All Party Parliamentary Group
Primary Care & Public Health

Inquiry Report into the Sustainability of the NHS
"Is Bevan's NHS under Threat?"

July 2013

Contents

i. About the APPG

The All Party Parliamentary Group on Primary Care & Public Health

The Group was established in 1998 by Stephen Hesford MP, Dr Howard Stoate MP, members of parliament until the May 2010 elections, and Lord Hunt of Kings Heath who is still a member of the APPG. The function of the Group is to raise the profile of primary care and public health within Parliament; to speak within Parliament on behalf of both users and those working in the NHS; to place primary care and public health high on the Government's agenda and to inform debate by parliamentarians with outside bodies.

Current membership

Officers:

Nick de Bois MP (Co-chair)
Kevin Barron MP (Co-chair)
Julie Elliott MP (Co-chair)
Baroness Masham (Secretary)
Baroness Gardner (Executive Officer)

Members of the Group:

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Powers:

Although APPGs are registered in Parliament, they are unofficial interest groups of cross party MPs and peers with the objective of raising awareness about issues in parliament, important because they represent parliamentarian opinion and keep Government informed of this. As far as powers are concerned, unlike Select Committees where Government is required to respond to inquiry reports and attend meetings if requested, there is no such obligation in the case of All Party Parliamentary Group inquiries and meetings. Attendance and responses from Government are completely at the discretion of Ministers.

Secretariat:

Secretarial services are provided by PAGB, the body representing the consumer healthcare industry. We would like to make it clear that the views expressed in this report however are solely those of the All Party Parliamentary Group on Primary Care & Public Health.

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ii. Structure of the Inquiry Report and Acknowledgements

This is the report of a six month inquiry into the long term sustainability of the National Health Service. Following a short introduction, the report begins with the conclusions and recommendations and continues with extracts from the written and oral evidence.

We would like to take this opportunity to thank those individuals and organisations that have supported the work of the APPG by providing written and oral evidence. (For a list of these organisations and individuals see Annex i).

We are also grateful to Government for contributing written evidence; which is included in Annex ii. If you would like to receive evidence from any of the remaining organisations, please contact the secretariat.

This report has been sent to Government for consideration.

1. Introduction

In 2012 the Nuffield Trust reported that unless health funding could increase beyond inflation, the NHS is set to face a funding gap by 2021/22 of around £50bn.

In 2013 the King's Fund revealed the NHS could consume over 50% of public spending in the next 50 years and the NHS Confederation told us the NHS is facing its biggest financial challenge, coping with a flat budget and rising demand and costs.

Added to this the burden of an ageing and expanding population, (the birth rate has risen by 22 per cent in 10 years), patients' and professionals' growing expectations as treatments and technologies advance and people's improper use of health services (each year there are 57 million GP consultations for minor ailments), we felt it was time to examine views on what can be done to ensure the future sustainability of the NHS.

This inquiry is not about alternatives to Nye Bevan's NHS. Our belief is that the only fair health service is one which is publically funded through taxation and, free at the point of clinical need and not ability to pay; although defining "clinical need" would be worth debating.

There is no doubt that the NHS is a precious institution and it is important that we protect it for future generations. We are also hopeful that future generations will have a better understanding of how to look after their

own health and as a consequence, require less health intervention than is currently the case. In fact, Don Bewick of the Institute for Healthcare Improvement sums up an ideology that we aspire to:

“Health care has no intrinsic value at all, none. Health does. Joy does. Peace does...the best health care is the very least health care we need to gain the long, full and joyous lives that we really want. The best hospital bed is empty, not full. The best CT scan is the one we don't need to take. The best doctor visit is the one we don't need to have."

1.1 Terms of Reference

Our terms of reference for this inquiry were as follows:

Can the NHS survive long-term under the current taxation funded system given the financial pressures and heavy demand on the service?

Do you believe that by working smarter, cutting waste, engaging health professionals to look for efficiencies and the public in their own health can improve productivity and health outcomes?

a) Can you identify areas where waste can be cut and are there barriers to this being implemented?

b) How can health professionals be engaged to look for efficiencies and are there barriers?

c) How can we engage people in their health to keep them healthy and out of hospital longer, are there barriers?

How can the new NHS produce better health outcomes and educate individuals about how to be healthy by working jointly across the NHS and local authorities?

What role can Government play at NHS England level?

a) DH and Public Health England level?

2. Conclusions and Recommendations

Conclusions

The 21st century threat to the long term sustainability of the NHS is lifestyle choices people make and their consequences for health.

Preventative illnesses are overwhelming the NHS; illnesses caused by obesity, smoking, alcohol and lack of exercise. Diabetes, for example takes up 10% of the NHS budget, of which 90% is spent on dealing with preventable complications.

In Aneurin Bevan's new NHS people sought help for health problems caused by communicable diseases, bad sanitation, poor housing and malnutrition. 65 years later the massive demand on the NHS is largely due to people's inability to look after their own health and choose healthy options.

This was highlighted in 2002 when Sir Derek Wanless told us the future of the NHS depends on engaging the population in their health. And yet, in 2013 people's self care seems to have disappeared as we access health care more intensively than ever. Changing people's health behaviour is now imperative as we are faced with huge demand, static funding levels, an ageing population, and as the birth rate increase, an expanding one!

There is also increasing expectations amongst the public of what the NHS should provide. And, as we have a funding gap of £50bn predicted by

2022, change has to happen or, we've been told, the NHS could be reduced to little more than an emergency service; which is inevitable if we do nothing.

With the July 2013 consultation on the NHS Mandate, Government has recognised the need for the NHS to make better use of resources in light of the challenging fiscal climate.

Improving people's health behaviour and keeping them out of hospital will not only improve our nation's health but will also reduce demand on the service and free up resources in the NHS. To do this we need a concerted strategic push to bring about the changes needed. We need a public debate about affordability of health services and we need strong leadership in the system, including a cabinet level Public Health Minister to focus policy around behavioural change:

Health Behaviour:

70 per cent of adults in England engage in two or more of the main unhealthy behaviours – there is a desperate need to address this in a strategic way and it is mainly the responsibility of local authorities. It is still early days, and we are anticipating great achievements from localism, but it is essential that all local health experts are brought together to support the local population in their health.

Public Debate:

As health service demand increases, there is a growing need for a public debate on Bevan's NHS, free at the point of clinical need. Even though it isn't, people see it as "free" and this has a bearing on their use of health services. And, "clinical need" has to be clearly defined. In short, we need a debate with the public to discuss affordability and limitations in the NHS and this has to happen on a national, regional and local scale.

Leadership:

We are uncertain where strategic leadership lies in the re-structured NHS. Strong direction across the health sector is needed; to connect the various strands of health policy implementation by local, regional and national health agencies. These leaders should be identified and promoted across the whole health fraternity.

Public Health Cabinet Minister:

Keeping people well and out of hospital must be a top priority for Government and a dedicated Cabinet level Public Health Minister should be responsible for this. The Minister will pay particular attention to health inequalities and work across all departments linked with health such as education, transport and housing.

The NHS is a precious institution of British democracy, it is essential that we make sure it continues to provide high quality health care to our population for generations to come.

Here are our ten considered recommendations:

Recommendation i: To help secure the future health of our nation, savings made as part of Government's efficiency drive must be reinvested in healthcare and prevention and not given back to the Treasury.

The NHS in England recorded a surplus of £1.6bn for the 2011/12 financial year and £1.9bn in 2010/11. Nearly £3 billion of this total under spend has been returned to the Treasury.

Recommendation ii: Government, politicians and Royal Colleges must begin a debate with the public, the media, patients and professionals to bring about an understanding of how to make better use of finite NHS resources in keeping with fiscal constraints.

Frank conversations are needed with the public and NHS staff about how the NHS should confront the pressures on the system and the consequences of rising expectations of the health service.

Recommendation iii: A dedicated Cabinet level Public Health Minister should be employed to focus on prevention and work across all departments that are linked with health such as education, transport and housing.

Leadership is needed in Public Health with sufficient power to question the impact of cross-departmental policies on the health of the nation.

Recommendation iv: Strategic leaders must be identified and empowered to ensure strong action is taken to improve professional, community and individual health engagement on a local, national and regional level.

Strategic leadership is needed across all sectors of the NHS to connect all the strands of health care policy on every level, bringing an end to management in silos.

Recommendation v: More school nurses must be employed to help educate children into looking after their own health and how to use the NHS properly as well as community nurses who can play a key role as community champions and ambassadors engaging with people about their health.

More investment is needed to help engage people in their own health as a matter of good clinical practice.

Recommendation vi: Perverse incentives that result in over use of the service must be removed.

