



65 VIEWS OF THE NHS AT 65

THE WISDOM OF THE CROWD

EDITED BY NICHOLAS TIMMINS

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A&E
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AGE OF AUSTERITY
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DR MARK PORTER
DR INTEGRATED CARE
DR PETER CARTER
ROBERT FRANCIS
TO RETIRE?
REjuvenate or RETIRE?
EQUAL ACCESS FOR ALL
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WAITING TIMES
LORD ARA DARZI
ROY LILLEY
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THE WISDOM OF THE CROWD

65 views of the NHS at 65

Edited by
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About this publication

On 5 July 2013, the NHS reached its 65th anniversary. To mark this milestone, the Nuffield Trust has been carrying out a number of activities to promote debate and discussion on the current state of the NHS and social care system, and its future prospects.

This publication is the centrepiece of our activities. Enclosed are interviews and essays with a cast list of 65 health and political leaders, consisting of current and former health secretaries and ministers, senior civil servants, clinicians, managers, academics, patient representatives, journalists and other key individuals. It is edited by Nuffield Trust Senior Associate Nick Timmins, who has reprised a role he performed for the Nuffield Trust back in 2008 when we took a similar temperature check of the views of leaders at the time of the NHS's 60th anniversary.

The contributors have been asked to provide their assessment of what they believe the state of the NHS and social care system to be at this moment in time and what they think the service will look like in the future. Critically, they have been asked to reflect on what they think needs to happen now and over the coming years to ensure the NHS and social care system is viable and fit for purpose in ten years' time.

This is not a representative group per se, but we have endeavoured to provide perspectives from a broad range of individuals that either are, or have previously been, in positions to help shape the direction of the health and social care system. We are indebted to each author, and our only regret is that we were unable to publish more contributions.

This publication is a special edition of the Nuffield Trust's Viewpoint series, which provides a platform for UK and international health leaders to explore, discuss and debate health care reform issues. It forms part of our work programme on NHS and social care reform.

The views expressed in this publication are the authors' own, and do not necessarily represent those of the Nuffield Trust.



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Foreword

by Dr Jennifer Dixon CBE

The Nuffield Trust commissioned essays on the NHS's 60th birthday – why do it again at its 65th?

Because, as many in this volume agree, the NHS is facing a watershed moment. After belt tightening over the last four years, and managing largely successfully, the next five to ten years must be the most difficult in its history. It isn't the reforms, distracting though they are, it's the money. The NHS has faced poor budget settlements before, but nothing like what is likely.

The good news is that there seems to be a consensus, at least among contributors to this volume, that the NHS should continue as a comprehensive service, free at the point of use. To a large extent there is also political consensus over what it should look like. After all, look at other health systems across the developed world and you see a technical evolutionary path which is very similar to that in the NHS, as well as better care and health outcomes helped by better information and patient/public assertiveness. Political tussles over the place of provider competition are somewhat quaint next to these long-run changes.

But long-run evolution in health care on the rising tide of economic growth is one thing, managing short- to medium-term financial shocks, then a likely 'new normal' of parsimony is another. Here the NHS's strengths and weaknesses tilt towards inherent weakness. On the one hand, there is the ability to make change centrally and relatively quickly: cuts; reconfigurations; big invest-to-save decisions using capital; price and wage controls; and to articulate this to the public on a national scale. Other countries look on with envy at this level of control. On the other, there is no one answer visible centrally as to how to improve efficiency – it will be the result of a myriad of everyday decisions at the frontline among staff who must be inspired, given autonomy, and held to account.

But on the former, big central decisions can be (and often are) bottled, in part due to politics, or can be plain wrong based on weak evidence or argument. On the latter, politicians can have very little idea what will improve efficiency locally. But more local autonomy without the right kind of accountability risks inertia at best or well-meaning staff doing the wrong thing because they lack information on the impact of their efforts.

The essential ingredients here must be information, openness, earned trust and respectful dialogue between the frontline and those making national decisions.

The path to chart over the next five to ten years must surely be a far more intelligent blend of the top-down bottom-up dynamic than we've seen over the last decade. The essential ingredients here must be information, openness, earned trust and respectful dialogue between the frontline and those making national decisions to thrash out creative solutions. There's plenty of talent and motivation around, particularly on the shop floor; what is needed is the injection of a very different culture starting at the top.

But that's my diagnosis. Read on and you will hear more; you are in for a treat.



Overview

by Nicholas Timmins

Nicholas Timmins is a Senior Associate at the Nuffield Trust, and a Senior Fellow at the Institute for Government and The King's Fund. Between 1996 and 2011, he was Public Policy Editor of the *Financial Times*. Nick is also a Visiting Professor in Public Management at King's College London, and in Social Policy at the London School of Economics and is also an honorary Fellow of the Royal College of Physicians.

Tender, fragile, fragmented, strained, vulnerable. In disarray. At a cross-roads. These are just some of the words used by key contributors to this review of the NHS on its 65th birthday.

Challenged is a word that almost all of them use to describe its future.

And its most recent half decade shows both what a difference three months can make, let alone five years – and the risks of trying to peer, however presciently, into the future.

Back in 2008, the Nuffield Trust produced a similar publication for the NHS's 60th birthday. On that occasion, the service felt tolerably comfortable in its own skin. That is not to say that all the worries about sustainability that have haunted the NHS since 1948 were not still rumbling along in the background and were not still being debated – hence the publication's title: *Rejuvenate or Retire?*¹

But spending had doubled in real terms during the decade. Waiting times were at record lows. Performance on a whole range of key measures was rising. There was a strong sense that not enough had been achieved with all that money – too much of it, for example, had gone into higher pay. Productivity was depressing. And in some key areas such as the overall performance

1. www.nuffieldtrust.org.uk/publications/rejuvenate-or-retire-views-nhs-60

on cancer, the UK still seemed to lag behind on key international benchmarks. But overall the service felt better than it had done in decades.

Northern Rock had gone under the year before, and the credit crunch was under way. There were worries about what was happening to Libor – the inter-bank lending rate about which most people up to then had never heard. And there were concerns that a recession might be on its way.

But despite the introduction being written by a *Financial Times* journalist who happened to sit right next to the paper's economics editor, there is no hint in that July publication of the storm about to break. In the September, Lehman Brothers went down. The ATMs were within 24 hours of ceasing to dispense cash. The credit crunch became a global financial crisis. And that in turn became a prolonged global economic one – with the knock-on to public spending set to have a far more profound impact on the future of the National Health Service than anything debated in *Rejuvenate or Retire?* Such are the risks of trying to predict the future.

Yet some of the assumptions – projections – in 2008 have held. A significant number of interviewees felt that despite the fact that record levels of growth were slowing, all that investment since 2000 should continue to pay off. And indeed it did – in terms of yet further improvements in waiting times, continuing gains in clinical outcomes and with patient satisfaction rising to record levels in 2010.² A number of contributors note this time round that – certainly at the time of writing – the service is doing remarkably well given that it is three years into a period of no real terms growth: something that in the past would have seen it fall over.

To be sure, in the spring of 2013, some 40 per cent of A&E departments missed the four-hour waiting time target in England, and waiting times had hit a three-year high. But that was all relative. Ninety-four per cent of patients were still being seen within four hours and the vast majority were still being treated

2. www.kingsfund.org.uk/projects/bsa-survey-results-2011/satisfaction-nhs-overall-results-1

within the 18-week target. The earlier investment, plus two years of public sector pay freeze will have contributed to that, although as several contributors note, “you always pay for a pay freeze” when it ends.

The question is whether the problems in A&E, which have since eased, are the canary in the mine – A&E so to speak being the meat in the sandwich of the NHS, with problems there tending to reflect both problems in out-of-hospital out-of-hours care and difficulties in discharging patients once admitted – or a temporary blip. Many fear the former, with surveys of NHS finance directors, those professional pessimists, showing increasing worry about the impact, as time goes by, of finance on performance.³

The NHS, right now, feels a little like a taut piano wire – still sounding pretty good, but with questions about whether it will go slowly out of tune or snap.

The NHS, right now, feels a little like a taut piano wire – still sounding pretty good, but with questions about whether it will go slowly out of tune or snap, or whether a complete retuning of the whole machine will let it continue to sing.

Aside from the money, many other things have happened to the NHS since 2008, some of them paradoxical. If anything, it has become even more “the closest thing the English have to a religion” in Nigel Lawson’s famous phrase,⁴ as outside observers looked on with awe, bewilderment and amazement at the central part it played in the Olympics opening ceremony. No other country sees its system of health care as such a central part of national identity.

Against that there has been Winterbourne View (the private hospital near Bristol where patients were persistently and seriously abused). The second inquiry by Robert Francis into failings at Mid Staffordshire, which has produced deep soul searching in 2013 over events that took place between 2006 and 2009. Morecambe

3. www.kingsfund.org.uk/publications/how-health-and-social-care-system-performing-june-2013

4. Nigel Lawson, *The view from Number 11*, Bantam Press. 1992. p 613.

Bay, where police are investigating after the deaths of a number of babies at the foundation trust – events that are still playing out as this goes to press. Newer data underlining the much greater risks patients face if they go into hospital over the weekend rather than on a weekday, and so on – all events that as David Behan, Chief Executive of the Care Quality Commission (CQC) notes, erode trust, in the same way that trust in other public institutions has been undermined by the MPs’ expenses scandal, by Hillsborough, Leveson, Jimmy Saville and some of the other child abuse inquiries. The NHS is suffering from its own share of that.

And then, of course, there was the Health and Social Care Act 2012. A Coalition Government that had promised ‘no more top-down reorganisations’ went on to impose what is arguably the biggest structural upheaval that the NHS has seen, while doing so in a way that reignited 20-year-old battles that appeared to have been broadly settled – but which in fact have still clearly not been remotely settled politically – over the role of the private sector in the NHS.⁵ If in doubt, read Andy Burnham’s contribution. No one saw that coming either.

The outcome, in many people’s eyes, has been two to three years of planning blight, or in the judgement of Alan Milburn, “five wasted years”, given his view that NHS policy started to drift under Gordon Brown’s premiership, while Andrew Lansley’s tenure as health secretary was consumed by the Bill.

And given that the terrible beauty of the reforms instituted by Lansley and the Coalition Government were finally lurching into life as the contributions were made to this publication, there has probably never been greater uncertainty – with two possible exceptions – about quite how things will work in future and over quite what the future holds.

5. A full account can be read at www.instituteforgovernment.org.uk/publications/never-again

The two possible exceptions are the dog days over finance and industrial relations that the NHS went through in the mid-to-late 1970s, and the unknowable outcome in 1991 over quite where the original purchaser/provider split would lead.

But if there is deep uncertainty about how the future will operate, there is a profound, almost unanimous, degree of certainty about what needs to be done.

Read through these contributions and a formula emerges. That what the NHS needs is more specialised care in fewer specialist centres, a smaller hospital base, more surgical ‘factories’ for elective operations in lower-risk cases, much more care at home or closer to home, patients more empowered to take control of their own care, much closer integration of health and social care, and far greater transparency on clinical outcomes and patient satisfaction to drive the argument for all of that and to raise quality.

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Almost all of these views were expressed before the recent joint report from the Academy of Medical Royal Colleges, the NHS Confederation and National Voices – an unprecedented alliance of clinicians, managers, board directors and a major patients’ grouping – which said the same, though in nuanced terms.⁶

This is now so much the received wisdom that one almost wonders whether it ought to be questioned.

There is a hope – perhaps a touching faith – that all this will release resources and save money for reinvestment. Some contributors do question whether that will in fact be the case, while still believing it will raise the quality of care, in other words it would deliver better value.

6. *Changing Care; Improving Quality*. www.nhsconfed.org/Publications/Documents/Changing-care-improving-quality.pdf

The need for it has raised some interesting issues – Sir David Nicholson in a recent *Health Service Journal* interview,⁷ and Mike Farrar in this publication – questioning whether the purchaser/provider split needs to be revisited, at least in part and in some places.

It could, of course, be argued that much of the formula for change that so many people highlight here has been the agenda for at least a decade – and that parts of it, including greater integration of health and social care and wider publication of clinical outcomes, have been around for much longer.

So why hasn't it happened? The issue being not that none of it has happened over the past decade or so, but rather that not remotely enough of it has.

Lord Darzi, the former Labour Health Minister, argues that while the extra spending in the 2000s brought big benefits, “we missed the best opportunity in the history of the NHS to actually reform it... we just threw money at it”.

And Sir David Nicholson, Chief Executive of NHS England, concedes that the extra money “allowed us to subsidise poor care when we shouldn't have done”.

But while there have been some notable exemplars of reshaped services – stroke in London, the best of the cancer networks, or care of the elderly in Torbay, to take just a few examples – there may be other reasons why it has not happened at scale.

For a start, despite the policy world and even much clinical leadership in the form of the royal colleges being in support of this agenda, the argument for it has yet to be won with clinicians generally. To an even greater extent – and at least as importantly – it has not been won with the public. And even when it is won as a high-level proposition, implementing it on the ground when individuals' NHS jobs and the public's services are affected –

7. www.hsj.co.uk/news/commissioning/exclusive-sir-david-nicholson-announces-major-review-of-nhs-strategy/5059398.article

indeed are at risk – is always difficult. It is a little like the housing issue: there is widespread agreement that more homes are needed. But not in my back yard.

Many contributors point to the need to make the argument better with the public, although there are differing interpretations over quite where the primary responsibility for that lies and who, in practice, is best placed to do it. Managers, clinicians, NHS England, clinical commissioning groups (CCGs), health and wellbeing boards, politicians more generally, some of the other organisations that now litter the new landscape – or to some degree, any and all of them? And if any and all of them, who is to lead?

But the delay may also be that while the population has been ageing for decades, and the NHS has, at least fiscally, coped well

Can the NHS, in an age of prolonged austerity, survive largely free at the point of use?

with that, it has only in recent years become quite so transparent that hospitals are now filling up with patients with exacerbations of chronic, sometimes multiple, conditions, that could in fact be cared for better elsewhere. That the evidence that specialist centres do specialist things better has only recently become quite so extensive – and indeed, even then, not for

everything everywhere. And that the huge cuts to social services budgets that are under way are only now finally underlining, more firmly than ever before, just how interdependent health and social care have become.

So the question is, how is it to happen?

Alan Milburn is far from alone in arguing – though he does so most forcefully – that what “is absolutely missing is the long-term explanation of how we are going to get there”. Some sort of NHS plan for this decade. “A process thing, rather than a product thing”, as he puts it. Lord Darzi feels the same: “a vacuum of strategic leadership”. David Mobbs reflects a similar and sympathetic view from the private sector.

NHS England's answer is that it is planning to fill that vacuum – preparing a three-, five- and ten-year appraisal (there seems to be a certain reticence about using the word plan) “of how we get from where we are to there with a declining budget”, in the words of Sir Malcolm Grant, the NHS England Chair. That, he acknowledges, will be a change programme that goes beyond the life of any one government, including this one. So it will be more than interesting to see first of all what it says, and how explicitly it says it. And second how the current Health Secretary and then his successors react to an independent board, rather than politicians, charting the way to the future – which, at least in theory, is meant to be the Coalition Government's new dispensation.

Alongside all that lie other unknowables. Data and transparency may not be a central part of the recent Health and Social Care Act. But they are a *leitmotif* of the current debate and a strategy that both the health department and NHS England are implementing.

But as more data, particularly on clinical outcomes and on patient satisfaction with individual services, are made available, how will the public react? Use the data, ignore it, or do a bit of both? See it as supporting some of the changes set out above? Or will wider publication of widespread variation in outcomes undermine faith in the NHS rather than produce consumer-driven support for change in the way it operates?

Transparency feels a little like Pandora's box. Open it – and who in principle can be against that? – and there is no going back. But there is equally no certainty about where it will lead. It certainly should create peer pressure for improvement – there is plenty of evidence that should happen, both from within the NHS and outside it. But what will parts of the media and the pressure groups and the public make of it if they do get their teeth deep inside it?

As for the NHS's performance in the medium term, Sir Hugh Taylor, the former Permanent Secretary at the Department of Health, makes a key point about the difference now, if the spending squeeze starts to lead to a serious erosion in performance, and the position at the end of the 1990s when the service was last, as he puts it, "in a parlous state".

Back then there was no CQC and no Monitor to report back regularly on performance. There was far less performance data in other forms available in public than there is now – and certainly than there is going to be, if the promises of more transparency are fulfilled. And commissioning was even less developed. In other words "every step downwards is going to be put under a microscope in a way that never happened before", Sir Hugh Taylor notes. The potential for "silent erosion" of the service, as happened then, is much reduced.

How will the public react to that? Demand more money, despite austerity? Lose faith? Or slide away to the private sector when they can afford it?

Which leads to the linked question of whether the NHS can indeed, in an age of prolonged austerity, survive largely free at the point of use? Or will the lack of money – or a somewhat different driver, namely the apparent policy requirement to link means-tested social care and free-at-the-point-of-use health care more closely together – produce a change in that?

Views from contributors to this publication are probably more deeply divided on that than ever before – and not remotely on party lines.

They range from the impeccably pessimistic warning from Roy Lilley – "I started life without the NHS and I expect to meet my end without it" – to that from Jeremy Taylor of National Voices. In the current economic slump, he argues, "through a mixture of defeatism, lazy thinking and, in the case of some, malign intent, we are in danger of sleepwalking towards dismantling the NHS".

And on to those who believe absolutely that despite the financial challenge it can and should remain largely free at the point of use.

Some – Stephen Dorrell, Alan Milburn, Shirley Williams up to a point – suspect there might be some movement at the margin, but no fundamental change. Others – for example, Lord Warner, the former Labour Health Minister in the Lords – believe a much more far-reaching reappraisal is inevitable.

One or two voices suggest that as the money gets really tight, a much more profound debate may emerge about end-of-life care

“Should we start exploring the basis on which we fund the NHS, with a more complex mix of hypothecated taxes, user charges and redefined boundaries between health and social care,” Lord Warner asks. “The answer to that is yes” – with the Dilnot approach of capped costs for social care a possible, though as yet undefined, model.

Others – Sir Hugh Taylor, for example – think that free care at the point of use could survive, but only if a new inter-generational settlement is reached where the baby boomers who have large chunks of the nation’s personal wealth locked up in their houses and pensions pay more inheritance tax as a way of preserving it.

Even those who vigorously support free at the point of use, however, tend to say that could only be achieved if the NHS changed. That a much better way has to be found of spending the £120 billion a year or so that goes on health and social care in England – and the larger sum that goes on those services throughout the UK.

Some, including Lord Norman Fowler and Dame Sally Davies, the Chief Medical Officer, make the point that – at least in the last few years – has got somewhat lost from the internal NHS debate. Namely that prevention is a key to that. Both of them emphasise that while this is an NHS responsibility it is also a much wider responsibility for government as a whole. Something to which the NHS can contribute. But not something it can do on its own. From the private sector, even allowing for a degree of

self-interest given the business he runs, David Mobbs makes the same point.

One or two voices suggest that as the money gets really tight, a much more profound debate may emerge about end-of-life care; about how much is spent in the final months and years of life, and whether a highly interventionist, hospital-based model is what the public really wants.

Which raises what may be the most fundamental question of all.

Can the NHS, in a time of prolonged austerity – and last month’s spending review underlined just how long the austerity is going to be – deliver changes that it failed to achieve at scale in a time of plenty? Will the lack of growth force into practice what the policy community – pretty unanimously – believes needs to be done in theory?

The answer, from many contributors, is that the NHS tends to respond to threat – and that there is no alternative if the service, as currently conceived, is to survive. Or rather, as Sir David Nicholson puts it, there is an alternative. But it is “managed decline” – or, perhaps, though these are not Sir David’s words, not-so-managed decline.

How well the service and social care between them rise to that challenge will probably define how happily, if at all, the NHS celebrates its 70th and 75th birthdays.

Never forgetting that, as in 2008, something or some things may happen that no one – or almost no one – has foreseen.



Parliamentarians

PARLIAMENTARIANS

RT HON. ANDY BURNHAM MP

The Rt Hon. Andy Burnham MP is the Shadow Health Secretary and has been Labour Member of Parliament for Leigh since 2001. He was previously Secretary of State for Health, Secretary of State for Culture, Media and Sport and Chief Secretary to the Treasury.

I think the NHS is feeling pretty battered and bruised at the moment – and demoralised by the whole process of reorganisation. Overall, quite fragile really.

If I think back to the 50th anniversary, the 15 years between then and now have been one of the strongest periods in its history. But there is a real feeling that an era is over and it's reaching a bit of a fork in the road. That I think will be very much the sense of the next election. What is the future for the NHS? Which path should it take?

There is a choice to be made about whether we want to allow the inexorable advance of competition in the market. Or do we want to hold on to a planned national system of the kind that we've had?

People might say that Labour opened the door to competition. But the Health and Social Care Act takes the door off its hinges and opens the floodgates as well. I think people feel now that if it carries on the way it's going, it's a path towards fragmentation, competition and privatisation. And there's another path, which is marked integration and collaboration.

There is a role for managed competition within the system, applying pressure where it's needed, bringing in innovation where it's needed. But the emphasis is on the word managed. If you pursue a route that in the end is just about moving to much more open competition and a free market, then the genie can't be put back in the bottle. I think that people feel we're reaching a fundamental crossroads on all of that.

