancy Rate at Highest Ever, with 50% Rise in Empty Posts", Pulse (29 April 2015)
8 NHS England

There are a range of options available to the State to encourage and intervene to reduce poor public health outcomes. They can be summarised as nudge, shove and push.[9] The truth is we need to employ all three to encourage individuals to make healthier choices. The wonderful outcome of a healthier society through healthier choices is not just the reduced number of chronic disease, but also a reduction in mental ill health, giving individuals not just less time in hospital but also happier lives.

Tackling health inequality is central to achieving a healthier society. The gap between the healthiest and least healthy in society is complicated and is decreasing in some ways, but not in others. What is worse is that differences in behaviour, education and access to healthier options, for which at the moment we are unable to measure, are actually storing future inequalities for later.[10] Health inequality is a social injustice which often has roots and solution outside of medicine. It impacts mental health and physical health across whole life courses and so needs to be addressed at a young age. The social determinants of health inequalities must not be ignored (as so often happens).[11]

2. Integrate, personalise and empower care

The London Health Commission Report, published last year, proposed a radical approach to reforming Primary and Secondary Care.[12] Instead of aligning people to services we should align services to people. By grouping patients with similar conditions and needs you can provide better holistic services including mental, physical and social services. This recognises the core understanding of health, that it is not only absence of sickness but also physical and psychological wellbeing.

"Instead of aliging people to services we should align services to people"

I can foresee each patient with complex needs having a healthcare 'advocate' embedded in their practice co-ordinating the delivery of their health and social care needs. On top of this we need to empower patients to look after their own health and manage minor illnesses through self-care and support from the wider primary care professionals, be they pharmacists, opticians, dentists or podiatrists. Patients, assisted by technology, need to become active participants and monitors of their own health rather than passive receivers of interventions.

3. Invest in infrastructure and IT

In order to deliver more services in the community, assemble multi-disciplinary teams, improve patient experience and improve the working environment of the health professionals, it is critical to invest in primary care premises. This is the rate limiting step in the progress to the primary care we aspire for the future.

Historically the majority of GP Practices have been in owner-occupied premises though currently GPs have no appetite to take on the risks of premises investment. The way forward is for the NHS to invest and develop premises and require practices to move into the new buildings (with appropriate compensation). This would ensure that practices are geographically well spread and practices can support each other either through amalgamations or collaborative arrangements.

I can see "polyclinic" type medical centres acting as hubs for community services and supporting a number of smaller practices if appropriate. Technology could revolutionise the way we approach primary care. We need to embrace it. Clustering services doesn't have to mean physical co-location. Services could be grouped over

9 Onkar Sahota, "Tackling Smoking: Time to Nudge, Shove or Push", Progress (22 January 2015)

10 The King's Fund, Tackling Health Inequalities: We Need a National Conversation (2014)

11 Institute for Health Equality, Fair Society, Healthy Lives (The Marmot Review, 2010)

12 London Health Commission, Better Health for London (2014)t

the internet, sharing skills and expertise as well as data and information gathering.

4. Make General Practice attractive

If we do not succeed in making general practice more attractive and increase the GP workforce by 8,000 GPs by 2020 (RCGP estimate) then we will fail to deliver the care we wish to in the community. And the number of practicing GPs will continue to spiral down at even a faster rate.

Over the years, GPs have felt de-professionalised by the need to chase clinically irrelevant targets, being burdened with increased paperwork, micro-management by the NHS and the culture of form filling. Combined with this, we have seen shifting of unfunded work into general practice, not enough time to spend with patients, an increasing workload of complex needs patients and a perception that the ailments of the NHS are due to the 2004 GP Contract. This is the perfect recipe for demoralising the GPs and making the profession unattractive to new entrants.

Fewer students are choosing to be GPs – and more are choosing to leave halfway through their career or opt for early retirement. Student doctors are becoming less likely to choose the role of a primary care doctor whilst training. Instead, they are opting for salaried hospital jobs. Although the number of junior doctors starting GP placements in England has marginally increased, it still falls far short of the Government replacement rate 3,250.

A GP leader recently informed me that the happiest day in his life was when he became qualified as a GP but the next happiest day of his life will be when he takes early retirement. This is a sad indictment of the state of general practice currently.