There is a need to re-think targets and incentives in the NHS so that they drive outcomes, quality, efficiency and effective partnership between commissioners, providers and other key stakeholders in local communities.

Recommendation vii: Senior managers in secondary and primary care must introduce, as a priority, processes to tackle waste in the NHS.

Recommendation viii: Community pharmacists must carry out Medicines Use Reviews (MURs) as much as possible; to work closely with patients and develop solutions around their use of medicines, and the cap on MURs in community pharmacies must be lifted.

There is a need to tackle over-prescribing of medicines and to better understand why some patients don't take their medication as prescribed which often results in medicines waste.

Recommendation ix: The NHS must implement continuing professional development (CPD) to address mental health and wellbeing at an experiential as well as theoretical level.

Addressing physical health without an understanding of the way mental health underpins this is profoundly wasteful.

Recommendation x: Both the GP and pharmacy contracts must have prevention and self care education built into it, to encourage CCGs to include it as part of their work with providers of secondary and community care.

Prevention, where possible, should be included in all NHS contracts.

3. Summary of Evidence

Can the NHS survive long-term under the current taxation funded system given the financial pressures and heavy demand on the service?

Our analysis is that from its inception and to an increasing extent over the last ten years the NHS has focused on increasing the supply and diversity of services rather than addressing the drivers of demand and health needs. We are now at a critical point where we need to move from acrimonious debates about closure and rationing of services to robust discussion with politicians, the public, the media, patients and professionals about the development of cost-effective ways to address demand.

This is the only way in which the NHS will survive as a universal taxation funded system, reflecting the original intent to establish a public risk pool.
NHS Alliance

The long term viability of the NHS is of concern to all respondents. Increasing demands on the service and static spending on health are the two main causes for concern.

The Nuffield Trust illustrates the position we are in with health spending saying that unless it increases beyond inflation the NHS is set to face a funding gap by 2021/22 of around £50bn. Improved productivity of 4% per annum across the NHS reduces the deficit by around 40%. However, even if this were possible, it still leaves a large funding hole.

Demands on the service are not helped by the increases in demographic pressures as highlighted by Dr Anita Charlesworth. Dr Charlesworth, who is chief economist at the Nuffield Trust, says these pressures are likely to cost the NHS around £1.1–1.4 billion extra each year (at 2010/11 prices) up to 2017.

Lifestyle risk is also thought to be a factor in health care demand. According to the King's Fund, 70 per cent of adults in England engage in two or more unhealthy behaviours, these risk factors impact considerably on the NHS. And, by 2016 3 million of us are expected to have no fewer than 3 long term conditions.

The NHS has simply not evolved to cope with the increases in demand according to the RCN's Dr Peter Carter. He points out that because of unhealthy behaviour people are living longer but not living longer healthily which is putting the NHS under huge strain. He reveals that in 1948 just 350 people reached 100 and in 2010 the number was 12,000.

Dr Charlesworth agrees that people are not living longer healthily and she says the advancement of more effective treatments enables people to live longer with complex diseases or disabilities which have expensive care requirements. Because of these advancements, people's and professional's expectations have grown, with people expecting more and more from the NHS.

Public expectations are of concern to other respondents including GP and Self Care Forum Board member Gill Jenkins who says GPs are overworked as a result of expectations and patient demand on the NHS.

Crystal Oldman from Queen's Nursing Institute says these expectations start at an early age, she wants to see more school nurses providing self care education in primary schools to help people look after their health.

The link between a sustainable NHS and engaging people in looking after their own health was made in 2002 by Sir Derek Wanless when Gordon Brown commissioned him to look into the future of the health system. Reminding us of this, the Faculty of Public Health said engagement is still very much the answer today. Dr Charlesworth, who worked with Sir Derek on his report, says we have to re-embrace the fully engaged scenario that Wanless spoke about. And, the NHS Confed believes people should be actively engaged in their own health and not simply passive recipients of care.

Integrated health care is thought to be a positive way forward in the drive towards a sustainable NHS. The RCN says it will improve the patient experience and provide value for money; Celesio UK believes integrated care will take us from a reactive healthcare system, treating episodic illness to one which seeks to prevent illness arising.

Do you believe that by working smarter, cutting waste, engaging health professionals to look for efficiencies and the public in their own health can improve productivity and health outcomes?

Working smarter and cutting waste, are essential to the achievement of an appropriate service however it is not without its difficulties. For the manager the primary concern is to keep costs down. The obvious way is to reduce the numbers of staff; the cleaning materials etc. Working smarter, cutting waste and looking for more effective ways of doing things is not the prerogative of the health professionals. Everyone involved has the opportunity to contribute to whatever degree to what is needed.
Frank Kenwood, Retired Mental Health Nurse and Physiotherapist

All respondents agree that by tackling waste and working smarter the NHS

will improve productivity. And, as a consequence of Government's efficiency drive to save £20bn by 2015, managers in secondary and primary care are already attempting to address waste in the NHS.

However, by joined up working in the health system, more can be done, particularly when it comes to NHS time. The PSNC for example, says the use of general practice for diagnosis of common and easily treatable conditions is no longer affordable. They claim the NHS has trained people to look to general practice for all their healthcare needs, and, workload pressures mean this is no longer viable.

Illustrating this, they refer to IMS research showing there is over 50m GP consultations a year for minor ailments, accounting for 18% of GP workload, and costing the NHS £1.5bn in GP time. PSNC's solution is to have community pharmacy help people understand and treat their common conditions.

Dr Jenkins agrees that GPs are overworked and says pharmacists have more time to speak to patients and the public and often sends her patients there for OTC treatments and advice.

Tackling service demand in primary care is something the Self Care Forum (SCF) is attempting to address. Dr Jenkins, who is a Board member, says the SCF has produced tools such as fact sheets and an online learning course to support primary care. The hope is to educate and encourage patients to look after their own minor ill health and provide them with the confidence and knowledge to also manage more serious conditions.

Medicines waste caused by over-ordering and throwing away un-used medication was highlighted by the RCN's Frontline First campaign and something that has to be addressed in both secondary and primary care.

Dr Jenkins agrees and says half of prescribed drugs are not used. She admits GPs often end consultations with a prescription to provide reassurance to patients; for common conditions this seems to be in line with IMS research which states 90% of GP consultations for minor ailments end in a prescription. These ingredients are available without the need for a prescription relatively cheaply, for example paracetamol, for which 21 million prescriptions were made last year, can be purchased as cheaply as 16p.

As far as medicines use is concerned, one solution is to optimise patient use of medicines by working closely with them, to better understand their issues around medication use and then how to develop solutions[1]. This can be done though community pharmacy and Medicines Use Reviews (MURs).

a) Can you identify areas where waste can be cut and are there barriers to this being implemented?

The need to treat lung cancer is waste – smoking cessation works and is far more cost effective at prolonging life than treatment for lung cancer.

The need to treat heart disease is a waste – increasing physical activity levels, stopping smoking, improving diet are all preferable and cheaper.

Treating measles is a waste – increasing vaccination uptake rates is more efficient; every case of HIV is a waste when it is easily preventable.

There are barriers to smoking cessation (quality of services, access to services for vulnerable groups) as well as things that can be done to prevent people smoking in the first place (standardised tobacco packaging).

There are barriers to preventing heart disease – transport systems and public open space that do not encourage incidental physical exercise; the availability of cheap high fat / salt / sugar food actively marketed to vulnerable populations (e.g. children); smoking (see above). **Faculty of**

[1] Royal Pharmaceutical Society – Medicine Optimisation www.rpharms.com/medicines-safety/medicines-optimisation.asp

Public Health

Prevention was cited by respondents as being the most sensible way to cut waste. Engaging people in their health, supporting and encouraging them to choose healthy lifestyles and teaching them to look after their long term conditions is the obvious way to ensure NHS resources are not wasted. However, the barriers to enabling this are numerous as a cultural change is required for clinicians as well as patients and the public; something that takes time and co-ordinated effort.

Service redesign could influence cultural change according to the NHS Alliance who wants a more integrated system; co-creating health through partnership and effective sharing of information between clinicians, patients and the wider public, which, they say would improve engagement and health.

A focus has to be on people's health literacy according to a report by the Patient's Association in March 2013 (Primary Care Access Denied?). The NHS Alliance agrees since those with poor health literacy are more likely to access emergency services, to be hospitalised, less likely to take medication correctly and to use preventive services and generally incur higher healthcare costs.

More localised examples of waste were identified by the RCN's Frontline First campaign such as: poor administration systems which take up too much time and too many resources; IT systems that don't properly support staff; incorrect disposal of clinical waste at great cost; inefficient electricity usage, with lights being left on in unoccupied rooms etc.