I've set out my stall on what needs to be done to keep the NHS viable for the next decade and that involves full integration with social care. For me, it's not enough to talk about pooled budgets, joint appointments. They are constructs to scale the Berlin Wall within health and social care, and I feel that the only answer for the 21st century is to have a system that can see the whole person.

The problem with the way the system is currently configured is that the preventative part is the part that is being squeezed and in which we've seen huge disinvestments over many years – arguably, under governments of both types.

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Social care is the human side of care. It is healthy daily living – washing, dressing, feeding, getting up and about, coping, delaying the day when you need more intensive support from institutions. Currently, that bit is de-prioritised and we allow people to fail and to drift towards our treatment service.

I think the only way this service becomes sustainable is by uniting the physical and mental with the social, so the system sees the whole person, and decisively tilting that towards prevention in the home – so the finances pull in that direction rather than pull towards the hospital. I think that until you reverse that tide, where the finances pull people towards the acute trust, and get the tide flowing in the opposite direction, so that it flows towards the home and keeping people there, we won't really crack sustainability.

Can it remain largely free at the point of use, given the financial restrictions? There's definitely need for an honest debate about that. My starter for ten would be that if you restrict treatment that the state pays for, the treatment still has to be paid for. It just means that people start paying for that more randomly, according to their need and means. It means some people will be exposed to costs that aren't covered, and that happenstance then affects what happens to you.

So I think the first 65 years have shown that this is the most cost-effective and fairest way of covering the whole population for its health care needs and, arguably, you need to keep hold of that when you're facing a century that is all about rising demand. It is the cheapest and fairest way to meet that challenge.

DO WE NEED TO BE
TOUGHER ABOUT PEOPLE'S
RESPONSIBILITIES IN RESPECT
OF USING THE SYSTEM PROPERLY?

I think there is a question mark about patient responsibility and self-care. Do we need to be tougher about people's responsibilities in respect of using the system properly? It's not acceptable to treat the ambulance service like a taxi service, so what are we going to do about that? I think the patient responsibility agenda needs tougher, sharper edges.

But overall I do we think we need to say 'no, we don't want to see the encroachment of charging or rationing or restriction' because in the end, people will still pay, but they'll just pay in a less fairer way than they're currently paying.

If we do manage to bring health and social care financing together it will definitely need clarity at a national level about what is free at the point of use, and what is not. Because, by integrating the budgets, you obviously can't pay for free social care completely.

So what we have at the moment is the ultimate lottery. Councils are individually deciding what to provide, and what we've seen is a process of serious retrenchment as budgets are cut. I think there's only one council in the country – I might be wrong about that, but it's something like that – which is still providing for 'moderate' social care needs, rather than critical or substantial ones. So I think there needs to be a national entitlement to social care.

We need to set out what can be paid for when you combine the budgets: the £100 billion NHS budget and the £15 billion social care budget.

As part of doing that, I recognise that there can be a switch from hospital to prevention and to social care when you go into that fully integrated model. You can obviously provide more and better care that way as a result of tilting it away from the hospitals. But clearly, it doesn't pay for everything that people will need.

So that's what would need to be in the Bill that I would introduce after the next election. It would be based on a national entitlement to physical, mental and social support, but it would have to be clear about what wasn't provided. On the social side, it would be a mixture of universal and targeted, but there remains a good argument that says that universal health care is a good idea.

And my message for future health leaders would be Aneurin Bevan's: that the NHS will be there as long as there are folks left with the faith to fight for it. And that needs to be passed down the generations.

RT HON. PAUL BURSTOW MP

The Rt Hon. Paul Burstow MP is the Liberal Democrat Member of Parliament for Sutton and Cheam. He is currently Chair of the Parliamentary Party. He recently served as Minister of State for Care Services.

In 2008 when David Nicholson first mapped out his £20 billion challenge, the aim was redesign of the NHS from the bottom up, driven by a commitment to quality, innovation, productivity and prevention. As the NHS creaks under the strain of delivering these four per cent efficiency savings year-on-year, the picture emerging is at best patchy.

Changes to acute care are stuck in the mud for want of credible plans for out-of-hospital care and the result has been an over-reliance on short-term fixes such as pay and tariff restraint to balance the books. This has left the NHS vulnerable and blinkered. The current panic about A&E performance is a symptom of that underlying fragility.

THERE IS NO REASON WHY A
SYSTEM THAT BALANCES WELLNESS
AND WELLBEING AGAINST PATCH-
AND-MEND MEDICINE CANNOT
REMAIN TAXPAYER-FUNDED

In 2015 all political parties will have to face the fact that growth in health spending will continue to be limited. There will need to be a second 'post-Nicholson' challenge to see the NHS through austerity. But this time it will have to leave a legacy, creating the foundations for a 21st-century NHS. That must mean looking at spending on health and social care in the round and offering meaningful guarantees on both quality and accountability.

The world has changed but the NHS has been slow to change with it. The unlocking of the genome, the information revolution that sees data held and shared in the Cloud, the rise in multiple long-term physical and mental health conditions, and the

profound age shift that sees the 85+ the fastest growing part of the population urgently demand a model of person-centred care where access to mental health support, social care and self-care tools are integral to a holistic approach to health and wellbeing.

This requires a shift in the centre of gravity away from hospitals towards our homes, schools and workplaces. It requires real progress on earlier diagnosis; delivery on the promise of parity of esteem between mental and physical health; much better planning and provision for end-of-life care, and it demands that we finally grasp the public health challenge set down by Marmot by prioritising action on the causes of ill health and promoting a wellness agenda that enables people to take greater responsibility for keeping themselves well.

Only by making these changes, building up programmes – through partnerships with local government and local communities – that promote wellness, and focusing on actions that promote the wellbeing of people living with co-morbidities, can a new NHS equilibrium be found. There is no reason why a system that balances wellness and wellbeing against patch-and-mend medicine cannot remain taxpayer-funded; indeed, evidence suggests that the more we move towards this model, the better the service will deliver value for money for the taxpayer and better health outcomes for the nation.

To get there, NHS and local government leaders will need to forge a new relationship; time must be invested now in building a consensus for change. Bulldozing changes through will simply drive people to the barricades. Nationally and locally there needs to be a citizen-led commission to weigh the evidence and agree the priorities for change.

The NHS is 65 this year. A person born this year can reasonably expect to live well into their 90s. Just as our deepening understanding of human biology tells us human longevity does not come with a best before date, nor should the NHS.

RT HON. KENNETH CLARKE QC MP

The Rt Hon. Kenneth Clarke QC MP was appointed Minister without Portfolio in September 2012. He is the Conservative MP for Rushcliffe. He was Lord Chancellor and Secretary of State for Justice from May 2010 to September 2012. He was Secretary of State for Health from 1988 to 1990 and Minister for Health at the Department of Health and Social Security from 1982 to 1985.

I think the NHS has almost continuously improved its performance ever since it was created. This is very rarely acknowledged by the public.

In every Western democracy, most members of the public think their health service is in a state of unprecedented crisis, whereas actually, clinical standards, patient service, efficiency and management, are on a steadily rising curve – and always have been in the UK.

I think it's in a pretty good state. I still meet people who argue that it's an impossible idea to provide global quality care free to all the population – and that this mad concept will have to be modified. Most Americans I meet offer me pitying sympathy about the socialised medicine we suffer.

But it is amazingly better than when I was first a junior health minister, which is only 30 years ago, and it is still arguably the best system in the world. So, as you may gather, I'm an undiluted fan.

To remain viable for the next decade it has to brace itself for a process of continuing change, which is always inevitable. I think most people now appreciate that the level of clinical change has been fantastic. I'm always impressed by the way in which clinical professionals, during the course of a career, utterly transform the way in which they treat serious diseases and adapt to changes to the best practice.

When I was a junior minister 30 years ago, if you had said that we would have 70 per cent of patients undergoing day surgery, you would have been attacked as a brutal butcher who did not understand the fundamentals of a caring health service. Any clinician now takes that for granted. But clinicians do tend to resist change in every other way.

However, there have been some remarkable instances recently of clinical people actually advocating a reordering of the NHS estate. For the first time I have doctors telling me that it is time the politicians accepted that we've got to close some hospitals. The need for them is now redundant.

And boy, is that a change. Every workhouse I tried to close was regarded as a centre of clinical excellence by all the staff who worked there and all its patrons. The most extraordinary dumps were defended by banner-waving demonstrators 30 years ago.

The politicians are being pushed in the direction of having fewer specialist units in the country, in order to raise the success rate, and it's the doctors having to push the politicians into bracing themselves for a decision that will be unpopular with the local newspaper and with the staff and all of that.

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I find the sentiments that lead to all the controversy wholly noble. People are totally wedded, and their communities are wedded, to the buildings of the NHS, which they understand better than anything else. And it is their extraordinary high British regard for the institution – you know, it is our only surviving religion – that makes people so passionate and defensive of what they know and understand, and fearful of any controversial change.

But the underlying theme is that there are more people in the service who do now believe it should be patient-oriented, outcome-led, constantly demanding on choices and priorities, and on value

for money, and that everything should be determined by the outcome you are delivering in restoring quality of life as far as possible to a patient.

The other great, big, new area is the changing nature of demand, which, again, even compared with my time, has been transformed. As long as they get vaccinated, almost nobody gets infectious diseases now. They were absolutely dominant when the service started. Now the question is how is my grandchildren's generation going to provide a full service to a population of whom probably one in five will be over the age of 80? What is the correct balance between health care and social care? How do you get the whole thing to function as an integrated whole, all the way across from hospitals to domiciliary services? How do you actually maintain the quality of life and basic health of elderly people for as long as possible before you cope with the vast demands they will make on your system – usually, in the last two or three years of life? That's a very big question.

It has always been there. But it's never been answered, or not very well. It's a mess, the relationship between health and social care, as everyone now acknowledges, and it is being worked on.

The demography means that there's a massive problem. We've been working on it for 20 years and so far have not produced an answer. It all in the end sorts itself out, but at the moment have you met anybody who knows exactly how to do that?

One of the problems is that left to themselves, without a properly organised system and a great deal of effort – and in every country in the world – where the public want to go is hospital. And all the pundits are more aware than ever before that we ought to be getting more people to go elsewhere.

None of this is totally new. It has been there since I first started debating these things. But the issues have become ever clearer as the nature of clinical practice, and the expectations of the public and the demography, have changed over the years.

The fact that we can no longer rely on trend growth year after year – and that we cannot be suckers the next time we have one of these South Sea Bubble type booms, thinking it means we can just pour money into everything – just underlines the case for radical reform.

I used to be accused of believing in Mao's permanent revolution if you recall, which I deny. But I actually think that a health care system, any health care system, is in a state of permanent reform. I understand that annoys and upsets everybody who works in it. But it is almost inevitable, it seems to me. It's not true that some magic plan will take you, in two years' time, to that placid grove, where, from now on, nothing will change – unless, that is, you can stop the clinicians improving medical practice the whole time, or unless you can stop the whole population growing older.

EVERY SECRETARY OF STATE
FOR HEALTH WILL FIND THEY
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DOWNWARD-GOING ESCALATOR.

It is like politics. It is the language of priorities, the language of outcomes, the language of how do we adapt to this latest demand? Every Secretary of State for Health will find they are trying to walk up a downward-going escalator. You shouldn't have anything to do with the running of the health service if you're not going to be able to stand that sensation. It is the only one you're ever going to experience, and you'll never get to the top.

I would be very saddened if we gave in to the siren voices saying that an NHS largely free at the point of use can't last. They've been proved wrong for 65 years, and just because the same daunting demands lie ahead of us, that does not mean you should give up the struggle.

And if you look at the one country that's always accepted that a patient has to pay – America – I mean, you're looking at one of the most failed health care systems in the world. They spend 17 or 18 per cent of the biggest GDP in the globe to get poorer health outcomes than most Western European countries, and there's about 40 per cent of the population whose health care is totally inadequate.

Why? Because once you go to a purely market basis you have no customer resistance, and no control over cost. Anybody can be sold anything. You think the chap who's demanding the most money from you is obviously the best, and if you're terrified about the state of your health, or of somebody in your family, you will pay absolutely anything that he or the insurance company, or the hospital company, demands.

Keeping it free at the point of use has always been a uniting principle of people who support the health service. It is a very difficult principle to maintain. People should understand that. But I am totally committed to it myself not least because it concentrates minds.

Keeping it free provides a discipline on expenditure, and that constraint does make you search for radical reform. Trying to get the health service to live for the time being with flat real terms spending is, I think, one of the things that's almost improving the climate for reform.

I'm sure neither Andrew [Lansley] nor Jeremy [Hunt] think so. But I never had any clinicians going public before saying that we should be closing some hospitals which are now redundant. So keeping it free is not only right in principle, it also concentrates minds and controls costs.

I would be very saddened if we gave in to the siren voices saying that an NHS largely free at the point of use can't last. They've been proved wrong for 65 years, and just because the same daunting demands lie ahead of us, that does not mean you should give up the struggle.

Rt Hon. Kenneth Clarke QC MP

Minister without Portfolio; Secretary of State for Health 1988 – 1990

BARONESS JULIA CUMBERLEGE CBE

Baroness Julia Cumberlege CBE was Parliamentary Under-Secretary of State for Health from 1992 to 1997. She founded Cumberlege Connections Ltd in 2003 and Cumberlege Eden and Partners in 2013. Both companies specialise in training and consultancy to the health sector. Julia started her career in local government, as Leader of the Lewes District Council and Chair of Social Services for East Sussex. She has served on many public bodies and has produced two reports for the government.

The NHS is not a perfect organisation, but on the whole it does give a good service. I think one of its bright sparks is the community nursing service, but clearly that needs to integrate with social care. When that happens, it works really well.

We did an experiment in a very difficult part of Brighton in the 1970s, where they bulldozed a residential home of 69 beds and put everything on the patch with health and social care working together, with a 20-bed nursing home, a community night nursing service and a twilight nursing service, all integrated with social care. It kept people at home. It kept them out of hospital and it was very impressive. I went back about eight years later and it had collapsed. It had collapsed because what was not totally integrated was the funding. And as times got tight everybody went back to their citadels, and would not share. But we know it can work, and it's getting the foundations of that right that will improve care hugely.

I think the GP service has become increasingly ineffective. It used to be very much people's first port of call. Now it's A&E. And it's A&E because they know they're going to get treated, even if they have to wait a bit. Some practices obviously run good open hours. But many don't. And why go to the GP's surgery if you're going to find it closed?

And on the hospital side, I think it is 45 per cent of staff who say they would not recommend their place of work. I think that's very sad, and that says a lot about management.

Inertia remains one of the biggest threats to the NHS. People yearn for stability, but that can lead to inertia. We talk a lot about the need for innovation and experimentation. But actually, I don't sense there's a huge will for that. There's a will for stability, and keeping things as they are now.

INERTIA REMAINS ONE OF THE
BIGGEST THREATS TO THE NHS.
PEOPLE YEARN FOR STABILITY,
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I've just come back from the States. In the US it is 'must do, can do, done it'. In the NHS it is 'must do... but there are five reasons why we can't do it'.

I do think we have to reassess the role of GPs. Increasingly, with more people with long-term conditions, and with people wanting to be treated and to die at home, this does require GPs to have the responsibility to deliver a 24-hour service, every day of the week. I am not saying that each individual GP has to do that. But they should have full responsibility. And we should revisit the Darzi proposals for polyclinics. Call them something else, if need be. But the idea needs to be revitalised and we need to build them. It will take some capital, but the NHS has acres and acres of unused land that can be used or sold for that.

I do think there should be a more managed competition between the state and the independent sector because I think that would ratchet up standards, and be much more patient-focused. In the States we saw some hospitals where 25 per cent of a consultant's salary depends on the feedback from the patients. I think that's amazing.

As to the future, if care at home is really successful we will see fewer hospital beds, because we know now a third of elderly patients don't need to be there, and probably don't want to be there.

I think the GP service will be divided. Some will be providing more specialist services with community nurses, who will be in charge of patients at home, with the nurses encouraged to prescribe. They are allowed to prescribe now, but sometimes GPs actually put pressure on them not to – and that's a pity, because

it took me 20 years to get nurse prescribing in. I think other GPs will be working a shift system in polyclinics, providing a form of 24-hour cover in those places.

We will see hospitals specialising more, with district general hospitals confined to the least populated areas. I think general practice will become more corporate with fewer independent surgeries. And I think all that will diminish the power of the British Medical Association.

I suspect one of the great game-changers for the future will be personal budgets. I think it's going to be a slow burn. But as more and more people choose to take them – and I don't want it to be compulsory – I think that's really going to make a difference. Power is in the purse, and patients may well choose a very different sort of service. And often that is not as expensive. Sometimes patients' demands are quite modest.

I do think the NHS can survive largely free at the point of use. I think it will, because the ethic is right. Essentially, we are a compassionate society, and we need institutions that have high principles as their foundation. I think the NHS embraces a very good philosophy.

There is room for more efficiency and we will see some of that. But greater efficiency will not offset the financial effects of longevity and medical advance, the huge pressures in the NHS. So I think we will remain with a tax-based system, and the government will raise more taxes. Health, along with pensions, is one of the two great imperatives.

RT HON. PROFESSOR THE LORD DARZI

The Rt Hon. Professor the Lord Darzi of Denham KBE FRS holds the Paul Hamlyn Chair of Surgery at Imperial College and is an Honorary Consultant Surgeon at the Imperial College Healthcare NHS Trust and the Royal Marsden NHS Trust Hospitals. Lord Darzi is Director of the Institute of Global Health Innovation at Imperial College and Chair, Imperial College Health Partners. He was Parliamentary Under-Secretary of State at the Department of Health from 2007 to 2009. He was appointed as a member of Her Majesty's Most Honourable Privy Council in June 2009 and was recently elected as Fellow of the Royal Society.

I have been in the NHS since 1990, and maybe it is my youth or I am getting older and a bit more cynical but I don't think there is enough reserve and stamina in the system to deal with the challenges that are facing us, whether the economic ones or the health burden. Most clinicians are disappointed, with a lot of unfinished business. It is coming in spades, and more so since April, for the simple reason that there's a vacuum of strategic leadership.

Now, I'm not in any way supporting the strategic health authorities because I think a number of them failed to have strategic leadership. But there is a vacuum of strategic leadership, and I don't think there is the resilience in the system to deal with the tsunami that is about to hit us, and which we have known is coming for three years.

There was the handling of the Bill which had a seriously detrimental effect on NHS England, which is still busy launching itself. Then there is what happened with David Nicholson, which hasn't helped, and then there is Francis. Those have been three major things over the past 18 months, which would be difficult for any organisation trying to launch itself. None of them are nuclear bombs. But they are significant challenges. And there is a leadership vacuum, and we have the tsunami of the money coming. It is just astonishing that we haven't got ourselves ready for it.

I don't think the NHS has any of the lifeboats out there as this thing is about to hit us, and which I think will hit us by the time David leaves and the new guy starts. And it is not going to be the one per cent deficit that fired Nigel Crisp. Something worse.

What the NHS needs to remain viable is an aligned political and clinical leadership, if that is ever possible. I am not sure the politics has the maturity to do that. I've never seen it before. I think it nearly got there in London, when we did the health reforms for London. But that became contaminated when I became a Labour minister and everyone turned on it. And the political leadership that was required to see through High Quality Care for All and ensure it was implemented didn't happen, so we are revisiting it 18 months later and talking about quality again. That aligned leadership is one thing that the NHS needs.

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A second is to ensure that there's no further restructuring in the next ten years. Third, we need to infuse more transparency into the system, and acknowledge the fact that there are certain organisations that will not be viable. And finally, we have a huge, huge, huge public engagement and public education job to do over what we mean by quality and over rebuilding expectations of what is local, what are the types of services that might be available if we are to get the highest

quality. If we fudge all that we will see more Mid Staffs. We need to engage the public. We need to get the public with us. And we need the political and clinical leadership and the transparent agenda to meet these challenges.

I think the opportunities in the next decade that will possibly disrupt the NHS will be technology. There is plenty of scope out there. I think it will disrupt the way in which we do risk stratification and wellbeing and prevention. It will disrupt the way in which we deliver health care. I think we will have a much smaller number of specialised hospitals, a larger number

of community-type provision, better integration of health and wellbeing and prevention and social care. All the things we have been talking about for ten years.

That's what we need. Will we get it? Well, the NHS has always responded to threat, and I think the tsunami could be turned into an opportunity. But that won't happen unless you have the engagement of the clinical leadership with that alignment of the political leadership to make it happen. Otherwise a tsunami could be quite destructive.

What happened in the last ten years is that the injection of money did a lot of good. There was a huge amount of progress, fantastic outputs, fantastic outcomes. But we missed the best opportunity in the history of the NHS to actually reform it. We just threw money at it, rather than actually reforming it.

To be fair Alan Milburn always said 'the money will come but we have to reform it'. But he left. And I don't know whether even he would have the balls to make the changes required now. And it is going to be much more difficult to make the changes now when there is no money coming in.

Can the NHS remain largely free at the point of use? I think co-payment will creep in. Probably around something to do with the patient experience. But I am fearful of it. Once it starts to creep in it is such a difficult thing to police. We have introduced it through the top-ups for cancer drugs not approved by NICE, although the need for that has been diluted up to now by the cancer drugs fund.