Since the 2012 Health and Social Care Act the responsibilities of running a practice and requirement for practices to be involved in running a Clinical Commissioning Group (CCG) has had the effect of reducing the numbers of doctors who want to become partners. Between 2000 and 2010 there was a 12-fold increase in doctors choosing to be salaried GPs, while partnership vacancy rates have increased fourfold in both 2013 and 2014.[13]

"The NHS should develop a salaried GP service"

Therefore I think it is important that the NHS should develop a salaried GP service. This will help the NHS to deliver the range of services, the timings of that service and the placement of that service in the premises which are most suitable for the needs of the patient. The aim of this would be to make a career in general practice and primary care more attractive guaranteeing hours and a better work life balance for GPs. This would also give the control to health planners to make the service more flexible for patients. Some CCGs are already looking into the plan on a local level.[14] Developing a salaried service will also focus the mind of NHS England on the level of investment required in General Practice to deliver the services they expect practices to deliver in the current system.

5. Establish a dedicated Out of Hours care service

Providing Out of Hours care is a challenge for the NHS. Both primary care and A&E have to deal with the increased demand on their services. It is more difficult to get GP appointments but some make a conscious choice to access healthcare through A&E or the Urgent Care Centres (UCC). We have seen a huge increase in A&E use by the young working population who find it more convenient to attend the A&E or the UCC where they will see a healthcare professional and have any necessary investigations done all on a single visit.

13 Jaimie Kaffash, "GP Vacancy Rates Quadruple in Two Years", Pulse (27 February 2013)

14 Christina Kenny, "CCG in Talks over Moving to Wholly Salaried Model of General Practise", Pulse, (28 November 2014)

I believe that we need to look at Out of Hours care as a separate service from that of the core hours. It makes much sense to combine the Urgent Care Centre budgets, the Out of Hours Services budget, Social Services care budgets and some elements of the Ambulance Service budgets to combine into a common fund for Out of Hours care. These services should then be resourced adequately, provided from designated premises and employing a workforce focused on providing Out of Hours care. There may very well be some GPs who provide the core hours services and will chose to work for this service, but it would not be a contractual arrangement on the GPs to provide Out of Hours care.

6. Align financial and care drivers

Patient care is currently provided through GP services, community services, social services and hospital care. Further diversity of providers is encouraged by the requirement to put out services to tender to Any Qualified Provider. This inevitably will lead to further fragmentation of services and create obstacles in the care pathway of the patient.

"It makes much more sense to have hospital, community services, general practice and social service budgets to be put in one single envelope for a borough wide health population"

Hospitals currently are paid by results and have the perverse incentives to admit more patients and discharge patients inappropriately when their beds are occupied by patients who cannot be discharged due to a lack of social services in the community. In the current system, health care and social care are not organisationally or financially aligned. It makes much more sense to have hospital, community services, general practice and social service budgets to be put into one single envelope for a borough wide health population. This health economy would act in a way to deliver the most efficient health care, in the most appropriate setting by the most appropriate professional and to get it right every time. It would ensure that all the parts act coherently in the best interests of the patient.

The financial incentives and flow of incomes needs to follow patient care to ensure that we truly are able to deliver an integrated and seamless care pathway. This has been an aspiration of the NHS since its creation but so far we have failed to deliver it due to the organisational barriers that have been created by the structures that exist in the NHS.

Democratic accountability in the NHS is important and especially for such a combined budget. This could be delivered through the Health & Well Being Boards of the Local Authorities. It is important to ensure the whole of the local health economy works in a way to deliver the healthcare of that population and that the organisation is acting in a way which is in the best interests of the patient.

Conclusion:

General Practice is the foundation and the bedrock of the NHS. However, it has been neglected over the last 10 years by falling investment and overburdened with service requirements that are not adequately resourced. This has led to stresses in the system, low morale amongst the professionals and doctors and nurses taking the first opportunity to retire or emigrate. If any company had the morale or an employee exit rate similar to that of the NHS that company would be a failure and its shareholders would be asking serious questions of the management. For the NHS the shareholders are the people of the United Kingdom and the management, ultimately the Secretary of State for Health, should be held accountable for what is happening in the NHS.

The future of General Practice can be and should be a bright one. The current crisis can still be turned around but it requires bold decisions, not just tinkering at the margins but fundamentally considering what are the needs of the 21st century of the Health Service in this country and how to deliver them. We need to invest in general practice, empower patients, and take advantage of technological advances. We need to recognise that until you create the environment where people enjoy working in the NHS you will not able to deliver a happy workforce or indeed deliver on the objectives of treating the ill, promoting wellbeing and illness prevention in the NHS.