Highlighted by a patient, Mary Ayers encountered waste through lost patient files and outpatient appointments booked without the co-ordination of having available results. To improve demand in A+E she wants to see GPs used for triaging.

b) How can health professionals be engaged to look for efficiencies and are there barriers?

Whole organisational 'buy in' and action is required as the issues of waste in the NHS are not unsolvable. Wastage will not be solved when even more is asked of staff who are working in increasingly pressurised environments, often with insufficient staff. Staff need sufficient time to feed in and to help implement any changes required, this means senior management support is vital. **RCN**

Having clinicians in primary and secondary care aware of perverse incentives would help considerably towards efficiency savings, since, according to the NHS Alliance and Dr Gill Jenkins, some incentives encourage increased service use, and focus on throughput such as waiting times and bed occupancy.

The NHS Alliance believes a re-think of the current system of targets and incentives is needed since, it discourages approaches that would make clinicians think "could this patient be cared for just as well or better elsewhere at less cost". Targets and incentives also encourage a silo rather than a partnership approach within provider organisations and services. Dr Jenkins agrees suggesting for example, there is a problem with the way secondary care colleagues are paid, she says there is an incentive to get patients into hospital and keep them there.

Other difficulties for health professionals are often about balancing the desire to do the best for individual patients with improving the health of populations. This is something people don't understand and should be more publically debated in the context of limited resources; for example, spending increasing amounts of money on cancer drugs to prolong life have opportunity costs in terms of less money available to prevent cancer.

Frank Kenwood agrees there is a finite amount of funding available and notes we should not mistake the 'wants' of the person with the 'needs' of that person.

c) How can we engage people in their health to keep them healthy and out of hospital longer, are there barriers?

The bottom line is teaching people that they are responsible for their health, young people need education about first aid, self care, drugs and alcohol before they are teenagers. **GP Gill Jenkins, Bristol CCG + The Self Care Forum**

Respondents recognise the need to engage people in their health and acknowledge the impact this will have on the sustainability of the NHS; indeed, the RCN says self care brings benefits to individuals, clinicians, the NHS, Government and society as a whole.

However, as the College of Optometrists points out, helping people to manage their condition is one thing but changing people's behaviour to prevent disease in the first place is much harder.

And, it's not helped, say the RCN when there are job losses of specialised nurses who help in the provision of self care education.

The importance of educating school children to look after their health and how to access NHS services cannot be underestimated in the drive towards a sustainable future. Dr Jenkins believes this is necessary to ensure they become true health partners of the NHS. For this to happen however there would have to be more integration between government departments.

GP Anita Nathan believes policies, recommendations and guidelines have to be simplified and this is hampering systems that could incorporate

greater engagement. She is also keen to see better communication of patient medical information within the multidisciplinary team; which requires more efficient IT systems in place to increase integration between primary care and secondary/tertiary care.

How can the new NHS produce better health outcomes and educate individuals about how to be healthy by working jointly across the NHS and local authorities?

Improving mental wellbeing will directly address many of the Public Health Outcomes Framework indicators local authorities must meet in order to prove they are improving healthy life expectancy for their whole population. Indicators include levels of social connectedness, employment for people with long term conditions, sickness absence rate, levels of health risk behaviours such as smoking, mortality from preventable health conditions, as well as self-reported wellbeing. **Mind**

Health and Wellbeing Boards are thought to be key to integrated care in local communities, bringing together local commissioners in health and public health to improve the health of populations.

Respondents however are concerned that some specialists such as pharmacists and optometrists will be side lined and not invited as part of the integrated team.

Pooling of budgets was also thought to be necessary to make localism work according to the Faculty of Public Health who believes the separation of the budgets are a barrier to close working, they say, for example, if local government spends money on smoking cessation it is the NHS that saves by not treating cancer or heart disease.

The British Acupuncture Council wants primary care professionals such as GPs to be flexible in who they use and how they work to achieve health outcomes. They should have the ability to bring in practitioners such as

acupuncturists, to practice, to help with specific issues such as medically unexplained symptoms or musculo-skeletal services.

What role can Government play at NHS England level?

> The NHS should sit alongside the Home Office and Treasury as primary functions of government rather than, as it stands, number nine on the list of government relevance and importance. The Secretary of State for Health must be someone that commands the respect of the NHS staff, the professionals and the public; capable of putting the NHS first rather than politics, respect the NHS and maybe performing the role of an advocate. **Albert Persaud: The Centre for Applied Research and Evaluation – International Foundation**

Whilst Government's vision is of having the NHS run from the bottom up, with ownership and decision-making in the hands of professionals and patients, respondents feel more leadership is necessary across the health sector as a whole, to connect the various layers and offer direction and focus for health and public health.

Respondents are keen to see government provide support, both political and financial to Health and Wellbeing Boards, to ensure their effectiveness in every local area. The NHS Alliance also wants to see accountability of Boards from local scrutiny and wider engagement of patients and the public rather than multiple targets and want this facilitated by NHS England. There is also a call for greater transparency in commissioning and in contracts.

IT was of particular concern to many respondents and the College of Optometrists want to see improvements between primary and secondary care as well as the collection and use of health data such as ophthalmic public health data.

4b) DH and Public Health England level?

Mental wellbeing and early intervention is crucial in mental health. Both the DH and PHE can play a key part in reducing barriers to good mental health and help promote mental wellbeing and resilience amongst the population. **Mind**

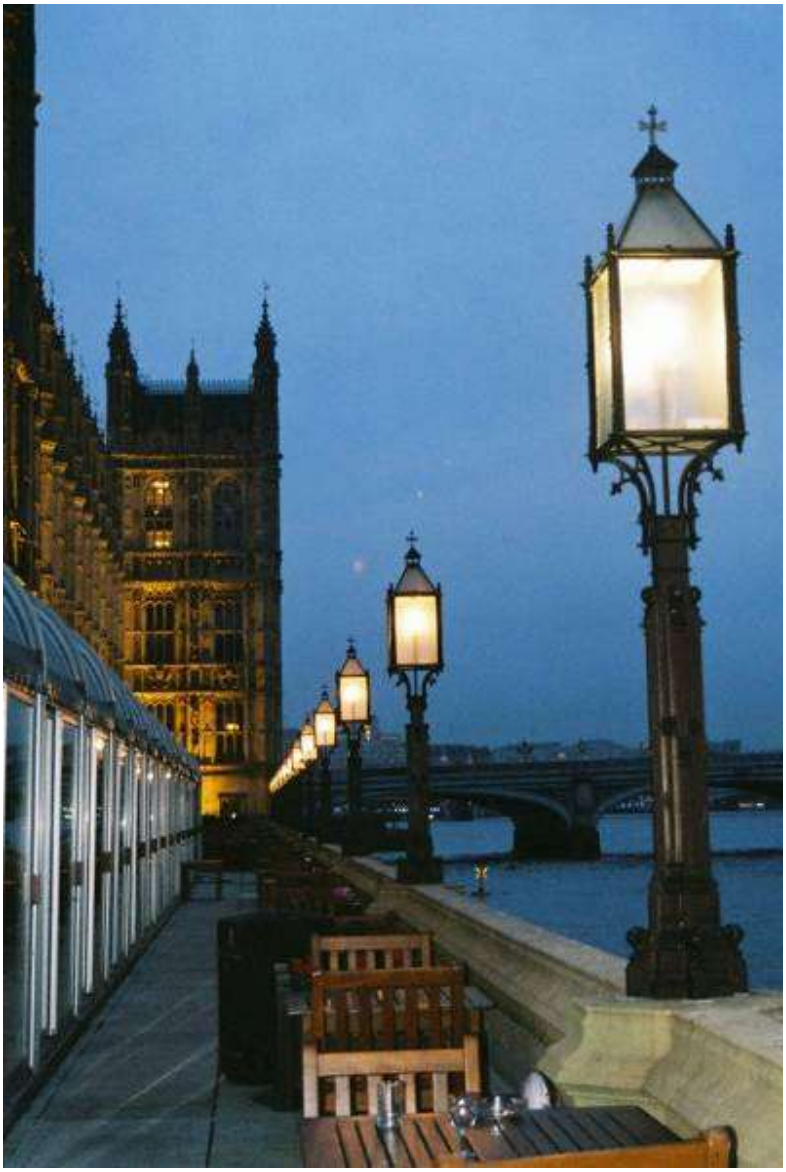
A major focus for the DH and PHE, according to NHS Alliance is to take a developmental approach to the current outcomes frameworks which are aligned with service and organisational silos and aim to provide a comprehensive approach. Over time, the framework needs to move towards addressing the key drivers of demand through a system of shared outcomes that will encourage partnership working at the level of local health and social care economies.