If we end up in a scenario where things are falling apart and the money is tight, co-payment may well happen. I don't know whether it will, or whether it is the right thing. But I have always feared it. How do you manage it? How do you police it? How do you have it without eroding some of the fundamental values of the NHS?

What happened in the last ten years is that the injection of money did a lot of good. There was a huge amount of progress, fantastic outputs, fantastic outcomes. But we missed the best opportunity in the history of the NHS to actually reform it. We just threw money at it, rather than actually reforming it.

Rt Hon. Professor the Lord Darzi

Paul Hamlyn Chair of Surgery, Imperial College, Honorary Consultant Surgeon, Imperial College Healthcare NHS Trust and the Royal Marsden NHS Trust Hospitals; Parliamentary Under-Secretary of State, Department of Health, 2007 – 2009

RT HON. FRANK DOBSON MP

The Rt Hon. Frank Dobson MP has been a Labour Member of Parliament for over 30 years (for Holborn and St Pancras South from 1979 and for Holborn and St Pancras since 1983). He was Secretary of State for Health from 1997 to 1999.

I think the NHS is being fragmented and that coordinated provision of services will become more difficult as a result, and that huge amounts of extra money will be diverted from patient care into the transaction costs of all these contracts – involving lawyers and accountants, and God knows who – draining money out of the NHS.

Contracting out is going to make any accountability more and more difficult. Because when anything goes wrong, people will be told that a lot of the information can't be made available because it's commercially confidential. I've had experience of that with a franchised-out GP practice in my constituency. So I think all that is shifting in the wrong direction.

TO KEEP THE NHS VIABLE, WE
MUST ADHERE LIKE LIMPETS
TO THE CONCEPT OF POOLING
THE RISK AND THE COSTS OF
EVERYBODY'S HEALTH CARE.

In terms of its current performance, I thought that the service would start falling apart as a result of Andrew Lansley's Pol Pot year zero stuff, but I didn't think it would start falling apart quite as quickly as this. I mean, why mess around with NHS Direct, which works? A proper Conservative doesn't change things that work, unless they are certain that a) the alternative will work, and b)

the process of change will not consume a lot of resources. But they weren't Conservatives. It was the Pol Pot year zero approach. And they are just going to end up falling out with all the people who actually do the work – the doctors and nurses, and therapists and even the managers. And good managers are invaluable.

To keep the NHS viable, we must adhere like limpets to the concept of pooling the risk and the costs of everybody's health care. That is going to be challenged by the very right and proper effort to better integrate health care with social care. Social care up until now has usually involved a contribution from the patient. And if this integration blurs the boundaries between health care and social care, then we could well be down the road of charging for some aspects of health care that are presently free – and we stop sharing the risk and cost.

There is clearly among the establishment, including some of the think-tanks who ought to know better, a shift against universal provision of some aspects of welfare and care. And with that in the background, the chances are going to build up of people suggesting that we ought to start paying for some aspects of health care that are presently free.

In the longer term there is a really big threat from all the work that is being done on the human genome, with all the potential that has for good and bad in being able to identify the things that make people susceptible to particular diseases or conditions. There are some big benefits that can flow from that. But also big risks.

Unless we maintain the pooling of risk at the heart of everything, then there's a real danger. If the Tories were to win the next general election – and bearing in mind these various developments – there will be pressure to move people over to some sort of insurance-based system. Initially for some people, and then eventually for everybody. A world in which the insurance companies will take their share of the profits, the transaction costs will go up, and the proportion of the money not actually spent on patients will increase even more. Eventually, they'd conclude that they could offer differential rates to people with different genetic characteristics. And, that would be the end.

If Labour wins the general election, which I'm reasonably confident we will, I think the first thing to do is to put the chock under the wheels of the adverse possibilities of these developments.

I don't think it would be sensible to throw it all up in the air again and have another super reorganisation. We need to see whether we can make better use of the new structure, and keep any structural changes to the minimum so that people working in the NHS can concentrate on the day job. And we need a renegotiation with Europe so that competition law does not apply in health. I tried to get Tony Blair to get an exemption for health in the Lisbon Treaty in 2007 but he didn't do it, which is why I voted against it.

It will, however, be very difficult retrieving the situation, because I think it could be quite anarchic in two years' time, with a very disillusioned group of people who are treating patients.

Can it remain largely free at the point of use? Well, it doesn't get any cheaper by not being free at the point of use. That is one of the myths. It still has to be paid for. People say we can no longer afford it, so we'll have to go over to some other means of financing. But of course it won't be cheaper because health care still has to be paid for.

Being free has two advantages over other systems. One is that it is fairer. But the second is that you don't have to have huge transaction costs logging how much Nick Timmins' knee operation cost, and then getting the money from some other part of the outfit.

I can see that there are disadvantages in block contracts for hospitals. But my calculation, and I think it is pretty accepted, is that the NHS is now spending about 12 per cent of its money on transaction costs when it used to be four per cent. And that's about ten billion quid. And I don't think there's been a ten billion gain from going over to the money following the patient.

The private sector by and large up to now has been creaming off the stuff that's easiest and cheapest, to the disadvantage of the hospitals and clinics that are left to deal with the complex and the poor, while doing most of the training and coping with A&E.

THE NHS IS NOW SPENDING ABOUT 12 PER CENT OF ITS MONEY ON TRANSACTION COSTS WHEN IT USED TO BE FOUR PER CENT. AND THAT'S ABOUT TEN BILLION QUID.

And charging automatically brings benefits to those who have the money to most easily meet the charges. And, they're already healthier and living longer than the ones who can't afford it. We have to cling to the idea of universality and of pooling the risk, both the risk and cost to the patient, but also the risk and cost of providing the services, which also have to be shared.

I think that view is still held by Labour. Some of the decrepit Blairites are probably still yearning to break up the NHS. But I don't think many other people are.

And I think that still holds more broadly. It isn't just that people know that they and their family and their next-door neighbours will be treated, people actually like the idea that everybody gets decent health care. My emotional line is the NHS doesn't just bind the nation's wounds, it helps bind the nation together – and that at a time when everything else is fissiparous. When everything else is fragmenting and breaking up, the universality of the NHS does appeal, and certainly appeals to me. I'm sorry if I'm sounding idealistic, but we do need to stick to the principle of a universal service with the costs and risks shared by the taxpayer.

RT HON. STEPHEN DORRELL MP

The Rt Hon. Stephen Dorrell is Conservative Member of Parliament for Charnwood. He is Chairman of the Health Select Committee, and has formerly served as Secretary of State for Health.

Well, the service has had – obviously – a period of institutional upheaval. But actually, from the point of view of the service that's been delivered, it's been relatively calm over recent times. But as the Select Committee has been saying since the beginning of this Parliament, it's becoming progressively more difficult as demand continues to rise, and given that resources stopped rising some time ago. The challenges are starting to come to the surface.

A large proportion of the slack has been taken out of the system and it's becoming, in my mind, increasingly urgent to address the question of how the service can meet rising demand without a growth in real resources.

The option of growth of real resources isn't available in the medium term, and so demand has to be met by restructuring the way care is delivered. And that's a process that is only now beginning.

That is politically difficult. But it is particularly difficult if you don't explain what is needed and what is involved, and if the public see changes in the way service is delivered and they experience them just as – you know, the old word – cuts.

Actually, quite a lot of the service changes that are needed allow care to be delivered in a way that ensures higher or better outcomes in terms of patient experience and in terms of more objective clinical measures. But that's not a message that's being delivered. The leadership of the system hasn't invested the time in developing that message.

You can't expect people locally to engage with that message if the case hasn't been made nationally. Local politics is both a top-down and bottom-up process. It's about public reaction, but it's about public reaction in the context of broader messages.

There is an urgent requirement to see the care model change in a way that reflects today's burden of disease and today's technology so that it becomes more of a genuine health and wellbeing service and less of an emergency national illness service. It's a system designed for, and still broadly good at, dealing with emergencies. What it's bad at is preventing the emergencies arising in the first place. And, in particular, what it's bad at is joining up the bits of the hospital service, primary care, community health and social care to support wellbeing rather than reacting to crisis.

It is an old observation that the system needs to treat people, not conditions.

IT'S A SYSTEM DESIGNED FOR, AND STILL BROADLY GOOD AT, DEALING WITH EMERGENCIES. WHAT IT'S BAD AT IS PREVENTING THE EMERGENCIES ARISING IN THE FIRST PLACE.

I think I know what it should look like in ten years' time, and I think so do most people.

We have something that should be one system but is in fact four systems all working in parallel, sometimes in competition but seldom together.

Leaving hospitals out of it, primary, community, social care and social housing should all be operating as one. They all have information at their disposal. They're not terribly good at using

it within their own systems, and there is almost no interchange between the four systems, all of whom have hermetically sealed information systems.

It is why we talk endlessly about the need for more joined-up services that are led from the front, from the community end, which recognise early symptoms and then support people with care needs rather than waiting for them to need acute medicine. And that way, in my mind, you deliver something that's a much better service from the point of view of the patient.

How do you do that? Well, what you don't do is go off looking for the perfect managerial solution because it doesn't exist. What you do do, is ask how you incrementally move in that direction.

Starting from where we are, I think there's a key role for health and wellbeing boards, which are the part of the system which are closest to the frontline management but which also have the ability to look across the different parts of the system. And they also, importantly, have genuine democratic roots. So they answer two weaknesses in the traditional system. First, they look across the silos, and second, they have more democratic accountability than any part of the traditional NHS system. And that's a good thing. It is back to the point about local politics being both top-down and bottom-up. You have to understand how people react but you also have to have something to say to them.

Given all the institutional upheaval, health and wellbeing boards have been expensively bought, in my view. But they are a step forward, nonetheless. I think the changes on public health are changes for the better. And I think if the new commissioning structures succeed in creating a more clinically led commissioning process, that will definitely have been a step forward. So those are the advances of the past four years.

Can the service remain largely free at the point of use? Well, different parts of the system have always been charged for and reviewed by governments, both Labour and Tory, around care of the elderly and the classic NHS charged-for services – pharmacy, opticians and dentistry.

But personally I'm not in favour of any radical new departures in that. I don't think it's actually necessary and probably not desirable. And if you look at the £125 billion that we currently spend on these services and ask yourself how it is possible to use that resource more effectively, I'm not yet persuaded that it's impossible to meet demand for the kind of service I described out of the budget that's available.

And looked at over the 65 years of the NHS, the money is a medium-term constraint.

We're going through a prolonged period where the financial growth is depressed. But, as the economy starts growing again, then there will be a rational choice for resources available for health and care to resume growth in line with the growing economy. And it would be bizarre if that were not the case.

And it follows from breaking down the barriers between health and social care that more resource will go into social care, and that's always been a charged-for service. And the more you invest in effective social care, the more you relieve the pressure, the more you reduce the demand for acute medicine and you reduce the resource conflicts that you're talking about.

Whatever the government thinks, consumers will spend more on care services, and expenditure on those services will enhance wellbeing and will reduce demand for acute medicine.

So charging for traditional definitions of acute medicine is almost missing the point. It's putting the resource in the wrong place.

RT HON. THE LORD FOWLER

The Rt Hon. the Lord Fowler, Baron Fowler of Sutton Coldfield, was Secretary of State for Social Services from 1981 to 1987.

My perception of the state of the NHS is that it is in some turmoil, thanks to yet another reorganisation. The service is weary of reorganisation, as I think is the public.

I did a conference recently for the British HIV Association in Manchester and Jane Anderson, the Chair, introduced me and said that I had been Health Secretary for six years. There was a polite scatter of applause on that. And then she said, what is more, that I didn't reorganise the health service – at which stage there was stupendous applause. Politicians do slightly need to be aware of that.

We spend too much time even now on reorganisations, and too little time on good management. And I would claim that what we did with Roy Griffiths years ago was exactly the way that the health service should have gone and we really can't go on forever sort of changing the style.

The second point I'd make is that far, far too little time and money is devoted to preventing ill health. It is still simply not taken remotely seriously enough. Much of my experience is with HIV at the moment and with the recent select committee we did point out that the Government was spending £760 million a year on drugs to treat people with HIV. I've got no complaint about that, but they spent £2.9 million a year on government publicity to prevent HIV. Actually they've now reduced even that. It does show something of the kind of priorities that we have.

And I think that prevention needs to be given priority. I mean it's all very well having a separate budget, and I'm all in favour of that, but what it really needs is to be given a lead, a strategy, a belief, because without that people are still not going to take it very seriously.

And that goes way beyond HIV. It goes to all the things that people talk about – sugar, obesity, smoking, alcohol. You are going to be shot at if you go into that area. People are going to talk about the nanny state and all that. But that just has to be taken on. If you do these things one by one, it is highly dubious whether you really have an impact. I'd be all in favour of a separate prevention budget. But what it really needs is a strategy and a belief and someone with that belief to push it forward.

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It is a broader government responsibility than just that of the NHS, I accept that, although I don't think you can divide the two too much. But it needs someone to lead and then it certainly needs someone in the NHS to follow up. And, you know, where is that in the government structure? Where is the NHS in that?

And it takes so long to change things inside the NHS. Think about home testing for HIV. The argument for that has been made. It is a pretty simple thing. But there is no sort of urgency to make it easily and widely available.

When I was health secretary, and I think it's still true, I always said that the NHS is probably the most cost-effective system in the world. It means that we don't spend as much on it as the Americans or the Germans or the French. And in spite of its failings it does actually use the money as well as – although I don't know if I could argue better than – most systems.

I think it should be there in ten years' time and I think almost certainly it will be. It does mean emphasising the importance of management in a more effective way. If you don't have good management we are going to have more problems than the obvious problems that are coming with an ageing population.

There clearly need to be considerable changes to the way we organise services. A smaller hospital base and more care closer to home. But that is not a structural reorganisation of the sort we have had too much of. Almost any system or structure can be

made to work if you give it time to settle down. I don't want to sound as though I am saying there should be no change, because in fact we need a lot of change in the way services are provided. I say, let's get on with it, but not another great structural upheaval.

Can it remain free at the point of use? Yes. For anything remotely serious I think it is free at the point of delivery. You can, I suppose, make an argument for charging folk to visit the GP. But I'm never sure actually how much that would raise by the time you've got the exemptions. I mean, you only have to look at prescriptions to see the vast number of exemptions. It raises a little bit of money, but it's not going to transform things.

PREVENTION HAS BEEN AND STILL IS A CINDERELLA PART OF THE HEALTH SERVICE. IT DOESN'T REMOTELY FIGURE ON THE CURRENT POLITICAL AGENDA AND IT HASN'T DONE FOR SOME TIME.

We could look at some stage at what a health insurance contribution – a national health insurance contribution in a public way, not a private way, made by those in work – could achieve. As a topping up, not as a substitution. You can see that operating in social security and pensions. It would add to the tax burden, but if we are forever going to be stuck by that then we are in some difficulty.

But the one thing that actually all the political parties can agree on, is that you should have a health system which is free at the point of delivery and which provides help for anyone irrespective of income. That is really what it is all about.

To keep that we do have to play to the strengths of the system, which include managing it as well as you can and making it as cost-effective as you can. My main message, however, would be to give vastly more emphasis to preventing ill health and disease, and postponing the need for treatment. Prevention has been and still is a Cinderella part of the health service. It doesn't remotely figure on the current political agenda and it hasn't done for some time. We do just need to recognise the importance of what that can do.

RT HON. PATRICIA HEWITT

The Rt Hon. Patricia Hewitt was Labour Member of Parliament for Leicester West from 1997 to 2010. She was Secretary of State for Health from 2005 to 2007. She is now Senior Independent Director of BT, a Director of Bupa and Chair of the UK India Business Council.

The NHS is under considerable strain. There's a huge amount of change going on. That may settle down, but patients' expectations are going to go on and finances are going to remain difficult for as far forward as we can see.

The challenge is to get the best for the patient, which fortunately is almost always the best for the taxpayer as well. We all know that despite the extraordinarily high levels of care that the NHS gives to the great majority of patients there is still far too much waste and inefficiency, and there is still too much poor care, often linked with waste and inefficiency. So creating a truly patient-focused NHS, which also means coupling it far more closely with social care, is actually the way to ensure that the NHS can go on meeting patients' expectations while remaining within a budget that is always going to be finite and will always be constrained.

To keep the NHS viable for the next decade there are many things that political and health care leaders need to do, most of which have been on the agenda for some time.

The new one, or rather the one which has really risen up the agenda more recently, is the close coupling, if not complete integration, between the NHS and social care. That is absolutely essential because we know that the main users of the NHS are elderly people and younger adults with severe disabilities who have got complex needs, extensive co-morbidities and an urgent need for personalised and integrated care. The needs of that part of the population, and the growth in that population, are probably the single biggest driver of increased costs in the NHS.

There certainly appears to be, at the moment, a growing number of elderly people who are stuck in hospital because the right care package isn't available. That means that if you can sort out the social care piece, you have an obvious source of financial savings that are hugely beneficial to the patient. And that is not a question of compromising on care.

Next to that is realising the benefits from the creation of the CCGs. There has been a lot of pain and upheaval in the move from PCTs to CCGs. But having taken the pain, it's an absolute imperative that we get the gain. We've always known that there are large potential gains from having clinicians close to the patient, in the community, leading on commissioning. But we've got to see the gains. Both for patients and taxpayers, because all of us are both patients and taxpayers and we should never forget that.

And then there is hospital reconfiguration. We all know that there are proposals coming forward for reconfiguration that were brought forward ten years ago, and there are probably still a few where they were first brought forward 20 years ago – and they still haven't been done. We all know that it is very difficult. But we have also learnt over the years that if there's a strong clinical case, and clinical leaders get out there and make the case to the public, and to the overview and scrutiny committee, it can be done. You can win these very difficult arguments.

And you do have the Independent Reconfiguration Panel. It is very powerful. There have been a number of cases where it wasn't possible to resolve the issue at the local level, and the independent panel, which is clinically led, went in and listened – not just to local clinicians and managers, but to local patients' groups, local councillors and so on. And they were able to say, for instance, you the public are absolutely right about the issue of patient transport, and how will people get to the new services – and that hasn't been sufficiently taken account of by the NHS. And they've modified the proposal. But the essential clinical judgement about creating safe services won the day, and you could do the reconfiguration.

We learnt a huge amount in the mid-2000s about how to do reconfigurations, and the mix of clinical leadership and argument that you needed at both national and local levels. We must not lose those lessons.

In a pre-election period, unfortunately, you're very unlikely to have major reconfigurations. But what we also know from the huge public involvement we did for Our Health, Our Care, Our

Say, is that when members of the public sit down and think about what they want for themselves or their elderly parents – well what they actually want is a reconfigured service. And it's high time that the NHS and the political leadership delivered that everywhere, and not just in some parts of the country. The inability to make decisions that are in the interests of patients is frankly shocking, just shocking.

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Depending on the local circumstances, it requires a dialogue between health ministers and local members of parliament. It requires a sensible process with clinicians in the lead, and everybody free to put forward their views and explain their concerns and so on. And then hopefully you can get a resolution at the local level, and if you can't, then you've got the Reconfiguration Panel as the safety valve.

Will the NHS still be here in ten years' time? Fundamentally, I think it will, and still providing wonderful care for the great majority of patients. And it will still be free at the point of need. I have little doubt about that.

As one of those ageing baby boomers, I know that I am going to be even more personally interested in the state of the NHS than I am now. My father just celebrated his 96th birthday, and my mum died two years ago at the age of 95. I am 64 – so I am conscious that when I am 74 I'm going to be even more personally interested in the state of the NHS than now.

But I do believe all the fundamental things will still be there so long as there have been significant changes in the configuration of services and in integration with social care services, with progress on clinical commissioning, quality and productivity. Because if those things haven't happened then what we will be facing is a crisis of waiting times, waiting lists and patient dissatisfaction – and that will just be unacceptable. It will put the service at risk. And, as we have seen in the past, it will drive more and more people to find various private solutions.

If you look at the Commonwealth Fund assessments, and other international studies, the NHS always comes up pretty much the world leader in terms of being the fairest health service. And that is so ingrained into the psyche of the nation. I think it would take something much bigger even than the kind of crisis over waiting lists that we inherited in 1997, fundamentally to put that at risk.

I think it is inconceivable that Labour would come forward with a proposal to abandon 'free at the point of need'. And for other reasons I think it's inconceivable that the Conservative Party would.

At a time of financial constraint, it is hardly going to say, let us spend precious money on tax relief for private health care. So over a ten-year horizon I don't see that changing. I think the development of personal budgets for health as well as social care could help achieve much greater integration of health and social care, and greater patient satisfaction. That has been the experience so far, though with fairly small numbers, and it has also been the experience in Germany.

There will be some difficult issues that come with that, such as should patients be able to top up their NHS care? I think Alan Johnson set out a very good set of principles in this area when he looked at that specifically in relation to cancer. The pressure came off that with some additional funding from the cancer drugs fund. But they will return, and, in truth, how do you avoid it? But it will continue to be an issue at the margins rather than at the centre of the service and the debate.

I do believe all the fundamental things will still be there so long as there have been significant changes in the configuration of services and in integration with social care services, with progress on clinical commissioning, quality and productivity. Because if those things haven't happened then what we will be facing is a crisis of waiting times, waiting lists, and patient dissatisfaction – and that will just be unacceptable. It will put the service at risk. And, as we have seen in the past, it will drive more and more people to find various private solutions.