The NHS should take the bold decisions to shift care from the hospitals into the community by investing in Primary Care premises and expanding the skills and number of the workforce. The future of the NHS is uncertain unless we invest and adapt General Practice for the needs of the 21st Century. The future is in our hands.

Dr Onkar Sahoka
Chair of the Greater London Assembly Health Committee

6

What does the NHS workforce of the future look like?

Robert Webster
Chief Executive, NHS Confederation

The NHS is made of people. The relationships between the people who work within the NHS and the people who use it defines its essence and its purpose. This is a simple truth that is overlooked at our peril.

"We must start with the needs of the population"

When thinking about the healthcare workforce for the future we must start with the needs of the population. These should shape the type of services that we provide and in turn this will shape the type of workforce we will need. There is now a broad consensus on what the healthcare needs of the population are likely to be in short term. This is set out in everything from the NHS Confederation curated 2015 Challenge to the Five Year Forward View. The key elements include:

- Greater demand for healthcare from all sections of the population due to rising awareness, healthcare innovation and lifestyle based conditions such as obesity
- A growth in demand from older people with multiple conditions
- Technological developments such as new diagnostic tests and biogenetics

These demands can best be met through a range of changes to how care is delivered

- A significant emphasis on prevention and the wider determinants of health
- Working more with the patient as an "expert" in their own care through a shift to supported self-care and self-management
- Moving healthcare closer to the patient through even greater provision outside hospital in community settings
- Looser collaboration within healthcare and greater integration between health and social care

These trends which are found across the developed world will accelerate. Beyond 2020 it is less clear how needs will change as we cannot yet see the full impact of fascinating developments such as genomics. Some believe that, using genetic markers, we may soon be able to treat cancer like an infectious disease or tailor drugs to specific people. There is also – as ever - a debate over future funding options for the NHS.

This link between people and service is simple. Yet talk about workforce planning in any room full of NHS commentators will quickly turn to hand wringing or easy shots taken at what is a difficult subject. It shouldn't be so.

There are three tools we can use to consider the healthcare workforce of the future:

1. Looking into a crystal ball

There have been various attempts in the past to predict future demands for healthcare staff based on extrapolating data on demographic need and supply trends. We have sophisticated methods for modelling future demand and supply. Many of these are elegantly designed to create elaborate models that map onto past workforce trends. Yet the past is not the future and societal and policy changes can dramatically alter plans.

The "holy grail" of all workforce planning systems in healthcare is to match service needs with supply. The length of time it takes to train healthcare professional and the rapid pace of technological change can create a mismatch between decisions on supply and output. The degree of choice for medical students also makes it hard to ensure that desired numbers are delivered. For example, at the moment there is a growing gap between projected numbers of trainees in General Practice and demand for GPs. Some steps are being taken to address these issues now but in the longer term more radical change will be needed in primary care delivery. A relative glut of pharmacists may hold the key.

"The "holy grail" of all workforce planning systems in healthcare is to match service needs with supply"

The recent push to increase staffing levels in the wake of the Francis report is causing severe strain in the short term as hospitals see to increase staffing levels to assure themselves and inspectors that services are "safe". This should not distract from the longer term need to shift services out of hospital settings.

Local employers are engaged in developing projections in the short term and Healthcare Education England has developed the first Workforce Plan for the NHS for 2016 onwards. The NHS is seeking to source more of its staffing from UK trainees and is also now operating on EU wide basis for recruitment. Major changes are under discussion for the shape of medical training.

Models suggest the future healthcare workforce will need to be both more specialist and more generalist, more female, more diverse and with a different mix of skills. It will also need to be more team based and multi-disciplinary.

2. Looking in the mirror

Seven out of ten of our staff that will be working in 2020 are already in the service. The future workforce is the current workforce. The length of training for professions and the length of service of NHS staff means that the existing workforce will be at the centre of provision in future. Unlike in other sectors role redesign and culture change will need to be largely based on working with existing employees.

Past attempts at centrally managed service redesign have had a mixed record. A more locally led approach will include identifying the education and training needs of our current workforce and equipping them with the skills to deliver new models of care, as well as expanding new health and care roles, to ensure we are 'future proofing' the system. There are calls for a more "generalist clinician" role in hospitals. This would reverse the trend to specialisation there has been over the past decade.

If we are to exploit the skills and assets that we have in front of us, we must also address the issues about race equality within the NHS. We cannot expect an organisation that does not allow BME talent to flourish to be successful.