Directors of Public Health (DPH) will also have a critical role in the leadership and management of public health services and initiatives. They must have the authority and independence to advise and guide public health decisions. The RCN believes DPHs should be appointed on an executive level and be accountable to the local authority chief executive.

Albert Persuad is keen for local NHS non-executives, and similar NHS roles, to be locally elected and not simply appointed. By doing this, the candidate will be able to provide their own manifesto for improvements of the local population's health. This way, Professor Persuad believes health care and services will have more of a local ownership and participation.

NHS Confederation highlights the role of competition in the NHS and believes while introducing or increasing competition is considered by local commissioners to be one route to improving care and outcomes, Clinical Commissioning Groups and other commissioners of NHS services need to be able to use it at their own local discretion, informed by evidence-based

national guidance. The Confederation expect Monitor to be flexible in the way it exercises its new roles and powers, keeping in mind the pressures on the NHS over the next few years.



ALL PARTY PARLIAMENTARY GROUP

Primary Care and Public Health

Annex i – Evidence from Organisations and Individuals

Written Evidence

Mary Ayres, (Migraine Action Association) + collaborators

British Acupuncture Society

Celesio UK/Lloydspharmacy

The College of Ophthalmologists

Faculty for Public Health

Frank Kenwood, Retired Mental Health Nurse and Physiotherapist

Government

Mind

Dr Anita Nathan, GP

NHS Alliance

NHS Confederation

Nuffield Trust

Lord Albert Persuad, Centre for Psychiatry

PSNC

Royal College of Nursing (RCN)

Seton During, Costcutters General Ltd

Oral Evidence

Dr Peter Carter, RCN

Dr Anita Charlesworth, Nuffield Trust

Dr Gill Jenkins, Self Care Forum, NHS Bristol CCG

Prof Klim McPhereson, the UK Health Forum

Andy Murdock, Celesio UK

Crystal Oldman, Queen's Nursing Institute

Dr Michael Sobanja, NHS Alliance

Annex ii – Evidence Submitted By Government

All Party Parliamentary Group on Primary Care and Public Health inquiry into working smarter in the NHS

Written evidence from the Department of Health

Efficiency and cutting bureaucracy

The Government's vision for the new health and social care system builds on the core values and principles of the NHS: a comprehensive health service, based on clinical need not ability to pay, and free at the point of use. Huge improvements have been made in health and care over the last 30 years, but continuing those improvements is extremely challenging in the context of financial pressures, our ageing population, changes in lifestyle and rising expectations of the health and care services. The purpose of the reforms is ultimately to deliver better care and to obtain better value for money.

The changes to the system are intended to improve efficiency within the NHS, ensuring that it is sustainable in the long term through cutting bureaucracy and duplication; delivering real autonomy for providers matched by transparency and accountability within a regulated system; and creating stronger incentives for quality and efficiency.

In order to manage resources more effectively, clinical and financial incentives have been brought together. Clinical commissioning, the centrepiece of the reforms, gives greater control and responsibility to the professionals whose decisions commit most NHS spend. By empowering clinicians to commission services directly, working closely with their local partners, there can be better management of people with Long Term Conditions alongside more efficient use of NHS resources.

Monitor, the new sector regulator, has a specific role to protect and promote patients' interests by ensuring that services are provided effectively, efficiently and economically, while quality is maintained or improved. It works closely with the Care Quality Commission (CQC) to do this. It also has a duty to enable joined-up care from different providers by working with CCGs and other organisations.

The reforms have also tackled excessive bureaucracy by reducing spending on unnecessary management and administration functions whilst protecting the jobs of health professionals. Over a four year period the cost of the administrative infrastructure is being reduced by a third in real terms – from around £4.5bn pa to £3bn.

Cutting bureaucracy, through other routes such as around performance managing process targets, will free up clinicians to focus on what matters most – improving outcomes for patients. Products such as the Back Office Efficiency and Management Optimisation Report and the NHS Atlas of Variation, give organisations and clinicians the tools and evidence to optimise key functions whilst freeing up resource to invest in driving through greater outcomes from clinical interventions.

The NHS has delivered £5.8bn of QIPP efficiency savings in the 2011/12 financial year whilst maintaining the quality of services that it provides (as set out The Year: NHS Chief Executive's Annual report 2011/12). This provides firm foundations for sustained delivery over the next three years, as the NHS continues to face ongoing challenges from rising demands in a funding-constrained environment.

Efficiencies can be achieved in two principal ways, first by driving out inefficiencies from the system, whether in procurement, pharmacy, or the way the service deploys staff. The second is to create significant improvements to the way services are currently delivered to patients, finding new and better ways of providing care. The new system provides more freedom for local clinicians and organisations to plan services according to local needs. It is crucial that service changes are led by clinicians, involving patients and are based on the best available evidence. The Government wants to encourage a greater focus on preventing ill health, and empower local communities to plan services according to local priorities. We expect to see, where clinically appropriate, significantly more care delivered in primary and community settings, reducing the need for them to go to hospital for expensive and often reactive care. This can only be achieved through a collaborative approach from all health organisations, sharing ideas and cooperating closely with each other and with key partners such as social services.

Innovation

Innovation is an essential tool in helping to address the challenges of an ageing population, chronic disease, health inequalities and rising public expectation – especially when resources are constrained. We know that the NHS can spread new ideas at pace and scale when that is its focus, and has a successful track record of doing so. Through our High Impact Innovation programme we intend to deliver long term sustainable improvements in key services and for the first time linking these improvements to the payment of Commissioning for Quality and Innovation (CQUIN) money by creating a qualification gateway. This embeds quality and innovation within a commissioner/provider discussion to create a culture of continuous quality improvement. The Department issued Guidance to the NHS in December last year to help it meet this requirement and have developed a website where they can provide peer support and share best practice.

The current total value of the CQUIN scheme is 2.5% of provider contract value. Innovation Health and Wealth, sets out that from April 2013, compliance with six high impact innovations will become a pre-qualification requirement for CQUIN. In practice, this means that providers will need to meet agreed implementation goals for the high impact innovations by this month - March 2013 - in order to qualify for CQUIN payments in 13/14.

The six high impact innovations are: 3 million lives; intra-operative fluid management; child in a chair in a day; international and commercial activity, digital by default; and carers for people with dementia.

Good progress has been made. Usage of fluid management technologies has risen by 23% in the last 12 months. Next month, we will have signed off the plans for the 3Million Lives pathfinder sites and reviews of children's wheelchair services are underway. Guidance on how the NHS can improve both the quality and cost of care by making use of digital

technology was published in the summer of 2012 and last month we published an online tool to allow CCGs to benchmark the provision and use of technologies.

Over time, innovation initiatives of the sort described will have a profound effect on the way people perceive and experience the NHS. Patients will see a focus on health and prevention from an NHS that is personalised, with services tailored to individual needs, providing integrated solutions, tackling inequalities, improving access and wherever possible delivering care closer to home.

Long-term Conditions Management

There are an estimated 15.4 million people in England with at least one Long Term Condition (LTC). Whilst the number of people with one LTC is projected to be relatively stable over the next ten years, those with more than one is set to rise to 2.9m in 2018 from 1.9m in 2008.

The annual health and social care cost per person per year for an individual without an LTC is £1000, this rises to £3000 for those with one LTC, and £8000 for those with three. In total around 70% of the total health and care spend in England is accounted for with caring for people with LTCs. This means that 30% of the population accounts for 70% of the spend. As the population of England ages, it is also important to note that LTC prevalence is strongly linked to age: only 14% of those under 40 report having an LTC compared to 58% of people aged over 60.

These demographic pressures and the rise in the number of people experiencing co-morbidities, mean that providing the right support to people with long-term conditions has never been greater.

Better management of patients with long-term conditions is fundamental to manage future demand in the healthcare system. Supporting the focus on improving health, care and well-being for older people, the Care and Support White Paper published last July aims to change care and support in two fundamental ways by promoting people's independence, connections and wellbeing, and by enabling them to prevent and postpone the need for care and support, and by putting them in control and ensuring services respond to what they want

Transforming Social Care and Support

The way in which care and support is structured also needs also needs to change to respond to the changes in demand and expectation. This creates an opportunity for local authorities to innovate and explore new ways of working, to better meet the needs of local populations. They are best placed to understand the opportunities that exist in their areas and the service transformations needed.