Rt Hon. Patricia Hewitt

Labour Member of Parliament for Leicester West 1997 – 2010;
Secretary of State for Health 2005 – 2007

RT HON. THE LORD JENKIN

The Rt Hon. the Lord Jenkin of Roding (Patrick Jenkin) is President of the Foundation for Science and Technology. He was Secretary of State for Social Services from 1979 to 1981.

When I produced my first White Paper, 'Patients First', in early 1980, the four general secretaries of the four general health service unions came in and demanded I change the title, saying 'we always put patients first' – and that was just after the Winter of Discontent! Their attitude was 'you look after us, and we will look after the patients'.

I sent them away with a flea in their ear. Because one of the real problems that the NHS has faced right from the beginning is that the people who work in it regard themselves as more important than the people they are working for. Not individually – I am sure there is a very large number of very committed staff at all levels who faced with patients really try to do their best for them – but collectively.

That is the problem which emerged in acute form in the Mid Staffordshire Inquiry. Which I think was a real wake-up call. And I think Jeremy Hunt has realised that. I am not sure that his answer of sending all his staff in the department to do a spell in frontline services is necessarily the answer, but we will have to see what happens.

But 'you look after us, and we will look after the patients' has been the collective view for a very long time, though I am hoping that will change.

Jeremy Hunt, and I think he is doing a very good job, has made absolutely clear that there has to be a cultural change, a real change of emphasis. There has to be a recognition that care of patients is the centre of everybody's focus. And it clearly wasn't

in Mid Staffs. People were much more concerned about ticking the right boxes and achieving financial targets. Financial targets matter, but not to the extent of refusing to give proper treatment to patients. You have to achieve both.

YOU CAN'T RUN SOMETHING AS
BIG AS THE NHS CENTRALLY.

The main thing needed to keep the NHS viable over the next ten years – and this will be difficult – is to devolve more authority to the local level, while subject to very clear guidance, including that their primary role is the care of patients.

I think there is still far too much central control. You can't run something as big as the NHS centrally.

I think at the moment the health service is struggling to implement the changes in the recent Act, so I find it very hard to say what the service will look like in ten years' time. I don't think we can go through another major change like the one we have just been through. This system has got to be made to work.

I think it will look very much like it does at the moment, and it is not going to change a lot, and I think that is a good thing. It needs some stability. You can change things more easily incrementally than through any sort of big bang. One of the problems with the Health Bill was that it was an unheralded big bang, of which there had been no warning at all before, at the 2010 election.

If there is going to be change, it has to be well tested and incremental, taking as many people along with you as possible.

Can it remain largely free at the point of use? If it breaks down it will be because of rising demand and some of the advances in technology, which can be very expensive – and then I think a future government will have to look at that. There are a lot of other things that patients pay for. Many people pay for dental treatment. You pay for your prescriptions – and one of the things that I think is ridiculous is why should I get free prescriptions? David Cameron gave these very, very specific pledges to pensioners at the last election and is reluctant to move away from that before

2015. But I think the party is going to have to recognise that this is no longer acceptable to the public – free television licences, free bus passes, winter fuel allowances and free prescriptions. So incremental change may be necessary. If you have rising demand, that is one way to meet it.

FREE AT THE POINT OF USE
IS ABSOLUTELY AT THE HEART
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A RELIGION.

When I was in opposition I had quite a high-powered advisory group of consultants and administrators – about 12 of us, not all of them of my party. There was a general feeling that we ought to look at an alternative to a tax-funded service. We did a lot of work to see if we could move more towards a social insurance, continental type of approach, which seemed to be doing better.

Those papers were extremely confidential. Nothing had been said about this, and there was nothing at all about it in the 1979 manifesto. And I handed them over with those caveats to the officials. Two or three of them were very interested. We had come up with the problem that if you are going to change, how do you move from A to B? And three months after they had studied it, the officials came back and said: ‘Well, yes, it is perfectly possible to imagine a service like that, but we cannot begin to see how you move from the existing to the new’. And at that stage I said ‘that was our problem. So I think we ought to forget this’.

So I don’t see a bigger switch over the next ten years, say to social insurance. There is no demand for it. Free at the point of use is absolutely at the heart of the NHS. It has become a religion. But you pay a price for that. We might, however, see some incremental change with better-off people paying more for their prescriptions or things like that.

But the one thing that I would want to say is that if in the future a health secretary writes a White Paper and says it has to be patients first, I hope nobody would ever have the brass to say ‘no, you have to look after us, and we will look after the patients’.

NORMAN LAMB MP

Norman Lamb MP was appointed Minister of State for Care and Support in September 2012. He has been the Liberal Democrat Member of Parliament for North Norfolk since 2001. He has held various positions in the Liberal Democrat party including Liberal Democrat Shadow Secretary of State for Health from 2006 to 2010.

The NHS is coping remarkably well with rising demand and having to find unprecedented efficiency savings. It's doing 400,000 more operations each year compared with 2010, fewer people than ever are waiting more than 18 weeks for treatment, there have been significant reductions in hospital infections and mixed-sex wards have been virtually eradicated.

Yet it is also a system under real strain. A&E attendances are up more than 50 per cent since the turn of the century. Large numbers of frail elderly people, many with dementia, end up being admitted to hospital due to failures of care and then too often get stuck there because problems arise in arranging a suitable care package.

I AM CERTAIN THAT INTEGRATED, PERSON-CENTRED CARE WILL BE THE NORM WITHIN THE NEXT FIVE YEARS, NEVER MIND THE NEXT TEN.

More people today live with multiple complex conditions, with both physical and mental health needs. Too often we leave people to live lonely, isolated lives. In short, we have a system that is ill-suited to the 21st century. And the pressure of limited resources is with us for good. Health spending in England has risen at an average rate of four per cent a year since 1950. Without any

prospect of substantial extra investment, we have no alternative but to find ways of making the money go further.

If we are to have a health and care system that provides the right sort of care and support, and that is sustainable, then we need to see four fundamental shifts.

First, we need to move from a sickness service to a proper health service. Too much investment has been focused at the acute end of the spectrum, generating more hospital activity, just when we should be doing everything we can to keep people healthy and out of hospital.

Second, we must move from institutionally fragmented care to joined-up care, shaped around people's needs. Health is separate from social care, mental health is separate from physical health, and primary care is separate from secondary care. For a patient, for clinicians and for taxpayers, this makes no sense.

Third, we must move from 'paternal' to 'personal'. The Care Bill, in Parliament at the moment, promotes wellbeing and focuses on the person, not the service. It will empower people to take control of their care and will bring greater consistency of access to care across the country. It sets the foundation for a different approach.

Finally, we need to acknowledge that institutions, however good they are, are only part of the story. We need to embrace the power of our communities and help local people and the voluntary sector to come together to support those with care needs. Around the country, the best local authorities are building collaborations with local people, helping to strengthen community resilience.

I think we have the chance now to create a shared vision based on these big shifts of culture and priority. The prize is better care and better use of resources.

You don't need a crystal ball to see the future of the NHS. There are many places in England that are doing this already. From Cheshire to Essex, from Leeds to Torbay, I have seen incredible examples of transformed care making a huge difference to individuals. I am certain that integrated, person-centred care will be the norm within the next five years, never mind the next ten.

Centred around the patient and properly integrated, there is no doubt in my mind that an NHS that provides comprehensive care, free at the point of need, will remain the most equitable and the most efficient way to meet the health needs of our country.

RT HON. ALAN MILBURN

The Rt Hon. Alan Milburn was Labour Member of Parliament for Darlington from 1992 to 2010. He served for five years in the Cabinet, as Chief Secretary to the Treasury from 1998 to 1999, and subsequently as Secretary of State for Health until 2003.

The current state of the NHS? It has been a trajectory of improvement interrupted. Five wasted years. People will look back on it as sort of a cock-up – which is unfortunate, given that I think the thing was probably overall moving in the right direction.

There are big challenges to come, which the chaos of the last few years will make more difficult to deal with, although not impossible. Transitioning from a service that is still focused on episodic care to one that has to become much more empowering of its patients and users, much more integrated within health, between health and social care, and much more orientated towards ongoing community provision. All of that has to be done if the NHS is going to be sustainable as a service based on the principles it's based on.

THE AMAZING THING, ACTUALLY, IS THAT GIVEN EVERYTHING THAT HAS BEEN DONE TO IT OVER THE COURSE OF THE LAST FEW YEARS, OVERWHELMINGLY, IT CONTINUES TO BE IN REASONABLY ROBUST HEALTH.

The amazing thing, actually, is that given everything that has been done to it over the course of the last few years, overwhelmingly, it continues to be in reasonably robust health.

It's performing quite well, considering that the glue's been taken out of the system and the superstructure has been turned upside down. Uncertainty rules OK. I've never known a time of greater uncertainty than now.

But nature abhors a vacuum, and the NHS does a bit as well. So you've got a whole generation of public service entrepreneurs who are coming through and innovating and introducing some interesting solutions and practices which will stand the NHS in good stead for the future.

There was drift in the latter part of the Labour years, and I think we've had chaos for the three years of the Coalition Government, and I'm expecting that for the next two years. It will be pretty hard to get the NHS out of chaos and into stabilisation mode in the immediate term – because you've got a combination of capacity disappearing from the system, uncertainty around structures and directions, cash shortfalls, and the system overall running pretty hot.

But in practice there is quite a lot of alignment politically about what needs to be done, more alignment in private than people are willing to concede publicly, about integration and all that. What there is not is alignment about how we are going to do it.

The most important thing is to be absolutely crystal clear about what your long-term ambition is for the service. And that's what's spectacularly missing.

I can see all the short-term stuff – you know, a touch on the tiller here, a bit of money and there, a piece of Elastoplast next to it, some encouragement of some interesting schemes hither and thither.

What is absolutely needed and is absolutely missing is the long-term explanation of how we are going to get there. I am not saying that the NHS Plan (of 2000) was the answer to everything, because it clearly wasn't. However, what it did provide was clarity about direction of travel over a lengthy period of time. And that's what is missing. It is a how thing; a process thing rather than a product thing.

If you decided to write an NHS plan today, it would be a far easier thing to do than the one that was written in 2000. Because actually there is so much commonality around integration, a sensible mixed economy, patients who've got to be empowered and own greater responsibility for their health, a bigger accent around the killer diseases that are behavioural – alcohol, tobacco, obesity, all of that sort of stuff. You can talk to virtually any leading

policy-maker or decision-maker, and they more or less trot out the same thing.

What people want above all else is to know where it is being taken and how. So people are constructing their own realities. The problem is there are going to be three or four hundred of them.

You want some of that. You want the future made as much from below as above. But if you're going to have an N in this NHS you need political leadership about how it is going to get there.

We had a really interesting experiment in the first two years of the Coalition Government when politics went absent from health policy. We'd had the argument for many years that if only we got the politicians out, everything would be hunky dory.

Well, we got a politician in who wasn't a politician, and see what happened. So whatever Andrew Lansley's great claim to fame is, it's not being very good at politics, which is why it all came asunder.

But oddly enough, his screw-up has created permission for an essential ingredient for future NHS success, which is political clarity.

I could write you an NHS plan that sort of described what it should be like in five or ten years' time, and to be perfectly honest – would it be a million miles away from what Stephen Dorrell would argue? Probably not.

But it is defining it in the right way, and making clear both the destination point and the direction of travel that is most needed. That is what is missing.

One thing that has really changed since my time is hospitals. In my time, hospitals were the answer to a problem. And today they've become a problem.

Hospitals are, of course, going to be important building blocks for any future health care system. But they are not the foundation for which a health care system that is going to have to deal with

an ageing population, chronic disease, less episodic and more continuous care. So we're going to have to reconfigure the whole system in a more fiscally constrained climate. And that is going to be really tough.

The old answer to how you reconfigured services was to pile more new money in. The answer will have to be to switch old money from old services to new, and that is going to be really tough. And that will require political leadership as much as clinical.

Every study tells you the same thing. I've read repeatedly over the years, that 25 per cent of patients in a hospital today are in hospital needlessly because of a mistake either before they got to the front end of the hospital or a mistake that doesn't get them out of the back end of the hospital.

We know that. And we know that patients are becoming more informed about their health and want to have a bigger share in shaping it. How do we utilise that willingness to engage, and the new technologies that allow us to do so, not least mobile health? How do we utilise that to make it into a new arm of what the National Health Service does? What forms of behavioural change do we think the National Health Service can challenge? How can we utilise the potential products that arise from genomics to provide better, more interventional, earlier care in a way that reshapes services to make the system more sustainable. This is new science that is going to have to be developed.

So there are a series of big questions. And I don't think it is that we don't know what the questions are. I don't even think it's that we don't know what the answers are. What we don't have is clarity of purpose or clarity of process to get there.

Can the service remain largely free at the point of use, despite the fiscal constraints? Yes, overwhelmingly, I think it can.

I'm a bit more of an economic optimist than perhaps the conventional wisdom would suggest. But I think it would be right

to be cautious and assume that flat or no growth is going to be where it's at for some time. I think at the margins you are probably going to see a bit more co-payment over time. But I think that'll be marginal, to be perfectly honest.

I don't think there will be any appetite, and I don't think politics is going to go anywhere near charging for GPs, charging for mainstream operations, all of that sort of stuff. I just don't buy it. And I don't think that there's an appetite in the public for that.

You can see a bit of it now in services that are under-supplied by the NHS. You see it most graphically in dentistry. You can see it in physiotherapy where people go privately because there is an under-supply, and the NHS does charge for a private room or Sky TV, but it's pretty incidental.

THE BULK OF NHS EXPENDITURE CONTINUES TO BE ON HOSPITAL BEDS, OUTPATIENTS, INPATIENTS, DIAGNOSTICS. DO WE REALLY THINK THE NHS IS SUDDENLY GOING TO BE INTO CHARGING FOR SOME OF THOSE SERVICES? UNLIKELY.

But what are we talking about here? The bulk of care is provided at the beginning of life and at the end of life. So where do we see the co-payment opportunity? Well, that's quite a difficult question to answer. The bulk of NHS expenditure continues to be on hospital beds, outpatients, inpatients, diagnostics. Do we really think the NHS is suddenly going to be into charging for some of those services? Unlikely, I would have thought.

Experiments with GP charges have been mixed around the world. So when you start to cut it down into its constituent elements, I can't see, other than at the margins, that this is going to be the answer. The answer is going to be much more in reconfiguring the way that services are provided to make them more clinically effective and more cost-effective.

The starting presumption should be – rather than asking shouldn't we now be charging patients more – how do we spend £110 billion better? Reconfiguring these services, closing a whole lot of hospitals that are actually not needed, reducing capacity that is not going to be needed in the future – that is not a pain-free option. Getting all that aligned is probably, in reality, past the election. Which is why the absence of long-term thinking about how we get there is what is so depressing about the political debate at the moment.

RT HON. THE LORD OWEN

The Rt Hon. Lord David Owen CH FRCP was a Member of Parliament for Plymouth for 26 years from 1966 to 1992. Under Labour Governments, he served as Navy Minister, Health Minister and Foreign Secretary. He was co-founder of the Social Democratic Party. He sits as an independent crossbencher in the House of Lords.

In England, the NHS at the moment is struggling to survive a hugely expensive and deeply demoralising reorganisation.

TO ENSURE THE NHS REMAINS
VIALE AND FIT FOR PURPOSE,
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TO BEAR ON ASSESSING THE
IMPACT OF THE HEALTH AND
SOCIAL CARE ACT 2012

To ensure the NHS remains viable and fit for purpose, health leaders need to bring all the disciplines of evidence-based medicine to bear on assessing the impact of the Health and Social Care Act 2012, and treat it at this stage as an unproven experimental legislation, not as a *fait accompli*.

Conservative ministers should draw up a new mandate for the unelected NHS England Board and suggest changing the mandate to implement far more slowly the provisions of the Act than they originally intended.

Labour should accept that in government they paved the way for some of this undesirable legislation and by the general election of 2015 promise a short emergency Bill in the Queen's Speech to change the 2006 and 2012 Acts so as to reinstate their commitment to provide a comprehensive, equitable health service drawing on an internal market, not this external market.

Liberal Democrats should recognise that they were wrong to put their name to this massive top-down reorganisation for which they had no democratic authority and work to find more common ground with Labour on the NHS by the next election.

There are many of us who are determined to change this legislation at the earliest opportunity. We will ensure that politicians better understand the merits of a democratic, rationed health care system and that health care should not be treated as a utility like electricity, gas or water. We will mobilise unprecedented people pressure on MPs and candidates at the next election to support emergency legislation in the first Queen's Speech. The legislative wording to do this is already before Parliament in my name in the National Health Service (Amended Duties and Powers) Bill, a mere 11 clauses, stopping well short of a repeal of the 2012 legislation. This wording is subject to consultation and I invite the Nuffield Trust to devote some of its resources to improving this emergency legislation choice and ensuring a wider debate, not appearing as supporting fatal flaws that are becoming ever-more apparent in the current legislation.

I believe the NHS can remain free at the point of use. To make that more credible, I would introduce urgently on everyone's income tax form in England a figure for their individual contribution to an ear-marked fund for NHS England. I would hope our NHS budget in economic crisis will at least keep pace with inflation then start to rise. There should be no co-payments. We already accept the right of an individual to pay for private care from their after-tax income and we should continue to offer no income tax concessions.

RT HON. THE LORD WARNER

The Rt Hon. the Lord Warner is a Labour peer. He has served as Minister of State for Health, and as a member of the Dilnot Commission on Funding of Care and Support.

We have had the reorganisation to end all reorganisations – we hope! Not necessarily a good one. But it is the only one we've got, so we have got now to try to make it work.

It is probably not the smartest thing to have thrown all the organisational cards up in the air given the sheer scale of the financial and demographic challenges that the NHS faces. The NHS has suffered from what you might call planning and delivery blight for the best part of two years.

My sense is that the so-called Nicholson Challenge has only been very partially achieved, and most of that has come through pay restraint rather than serious service delivery changes. And pay restraint is not sustainable forever.

I think the NHS has been slow to realise that the period of austerity goes on well beyond the four years of the Nicholson Challenge. Given the economic forecasts, the NHS budget can't be protected, whatever the protestations of the political parties, unless you're prepared to either make very substantial tax increases or cut other public services even further.

The implications of that are really quite serious. I am in favour of both competition and integration. But neither on their own is quickly going to produce such a huge swathe of innovation that it would change the financial equations.

So the only serious show in town basically is to reduce the expenditure on the acute hospital services, take money out of the system, and transfer it to other uses, which are cheaper alternatives. Possibly linked to some kind of user charging regime.

Unless, that is, you are going to allow 1990s rationing to take over. But it seems to me that the idea that you could go back to that – long waits for elective surgery, long waits to see GPs, long queues in A&E, doctors prioritising who they will and will not see – is not on. All the evidence on the killer diseases is that we need earlier intervention and diagnosis rather than waiting to see a doctor.

I THINK THE NHS HAS BEEN SLOW TO REALISE THAT THE PERIOD OF AUSTERITY GOES ON WELL BEYOND THE FOUR YEARS OF THE NICHOLSON CHALLENGE.

And if we want to have genuinely 24/7 acute services – with all the evidence that the chances of staying alive are much less if you go into a hospital at the weekend – you’ve got to consolidate many of these specialist services on a smaller number of larger sites. And that means people accepting the need to travel further to get them. But we are, after all, a small country.

And this isn’t simply one hospital giving up cancer and taking on coronary heart disease, but still keeping the same volume of beds. This is about making changes which take cash out of the system. If you don’t do that, you haven’t got the money to develop more services closer to home and on a cheaper basis.

That is where you get into the territory of what are you going to define as health and what are you going to get done on a means-tested basis in social care?

There’s been study after study about the proportion of people in acute hospitals who should not be there. And the figures range from 25 per cent to 40 per cent. Now if you had a model where you could respond quickly to elderly people who have minor medical crises, having a nursing home/hotel, with medical cover and nursing care that might cost £1,000 a week – rather than getting them sent to A&E, admitted by a junior doctor and staying for four weeks, and coming out disorientated having cost £2,000 to £3,000 a night – that’s the kind of care closer to home that does actually deliver the bacon. That’s not to say you don’t put some health and adult social care facilities on those district

general hospital sites; but what they are not is A&E departments and acute hospital beds.

Our health care system has never done that sort of nursing home. Many other systems do. But it is a moot point as to whether you put this in the NHS or whether you put it in social care.

I do think that the changes that are needed will shift the boundary between health and social care, and what is paid for. It's happened with dentistry. It has happened with spectacles. There might be some redefining of what is included in the NHS – IVF for example.

SOME OF THE CHOICES ARE NOT IDEAL AND THEY'RE VERY UNCOMFORTABLE POLITICALLY... BUT YOU HAVE TO DO SOMETHING ABOUT DEMAND AND YOU HAVE TO DO SOMETHING ABOUT HOW THE SYSTEM IS FUNDED.

And you could bring in user charges, which have two advantages. They raise revenue and they probably choke off some unnecessary demand, so they have a double benefit. They may choke off some need as well. I accept that. But we can't have it all ways. Some of the choices are not ideal and they're very uncomfortable politically. But if you have no growth and you're not prepared to increase taxes, you have to do something about demand and you have to do something about how the system is funded.