3. Answers on a postcard?

Some have argued that the NHS needs to adopt workforce models that have been developed in other healthcare systems such as the "Hospitalists" i.e. general physicians found in some American hospitals. Clearly the NHS can and should seek to learn from other systems. The challenge will be to "borrow the best without trying to drive on the wrong side". The NHS has historically been slow to adopt innovations found elsewhere for example physician assistants are far more widespread in the USA and integrated care roles more common in the Nordic countries. We do also need to get better at spreading and learning from good practice within our healthcare system. There are myriad examples how healthcare roles are already changing to meet new needs. The NHS has not been good at sharing this experience. It also needs to be accepted that the solution that works in rural Northumbria will differ from what is right in inner city London. Common principles do not require a standard solution as needs differ. Local health and social care bodies from Sheffield to Somerset are already working out innovative ideas based on existing practice and we can also share experience across the UK

"It also needs to be accepted that the solution that works in Northumbria will differ from what is right in inner city London"

Challenges

The NHS Confederation 2015 Challenge called for Government and national policy-makers to help build a consensus around the expectations on the health and care workforce in a modern, 24/7 service. The Five Year Forward View is a significant step toward this. There remains a significant risk though that the Five Year Forward View, and our own 2015 Challenge manifesto, will suffer the fate of strategies that have come before them: warm, even inspiring, words will achieve little without concerted leadership. NHS organisations need support from national bodies to experiment with new approaches.

The Healthcare Education England Workforce Plan 2015/16 takes some essential actions to address pressing workforce problems. We need go further to find innovative solutions on a longer term basis. For example looking to the developing of new medical roles with greater generalist sills and making greater use of non-medical professionals in primary care.

Beyond the NHS workforce

"When considering the healthcare workforce we must remember that a large amount of healthcare is not delivered by paid staff"

All of this misses the biggest opportunity of all. When considering the healthcare workforce we must remember that a large amount of healthcare is not delivered by paid staff. It is provided by patients and service users or their carers. There are 18 million people with at least one long term condition. There are around 6 million carers providing a wide range of care. Volunteers – 3 million of them - also play a crucial role in sustaining the service as has been seen in recent winter pressures. A large and growing proportion of healthcare is delivered by staff who are not employed by NHS bodies, independent and third sector providers. Most social care is delivered by the independent sector. All of these organisations need to be fully involved

And looking further beyond this still, investing in people with the right skills elsewhere in the system - in schools and nurseries; in housing, leisure and employment services; in the criminal justice system, is all important too if we are serious about improving health and wellbeing and reducing health inequalities.

Change

For the existing workforce, this may require enhanced communication skills, greater knowledge of resources in their local community, or the ability to work with group and family dynamics. It might also mean embracing new technologies and media so that they can engage with people in ways that are most convenient and meaningful to them

This is why the 2015 Challenge calls for the resourcing of a sector-led programme to equip our existing workforce for the challenges of working in new ways, including with different sectors and professions, engaging service users and supporting personalised care and support planning, shared decision-making and self-management. People who have spent a career learning how to operate in one team are about to be asked to join another.

As part of the to and fro of the election campaign parties were drawn into a bidding war of promising increases in specific numbers of particular staff groups. As we have seen in the past this can all too easily lead to a focus on "delivering" the numbers rather than changing how care is delivered. Now the "sound and fury" of the campaign is over we hope we can return to a more informed dialogue about what type of services we need to provide the care that the public are entitled to expect. In areas such as midwifery this could require further increases in staff numbers whilst in other areas the focus will be on changing how care is delivered alongside better management of existing staff.

"For medical staff we need to take long term decisions about career pathways to adress shortages in primary care and potential oversupply in hospitals"

For medical staff we need to take long term decisions about career pathways to address shortages in primary care and potential oversupply in hospitals. The NHS needs a debate about the type of workforce that it needs to deliver changing health and care needs. The NHS Confederation will work with Jeremy Hunt to help make this vision work effectively on the ground.

Conclusion

The workforce of the future is largely the workforce of today. If we open up our minds and broaden our perspective about who is in the team, we can change to meet future needs. This will require a values based approach to leadership that takes a long cold look in the mirror, in the crystal ball and in the box of postcards on top of the wardrobe. The future for health and social care is its people - some of the finest people doing the toughest and most rewarding jobs in the country. We have a workforce that can be fit for the future. The NHS will only survive if we work together to ensure that it is.

Rob Webster
Chief Executive of NHS Confederation

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