The Department of Health's A Vision for Adult Social Care set out some of changes that local authorities should look to take forward in order to maximise value for money in adult social care. These included:

Maximising the potential of re-ablement services. Re-ablement can help people to regain their independence after a crisis, and can have a significant positive impact on people's

quality of life. The Personal Social Services Research Unit and the University of York has provided evidence that re-ablement services improve outcomes and are cost effective for local authorities.

Rolling out telecare support, which can help people to live at home independently for longer by providing technologies that make their homes more safe and secure.

Reducing spending on long-term residential care for reinvestment in other services. In A Vision for Adult Social Care, the Government set out how supported housing and extra care housing can offer flexible support in a community setting, which may provide better outcomes at lower costs than traditional high-cost nursing and residential care models.

Ensuring that the separation of responsibility for commissioning and providing services becomes standard practice. As set out in A Vision for Adult Social Care, the Government believes that local authorities with substantial in-house provision should look to the market, including social enterprises, mutual and voluntary organisations, to replace them as a local service provider.

The Government is working with the Local Government Association's Adult Social Care Efficiency Programme to support local authorities to deliver these savings.

Improving public health

The Government has an ambitious programme to improve public health through strengthening local action, supporting self-esteem and behavioural changes, promoting healthier choices, and giving appropriate information to support healthier lives.

The White Paper 'Healthy Lives. Healthy People' (November 2010) has given, for the first time, a real priority to prevention and early intervention together with ring-fenced funding for local authorities to take action to improve the health of their local populations. Also for the first time, there is a real recognition of the wider determinants of health and adoption of a 'life course' approach to tackling health inequalities.

The Government is taking wide-ranging action to tackle the risk factors giving rise to the major burden of premature mortality, morbidity and disability including setting national ambitions to reduce smoking, obesity and unhealthy diet, physical inactivity, and the harmful consumption of alcohol.

The Department is working with industry through the Public Health Responsibility Deal which has been established to tap into the potential for businesses and other organisations to improve public health and tackle health inequalities. Five networks – considering food, alcohol, physical activity, health at work, and behaviour change – have been established to develop and implement pledges for action. Over 500 partners have signed up to the Responsibility Deal, including all major supermarkets.

The Change4Life social marketing campaign is encouraging individuals to make simple changes, such as eating more fruit and vegetables, cutting down on snacks and fatty foods, reduce harmful levels or patterns of alcohol consumption and be more active.

In addition, the NHS Health Check programme is a risk management programme for people in England aged 40-74, with around 15 million people eligible. Its aim is to help prevent heart disease, stroke, diabetes and kidney disease, and will help people stay well for longer. The programme has the potential to detect at least 20,000 cases of diabetes or kidney disease earlier. It could also prevent over 4,000 people a year from developing diabetes and 1,600 heart attacks and strokes. NHS Health Check risk assessments will be mandatory for local authorities to commission in the new public health system.

ALL PARTY PARLIAMENTARY GROUP
Primary Care and Public Health

Annex iii –Write Up from First Oral Evidence Session

Inquiry: Is Bevan's NHS Under Threat?

2 – 4pm, Monday 15th April 2013

Name	Org	Job Title
Anita Charlesworth	Nuffield Trust	Chief Economist
Michael Sobanja	NHS Alliance	Policy Director
Andy Murdock	Celesio UK	Pharmacy Director
Dr Peter Carter	RCN	Chief Executive & General Secretary

APPG Members	
Nick de Bois MP	Chair
Kevin Barron MP	Chair

Over the last 10 years, investment in the NHS acute sector in England has seen fast growth, but the primary and community sectors have experienced none – even though they are producing better outcomes and patient satisfaction rates at reduced cost, MPs have been told.

By investing in acute care but not primary and community care "we are backing the wrong horse," Michael Sobanja, policy director of the NHS Alliance, told the All-Party Parliamentary Group (APPG) on Primary Care and Public Health recently.

"The NHS cannot survive without significant change – there needs to be a much greater focus on the development of primary care and public health," said Mr Sobanja, who was giving evidence to an inquiry held by the APPG to consider whether the vision of the NHS held by Nye Bevan, the Labour Health Minister who spearheaded the development of the Service in 1948, is now under threat.

Bevan's vision - of a health service available to all and financed entirely out of taxation – was hugely ambitious, APPG co-chair Kevin Barron told the inquiry.

20th century Service, 21st century demands

"He wanted the health service to be constantly changing, growing and improving, to always appear to be inadequate – and at the moment it appears that it is inadequate, coping with the demands of the people in the 21st century," said Mr Barron, who is Labour MP for Rother Valley.

"The NHS is not the same as it was 60 years ago. Services and treatments that are now available on the NHS have expanded – which is great news for the population since we are all living longer – but this has clearly had an impact on the NHS," he said.

Over the last 30 years, demands on the NHS have been increasing and all the evidence suggests that this will continue – but funding for the Service will not be able to keep pace, the inquiry heard.

This latest APPG inquiry had been prompted by a remark made to the Group at a roundtable discussion last year by a director of a clinical commissioning group (CCG), who told the panel that "the NHS is not short of cash, but we are short of the sensible use of it."

"It was this discussion that made us think that we should hold an inquiry and invite experts and commentators to share their ideas of how to cut waste and help lessen demand on the Service, to protect the NHS and keep it safe for future generations," said Mr Barron's fellow co-chair, Nick de Bois, Conservative MP for Enfield North.

However, he emphasised that the debate is not about ways of funding the NHS other than through taxation. "I would hope that no parliamentarian would advocate a health service that is anything but free at the point of delivery or funded through taxation," he said.

In fact, the rapid growth in health spending has not been accompanied by an increased tax burden, Anita Charlesworth, chief economist at health policy think tank The Nuffield Trust, told the inquiry.

In the 30 years before the current economic crisis, UK public health spending had increased from 4.4% of Gross Domestic Product (GDP) to 7.1%. This was made possible by significant changes in the composition of public spending, with considerable reductions in the share of GDP spent on other public services, such as defence and housing, the Trust points out.

Spending on health in the UK is in line with the average for member nations of the Organisation for Economic Cooperation and development (OECD), but in response to the economic crisis, the rate of growth has been sharply reduced - in real terms, it has fallen for the last two years. "The UK has robust measures in place to contain health spending in the short term, including a budget which provides for health spending to increase broadly in line with whole economy-wide inflation until at least 2015," says the Trust.

A rising and aging population, more NHS interventions

Pressures on the NHS are divided fairly equally between demand and supply, and the demand side includes not only an aging population but also an expanding one, said Ms Charlesworth.

The NHS is also intervening more. Over the last decade, not only have rates of diabetes soared, but also, in 2010 a woman aged 50-55 with diabetes was far more likely to be receiving NHS treatment than in 2005. Increased spending on hospital and outpatient treatment is raising funding by about 2% a year in real terms, she said.

The NHS is broadly coping with the current tight funding situation – in fact it is slightly underspending, but this is partly due to public-sector pay having been held constant for two years and now capped, she told the APPG. But what will happen when pay pressures re-emerge?

Moreover, beyond the current economic crisis, health spending is – along with pensions – a major driver of long-term growth in public spending, and it is projected to increase at a faster rate than government receipts, she warned.

So can the NHS survive long-term under the current taxation-funded health system, given the financial pressures and heavy demand on services?

Healthcare is more than just the NHS - it involves GPs and pharmacists contracted to provide professional services on behalf of the NHS and it encompasses individuals taking

responsibility for their own health and wellbeing, Andy Murdock, external relations and policy director for Celesio, told the inquiry.

And this is critical because it determines whether or not we can move from a healthcare system which is primarily designed to treat illness in an episodic fashion to one which seeks to prevent illness arising and, when it does, for healthcare professionals to work together in a joined-up manner based around the needs of the patient.

But such integrated care requires new contractual arrangements to provide incentives which encourage joint working and better collaboration, says Celesio, an international trading company and provider of logistics and services in the pharmaceutical and healthcare sector. In the UK, Celesio comprises companies such as Lloydspharmacy, AAH Pharmaceuticals, Evolution Homecare, Wilkinsons Healthcare, Dr Thom and Betterlife.

Community pharmacy: "one of the nation's most under-utilised healthcare assets"

"Our recommendation to the APPG would be this - to recognise that there is existing potential for community pharmacy to deliver better patient outcomes and illness prevention within a finite NHS budget which needs to achieve efficiency savings," Celesio told the inquiry.

"We increasingly need our GPs focused on providing support for those with complex conditions, yet over 20% of a GP's time is spent dealing with minor ailments which, in most cases, result in a prescription. It is not only cheaper to provide a minor ailment service in community pharmacies, it provides improved access to healthcare, particularly in deprived communities. From April 2013, England is the only country in the UK which does not have a national minor ailments service provided in community pharmacies," the group points out.