One way you could make the NHS more like social care is to say the hotel costs of the NHS are borne by the citizen. Too bad. You've got to go into hospital, this is the cost. Now that might in itself incentivise people to have care at home.

I mean, we have some strange paradoxes. Somewhere between 50 and 60 per cent of people die in hospital. A hundred years ago nobody did. Most people want to die at home. We almost force them to die in hospital against their wishes, which is pretty bizarre.

So you could make some user charges not so much to choke off demand but to incentivise a system where you were going to go

for a cheaper option. If you look at the Hospice at Home work that Macmillan have done, they've asked: 'can we actually meet people's wishes to die at home and provide a hospice service to the home?' They've done it and shown it to be, give or take, a third of the cost of dying in a hospice, with punter satisfaction. So there is some evidence that it could be done.

And we have to have the conversation about end-of-life care. I think the public may be ready for that. The assisted dying movement, of which I am a supporter, is quite interesting. The public is ahead of the professions and the politicians on this. The public looks to me to have an appetite for discussing the whole issue of end-of-life care in a more radical way.

At the other end of the spectrum, we need to rather brutally rationalise elective surgery, so that we have surgical factories as they do in India and Finland. Does it really matter if I drive or am driven 50 miles for my day surgery when I am not going to be there very long?

The greatest barriers to this are an unwillingness to have the conversation with the public, professional protectionism, and an unwillingness to engage with people who can do things differently, and let them into the magic circle of the NHS. Those are the impediments. Somewhere in the world there are examples of doing things differently, which work. And somewhere in Britain, in some cases, there are examples. But we never go to scale at pace on these things.

And you could apply some of the Dilnot logic to the NHS. Take dementia, which the NHS tends to want to treat as a social care problem. If we were being logical, it would be very hard to argue that dementia is not a disease and therefore it's not part of the NHS.

You could potentially apply the Dilnot logic to bits of the NHS. So there are payments, but the state picks up the catastrophic

costs. So the costs are capped. Don't ask which bits, because I haven't actually thought about it. But probably conditions associated with longevity. In principle, you could take bits out of the health care system and say actually we're going to redefine it. But that starts to overlap with the whole issue of user charges.

You could also build a bit more resilience into NHS funding. The Treasury hates hypothecated taxes. But if you look at the duty raised from alcohol and tobacco it is quite buoyant money. It taxes sins which may be very pleasurable activities, but which are contributory to disease. Or taxes on fast foods as Bloomberg is doing in New York. It wouldn't raise all the money, but a proportion of it.

It is part of a bigger question about whether we should start exploring the basis on which we fund the NHS, with a more complex mix of hypothecated taxes, user charges and redefined boundaries between health and social care? The answer to that is yes.

I don't know what all the answers, the endgame, would be. But I think things are serious enough to start opening this up for public debate. Because if you can't build politically acceptable resilience into the funding of something called the NHS, you have a major political problem.

The idea of a health system that is largely free at the point of use is very deep in the British psyche. But it may be we have to dig it out of the British psyche and start asking some questions about it. Not because one wants to, but because the fiscal and demographic issues are forcing a re-examination of some of those pieces of accepted social wisdom.

RT HON. BARONESS WILLIAMS

The Rt Hon. Baroness Williams of Crosby is a Liberal Democrat peer and former Cabinet minister. She was Co-Founder of the Social Democratic Party and its first President from 1982 to 1988. She served as Leader of the Liberal Democrats in the House of Lords from 2001 until retiring from that position in 2004.

To be perfectly honest, it's extremely difficult to say quite what the state of the NHS is. The Secretary of State, partly because he's relatively new, goes for what you might call the neuralgic points of the health service. But he hasn't really gone deeply into where the NHS is going to go. So let's just pick up two things.

I think the A&E crisis is partly because the previous health secretary, and indeed most other people, decided that there should be a move towards community provision, with strong emphasis on the involvement of voluntary bodies as well. But that hasn't really been set up properly. Indeed, given the local government cuts, it's very difficult to do that. So the public, desperate to get attention, in some cases finding it difficult to reach their GPs, flood into A&E.

Now, that was a sequencing mistake. I think it would have been better to have got on with building up good local provision, taking the examples we already have like Cumberland and the Torquay area, where you really have got effective provision for elderly people and the chronically sick. But that's patchy at best. An awful lot of the country hasn't got that provision.

So what people do is go to A&E, and then complain like mad if it's decided that some A&E units will close – because that means there is a lack of adequate alternative provision.

What can we do about that? Well, I know I shouldn't say this, but the answer is that you have to move a bit more slowly towards concentrating specialist care and diminishing the number of smaller hospitals. Take it reasonably slowly. Take it over two

parliaments, not two years, because otherwise you are going to get this huge pressure on A&E and it can't take it.

The other great move would be to bring in the professions ancillary to medicine, as the essential second line of protection.

You begin to register people with chronic sicknesses with pharmacists to look after their drug regimes. I'm not saying that pharmacists should replace GPs. But GPs spend an awful lot of their time on fairly frequent visits from exactly the same group of patients – the ones that have chronic conditions. With a good pharmacist service you could lift quite a lot of the burden from GPs.

I do think the contract made with the GPs was a huge mistake. Not because I think GPs should be compelled to work 24/7, because you can't expect that of any profession. But I do think they should have accountability for that service. CCGs should take responsibility for out of hours. They can choose who they select to provide it. But the buck has to stop with them.

IF WE DON'T GET ALL THIS RIGHT,
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BASIC SERVICE, WHICH APPLIES
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TO GO PRIVATE.

A third crucial area is shifting part of the responsibility for caring for elderly people away from the NHS, particularly towards hospices. You might even extend hospices from being just the last few weeks of the end of life to perhaps the last couple of years, once people start declining to the point where they need full-time care.

But that means that if you are going to retain hospices as essentially voluntary agencies, then we have to consider whether it might be appropriate to subsidise the cost of a hospice place for people from disadvantaged backgrounds.

I know that means means-testing. But I think everybody should be entitled to go there if they want to, and it would probably be less expensive than having them in geriatric wards in acute hospitals.

I think the key thing for the next decade must be getting the sequencing of changes to the way care is provided right.

I THINK THE KEY THING FOR THE NEXT DECADE MUST BE GETTING THE SEQUENCING OF CHANGES TO THE WAY CARE IS PROVIDED RIGHT.

And there needs to be a move towards something like polycentres. I've recently seen a very exciting experiment where a group of young GPs are reaching an agreement with Brighton council, under which the council, which has a completely desolate spot on the sea shore at the least posh end of town in East

Brighton, is going to redevelop it as a centre, not only for health, but related services including a nursery school and provision for health exercise, particularly directed at people with diabetes and so forth. All on the same site.

In a sense it is the future of the NHS, but one that combines health with other forms of care and quality of life.

But as we concentrate more specialised care we have to think about access for people who are seriously ill. I've been following what is happening in Canada. Alberta, which is a huge province, has now got only two hospitals, often 60 to 70 miles away from the patients. But they use helicopters to get people there quickly, and they have found that they save money and see morbidity drop. That could be a concept for places like Cumbria and the South West, for example.

If we don't get all this right, there is a real danger that we will end up with a minimal basic service, which applies to people who cannot afford to go private.

If you're absolutely stuck for money, there might be a case for at least considering a nominal charge for GP appointments, because for a lot of appointments people simply don't show up. And sadly that's a growing trend, particularly among younger people. The French I think charge something equivalent to £5 per appointment. It might get people to value the service.

You could also have a nominal charge for prescriptions for older people, with appropriate exemptions. An awful lot of people do actually have quite substantial pensions in addition to the state pension.

I don't want to see that. I am a believer in everything being free if possible. But rather than see the NHS go down, one might be forced to consider that kind of thing. But only as an alternative to more people seeking or being forced into private provision, and with a clear statement by the government of its complete commitment to the retention of the NHS.

Officials

OFFICIALS

LORD ADEBOWALE CBE

Lord Victor Adebowale CBE is Chief Executive of leading health and social care organisation, Turning Point, as well as Non Executive Director of NHS England, Commissioner of the UK Commission for Employment and Skills and Chancellor at the University of Lincoln. In 2000, Victor was awarded a CBE for services to the New Deal, the unemployed and homeless young people and in 2001, was appointed a cross-bench member of the House of Lords.

The NHS is facing the most challenging period since its creation. The future of our health service now depends on how it rises to these challenges. Stasis is not an option. If we do what we have always done, then we will get what we've always got, which is unacceptable in this day and age.

THE NHS IS FACING THE MOST CHALLENGING PERIOD SINCE ITS CREATION. THE FUTURE OF OUR HEALTH SERVICE NOW DEPENDS ON HOW IT RISES TO THESE CHALLENGES.

Appropriate leadership at an operational and executive level is crucial for the NHS to remain fit for purpose in ten years' time. There needs to be more risk-aware decision-making among health and political leaders and this decision-making must be visibly accountable to the public.

This means that NHS England has to be brave enough to hold a mirror up to its own activities, to learn from its reflection in the eyes of the public. The concept of commissioning which truly involves local communities is frightening to some. However, this approach is essential to realise the vision of an NHS grounded in the patient and consumer experience.

Leadership needs to take us from where we are now to where we haven't been. Those in charge must do exactly what it says on the tin because the system can be confusing for the public.

As for political leaders, they need to understand that using the NHS as a tool to win votes is short-sighted and does not benefit the NHS in the long term. What is needed is political leadership which upholds the principles and values of our health service, leadership which is proud of this remarkable institution – and defends it.

There has been much talk – and promise – of a health service which puts the patient and consumer experience first. I hope this is the reality in a decade's time; that the NHS will be 'owned' by the consumer and developed by them. As one of these consumers, I would want to have immediate access to my own patient records, be able to easily navigate my way around the system and be an equal partner in the provision of my own care.

Another essential goal for the future is that health and social care are totally integrated so that those in society with the most complex conditions receive a brilliant service. If we have a health and social care system that is geared towards both those with the most complex needs and the least means then we will ensure that we have a service fit for the purposes of every member of society.

IF WE DO WHAT WE HAVE ALWAYS
DONE, THEN WE WILL GET WHAT
WE'VE ALWAYS GOT. WHICH IS
UNACCEPTABLE IN THIS DAY
AND AGE.

The only way to achieve this goal is through a workforce that understands that the distinction between health and social care is a meaningless debate to the patient.

The NHS is a precious institution. Led well, it could become a polished jewel in the crown of public service provision.

PAUL BATE

Paul Bate is Director of Strategy and Intelligence at the Care Quality Commission. He has worked at the centre of policy and delivery on health for more than ten years. He joined CQC from Downing Street, where he was the Senior Policy Adviser on health and adult social care to both the Prime Minister and the Deputy Prime Minister.

Health policy is beset by conversations that start radically and end with “but that’s too difficult”. Thankfully Nye Bevan battled through such debates, and the result is an NHS to treasure and a health brand that is globally unrivalled.

WE NEED A SYSTEM WHICH CARES FAR LESS ABOUT WHO OWNS THE PROVIDER AND FAR MORE ABOUT THE QUALITY OF CARE THEY PROVIDE... AND WHICH ACTIVELY ENCOURAGES THE GOOD TO DISPLACE THE BAD.

The “too difficult” argument encourages lazy thinking – if there’s someone to blame for an idea not working, why think through whether it really is the right answer? Reconfiguration of A&E services is a good case in point. The clinical and business cases say lives and pounds can be saved, and consultant and junior grade rotas can be safely staffed. But what about opportunity cost? What are the other ways to improve lives and control costs – and could these bring greater benefits, take less time to implement, or better

maintain people’s trust in the NHS? What else is in the “too difficult” box?

1. *Patient self-activation, starting with diabetes.* In 2002 Derek Wanless showed the value of the “full-engaged” scenario, in which people better look after their own health: 1.9 percentage points of GDP in 2022/23, or around £20 billion. We could be making this a reality through the mobile internet, personal health and care budgets, and allowing people to truly own their electronic medical and care records – preferably joining them up first. Let’s start with diabetes – a disease that accounts for

approximately ten per cent of NHS spend and for which 80 per cent of health costs are avoidable. Now that's a business case worth exploring.

2. *A fair playing field, where the best providers flourish.* The differences across acute trusts in standardised hospital mortality rates and reference costs are well documented. The data are poorer in primary and community care, but few doubt the variability is there. The truth is that some providers are simply better managed and led than others. But they rarely expand, and certainly not beyond limited geographical boundaries. We need a system which cares far less about who owns the provider and far more about the quality of care they provide... and which actively encourages the good to displace the bad.
3. *Getting serious about mental health.* Let's start with some honesty – people with schizophrenia and those with anxiety disorders deserve better than to be bundled into one catch-all 'mental health' clump. What is true is that people with long-term mental health conditions cost more on average per person per year, continue to use services intensively for longer, and impact on a wider range of other public services than those with exclusively physical health conditions. One in six adults suffers from diagnosable anxiety or depression, and the impact of poor mental health on our economy is estimated at £12 billion per year. So let's get serious about mental health.

This isn't an exhaustive list by any means – plenty of other ideas sit in the dark of the "too difficult" box. Tough times call for radical action – so let's work out the ones that are both radical *and* right.

DAVID BEHAN CBE

David Behan CBE is Chief Executive of the Care Quality Commission. He was previously the Director General of Social Care, Local Government and Care Partnerships at the Department of Health, the President of the Association of Directors of Social Services and the first Chief Inspector of the Commission for Social Care Inspection.

My personal belief is I think there's been an evaporation of trust in some of the institutions of modern society and I think Mid Staffs has shaken the trust that there is in the NHS.

I think the polling shows that trust in doctors and nurses is still as high as trust in any public professionals. But there is an issue about unconditional trust having evaporated. Other things that have happened contribute to that: MPs' expenses, Leveson, Hillsborough. There is a whole raft of examples where the trust and confidence we traditionally have in public institutions has been shaken. For me what was significant about Mid Staffs and the Francis report is that the NHS normally rides those crises of trust and confidence – but it's not ridden this one as easily because that erosion of trust is a broader thing across society, not just confined to the NHS.

So I think that sets the backdrop, along with the economy. For me, I think there's less optimism about than at any time since the mid-1990s. It feels a bit like those recessions in the 1980s and 1990s when things were tough, but a bit more than that because we've no confidence of when we're going to come out of it.

All that has made the debate about whether the NHS should be free at the point of delivery seem more tentative than at any time I can remember. So there are people debating about 'will we have to pay for health care?' in a way that would have seen them shouted down previously. I think the economic position is allowing people to think the unthinkable.

I don't think the political parties will differentiate themselves on that at the election. But it could be different afterwards if we get a government with a majority. If there are to be any radical decisions we will get them then – although a lot of the radical decisions may be more around 'how many hospitals are we going to have and where are we going to have them? What's in a hospital?'

WHAT THE FRANCIS REPORT HAS
DONE IS SAY THAT IT IS NOT
ACCEPTABLE TO TRADE QUALITY
AGAINST ANYTHING ELSE.

The debate about quality and health care is an important one, and it will get more important over the coming months.

I think when people felt they could be dismissed for losing the budget in the NHS, what they ended up doing was trading things like staffing levels and therefore quality against the budget.

What the Francis report has done is say that it is not acceptable to trade quality against anything else.

And at Mid Staffordshire, when they did start to appoint sufficient staff to cover the wards in order to safeguard quality they then ended up overspending – which has in turn led to the decision by Monitor that what they are doing is neither clinically nor financially sustainable. I strongly suspect there will be more places where those trade-offs are just too difficult.

There's a political resistance to making any reconfiguration decisions. But the money is fixed and the expectations around quality are going to continue to work their way through.

What politicians need to do is expose these trade-offs. Instead of defending the status quo, defending hospitals from reconfiguration, I think they need to open up the debate about quality and safety.

Jeremy Hunt, in my view, is a very astute politician. Inside weeks he has reinvented the role of Secretary of State as being on the side of patients and championing quality and safety – leaving behind all the conversations from Andrew Lansley's day about systems.

He has invested in CQC at a time when it would have been easier for him not to have done that, because we were seen as a failing organisation. But I think he's been right to focus on quality and safety.

My belief is that the Francis report is a seminal one, because of its timing and the context in which it has occurred. Everybody has a tale to tell about the quality of care in hospitals, whether good or ill, and about how people with two or three complex conditions get a poor service from the system. The report touches a nerve, and has a hit a moment when the moral, political, economic debate is open to the issues he's raised.

THAT BALANCE IS CHANGING.
TECHNOLOGY WILL CHANGE IT. THE
HUMAN GENOME PROJECT WILL
CHANGE IT.

In terms of where the NHS is now, our last state of care report said eight or nine out of ten places are actually doing exactly what they should be doing. One or two out of ten are not. So, on the whole, it's making really good progress. But 20 per cent of the millions being treated who are not getting access to a good service is too many people. This is not about running down the service, which is the envy of the world when you compare it with many other systems. But there are challenges about whether we've got high mortality rates in certain disease and treatment areas, and we should be open to what we need to do to improve that.

I am optimistic about the future. I do believe it is possible to continue to extend performance over the next few years. There is evidence of people thinking creatively about how best to use the money that is already in the system. It will take leadership, and staff will need to be open to change. But I'm not sat here thinking the basic concept of the NHS is broken.

There are some tough choices. The issue about the balance between what takes place in a hospital and what takes place in a community is a really tricky one. That balance is changing. Technology will change it. The human genome project will change it.

And the generation that is about to age is the baby boomers. They are used to dictating what happens in their life, not being dictated to. So the balance of power between people that use services and people that provide services is going to change. This will be a technologically literate generation. So they are going to know about their condition and their drugs and what the leading technology is in America or Australia.

I think there will be a drawing together of health and social care because people will demand access to the help and support that they need to live independently. I think more of us will push for that to be in our own homes. I think more of us will push to die at home rather than die in hospitals, and all that will pull more services out of the institutions and into the community. And I suspect CCGs will drive all sorts of different decisions about care closer to home.

I think the NHS will continue to be free at the point of delivery for ten years, but I'm not sure ultimately. I don't think we will go the way of America or other insurance-based services. But some people already pay for prescriptions. We pay for glasses and dental care. And bringing health and social care more closely together will raise questions about what is means-tested and what is not. I don't think that is a reason for not doing it. But it will raise the issue. It will, however, be a brave politician who sets out to renegotiate the relationship.

DR DAVID BENNETT

Dr David Bennett is Chief Executive of Monitor. Before joining Monitor he was the non-political Chief Policy Adviser to Prime Minister Tony Blair and Head of the Policy Directorate and the Strategy Unit in 10 Downing Street. He has also worked as an independent adviser to various NHS bodies.

In some senses I think the NHS is doing surprisingly well. We had the A&E problem last winter but, serious though this problem was, on the whole the financial year that's just finished wasn't bad. Certainly from the foundation trust point of view it was otherwise satisfactory in aggregate. There were some trusts in difficulty, there always will be, but in aggregate it was fine.

The question is, is the NHS heading for more serious problems? We're watching closely, but we can't really know for certain. So the question about A&E is to what extent was that just a one-off – an unusually cold March, a few other one-offs, like the implementation of 111 and so on – which will all be fixed for next winter, or was it a symptom that the system is feeling the strain, that it might be near some sort of tipping point?

That's something of an unknown, although everyone's working hard to avoid it. But at the moment, given the amount of turmoil that's been going on and the fact that we have had this downward pressure on the finances for several years, the sector is actually proving surprisingly resilient so far.

I'm pretty clear that, whether or not the NHS is approaching some sort of tipping point, it will reach one sooner or later if it doesn't get to grips with more fundamental change than it's achieved so far. It is striking, for example, how much of the productivity gain achieved over the last few years has been driven by the wage freeze which, of course, can't continue for ever.

There is, in fact, a lot of agreement about the sort of change that's needed. So what local health and political leaders need to do is plan ahead. Really think through, over a five- to ten-year timeframe, what's necessary and then get on with it. Because these are big changes. You can't wait until half way through a year and your quality performance or your finances start to go wrong and think you're going to fix it by the end of the year. These changes will take years in preparation in some cases.

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Three things fundamentally need to be done. One, I still think there's a lot of genuine productivity to be had. If you look at the variances between trusts on all sorts of measures, they suggest there is still a lot of genuine improvement to be had. If you look at other sectors that have been introducing lean technology, which is entirely suitable for elements of health care, they suggest substantial further opportunities.

The second thing is to make sure we are providing care in the right places. Moving it out of hospitals where that is genuinely lower cost, but also consolidating into fewer centres. That second part is often as much about quality as anything. It's not necessarily financially driven, but it should help with productivity as well.

And the third, and most difficult thing, is to genuinely innovate in ways of delivering care. So whether you're talking about what they have done with the Aravind Eye Care System in India, or what they are doing with primary care in Mexico, it is those sorts of really different ways of delivering care that will be needed.

This is massive change. What local health leaders need to do is understand the nature of the change and plan for it and work out how to do it. It won't be easy for them.

The thing the politicians need to do is resist the temptation to change the structure of the system again. No architecture will ever

be right, will ever be perfect. But leave it alone, because the worst thing you can do is to just keep altering it. Instead they need to support the change that's needed on the ground, and the people making that change.

These are not unfamiliar messages, and I appreciate that expecting MPs and local politicians in particular to support big changes and major reconfigurations is a huge ask. But they have got to do it. Or at least they ought to do it.

And they must support the individuals doing all of this. It is an incredibly difficult job being, for example, a hospital chief executive. Those are the people I see most closely, but I'm sure it's true of many other people in the system. And what the politicians can often do – and again I mean MPs as much as, if not more than, ministers – is make the job more difficult and less attractive, even if unintentionally.

I think we are at risk of having a real leadership crisis in the NHS, especially in relation to the scale of the challenge we face. I keep hearing that good people don't want to step up to the job of being a chief executive because it is so exposed and stressful. I would ask that wherever possible local politicians support these people, recognising that most of them are trying their best in often difficult circumstances.

What do I think the NHS will look like in ten years' time? I hope it will look very different, and be widely recognised as a health care system that puts patients first and has an active culture of compassion. I think the NHS will come through its current travails one way or another, but I do fear it may well significantly under-perform against what it could really achieve – that it doesn't do all the things I've just described because health leaders will be distracted, for example by further reorganisation from the centre, or diverted from the immediate task at hand by local pressures. So yes, it'll be more integrated, it'll be somewhat less hospital-focused, it'll be more patient-centric, but it may not have made all the radical changes it needs to.

I hope I'm proved wrong, but if it doesn't do all this, there is a funding gap, so how does the NHS cope? I think it would be a mixture of three things. One, there would probably be a squeeze at the margins on the 'offer', with some services that are not deemed an absolute top priority for all patients falling by the wayside. So there would be a bit more fine tuning, you know, a few less IVF sessions here and there, or similar.

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Second, I expect there would be, again at the margin, a little bit more co-payment. It is nonsense to say that there shouldn't be any at all, because there already is some, and no doubt there could be a little bit more. However, I'm guessing. This will be very sensitive politically, and I think increasing existing payments or adjusting eligibility is more likely than the introduction of forms of co-payment that don't exist at the moment.

And third, though I don't want to encourage anyone to believe this is the way out, I suspect in the end there would be a bit more money. When the economy, as it must eventually, starts growing again, it will be a bit easier. And maybe one day a future generation of politicians will accept that what we really need to do is put the health and social care budgets together, merging them properly.

PROFESSOR DAME SALLY DAVIES

Professor Dame Sally Davies is the UK Government's Chief Medical Adviser and Chief Medical Officer for England. She also chairs the UK Clinical Research Collaboration, and is a member of the board of the Office for Strategic Coordination of Health Research and the Medical Research Council. She developed and leads the National Institute for Health Research.

I think the NHS continues to do a wonderful job. That doesn't mean it can't be improved. But I believe in it and I think it generally does very well. We've got some issues – and you would expect me to say this – such as antimicrobial resistance, which show that we need to think hard about stewardship and what we're going to do. We've clearly got pressure on A&E at the moment, and we need to understand the causation and sort it out. But as I travel the world and look at other systems, I think for what we're paying, we're doing pretty well.

The main challenges include austerity, integration – not just in health care but with social care – and prevention. We need to move much more into a prevention model.

We know that if at the beginning of pregnancy women stop smoking, not only are their outcomes better but their babies' are too. If they have good nutrition, their babies benefit right through into adult life. We know that if people have an early pre-operative assessment and they're smoking and we get them to stop smoking, they do better and cost less to the NHS as they go through the operation and the post-op period.

So there's an impact on the NHS itself from that, but then there's the impact on the population. I am very hopeful and enthusiastic about Public Health England and what it can do.

The rise of lifestyle diseases and chronic disease means we should probably put any rises of money we get into prevention rather

than into more acute care. But we'll only get that if we build the evidence base while using economic modelling to make the case.

We have absolutely got to build the case for investment, but we have got more economists in the department working on the job and we are commissioning more economics on prevention.

So we have worked out, for example, that the cost to society from antimicrobial resistance is £30 billion a year, and that starts to say 'hey, we should do something about it'.

I think technology will play a role as well. I am not of the right generation to be a digital native. But I've watched my daughter take up running because of the Nike app on her iPhone that tells her how far she's run, how many calories she's burnt, how it compares with previously – competing with herself, but able then to compare it with other people.

It is having a massive impact. It will play a role in understanding our health system better by the linkage of anonymised protected data. It will play a role in actually helping people be independent longer. It will connect single people and elderly people into the community. And the coming generation of older people will be much more digitally literate.

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There's a wonderful example in Southwark that simply connects people who can offer services to other people. It is a very nice model. And that is part of the public's health. So we need to stop talking about health care, and start talking about health, wellbeing and care.

And we are having to do all this because there's not enough money. I think austerity drives people not to salami slice but to really re-engineer what they're doing and how they're doing it. But we have to take people with us. You have to oil the wheels with facilitation and conversation to help people move, but it can be done.

Looking ten years ahead, I think the NHS will be much more integrated. I think Public Health England will be a significant player on the field, talking not just about health protection and pandemics and nasty bugs, but actually helping people live healthier lifestyles. I think over a decade we can shift the cultural approach to alcohol, and austerity will help there.

Much of what I am talking about is more about culture and different ways of doing things rather than massive expenditure. I think austerity will help drive that and make it happen. So I remain optimistic.

Can it remain free at the point of use? I want it to. If spending remains flat in real terms over the years then I think the core service will remain free at the point of use, but co-payments of some form may well creep in – whether it is for hotel services or for drugs that NICE hasn't agreed. That is not policy, of course. And I don't want it. But if we don't recognise that it might happen we can't have the debate about whether we want it.

We can, in fact, crack lifestyle diseases. But we need to stop tackling them in silos with a tobacco cessation clinic here, a contraception clinic there and alcohol treatment somewhere else. We need a broader cultural change across society to achieve that, and one that embraces Public Health England, schools and the health care system.

PROFESSOR SIR LIAM DONALDSON

Professor Sir Liam Donaldson is Professor of Health Policy at Imperial College London and Chancellor of Newcastle University. From 1998 to June 2010, he was Chief Medical Officer for England and the UK's Chief Medical Adviser. He has served on the World Health Organization's Executive Board, conceived of, founded and led the World Alliance for Patient Safety and is now the Envoy for Patient Safety, as well as Chairman of the Independent Monitoring Board for the polio eradication programme.

I think the NHS still holds up very well internationally, on two levels. One, citizens of the UK don't have to worry about what happens to them financially when they become sick. And two, it is a pretty fair system as far as barriers to access go – looking at socio-economic status, ethnicity, and so on. There are always things that can be improved there. But you don't see the gross discrepancies that you see in some other countries. So as a health care system, compared with 192 other countries, I think it stands up pretty well.

As far as its performance in recent years goes, looking at it only within the country, I think it could and should be doing a lot better. I think it's been plagued by reorganisations that have really been a distraction. It has never gripped, truly gripped, placing quality and safety in the lead when delivering care – rather than them following on behind once the money and productivity targets are sorted out.

On the scientific side, in terms of breakthroughs in understanding disease and treatment, and in terms of publications in the world research literature, we still punch way above our weight.

But when it comes to transforming research excellence and innovation into practice, that still isn't so impressive – although I've heard Sally Davies say we have the highest proportion of patients in clinical trials anywhere in the world.

What needs to happen for the NHS to remain viable? I don't think there is a health system anywhere in the developed world that can sustain the level of care required unless it does something about the high burden of preventable chronic disease, unless it gets serious about treating more conditions that are currently treated in hospital in primary care, and unless it deals with the variation in outcome of care that has been there since the NHS started.

It's not unique to our country. But if we were able to make major reductions in variation – to take just one instance, in how well diabetes is treated and controlled, for example – the savings would dwarf anything we've ever saved so far. That is to do with clinical behaviour. So we need population behaviour to prevent or postpone disease. Strong government action. Much better organisation of care. And a wholesale embracing of evidence-based practice.

THE NHS HAS A TENDENCY TO
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THE DIFFICULT THINGS.

All of those things are incredibly difficult to achieve because the NHS has a tendency to bury its head in the sand on the difficult things.

Look at the row about whether we have got too many acute hospitals. You could go back 20 years and people would be making tentative suggestions about that. And the only time when anything is ever really done about it is when there is a well-endowed capital programme, and you get a bit of tidying up in the big cities.

I am not sure that the lack of money now will force it, because at times of crisis there's always a bit more money squeezed out to keep things going. I suspect that will happen this time. If it became such a political hot potato, the money would be found.

Difficult decisions are not compatible with the political cycle, so a health secretary is not going to come in and do really difficult things. The only area where long-term decisions do seem to get taken is in pensions. That is being gripped. But I don't think there are too many other examples where politicians do unpopular things in order to secure the future beyond their lifetime.

I don't think that is a gloomy view, just a realistic one. I am still passionate about my areas – public health, and safety and quality of care. But I make this point a lot in my lectures, that for most of my career I've been working with fellow enthusiasts, rather than mainstreamers. There are always so many false dawns, with the thing supposedly moving into the mainstream.

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There is quite a lot of consensus about what needs to happen to the NHS on the professional side, but not on the public side. The public is still very wedded to the NHS as a sacred cow. It's wedded to institutions. When I was a manager in the north east we closed Middlesbrough General Hospital and replaced it with what's now called the James Cook Hospital – which is a brilliant, lovely, modern hospital. But there was uproar about the closure. I often feel I'd like to go back and say to people, would you like to have Middlesbrough General Hospital back? And the answer of course would be 'no'. But the row was stupendous.

As for the future, the hope, I guess, is that you see disruptive transformation as a result of technology. If you get – and I think this is likely – diagnostic and treatment equipment that can be used by a non-skilled user, and which is miniaturised and much cheaper, you could see a very big transformation with many more things going into primary care and a lot more self-management and self-monitoring.

And you could get super specialist care, which basically switched off diseases such as cancer, or dementia, or significantly slowed it. That could totally reform things. I don't know how you can plan for those sorts of things, and I am not sure that anyone is trying to plan for it.

What needs to happen for the NHS to remain viable? I don't think there is a health system anywhere in the developed world that can sustain the level of care required unless it does something about the high burden of preventable chronic disease, unless it gets serious about treating more conditions that are currently treated in hospital in primary care, and unless it deals with the variation in outcome of care that has been there since the NHS started.

Professor Sir Liam Donaldson

Professor of Health Policy, Imperial College London; Chief Medical Officer for England and the UK's Medical Adviser, 1998 – 2010

DAVID FLORY CBE

David Flory CBE is the Chief Executive of the NHS Trust Development Authority. He joined the Department of Health in 2007 as Director General for the NHS Finance, Performance and Operations and has over 20 years' board-level experience in NHS bodies in the North East of England in Director of Finance and Chief Executive roles, including being the first Chief Executive of NHS North East.

Over the last ten years the NHS has done much to enhance both access to services and quality of care – two of the three critical ingredients to maintaining a high-performing, free at the point of delivery health service our patients and communities value so highly.

In the early part of the 2000s much was done to enhance capacity and reduce what today would be regarded as wholly unacceptable waiting times. Having reduced waiting times, staff in the NHS capitalised on their new-found ambition and focused on delivering even better quality of care, with the Next Stage Review helping to create the environment where there was much greater attention to safety and effectiveness of care as well as enhancing the experience patients had.

TO ENSURE THAT THE NHS IS IN A
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The four or five years until 2013 saw record breaking delivery against almost any ambition, target or standard you could care to mention, and a new-found confidence could be detected in every part of the NHS.

That confidence was hard won and a prize worth preserving to hand on to the next generation of NHS leaders emerging through the ranks. However, to ensure that the NHS is in a fit state to celebrate its 75th

birthday in 2023, the current decade will absolutely need to be remembered as the period in which we truly got to grips with the issue of sustainability.

Sustainability – the ability to endure – is just as important to maintaining the NHS as capacity and quality. However, unlike capacity and quality, sustainability can be much tougher to deliver because the outputs of achieving it can often be perceived as threatening the very fabric of the NHS.

Clinically led and data-driven reconfigurations, which enhance the quality of services patients can receive, reduce waste and help to eradicate harm. This will often lead to necessary disinvestment in parts of the NHS that are no longer fit for purpose, as well as investment in new and modern services going forward. Whether as a clinician, a manager or even a politician, closing a service, shutting a ward or closing a hospital as part of a package of delivering services differently is among the hardest things to achieve, not least because these invariably hold a special place in the hearts of patients and families who have benefited from the care they have previously received there.

The ability to take those tough decisions and to back the cadre of clinicians and managers wanting to forge a modern NHS to hand on to the next generation and the generation after that, is what will ultimately determine whether we can achieve sustainability and maintain a free at the point of delivery health service.

I am confident we will always back the right decisions at the right time because the NHS has consistently displayed one characteristic greater than any other throughout the first 65 years of its existence: its ability to renew, adapt and keep pace with the broader changes in the society it serves while holding true to its core values. It is through the prism of those values we need to redouble our efforts to make the case for delivering the necessary changes we need to make to ensure our NHS can be sustainable in the future and has the ability to endure.

PROFESSOR SIR MALCOLM GRANT CBE

Professor Sir Malcolm Grant CBE is Chair of NHS England. He is also the President and Provost of University College London. He is a qualified barrister and academic lawyer with wide experience of public service, including roles in the Local Government Commission, Higher Education Funding Council for England and as a UK Business Ambassador.

The NHS is one of the most noble, social institutions that any country has ever created, but its position at the moment is clouded in a great deal of uncertainty.

First because the reforms that we've just gone through haven't yet taken effect fully. So I think it's in a tender state. But one thing I have learnt in my 18 months or so in this role, is that almost every generalisation you make about the NHS is false.

It is an extraordinarily varied operation. It employs over a million people. It employs them in a wide variety of autonomous and semi-autonomous organisations. It employs some people who are absolutely the best in the world. And it also employs a number of people who are not fit to be employed in an organisation that cares for patients. So I think we've got huge variety across the country, and within institutions as well as between them.

And at the moment I think it is providing a high-quality service. If you look at the recent data from the Commonwealth Fund, it is ranked very highly by its users and its practitioners in terms of access, and that's a big improvement from ten years ago and is worth noting, not least because this is one of the cheapest health care systems in the world.

But I put alongside that the recent *Lancet* report on health outcomes, which I think was quite troubling. In relation to a number of conditions, our position is below the median of the European 15 and in the last decade our relative position has deteriorated rather than improved. Health outcomes, of course,

are not a measure just of the NHS but a measure of the health of the population as a whole. We know that many of the issues contributing to poor health in the UK are around tobacco use, alcohol, drugs and obesity – issues that cause us to reflect on how the NHS can become a health service as opposed to a treatment service.

The second reason for tenderness is the finance issue. We know that investment in the NHS has gone up something like four per cent real growth a year over 65 years and we can't see that for the next five years, if not the next ten. That is a huge challenge hanging over everything, because demand isn't diminishing.

So I don't think there is any option but to be thinking in longer terms than are normally feasible in the life of a secretary of state for health. We've had some really quite good health secretaries in the last two decades, but two years is the average time they've served. And the political salience of the NHS is such that it's immensely important for a health secretary to be seen to be doing things, and often to be seen to be doing things that are different from their predecessor.

This doesn't create long-term stability, and the series of reforms that have taken place both on the provider side and on the commissioner side haven't tended towards generating a fresh vision for an NHS that hasn't got four per cent real growth a year.

IF YOU START PUTTING PATIENTS AT THE CENTRE OF EVERYTHING, YOU HAVE TO START CONCEIVING OF THE COMMISSIONING OF SERVICES IN A COMPLETELY DIFFERENT WAY.

So I think the first task for NHS England is to prove that commissioning can work. We have had so many incarnations of it and the impression I get from all those I speak to is that we haven't got it right.

We need to think again about primary, secondary and tertiary care and to think much more in terms of a continuum of care for patients. If you start putting patients

at the centre of everything, you have to start conceiving of the commissioning of services in a completely different way.

Hospitals have become something of citadel of modern health care – totemic and iconic. But the growth in the proportion of the population with one or more long-term conditions which are capable of being self-managed, or managed in a non-hospital setting, does call for a fundamental reappraisal of the roles and relationships.

And it's really difficult to do this on an annualised basis. So what we're proposing is a set of steps over the coming year in which we will try and do a very significant reappraisal, which looks at the three- to five-year needs – and the ten-year needs – of the NHS, to see how we can help create the greater community capacity that allows people to live independently for longer or live with high-quality care but outside a hospital.

None of this, of course, is new. The new is how we get from where we are to there with a declining budget – and with NHS England being independent from government to the extent that we're reporting against outcome measures as opposed to process measures. This is still in the settling-down stage, of course. We're only eight weeks into this new regime, and it is not without its tensions as we try to move into a new model.

There is the tension on the one hand between moving away from being operationally accountable to the secretary of state to being accountable through a mandate – which is what it says in the legislation. And on the other, actually supporting the government in ensuring that along with our other partners such as the National Trust Development Authority, NICE, Monitor and the CQC, that the issues such as waiting times in A&E, such as 111, respond appropriately to public need. We can't do everything by the mandate. We have to be on the front foot, working with the Department of Health and others to ensure that operationally the system doesn't keep tripping over.

I think it's the transparency of NHS England which is the new kid on the block. We are committed not to doing deals behind closed doors but to being very public about how we act. So not just having our meetings in public but web-streaming them while trying to have debates in public about stuff that belongs to the public.

NONE OF THIS, OF COURSE, IS
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Now if we want to have a three-, five-, ten-year change programme that does indeed go beyond the life of the current secretary of state. And that is an issue. But there are two differences from the past. First, I am not a civil servant, I can talk to whoever I want, and I will talk to all parties.

This is not an advocacy role, it's an explanatory role: Why we are doing what we are doing, what are we aiming to do, and how it fits with what we think is needed for patients in a highly constrained service. And I don't think there's a huge difference actually around this. I mean we talk about, for example, a greater proportion of services being provided in the community setting and more specialised work in fewer specialist centres. But that has been the watchword of the last government and of the present government. And there is also a stabilising mechanism, which is the primary legislation and the mandate.

It would take primary legislation to create something different to NHS England, and the mandate is also a stabilising mechanism. It would be possible for an incoming secretary of state to rewrite the mandate. But the difference now is that would all be in public – and I've been given a hugely privileged ability to find some very strong non-executive directors in NHS England who I think have the capacity to not only think strategically but also independently, and to maintain the independence of the organisation even in quite turbulent political times.

We've got to be able to write out the direction of travel that will be inconvenient for people, certainly for those employed within the NHS, if it does mean that roles and responsibilities change. But rather than doing it as – I hesitate to use the words – top-down reorganisation, instead making it easier for people to grapple with

if they can see the direction of travel, how it's mapped out and how it will be achieved – and that has to transcend the electoral cycle.

So I think in ten years' time we will be looking at a hospital structure that's quite significantly different from today, and I think we will see a different array of provision in the community – though I think it's still too early to try to capture that in specific terms. The question that we need to raise with GPs in particular is why primary care and secondary care? Where do we reset the boundaries between these two? How do we make it possible for GPs to provide a greater range of care and supervision? We need a different approach for providing high-quality care for a population that's chronically unwell, which also means a different relationship with social services. And all of that is a question of funding, of premises, of investment, and also of training. It is challenging.

Can it remain largely free at the point of use? It is a fundamental principle and it's politically tremendously totemic, so I think it is secure. But only if we can find the ability to live within the existing budget by making sure that every pound secures best value for patients. It can survive largely free at the point of use, but only if it changes.

The question that we need to raise with GPs in particular is why primary care and secondary care? Where do we reset the boundaries between these two? How do we make it possible for GPs to provide a greater range of care and supervision? We need a different approach for providing high-quality care for a population that's chronically unwell, which also means a different relationship with social services. And all of that is a question of funding, of premises, of investment, and also of training. It is challenging.

Professor Sir Malcolm Grant CBE

Chair, NHS England

TIM KELSEY

Tim Kelsey is National Director for Patients and Information at NHS England. He joined NHS England from the Cabinet Office where he was the first Executive Director of Transparency and Open Data. In 2000 he co-founded Dr Foster, a company that pioneered the publication of patient outcomes in health care. Before Dr Foster, Tim was a national newspaper journalist and a television reporter. He is a Trustee of the Nuffield Trust.

You attend a hospital with your disabled daughter. You do this pretty much every day because your daughter has regular seizures and emergencies. Every time, you have to start all over again because the hospital doesn't know who your daughter is. More paperwork. Then you wait and wait because the staff have to find a hoist to lift your child out of her wheelchair onto a bed. Why couldn't you have called in advance to tell them she was coming? Hours and hours of waiting.

This is the NHS in the experience of one mother I met recently: everyday indignities and inhumanities and, in her face, the real human cost is clear enough. This isn't everywhere, or everyday or every patient. But we need a transformation in the quality of customer service in health and care: patients must be respected as people. The NHS belongs to us all.

TRANSPARENCY IN HEALTH CARE...
WILL BE THE MOST IMPORTANT
CONTRIBUTION THIS GENERATION
MAKES TO THE SUSTAINABILITY
OF THE NHS

I have twins and we get letters from the hospital inviting us to appointments after they have expired, or mixing up the boys and their conditions. Inconvenient for us – but a service that is unintelligent about its patients, carers or clients, that does not always know with accuracy who it is treating, cannot guarantee its safety.