We need productivity rather than efficiency - the NHS cannot cope without service redesign. People are being treated more intensively in hospital, but we need to restructure services rather than pushing more people through hospitals, said Michael Sobanja.

"The early stages of the Quality, Innovation, Productivity and Prevention (QIPP) programme were about national initiatives, but QIPP 2 must be about service redesign and doing things differently," he told the APPG.

He called for more initiatives like the Super Six model of diabetes care developed by Southern Health Foundation Trust and Portsmouth Hospitals. This states that the diabetes services which should be provided within an acute Trust are: inpatient diabetes; foot diabetes (with predefined criteria); poorly controlled type 1 diabetes - including adolescents; insulin pump services; low eGFR or patients on renal dialysis; and antenatal diabetes.

Common risk pool, monopoly provider

Bevan's vision of the NHS was about setting up a common risk pool and monopoly provider of services – it was about taking over responsibility from the self to the state. While the risk pool is not now under threat, the monopoly provision element might be, said Mr Sobanja.

And the debate about a monopoly provider ignores the role of pharmacy, and of informal carers, he added.

"We are now at a critical point where we need to move from acrimonious debates about closure and rationing of services to robust discussion with politicians, the public, the media, patients and professionals about the development of cost-effective ways to address demand. This is the only way in which the NHS will survive as a universal taxation-funded system, reflecting the original intent to establish a public risk pool," the NHS Alliance warns.

The wrong incentives?

But, under current and recent government policies, clinicians' behaviour is largely driven by incentives that encourage increased service use and targets that focus on throughput; they do not encourage a search for efficiencies in terms of "could this patient be cared for just as well or better elsewhere at less cost." The current system of targets and incentives also encourages a silo rather than a partnership approach within provider organisations and services, the Alliance points out.

The APPG inquiry also took evidence from Dr Peter Carter, chief executive and general secretary of the Royal College of Nursing (RCN). He told the panel that while the College fully accepts the big financial challenge facing the NHS, "our issue is about the way in which many NHS organisations and Trusts are going about dealing with it."

The RCN has concerns about the "short-termist" implementation of QIPP by some employers who are closing services and reducing staff numbers. This is potentially negatively affecting patient care and safety and leading to "boom-and-bust" workforce planning, it says.

Nor does the College oppose service closures where they are based on what is clinically best for patients and communities. Service redesign must be intelligent, well-thought-through and look at how patient needs can be met in another way – but, when this isn't the case, a short-term perspective of achieving financial savings can damage patient care and service provision, it warns.

People "are living longer, but not living healthily"

"Is the NHS under threat? It is certainly under huge strain - the population has changed in a way that in Bevan's day would have been unforeseeable," said Dr Carter. Back then, just 350 people each year reached the age of 100 - in 2010 the number was 12,000. But the Service has not evolved to cope with this. For too many people, they are living longer but not living longer healthily, he told the MPs.

And there is the care issue - money is not being spent wisely, he said.

"There is still a huge amount of informal care and we would be sunk without it," said Anita Charlesworth. "Traditionally, such care was provided by daughters, but male life expectancy is now catching up with female, and more and more, older people are being cared for by elderly partners. They are limited physically, but with support they can care for longer."

"We need to recognize who is caring, and get respite care for them – a little bit of state support when you need it can pay the NHS back enormously," she stressed.

So how can we engage people in their health to keep them healthy and out of hospital for longer?

"Increased self-care brings many benefits, not only for the individual, but for clinicians, the NHS, government and society as a whole. Over the years, support for self-care has grown. It is essential for sustainability in the NHS, managing expectations and targeting resources," says Dr Carter.

But what about people who won't or can't look after their health? Nick de Bois asked: should the taxpayers be picking up the bill for treating "Friday night boozers" in A&E?

This is a problem for society - such treatment is regarded as an entitlement, which is unintended consequence of a free service, said Dr Carter. But the UK now has very high rates of type 2 diabetes, while lower-limb amputation rates among have never been higher among the young, and they have the highest rates of liver disease in Europe.

And this entirely due to binge drinking, he said.

The government has to have the debate with people to help them make the link, to realise that these problems are a direct result of their lifestyles. We need to do much more work on this, Dr Carter urged.

And Mr Barron asked: should people who end up in A&E because of overdosing on alcohol or drugs be charged for their overnight stay?

You would have to look at each case on its merits – some people will be impervious to such sanctions, but others should be charged, said Dr Carter, but Mr Sobanja asked: where do you draw the line? This would involve making thousands of individual decisions.

Regulation, education, taxation

The experts saw an important role for politicians. Without enforcement moves such as the establishment of minimum alcohol prices, advance has been slow in dealing with alcohol-related health issues, but when Parliament passed legislation aimed at getting people to stop smoking, progress there was much faster than had been anticipated.

“Making smoking illegal in public was what worked. To improve lifestyle behaviours, you need education, awareness and legislation,” said Dr Carter.

Regulation, taxation and public education combined will create cultural change – they are all part of the mix, the inquiry heard. However, it was also pointed out that while it is very straightforward to tax cigarettes – which are clearly “bad for you” - it is much more difficult to do so for food and alcohol.

Regulation and taxation matter but they do not change behaviour and the NHS must not say that it is no longer its job to deal with problems such as binge drinkers, Anita Charlesworth warned. A good A&E department will identify those people with serious drink problems and link them into the right services – this is part of “every contact counts,” she said.

Also, A&E cannot turn away patients with chronic obstructive pulmonary disease (COPD) who are smokers. Personal responsibility happens within a context, she stressed.

What else should politicians be doing?

They need to engage the public in a discussion about the importance of using the NHS responsibly, Ms Charlesworth urged.

“Over the last 30 years, we’ve spent dramatically more on healthcare without the public feeling that they’re paying for it. There is not yet the perception that there is a problem. But we must use the NHS responsibly or we will lose it, and we must have this conversation with the public,” she said.

“But politicians will need courage to have this conversation – and we won’t win it,” said Nick de Bois. “We need the health professionals to stand up and do this.”

“If an A&E director says ‘this place is unsafe,’ people listen,” he said.

The panel deplored the actions of some MPs in defending service changes in general but also attempting to prevent closures in their own constituencies. Politicians must not interfere when service changes are agreed in their areas, they said, and noted that some of the most “interesting” service changes have happened in the safest parliamentary seats.

But the public are very concerned, Anita Charlesworth warned. “They are being told that care needs to be moved more into the community but they wonder if the services will actually be

there, so they need to be getting much more convincing evidence. We are putting so much effort into the closures but not into the new services," she said.

"Which is why we need whole-service redesign, otherwise you get destabilisation. Narrow bespoke changes rarely make the paradigm shifts," Dr Carter responded.

What can and should community pharmacy be doing to help people self-care?

Pharmacy can play a vital role, and the pharmacy contract has support for self-care, but there is a tension with the General Medical Council (GMC) GMC contract which covers doctors, said Mr Murdock. We need to see where we can establish joint ventures and to develop more systematic risk-based interventions rather than ad-hoc ones, he told the panel.

Pharmacy "has the whole agenda"

Pharmacy has the whole self-care agenda and the whole public health agenda, he said. It also has the medicines optimisation agenda, making sure people are taking the right medicines at the right time, and making the best use of them. 35%-50% of people are estimated to be not taking their medicines properly, or at all, and the result for patients is a lower quality of life, avoidable hospital admissions and premature death.

Community pharmacists could and should be playing a leading role in both reducing medicines waste and increasing adherence – "we have the New Medicines Service (NMS) and Medicines Use Reviews (MUR), but there is a monthly cap on the number of MURs – this is absolute nonsense. And we need to be able to access patient records," he urged.

Mr Sobanja pointed out that community pharmacy in Scotland has developed at a much faster rate than in England. "Government policy there is putting incentives and contractual arrangements in place. But in England, the funding stream does not encourage doctors and pharmacists to work together and nobody pays anyone to make sure patients are taking their medicines properly," he said.

But the extension of the National Institute for Health and Care Excellence (NICE)'s role into developing Quality Standards is a reason for optimism; "internationally, people are very jealous," said Anita Charlesworth. However, while we do now in the UK have a "do not do" list, there is no level of accountability to go with it. "We need good data and transparency about delivery against standards – this is now weak," she said, and repeated: "we must start with transparency."

Clinicians are increasingly having to make decisions about providing care. They need to get patients to understand that, for example, if they write them a free prescription for paracetamol, that might well impact on whether or not another patient gets their hip replacement, said Nick de Bois**.** And he wondered why 21 million prescriptions were issued last year for paracetamol, an easily-available pain reliever which can cost as little as 16 pence per pack over the counter. This has massive cost implications, he said.