It is this lack of data, insight and information that is our greatest problem – and our greatest opportunity. Transparency in health care – development of a safe, open culture of data sharing between clinicians and patients – will be the most

important contribution this generation makes to the sustainability of the NHS. It is the most important public policy innovation of our time. The viability of our health service, in an age of financial constraint and demographic challenge, depends on patients taking much more control of their own health and care – a new operating model where, through the seamless sharing of information, the NHS unleashes the power of the people it serves.

For the transformation of customer service, we need a revolution in transparency and this is why it is one of the core strategic priorities for NHS England. The 65th year of the NHS is full of landmarks – real initiatives that will put much better data in the hands of clinicians so they can improve their outcomes and give patients new tools and new freedom to make more informed decisions and be empowered as participants in their own care and wellbeing.

Here are three innovations that are unprecedented:

- Clinical outcomes data by individual consultants will be published by ten professional associations including cardiac, vascular and orthopaedic surgeons.
- Every hospital in England will publish Friends and Family Test data – providing a new insight into the quality of customer satisfaction with local services.
- The first anonymised data that link the patient pathway between primary and secondary care for services in England will be made available. This will transform our understanding of outcomes in care.

Put together, these represent the biggest moves ever taken anywhere in the world to put transparency and patient participation at the very core of a health and care service.

There are other steps we urgently have to take to make the data revolution real: NHS providers must quickly make the NHS Number the primary identifier on all patient records so that all data can be linked and patients identified, with accuracy. Never again should the mother I met have to wait for hours for a hoist to arrive at the bedside of her daughter. From April 2014, this will be a contractual requirement for trusts.

BY THEN – WHEN THE NHS IS 70 – WE MAY OBSERVE THAT DATA TRULY IS THE BLOCKBUSTER DRUG OF THE 21ST CENTURY: THE MOST POWERFUL TOOL WE HAVE TO IMPROVE OUR COLLECTIVE HEALTH AND WELLBEING.

That's one key step on the road to the full implementation of safe, digital record keeping in the NHS – and it is the prize of seamless, interoperable data, accessible to the patient and the clinician in real time, that will finally guarantee high-quality outcomes and customer service for all. Our ambition is to have reached that objective for all health and social care services in England by 2018. By then – when the NHS is 70 – we may observe that data truly is the blockbuster drug of the 21st century:

the most powerful tool we have to improve our collective health and wellbeing.

Transparency is the future of the people's NHS and the future is Open.

PROFESSOR SIR BRUCE KEOGH

Sir Bruce Keogh has had a distinguished career in cardiac surgery nationally and internationally. He was Professor of Cardiac Surgery at University College London and Director of Surgery at the Heart Hospital before being appointed NHS Medical Director in 2007 and National Medical Director for NHS England in 2013. He has a longstanding interest in the measurement of clinical outcomes and has been a commissioner on both the Commission for Healthcare Improvement and the Healthcare Commission.

I think the NHS is the most fragile it's ever been. On the one hand because of the uncertainty that surrounds the opportunity that the recent reforms have offered. And it is fragile because of other influences that are outside its control.

Number one is the economics and the impact of the global financial crisis which has affected every health care system in the world, with the possible exception of Australasia.

Number two is a combination of medical science and technology. Medical science will continue to advance inexorably. But information technology is also changing things radically. It brings access to information, greater transparency and greater immediacy. But I do wonder whether it will force us, in time, to rethink the way we fund our health service and regulate it for quality.

So supposing that online diagnosis and online prescribing – both of which already exist – really emerge, and I live in Birmingham but want an online consultation with a GP in London, or in New Zealand, or the US where some American universities already offer online consultations. Or I do what some UK hospitals are already doing and use daylight hours in Australia and New Zealand and other parts of the world to report X-rays.

How does that influence the way we fund those services? And how do we regulate the quality of services for the NHS when they are in south-east Asia or New Zealand?

What is the compact with our citizens about who pays for and regulates those sorts of things? And then there is the ‘unholy trinity’ question. How do you get high-quality care across all specialties for all citizens? The Americans are good at high-quality care, but not for everyone. We are probably better at providing access for everyone across the full range of specialties. But nobody’s been able, I think, to equilateralise that triangle. All of these expectations are on a collision course with the new economic reality. And I am not sure that we are yet politically, socially or professionally ready for some of the difficult debates that will fall out of those challenges quite soon.

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And health care has fallen behind a whole bunch of other industries – retail, travel, banking, utilities – in terms of access and a seven-day service, some of it online.

Take a 34-year-old single mother with two kids who is just drying herself on a Friday afternoon after going to the gym and feels a lump in her breast. How long is it before somebody can put a hand on her shoulder and say, ‘don’t worry,

it’s just a cyst, there’s nothing to worry about’, or ‘don’t worry, it is serious but we’re under control’? It’s difficult to get to your GP, the walk-in centre can’t offer you the advice, A&E just give you an appointment for the next week, and you can’t get access to specialist services.

And as people get older they find transport more difficult. So young people have to take half a day off work to bring them to the clinic.

So we live with a system where people go into work and want to be compassionate, but where the system doesn’t help. So isn’t it better to help people by running more services at weekends?

We need a strategy for the NHS which recognises that there are more technological and societal changes happening now than the NHS has ever had to face, and NHS England wants to get on top of this.

And there is an issue around urgent and emergency care, where I have been asked to lead a review. We have to recognise that people like to have services close to home. It is utterly unfair to expect old people, poor people, mothers with young children to have to get three buses to get to access to the NHS. Yet at the same time, medical science is dictating that some of the most serious conditions can now only really be treated well in specialist centres. But one of the things that niggles at me is there is a long history over the years of things starting off in specialist centres and then becoming routine – pacemakers, angioplasty, warfarin, for example. Things move back down the food chain and can be put in anywhere.

IF YOU LOOK AT SUCCESSFUL COMPANIES THAT SURVIVE TRAUMATIC ECONOMIC CIRCUMSTANCES, THEY CONTROL THEIR FINANCES, ASK THEIR CUSTOMERS WHAT THEY WANT, INNOVATE, AND DO IT WITH URGENCY.

So we need to be careful in this centralisation that we don't shut off the return channel. At the moment we say you should only treat stroke in a specialist centre because you need 24/7 access to a CT scanner for that, and the ability to treat a bleed as well as a block. But what if someone invents a smaller CT scanner that anyone can use? Or a blood test, or a fingerprint test, that tells you whether it is block or a bleed? Suddenly you could move at least some of it out into the community. So we have to remember in all these debates about centralisation that it may not always need to be done in a centre.

These debates are difficult. If you were in a time machine and came here from being a surgeon at the Edinburgh Royal Infirmary 100 years ago, you would pretty much recognise what you saw. The operating theatre would be pretty much the same, the wards would look not too dissimilar. The way we deliver secondary care hasn't really changed. But if you were a martian landing,

you would say, 'What are these buildings? Why are we treating people in massive pieces of real estate like this, putting them in dormitories? Doing nothing much to them for 23 hours a day, and letting them languish? Why aren't you looking after them in their own homes, where they are familiar with their environment, where their families and friends are nearby?'

So ten years' time may be a bit soon, but I think not long after ten years we need to be in a place where our hospitals are diagnostic and major interventional, therapeutic centres, operating seven days a week, and where we have clinical teams who work in the community to ensure that people are safe in their own homes. And if people think that is a flight of fancy, think about diabetes. When I was a student, if somebody was diagnosed with diabetes, they were admitted to hospital while people worked out what dose of insulin they needed. Now there's virtually no need for a diabetic to come into hospital, except under very, very serious circumstances. So this can be done. One of my strategic health authority medical directors said that to admit someone with dementia into hospital is an act of violence. And then I saw my father-in-law being admitted, and what it did to him. We have the example of mental health, with people in the community, and virtual wards are already happening. I don't know whether all this will happen, but I think it's what we need.

Can the NHS remain free at the point of use? I am not sure. But I want to be absolutely clear that it remains my dream and ambition that it does. If you look at successful companies that survive traumatic economic circumstances, they control their finances, ask their customers what they want, innovate, and do it with urgency.

The NHS is in reasonable financial shape at the moment. We have got a bit of headroom. But we have no real history of asking our customers what they want and innovating accordingly. So whether free at the point of use survives the economic turmoil depends on our ability to do those things and innovate. And the solution to innovation lies in the intellectual capital of the 1.4 million people who work in the NHS.

ANDY MCKEON

Andy McKeon was formerly a career civil servant at the Department of Health, where he led on several major White Papers. He was Managing Director, Health, at the Audit Commission from 2003 to 2012. He is a Trustee of the Nuffield Trust and an Adjunct Professor at the Centre for Health Policy in the Institute for Global Health Innovation at Imperial College London.

The NHS is becoming more totemic by the day. It isn't just the reality TV programmes in which patients in hospital are asked 'What would you do without the NHS?' or the Olympic legacy of Danny Boyle's opening ceremony. The 'values' of the NHS and those of the society it represents are a constant reference point for any speech or statement about it. The old Nigel Lawson quote about the NHS being the nearest thing the British have to religion is truer than ever.

But we are in danger of knowing the values of the NHS and not its price. We are also losing the capacity to have a rational view of its weaknesses and (many) strengths in the wake of Mid Staffordshire and screaming headlines about failures in out-of-hours care and deaths in hospital following elective surgery.

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Within the next three years, we will have to have a serious debate about what we are prepared to pay for in the NHS, and how, and what we can expect from it. This cannot be a debate about structures or competition versus 'integration'. There is a risk that the government will believe either that reversing some of the changes introduced by the 2012 Act will release both cash and efficiency, or that the changes brought about by the Act will deliver huge efficiency gains.

Both views are deluded. The issues are more fundamental.

It is easier to know the price than the quality. The service is moving steadily towards a funding crisis, despite the relative protection given in recent spending rounds. It is already clear that it cannot survive a decade of austerity. The acute sector is struggling to meet the pressure being applied in the first three years. Growing problems in A&E and in GP services will highlight issues, even if they may be less about money and more about recruitment and ways of working. It will also increasingly need to bankroll social services, just as the demographic spike of baby boomers move into old age. The NHS has seen major improvement over the past decade, but stagnation rather than taking advantage of new technologies and services is now the most optimistic scenario.

We do not yet have a consistent, transparent, comparable way of measuring quality. We need to look at quality more rigorously than in sound bites arguing for reform. High Quality Care for All set a programme in 2008 for transparency and measurement of quality that has not been coherently and consistently pursued. For example, the National Quality Board was tasked with producing an annual report on quality including, importantly, international comparisons but none has been produced.

Consistent, objective quality measurement, which needs to go much wider than a Family and Friends Test and include international comparisons, however difficult they can be, would put us in a much better position to know what the NHS and its institutions were delivering. This, rather than new incentives, new commissioning schemes, competition or regulation should be the priority, alongside the money.

DAME GILL MORGAN DBE

Dame Gill Morgan DBE was Permanent Secretary of the Welsh Assembly Government from 2008 to 2012. Prior to that she was Chief Executive of the NHS Confederation for six years. She is currently Chair of the Clinical Board at the London Cancer Alliance and is a fellow of the Royal College of Physicians and the Faculty of Public Health.

Five years ago the NHS was upbeat. Patient satisfaction was at its highest level ever and clinicians were re-engaging to plan and develop services to improve outcomes and responsiveness to patients. Five years on, the press is uniformly negative, clinicians are disengaged and cynical, and the leadership has lost touch with the frontline. The service in England has become increasingly fragmented and complex. Everybody is blaming everyone else for culture, poor practice or just coasting, but no one seems to be accountable or take responsibility.

WHILE ENGLAND IS TRYING TO MAKE SENSE OF A NEW SYSTEM OF GARGANTUAN COMPLEXITY, THE DEVOLVED ADMINISTRATIONS HAVE YET TO PROVE THAT AN NHS, RECOGNISABLE TO NYE BEVAN, CAN RESPOND TO MORE DEMANDING AND SICKER 21ST-CENTURY PATIENTS.

Meanwhile, the devolved administrations have taken very different paths. They too are bedevilled by rising demands and expectations, together with increasing mistrust and challenge from the public. While England is trying to make sense of a new system of gargantuan complexity, the devolved administrations have yet to prove that an NHS, recognisable to Nye Bevan, can respond to more demanding and sicker 21st-century patients.

So what now? Will the NHS implode from increasing demand and financial constraint? If failure is asserted often enough then it can become a self-fulfilling prophecy. Great organisations are good at listening to users and staff to help them focus on what matters most to people; keep their promises; are self-aware; reinvent themselves to respond to

changing demands; and consistently communicate well about all these things. Meeting these standards is our challenge.

The NHS is delivered through people. The Macleod Report told us a lot about how to get the best out of people. Effective staff engagement improves performance and outcomes. In industry this translates directly to the bottom line; in health services it means better outcomes for patients. Most of the difference between the best and worst performing organisations is accounted for by three simple statements: “I understand where we are going and why”; “My senior managers care about me and my work” and “I can realise my potential in this organisation”.

Macleod identified four key requirements: leadership (setting a simple, understandable vision); engaging line managers (who account for 80 per cent of intra-organisational variation in performance); giving employees a voice (and acting on what they tell you); and integrity. Managers and politicians have failed to act on this knowledge. Leaders have failed to simplify and explain what really matters and have not cut through the argument and debate to find solutions that are understandable to the people expected to implement them. People working in the NHS are not stupid; they know the problems but the system has ground them down and convinced them that nothing can be changed.

Good services do not come from 64-page specifications or from 50 unannounced visits. They come from leaders engaging, listening to, and supporting their staff and patients. They come from honesty about failure and a zero tolerance approach from clinicians at the bedside, through the boardroom to the Palace of Westminster. They come from simple values and rules that are understood by all and they come from pride in what we do and the privilege of working in a great system. Reaffirming this is the task for the next leader of the NHS.

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Dame Gill Morgan DBE

Permanent Secretary of the Welsh Assembly Government
2008 – 2012

SIR DAVID NICHOLSON

Sir David Nicholson was appointed Chief Executive of NHS England in October 2011. Up until April 2013, he was also Chief Executive of the NHS in England, a role he had held since September 2006. Sir David's career in the NHS spans over 35 years. He started in the service as a management trainee, having graduated from the University of the West of England. He has held senior leadership positions in acute and mental health services, and at four regional health authorities. He was awarded the CBE in 2004 and was knighted in 2010, both for his services to the NHS.

The NHS is at a crossroads. It is in quite a robust shape in the sense that this is the fourth year of no growth and we are still delivering on most of the things that we set ourselves up to do. And although some parts of it are difficult, overall the NHS is on a sound financial footing. But you can absolutely see the challenges that are coming, and austerity for the foreseeable future means that there's a really important set of decisions to be made.

The first and most obvious question is what is the overall direction? So, you know, you've got some advanced health care systems that are cutting costs significantly – the Irish for example. Some are cutting the offer to patients – the Greeks and the Spanish – saying you have to pay more, all the rest of it. Some are even giving more money and growth: the Netherlands and Germany.

But we've concluded that we can take the NHS forward, keep it free at the point of use and keep the offer – although pay restraint will always be an important part of the equation – but do it through transforming the service. And that is what we need to get ourselves geared up to do.

That will involve a whole load of stuff. Start with patient power. If you look at the transformation of other industries and other parts of the economy, whether it's retail or banking, or whatever, what's happened is that customers have taken more responsibility and do more. That has saved enormous amounts of money for those industries, and I don't think the NHS is any different.

And that completely changes the nature of the relationship between the NHS and the public. At one level it is people with long-term conditions taking more responsibility for their own health and care. At its best some do. But it is by no means universal and by no means the large numbers that we need. It is patients taking control of their own notes, their own information about themselves, and using that to transport their knowledge about them around the system. It is taking over quite a lot of the administrative arrangements in relation to their own care: booking their own appointments online and what have you.

I think that will have a massive impact on the NHS and is a distinctive bit about how it will be different. The days when NHS managers and clinicians went over in a corner and said “we’ve got a crisis in the NHS, this is how we’re going to solve it, here you are, let’s try and sell it to you” – those days have gone. That is not how it’s going to change.

The two other things will be the concentration and the centralisation of services in fewer health care organisations, whether that be specialised services – probably ten or 12 big organisations responsible at the centre of a specialised services network. So the sickest 15 to 20 per cent of patients who currently go into district general hospitals going elsewhere in a variety of networks, whether it be stroke or cardiac or whatever. And then on the other side there will be a significant increase in the community support and community arrangements for patients – and that will mean fewer hospitals. Fewer hospitals and slimmed-down hospitals. I think there will be both, but it is hard to imagine how you get the fixed costs out without closing some.

You say that’s been on the agenda for the last ten or 15 years. But I think the ideas that I have just crystallised have been crystallising for some time. The things that have militated against doing it are, first of all, that we’ve been able to buy off some of those things. So extra money has, in a sense, allowed us to subsidise poor care when we shouldn’t have done.

And second, we haven't had the kind of comparative and benchmark information available around outcomes and all the rest to enable the arguments for all this to be put in a very direct and obvious kind of way.

EXTRA MONEY... ALLOWED US TO
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And of course the money for the foreseeable future has run out. I mean, even when we did QIPP (Quality, Innovation, Productivity and Prevention) in 2008 and we worked out what was needed for the next four years, underneath it all we sort of assumed that at some stage we would go back to four or five per cent growth. That is quite clearly now not the case. So the burning platform of the financial circumstances of the NHS means we have to do it.

I can't see any alternative to doing this. The only alternative is managed decline, with, every year, the winters getting more difficult, the A&E problems getting greater and all of that. And that would be a disaster for the NHS.

In terms of the political leaders, they need to allow the new system to work. Because I do think the development of clinical commissioning on the one hand, with general practitioners and other clinicians working at a local level to redesign services, and an independent national body on the other, which can take a five- to ten-year view – which we intend to set out – can provide a consistency of purpose across the NHS over the next period. Those are important ingredients.

I don't think it's viable or sensible to berate national politicians, saying, "you shouldn't be running around saying hospitals should not be closed" and all the rest of it. But equally we can't have a situation where there is, at the moment, this unsaid thing that if you were to have a little bit of growth, and you make some management cost savings, and you save a bit on procurement and you talk about integration a bit, somehow that will solve the problems of the NHS – so that you don't have to make the big changes that we know need to be made.

If the political manifestos at the next election say that, they won't be telling it straight. It would be an essentially dishonest position with the public and that is a really dangerous place for the NHS to be. So politicians have to buy the case for change. I think they can allow local people to think about what that change is, and all the rest of it. And the NHS has got a big responsibility to engage with people and explain it. But from the politicians, I think it is more a case of permission in creating the environment to let it happen rather than them driving it. I don't think that will work.

Can the NHS remain largely free at the point of need? It can. It can and it should. It is one of the things that drives me and has done throughout my career.

SIR HUGH TAYLOR

Sir Hugh Taylor is Chairman of Guy's and St Thomas' NHS Foundation Trust. He has held senior roles in the Department of Health and NHS Executive, the Cabinet Office and the Home Office. His most recent appointment before becoming Chairman of Guy's and St Thomas' was Permanent Secretary at the Department of Health, from which he retired in July 2010. He is a Trustee of the Nuffield Trust.

Thanks to the impact of the investment made over the previous decade, the NHS, in historical terms, remains in good shape. The infrastructure remains really pretty positive, and the quality of care as a whole, with real exceptions, is holding up – given that spending has been squeezed hard for three years.

But the word I would use at the moment is fragile. If you go back to 1997, the NHS was in a parlous state: very fragile. But as you look at all the pressures and strains on the system that are happening now, and think of all the things we didn't have then – no effective regulatory environment, no CQC or equivalent, commissioning even less developed than it is now, nothing like the same degree of transparency about the quality of care – all these mean that as things start to crack and fracture under the pressure of the existing resource restriction (and we don't know how that will play out), every step downwards is going to put under a microscope in a way that never happened before.

So there is much less scope for silent erosion. It is going to be a very transparent process. I think the real crunch will come if the economy does start to move and we get what's been described as private wealth and public poverty. Then the workforce will be a real issue. People will start to go to jobs in the private sector and we'll have a workforce crisis, which is the one thing we haven't got at the moment.

What's surprising is how well all that's stood up given we've had three years of pay freeze. If I am looking at three years that's one of the main things I'm worried about. Newly employed professionals, doctors and nurses and others, will vote with their feet.

To keep the NHS viable over the next decade, we've got to find a way of investing in the system. The money, certainly as far as the government is concerned, is the \$64,000 question.

THE NHS IS SUCH AN ECONOMICAL WAY OF PAYING AND DELIVERING FOR HEALTH CARE. THE FACT THAT IT IS PUBLICLY FUNDED DOES PUT PRESSURE ON IT TO BE EFFICIENT AND TO PRIORITISE.

There are two problems. One is maintaining the status quo, which will be impossible on the current projections of funding – certainly without a level of rationalisation of the sector, which no government seems likely to sanction. And second, all the pressures are going to be to invest in further treatments and quality improvements.

So what aspects of our system are still scandalous? Care of the elderly is really a scandal. And even if we succeed in improving home care and preventive work in chronic disease management and all the rest – which I think we should try to do – the cost benefits are going to be marginal. I think they can improve quality significantly. But the cost savings are likely to be marginal – and you have still got the pressure of improving technologies in almost every field of specialist medicine.

So I am not saying investment needs to be anything like the same level we had in the last decade. But we have got to find a way of at least matching growth in GDP – and I think in practice GDP plus one or two per cent.