Andy Murdock responded that GPs may write prescriptions for paracetamol for various reasons - for patients who are exempt from prescription charges, for example. But, he added: "there are two issues here. First, shouldn't the pharmacist have been handling the problem that required treatment with paracetamol through a minor ailment service, and also be telling the patient that it is cheaper to buy it OTC rather than on prescription?"

One vital step

Finally, the experts were asked: "if there was just one thing that you believe must be done in 2013/2014 to get us on our way to a sustainable NHS, what would it be?

Anita Charlesworth: “everything points to the centrality of primary care, but we have not seen any investment there. It is very difficult to explain why so many out-of-hospital services are run separately. We need a serious root-and-branch look at primary care as the hub of out-of-hospital care, and to revisit initiative such as polyclinics.”

“And we won’t convince the population about the need for change without a proper conversation.”

Michael Sobanja: “the complexity of work undertaken by GPs has grown immensely in the last 10 years - many patients have long-term conditions and co-morbidities, and more people are now treated in primary care and community services. Yet there has been fast growth in the acute sector but none in primary care, which is producing better outcomes and patient satisfaction rates at decreased cost. We are backing the wrong horse.”

“We need to be backing the right horse, having the right conversation – and for the Health Secretary to be acting as the Public Health Secretary.”

Andy Murdock: “we need to take a long hard look at who does what. How long-term conditions can be moved to community pharmacy. And we need an element of joint incentives if we want improved outcomes.”

Peter Carter: “my wish is for the Health Secretary to get a health promotion and prevention campaign going. With the growth of lifestyle diseases and diabetes, the NHS is unsustainable as it is. We have to do something about that.”

ALL PARTY PARLIAMENTARY GROUP

Primary Care and Public Health

Annex iv – Write Up from Second Oral Evidence Session

Inquiry: Is Bevan's NHS Under Threat?

2 – 4pm, Wednesday 24th April 2013

Name	Org	Job Title
Crystal Oldman	Queen's Nursing Institute	Chief Executive
Dr Gill Jenkins	The Self Care Forum / NHS Bristol Clinical Commissioning Group	LTC Clinical Lead
Professor Klim McPherson	The UK Health Forum	Chair, Board of Trustees

APPG Members	
Nick de Bois MP	Chair
Kevin Barron MP	Chair

People must start using the NHS in a more responsible way and take greater control of their own health care, if the Service is to be sustainable for future generations, MPs have been warned.

The public need to understand the unprecedented financial pressures which the NHS is now facing and use it more responsibly, experts have told a recent inquiry held by the All-Party Parliamentary Group (APPG) on Primary Care and Public Health at the House of Commons.

Otherwise, there is a danger that the NHS could dwindle down into becoming an emergency service only, warned Dr Gill Jenkins, a GP and clinical lead for long-term conditions at NHS Bristol Clinical Commissioning Group (CCG).

"And people have to realise that if the NHS did go bang, they would have to look after themselves" – insurance companies won't cover their problems with alcohol, diabetes and other issues, she added.

The APPG has been inquiring into whether the vision of the NHS held by Nye Bevan, the Labour Health Minister who spearheaded its development in 1948 - as a health service available to all and financed entirely out of taxation - is now under threat.

Dr Jenkins, warned that, as it now stands, the NHS is not sustainable for various reasons, including an ageing and growing population, the growing chronic disease burden, high costs of new diagnostics and treatments – and the public's very large expectations, said.

Her CCG in Bristol now requires around 160 conditions to be approved by its Exceptional Funding Committee, many of which, like varicose veins, people expect to be treated routinely on the NHS. And "we will be reviewing the conditions to see what we might have to add," she said, adding: "patients are not happy."

NHS funding by taxation "the only way"

Professor Klim McPherson, chair of the UK Health Forum at New College, Oxford University, told the panel that while he hoped the NHS can remain fully funded by taxation, "I am not optimistic."

But, he added, while continuing to fund the NHS by taxation will be expensive and cause problems, it is the only way to do it if we want to minimise costs.

Patients' "ambiguous" needs can be met by methods such as waiting lists, while independent GPs, who are well-informed about their communities, should have greater discretion about who to refer for hospital treatment, he proposed. But people must become more aware of what healthcare does and about prevention. And while we may not be keen on creating new laws, "we will have to do it when 50% of certain populations have type 2 diabetes," Prof McPherson warned.

The importance of managing the public's expectations was also emphasised by Crystal Oldman, chief executive of the Queen's Nursing Institute. "Currently, the belief that 'the NHS will pick up everything' is widespread," she pointed out.

So where do these expectations start? Right from a very early age, and this is why we need to bring back school nurses, she said. In recent years their numbers have declined hugely, but they are in a great position to start the health and self-care education process.

"People say: 'we know what a healthy lifestyle is,' but in fact not everyone does know, and they need educating," she said.

GPs "utterly overworked"

Dr Jenkins gave the MPs a stark insight into the effects these challenges are having on the Service.

Patient demand has racked up expectations, and as a result GPs are now "utterly overworked" and many may "have reached a point of despair," she told the inquiry.

The public believe they have the right to demand everything – and to have it "now." In Bevan's day, GPs were the gatekeepers to the rest of the NHS, but now, people want to be referred – "today."

And A&E departments are "swamped" - they are not achieving their maximum four-hour wait times, while the introduction of the 111 number has led to an increase in 999 ambulance call-outs. 111 is "the ultimate triage service, but it is not working," because it is staffed by non-clinicians – and they are very risk-averse, she said.

Dr Jenkins saw a need for both long-term and short-term solutions. Long-term, her CCG is looking at work around educating people in self-care and self-management, with both better primary prevention and secondary prevention to help stop exacerbations of their conditions.

The GP Quality and Outcomes Framework (QOF) and the Quality, Innovation, Productivity and Prevention (QIPP) are also drivers for GPs to be looking at different ways to prevent ill-health and prevent waste, and "the projects are getting the whole team working together."

But we need to get people aware of other sources of support. Including the Internet? Yes - but this is also a big factor in increasing patient demand. "If you Google 'headache' you get 'brain tumour' - the Internet is scuppering us," she warned.

What can and should pharmacy be doing?

“Pharmacists are part of everything - advice, education, etc. We have seen the value of working with pharmacists in medicines management, in terms of increasing the appropriate use of medicines and saving money, and have expanded our work with them,” she said.

Healthcare “that does more harm than good”

Prof McPherson surprised the MPs by telling them that “a good deal” of current healthcare is provided on the basis of inadequate evidence and possibly does more harm than good, or does not provide sufficient net benefit for its cost.

How is this possible?

Because “intrinsic plausibility” influences the way we judge things, he explained. In the way our minds judge the efficacy of an intervention, all the weighting is pushed towards “we want this to work.” So when you do experience it, it seems to work, when it fact it doesn’t. This is not deliberate, nor is it malicious or stupid, he emphasised.

Some examples of such “lifesaving” interventions which have been found to be more harmful than helpful include high trauma in children, hernia repair, tonsillectomy and, in the past, hysterectomies. Also, in the US, gallbladder treatment given prophylactically to asymptomatic patients, “just in case.” And radical mastectomy for breast cancer, on the grounds that “it would be unethical not to do it.”

“The problem is that doctors are not getting funding to do proper research,” he said. “Unless you test an intervention, you simply don’t know. A lot of healthcare is based on plausibility.”

APPG co-chair, Conservative MP Nick de Bois, asked: is this widespread? Do people know about it?

The Evidence-Based Medicine (EBM) movement is quite strong, Prof McPherson replied. Up to 30% of healthcare provided is not evidence-based, and on an individual patient basis, you just don’t know if it is good or not.

Another example is statins, for which the original work was done in men with heart disease, said Dr Jenkins. There is no evidence that statin treatment might help a 68-year-old woman who does not have heart disease but does have high cholesterol - but plausibly, you think it might help, she said.

In a tax-funded NHS, you’ve got to be clear about what you’re funding, and this must be only those treatments which you know to work, Prof McPherson told the panel. But, he pointed out, the National Institute for Health and Care Excellence (NICE) has guidelines for some treatments for which there is no evidence.

Systems and mindsets “must change”

The NHS is funding the most important treatments, Nick de Bois responded. But, he added, what is needed is a big switch to public health and primary care, and a mindset shift - among clinicians as well as the public - that people should be managing their own care.

We need system change and mindset change - also among acute care professionals, Ms Oldman agreed. She pointed out that media coverage of healthcare issues is always about hospital care - there is the assumption that health care always means hospital care.

Yet the context of patient’ lives is the home and the community, not the hospital.

Stunning new evidence on obesity

Prof McPherson also produced some startling evidence of the effects of an ambitious cross-government strategy aimed at tackling England's obesity crisis. The strategy, entitled Healthy Weight Healthy Lives, was published in January 2008. In its foreword, then-Prime Minister Gordon Brown wrote about the "growing problem of the so-called 'lifestyle diseases,' of which obesity is the foremost, creating a future of rising chronic disease and long-term ill-health." On current trends, it is forecasts that nearly 60% of the UK population will be obese by 2050, he wrote.

"Our response as a society to this challenge will be one of the defining elements in our lives over the next 20 years," Mr Brown stressed. While "there should be no doubt that maintaining a healthy weight must be the responsibility of individuals first…the responsibility of government and wider society is to make sure that individuals and families have access to the opportunities they want and the information they need in order to make healthy choices and exercise greater control over their health and their lives," he said.

What has happened since then?

"People aged under 40 seem to have taken the message about obesity – in this age group, the rise in obesity has completely flattened off, and among men aged under 40 the rates are actually going down. This is unprecedented," said Prof McPherson.

He explained that these extraordinary results have not yet been published because, so far, only data from the most recent years has been examined. "We're currently looking at 2010, and yes, something serious has happened," he said.

"If this flattening of obesity rates is a cohort phenomenon it will have big consequences if it continues to when people reach 50."

The initiative begun with Healthy Weight Health Lives is continuing through Change4Life, which began in January 2009 and is England's first social marketing campaign aimed at tackling the causes of obesity.

"Fantastic" impact of Jamie Oliver

And nutritional standards in schools do work. "When I was at school I would eat dripping on white bread every day. Now my grandchildren tell me off for snacking, and this awareness is coming from school," said Prof McPherson.

"Jamie Oliver has had a fantastic impact and is the reason why men are losing weight more than women – they identify with him."

"I believe very strongly in the role of approving preventive interventions. Changing the environment in which we live is a way that is painless yet massively underused," he said, adding: "There are lots of quite benign things that you can do, but this does require government action."

Dr Oldman agreed. "Whole-population based changes, such as action on seatbelts and smoking - these make huge changes immediately," she said.

And we have to start doing things differently, said Dr Jenkins. Initiatives such as patient participation groups (PPGs) are "talking to the converted." But in Bristol, 28% of primary school children are of black/ethnic origin, and we need new methods of reaching them.

The experts also welcomed initiatives such as one described by APPG co-chair Kevin Barron MP, who said that GPs in his constituency have for the last 20 years been paying for patients' gym membership to help them change their lifestyles. He asked: should the cash-strapped NHS keep doing this?

If it's cost-effective and it works – yes, keep it, said Prof McPherson. Dr Jenkins added that in her area, such patients can get their gym memberships cheaper. "Every GP can run pilots, through different funding routes, but they must produce evidence," she said.

Mr Barron also asked the experts for their views on comments made to the Group by a GP, who said the new structural reforms to the NHS would make it easier for surgeries, CCGs and local authorities to come together to engage with their local populations, do more on prevention by encouraging people to look after their health, and so reduce the need for people to go to hospital.

He asked them: is there any evidence yet of this happening in your area?

Dr Jenkins agreed that there is now greater awareness and pressure in primary care to work with secondary care to make care more community-based, with more patient and public involvement. In the current transition phase, most CCGs have plans, and these should be secondary care-facing, but "the real problem is the way our secondary care colleagues are paid. There is an incentive to get patients into hospital and keep them there," she said.

Innovative ways of bringing care closer to the patient are being sought by many Trusts – for example, Portsmouth, Leicester, Derby, Bristol are all trying different systems of tackling diabetes, she said.

"Our secondary care colleagues see the writing on the wall. They've got to do something. Secondary care won't be paid less but it will be coming out into the community, not necessarily to save money, but it will be better for patients."

"Know your condition, take responsibility for yourself. We've got to shift our heads towards more self-responsibility, realistic expectations of the NHS and moving care back into the community," she emphasised.

Ms Oldman agreed, and added: "we need to start with younger people and younger families. Giving them access to their patient records can help them start to understand and gain ownership of their own health."

She also pointed to the continuing perverse financial incentives which lead to patients being required to attend an outpatients clinic for just a five-minute conversation with a doctor - "and when it can take them half a day to get there!"

Financial penalties, awareness

Missed appointments are estimated to cost the NHS £500 million a year. Would charging people who miss medical appointments and otherwise misuse NHS services help change their behaviour? Or sending them details of what their actions have cost the NHS and the taxpayer?

Printing itemised cost details onto prescriptions – including the costs of an A&E visit, GP consultation, etc, is sensible – provided people don't think they are being charged, said the experts, and Ms Oldman suggested that clinicians also need to be told what things cost.

But the system can work against innovative solutions; Nick de Bois told the meeting about a fracture clinic nurse's suggestion that patients should be reminded of their appointment with a phone call the day before – a simple plan, but it took the Trust five months to approve it.

People who end up in A&E after overdosing on drugs or alcohol need help, but they should also be aware of what the treatment costs, the experts agreed. However, they also saw practical problems with charging them for this care. They asked: how would you police such a scheme? Where would you draw the line? Would it contravene their human rights? And the costs of administering the charges could be "enormous."

"The bottom line is teaching people that they are responsible for their health," said Dr Jenkins. "With young people, we're just firefighting at the moment, but they need education - about first aid, self-care, drugs, alcohol - before they reach teenagerhood."

And if the government decides to put taxes on alcohol, the money raised should come back into health care, she added.

Reassurance, advice or a prescription?

The APPG has heard that patients often visit their GP seeking reassurance but the consultation ends with a prescription, Kevin Barron told the experts.

Dr Jenkins agreed. "We try not to end with a prescription but they are a way of ending the conversation. A third to a half of prescribed drugs are not used - but the patients are reassured."

But she added, she also does a private surgery, where she is able to spend more time with patients and, as a result, "I don't give a prescription just to end the conversation."

But she also frequently sends people to pharmacists for over-the-counter (OTC), treatments and advice. Pharmacists are a very good source of information and advice, and they have more time, she said.

And her practice has plans to station a nurse at the front door (and possibly a GP as well) who will send people away if they are attending inappropriately.

Out-of-hours (OOH) services are also costing the NHS and taxpayers money. "If someone hasn't done anything about their problem before calling me OOH – for example, one person had done nothing to treat her constipation even though she'd had it for two weeks - I tell them to go to a pharmacist," she added.

20 million paracetamol prescriptions a year

Nick de Bois wondered why 20 million prescriptions were issued last year for paracetamol, an easily-available pain reliever which can cost as little as 16 pence per pack OTC.

"Some population groups expect to get everything for free, and some people think that if a product is prescribed it must be better than an OTC," Dr Jenkins responded.

"Also, I have an elderly patient with arthritis, and I would rather she takes paracetamol, not ibuprofen," she added.

Kevin Barron pointed out that in other countries such as Spain, a patient will consult a pharmacist before visiting a GP. He asked: should we empower pharmacists to be able to change medicines without having to see a GP? Or would that be a step too far?

The experts were unsure. Dr Jenkins pointed out that her group has good relationships with pharmacists, and they tell them if medicines in a patient's dosette box pill organiser are not being used.

This is also a problem for practice, specialist and community nurse prescribers, said Ms Oldman. Since 1996, they have had a very small formulary from which they can prescribe, and this includes paracetamol. "We have had debates with nurses about this, but they say a patient will tell them: 'the baby has a temperature, but I have no money'," she said.

Finally, the experts were asked: what is the one thing you think the government should be doing to ensure that the NHS is round for future generations?

System change, responded Ms Oldman - more emphasis and more resources need to be going into the community, and medical professionals and politicians both have to step forward and make the case.

Prof McPherson and Dr Jenkins both called for the 2012 Health and Social Care Act to be repealed.

The Act is un-thought-out, massively opposed by doctors and will not reduce bureaucracy, said Dr Jenkins. "I'm not convinced that adding money will save the NHS - we need to work on public education, and while there are local differences in terms of populations and needs, we must have nationwide policies," she said.

"The Act is the major threat and cause of the demise of the NHS. It will fragment and privatise unnecessarily in order to save taxpayers' money," said Prof McPherson. "The NHS is a massively popular public institution – we need to build on this, being clear about the implications of rationing. Some things will need special pleading – these can be identified."

But he welcomed the Act's returning of public health responsibilities back into local government and that it is seeking to address health inequalities. "I wouldn't want to remove that," he told the APPG.