If we just stick with nothing but real-terms growth, as at present, it can't be done. Definitely not. You won't preserve

the status quo and you certainly won't invest for the future. But that's in terms of public funding.

So I suppose that leaves the question of whether either managed or unmanaged discretionary spending on health increases. In other words, we find some way – either as a matter of conscious government policy, or as a matter of a failing public system – to boost non-NHS expenditure. And I think that's the next \$64,000 question.

This is just a personal opinion. But I think the answer to some extent lies in having a period of intergenerational exchange of resource. The older generation has got to pay for the fact that most of the pressures on improving health care are for older people and arguably for children. The burden of that needs to fall on the baby boomer generation who've got all the assets of the country stacked away in their houses and their pensions.

And I've always felt there's a potential, once the government takes the brave step of opening up the route of inheritance tax – which it has done to support social care funding – then there is a way to having a bigger ring-fenced budget for that more broadly. I have sympathy with the government's position that taking more money out of working taxpayers is a difficult challenge, certainly at the moment. So I think – partly in the interests of the health of the population, but also in the interests of wealth generation – we should be taxing the elderly, or the middle-class elderly. Some form of inheritance tax is a good way to do that.

You have got things like the travel passes and winter fuel payments and prescriptions that you could means-test. But that doesn't raise an awful lot of money, and there is the cost of means-testing them. It reduces your administration costs if you use some form of general taxation. So you give them the freedom pass but you charge more out of inheritance tax.

There are all sorts of issues to be resolved in that. And you get into tax avoidance, and I am not a sophisticated tax lawyer. Wiser

people than me will know how to do it. But I feel that we've got to find a way of doing this. I think that there are huge advantages in linking for a period – because it won't work for ever – a way of older people making an extra contribution to their own care, and to the care of future generations, because I'd like to bring children into the argument as well.

The NHS is such an economical way of paying and delivering for health care. The fact that it is publicly funded does put pressure on it to be efficient and to prioritise. You lose that at your peril.

We should build on what we've got – which is a strong commitment to a health and care system delivered free at the point of need, supported by an increasingly sophisticated range of tax-raising measures. If that is dodged we'll end up with a two-tier health system by accident if not design.

Health and social care leaders

HEALTH &
SOCIAL CARE
LEADERS

PROFESSOR DAME CAROL BLACK DBE

Professor Dame Carol Black DBE is Principal of Newnham College Cambridge, Expert Adviser on Health and Work to the Department of Health, England, Chairman of the Nuffield Trust, and Chairman of the Governance Board of the Centre for Workforce Intelligence. She is a past-President of the Royal College of Physicians, the Academy of Medical Royal Colleges and the British Lung Foundation.

It appears that the founding principles and aspirations of the NHS remain largely intact, but they are under great and increasing strain. This relates in part – but only in part – to increasing demands and costs brought about by demographic change, high expectations and new therapeutic opportunities offered by technological advance. But these factors are not the sole cause, nor in the views of patients, public and staff are they the most important.

As the Francis Inquiry – the latest of several into shameful events – has so painfully shown, unless certain conditions are met, patients cannot be sure of humane, dignified care. The evidence revealed – or rather confirmed, because many had been reported and known for years – that dark factors in the culture of the NHS have allowed and tolerated attitudes and behaviours that are wholly unacceptable. They betray values that should be accepted or assumed without question by all.

At another level it is clear that the resources available to the NHS, which necessarily are limited, are not used as productively or efficiently as they should be. In a service where investment in trained staff is the major cost, this can mean that the numbers and levels of competence of staff are not sufficient everywhere for safe, high-quality care and, at worst, blunt compassion.

What do health and political leaders need to do? They are not a cadre apart; the qualities we look for in leadership are necessary at every point of service and level of organisation. But senior leaders set the tone, the example, and enable the conditions necessary for health organisations to flourish and their staff to serve patients well.

We recall that the NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, the public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which they owe one to another to ensure that the NHS operates fairly and effectively. The staff pledges of the NHS Constitution require organisations to engage staff in decisions that affect them and the services they provide... to deliver better and safer services. Senior leaders are motivators and catalysts of engagement. But unless the values they claim to espouse are reflected in day-to-day behaviours, they will fail.

SENIOR LEADERS ARE
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The extent of the failure of the system shown by Francis showed the need for a fundamental change – not of organisation but of culture. It will restore a culture in which the proper concerns of patients and their families, and staff at all levels, are expressed fearlessly, heeded willingly and acted on.

All are necessary but they are not sufficient.

There must be a unified effort to ensure that resources are used well, and useless interventions and unjustified variations in practice should cease. Education and training, and continuing professional development, should be designed to ensure that staff are ready to meet changing patient and population needs and working conditions.

For political and societal reasons, and the powerful hold of the NHS on people in the UK, I believe that it will remain largely free at the point of use. However, even if possible cost savings are realised and productivity increased, should the national economy be unable to keep pace with need and opportunity, it seems likely that some form of co-payment will arise.

My single message reflects the findings of many reports and inquiries, which long ago should have been sufficient to bring about the changes needed: the value and quality of the NHS is measured through the views and experience of patients, which must be heard, heeded and acted upon.

DR PETER CARTER OBE

Dr Peter Carter OBE is Chief Executive and General Secretary of the Royal College of Nursing. Previously he spent 12 years as Chief Executive of the Central and North West London Mental Health NHS Trust. He started his career by training as a psychiatric nurse and is also a general nurse.

As we celebrate the 65th anniversary of the NHS, it is worth remembering just what an established and well-loved institution it is. Few of us can imagine a world without it; very few of us would ever want to. It remains, despite constant change and perpetual restructure, remarkably popular and widely appreciated.

If anything defines the last 65 years, it has been constant change; change not only in how the NHS works, what it does and how it does it, but change too in the reasons that people rely on it. In 1980, the Queen sent just 2,500 telegrams to people reaching their 100th birthday; in 2010, she sent 12,640 (in 1951 it was just 300). This dramatic statistic shows how our society has altered in the past few decades and it gives us real clues as to the pressures and challenges facing the modern NHS.

THE DAYS OF SIMPLY NEEDING
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AGAIN ARE BEHIND US.

We are indeed living longer, but what few people remember is that we are not necessarily living healthier. Around two-thirds of people who use the NHS are aged 65 or over. While these people can expect to live to a good age, they will invariably do so with a number of long-term conditions. What all this means is

that the pressures placed on the NHS are changing. The days of simply needing hospitals that keep people in beds until they are better again are behind us. In 2013, patients aren't always going to the NHS; the NHS is often coming to them. Patients are being visited in their own homes, offered tailored health plans and are building relationships with staff that can last years, not

days. This represents the future of the NHS, although it is facing unprecedented strain.

THE NUMBER OF PEOPLE LIVING
WITH AT LEAST ONE LONG-TERM
CONDITION IS SET TO INCREASE
BY 250 PER CENT BY 2050.

In a recent Royal College of Nursing survey, just six per cent of community nurses said they 'always' had time to meet the needs of their patients, and 89 per cent said their caseload had increased in the last 12 months. Three quarters said that work pressures had increased as a result of cuts in health and social care funding.

These figures would be concerning at any point in the 65-year history of the NHS. However, when we know that these services represent the future of care delivery, they present a very serious problem indeed.

The number of people living with at least one long-term condition is set to increase by 250 per cent by 2050. That isn't a typographic error; it really is 250 per cent. If we stand any chance of being able to meet the challenges posed by such an increase, we need to see a rise in investment in our community services like never before.

The next ten years of the NHS will be dominated by an ongoing battle to meet the needs of our older population. In the past 65 years, the NHS has established itself as a hospital-focused care service, and understandably so. Now though, we need a revolution in how we think about delivering care. I can only hope, when we celebrate 75 years, we will have risen to this critical challenge.

In 1980, the Queen sent just 2,500 telegrams to people reaching their 100th birthday; in 2010, she sent 12,640 (in 1951 it was just 300). This dramatic statistic shows how our society has altered in the past few decades and it gives us real clues as to the pressures and challenges facing the modern NHS.

Dr Peter Carter OBE

Chief Executive and General Secretary, Royal College of Nursing

COUNCILLOR SIR MERRICK COCKELL

Councillor Sir Merrick Cockell is Chairman of the Local Government Association. From April 2000 to May 2013 he served as Leader of the Royal Borough of Kensington and Chelsea, having been an elected councillor since 1986. He is Deputy Chairman of the London Pension Fund Authority and Chairman of the think-tank Localis.

It is putting it mildly to say that the NHS has been through the wars in the past year. It has undergone the most significant restructuring in its history and been set the ambitious challenge to find £20 billion efficiency savings. Its status as the closest thing we have to a national religion has been rocked by the Francis Inquiry into the systemic abuse and neglect of frail and elderly patients at the Mid Staffordshire Hospital Trust. And, most recently, Health Minister Anna Soubry has forecast that A&E departments may ‘fall over’ if demand is not checked.

But despite this, the NHS manages to provide high-quality and comprehensive services to a population that is increasingly old, whose health needs are increasingly complex and whose expectations are ever higher. We continue to do well in comparison with other developed countries. Compared with Australia, Canada, Germany, the Netherlands, New Zealand and the USA, the NHS was found to be the second most impressive overall in 2010. It was rated the best system in terms of efficiency, effective care and cost-related problems. It was also ranked second for equity and safe care.¹ However, in the categories of long healthy and productive lives (sixth) and patient-centred care (seventh), the NHS fared less well.

Despite everything, the NHS is holding up well. My view of how healthy it will be in ten years’ time is less certain. I see two possible futures for the NHS and, in both, the fortunes of the NHS and local government are inextricably linked. The worst

1. www.nhsconfed.org/priorities/political-engagement/Pages/NHS-statistics.aspx

case scenario is that we continue along the path of current service provision, in which the majority of resources go into treating largely preventable conditions in hospital. This approach will quickly become unsustainable and health and social care services will buckle under the twin pressures of growing demand and shrinking resources, dragging the rest of local council services down with them.

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The more optimistic future is that health and local councils work together with their communities and providers to radically re-engineer our planning and service provision, using the totality of public resources to focus on prevention, early intervention and supporting people to maintain their capacity and independence. The answer lies in integration, not at the margins of health and social care in some beacons of best practice, but as the mainstream approach adopted everywhere.

We already have some practical examples. The tri-borough pilot – comprising Kensington and Chelsea, Hammersmith and Fulham, and Westminster – has jointly commissioned localised health and care teams to make sure people at high risk of admission get the right care at the right time. They expect to save around £50 million a year by reducing unplanned hospital admissions by 25 per cent, care home placements by 15 per cent and unnecessary outpatients' appointments and A&E attendances.

Nationally, we are working with the government and health commissioners to dramatically step up the scale and pace of integration. Our 'pioneers' programme is seeking a first tranche of ten areas to work across their local health, public health, care and support systems to achieve better services, better outcomes for individuals and communities, and greater efficiency. The national partners will provide tailored support to pioneers over a three- to five-year period. In return, they will share and promote

what they've learned for wider and, I hope, rapid adoption across the country.

I am confident that the NHS will reach its 75th birthday if it redirects its efforts and resources towards early intervention, health improvement and broad social support. My key message, therefore, is that integration with social care and other preventative support services is the only way that we can continue to afford the NHS.

STEPHEN COLLIER

Stephen Collier is Group Chief Executive at BMI Healthcare. He was in practice as a barrister before joining BMI in 1982. He has since worked operationally in health care in the UK, France, Scandinavia and the United States. He worked with the Department of Health on the framing of care standards and is also Deputy Chair of the NHS Partners Network.

Almost three years ago, the White Paper ‘Liberating the NHS’ envisaged the NHS moving from being a closed organisation to an open system, within which patients would have a freer choice of doctors and hospitals based on relevant information on quality and outcomes. At the same time, there was an explicit requirement to reduce spend by some £15 to £20 billion over the following four years. My view then was that the scale of each one of these two tasks could not be overestimated. But taken together they represented the most difficult challenge that the nation’s health delivery system – public and private – had faced in two generations. To get them wrong, I said, could potentially be cataclysmic.

So how is the NHS now faring at 65, an age when many mortals are thinking of retiring and leaving the field to a leaner, faster, younger generation? Overall, well: but well ‘in the circumstances’. For better or worse, the service reorganisation has been enacted, and the initial signs of heightened clinical focus are encouraging. However, the scale of the funding challenge was underestimated. What was considered a one-off, four-year programme is now an embedded reality for the next decade.

There are no simple answers as the gap between funding and health care demand widens. Further service integration, increasing quality of outcomes, and better staff and resource utilisation can all make a contribution. But underlying inflation and – potentially after the next election – reduced real-terms funding will require much harder choices to be made in the future about what the fundamental nature of the service should be.

Those choices go to the root of what the NHS actually is; the outcomes will define its core role and service coverage and lead to hard choices about what is included and what is not. Historically included elements of provision such as accommodation and food will inevitably be part of the debate, but so too will newer elements of the service; can incentives be aligned to reduce unnecessary consumption of secondary care services; should co-payment be extended beyond the presently permitted charges for amenity beds, or top-up payments expanded beyond high-cost drugs?

For the politicians who will ultimately decide, a holding pattern is the easiest, but will do nothing to resolve a worsening situation. However, with the impartial support of the service, a consensus on health and health funding can be reached – as it has been for social funding (although the solutions could be very different).

CONCEIVABLY, THE PATIENT OF 2023 COULD BE EMBOLEDENED AND INFORMED TO BE AN ACTIVE NAVIGATOR OF TREATMENT OPTIONS, DISCERNING BETWEEN THE FANTASTIC, THE MEDIOCRE, AND THE INEFFECTIVE OR INEFFICIENT.

What can and what should be provided is critical; how it is provided is also key, and can influence the level of service available within the resource limits. Conceivably, the patient of 2023 could be emboldened and informed to be an active navigator of treatment options, discerning between the fantastic, the mediocre, and the ineffective or inefficient. Those providers capable of demonstrating tangible benefits – better outcomes, patient-centric approaches, convenient and comfortable settings, effective use of scarce resources – would then be rewarded by patients,

or commissioners on their behalf, voting with their feet. This depends on the system (legislation, regulators and participants) collectively working to ensure that a broad range of care options is available, and making it as easy as possible for patients and commissioners to choose between them and removing the obstacles that would otherwise limit choice and access.

So looking forward ten years, I see a number of significant shifts. Health funding will have to be more focused on health maintenance and population health, rather than by reference

to caseload throughput. There will be fewer hospitals but each working 24/7; stronger and sustained integration between primary and secondary care; and much greater awareness in the population that a service which is free at the point of delivery is not a free service. Finally, if people's health aspirations are to be met, there must be innovation in funding mechanisms, and a recognition that the system as a whole can learn from different types of provider.

THE CORE MESSAGE FOR STAFF,
NOW AND IN FUTURE, IS THAT
WHATEVER THE MODEL AND
FUNDING STRUCTURE OF HEALTH
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PATIENTS COME FIRST.

In all of this the underlying values of the NHS must be maintained. The core message for staff, now and in future, is that whatever the model and funding structure of health delivery you are engaged in, patients come first. What remains critical is fairness of access to treatment which is free at the point of delivery, and maintenance in service delivery of the universal values of care, compassion and empathy.

So how is the NHS now faring at 65, an age when many mortals are thinking of retiring and leaving the field to a leaner, faster, younger generation? Overall, well: but well ‘in the circumstances’. For better or worse, the service reorganisation has been enacted, and the initial signs of heightened clinical focus are encouraging. However, the scale of the funding challenge was underestimated. What was considered a one-off, four-year programme is now an embedded reality for the next decade.

Stephen Collier

Group Chief Executive, BMI Healthcare

PROFESSOR LINDSEY DAVIES

Professor Lindsey Davies is President of the UK Faculty of Public Health. Her previous roles in public health include those of Director of Public Health for Southern Derbyshire and for Nottingham, Regional Director of Public Health/ Regional Medical Director for the Trent region, the Department of Health's National Director of Pandemic Influenza and Olympic Preparedness and interim Director of Public Health for London. She holds an Honorary Chair in Public Health at Nottingham University.

Four rather different versions of the NHS currently operate across the UK, resulting in a natural experiment which, if allowed to operate with organisational stability for the next ten years and if evaluated systematically, will provide important lessons for the next generation.

FOR THE NHS TO SURVIVE AS
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For the moment at least, in all four countries, the NHS is a remarkable public service, accessible to all and largely free at the point of use. The experiences of my son and his family, living in the USA and getting rapid access to excellent care when they work for organisations which can afford to pay for high levels of insurance and frighteningly little care when they don't, has brought into sharp focus for me the societal and individual benefits of universal free

access. But a health service that successfully keeps people alive for longer cannot escape from the consequence that in time there are likely to be more frail people who need its help. Demands and needs are increasing and sustainability has been called into question. What is to be done?

The NHS is just one player – important, but nonetheless just one among many – in the much wider national health system. For the NHS to survive as 'free' and accessible, the whole system must recognise and realise its potential to protect and improve people's

health. This includes, of course, national and local government playing its part in education, care, built and natural environments, transport, public safety, justice, employment, regulation and health services; but it also means private, public and third sector organisations, including the NHS, paying attention to the health of their staff and to the health impact of everything they do and produce. Although this is by no means a new idea, and there are some encouraging green shoots, we are still a long way from a flourishing, sustainable 'health meadow'. This will only happen when every NHS organisation, large and small, accepts and acts on its responsibilities to the wider system; and when national and local governments are prepared to take the difficult decisions needed to create a society fully engaged in protecting and improving health.

To survive as a service provider, the NHS will also have to address some important imbalances in its current functions. It needs to offer:

- A better balance between proaction and reaction. Investment in prevention and in support for self-care, for example, will bring immediate and longer-term dividends.
- A stronger focus on patients and staff as people. This means people being cared for by multidisciplinary teams who know, understand and respect their patients, their communities and each other; and who have the time and expertise to do a proper job.
- Equal attention to meeting physical and mental health needs.
- Primary care services throughout the UK which are all at least as good as the current best.

None of this will be straightforward, but it is achievable. With real commitment at every level it could – and should – all be in place well before the NHS is 75.

CIARÁN DEVANE

Ciarán Devane is Chief Executive of Macmillan Cancer Support. In January 2012, he was appointed a Non-Executive Director of NHS England. He co-chairs the National Cancer Survivorship Initiative, is a Trustee of both the National Council for Voluntary Organisations and the Makaton Charity and sits on the Advisory Council of the Cicely Saunders Institute.

There are a couple of things we need to remember about the NHS at 65. Overall mortality continues to improve. While we are not among the best (such as Australia or Spain), the NHS is broadly as good as Germany and France and much better than the US. Every five years, life expectancy in the UK goes up by one year. And we achieve this at among the lowest cost per person. Every day most people get good treatment and good care. So we're doing pretty well really. But things could be better.

My rather large worry for the future will, of course, not be unique to me. It is whether we can galvanise the NHS and the public to make the radical changes required so we have the NHS we need for the future. As we age as a population, the more we will get cancer. By the time the NHS is 75, half the population will get cancer in their lifetime. However, more people will also survive cancer.

WE NEED TO RESHAPE THE NHS
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Continuously improving treatment will mean that the median survival of cancer patients will have moved well beyond the current six years. The compound effect of both will lead to cancer prevalence in the UK having moved from today's two million to beyond three million, on its way to four million by 2030. And that is just cancer. Every condition will have its version of this trend.

My point is that the 'ageing population' we all talk about is an exponential problem and the next ten years of the NHS will see the curve take off. In other words, the next ten years is when we

need to act urgently. We need to reshape the NHS now in order to provide care for the population as it will be, not as it was.

This means doing three things. The first is spreading and adopting good ideas quickly, which is really a cultural issue. The second is focusing much more on services based in the community. The third is being radical in redesigning health systems, in building a workforce with the skills needed for the future and in empowering people to take control of their own health. We need to push these things now.

So how do we do this? It will require leadership. The leadership of the NHS will need to keep as single-minded a focus on assuring the future as on improving the patient-centredness of the NHS. Those of us leading organisations linked to, but not of, the system must work collaboratively to help our constituents and the public see the benefit of change. And politicians must do what they are good at – helping the country make the decisions none of us wants to make on our own.

NIALL DICKSON

Niall Dickson joined the General Medical Council as Chief Executive and Registrar in 2010. He joined the GMC from The King's Fund, where he was Chief Executive from 2004 to 2009. He is a member of the Department of Health's National Quality Board and End of Life Care Implementation Advisory Board. He was previously Editor of *Therapy Weekly* and *Nursing Times*, and Health Correspondent, Chief Social Affairs Correspondent and Social Affairs Editor at the BBC.

The NHS is so large that almost any statement about it is bound to be true – it incorporates the best and the worst of care, the most innovative services and those most resistant to change, the kindest and most dedicated professionals and a few who probably are not that bothered. It has probably always been this way.

Today the service is bigger and more effective than ever – it has more staff, and is more able to deliver interventions that make a difference. Medical science and information technology are the principal agents of change here, together with a growing realisation that this is a safety critical industry which, until now, has had a poor record in preventing harm and maximising its potential.

But while it is doing more, and every day does wonderful things, the overall organisation of care leaves much to be desired. Too often patients of all kinds find that no one is coordinating their care, no one is taking overall responsibility and that, although individual interventions are generally good, they are seldom joined up.

This is allied to the area of greatest weakness – the care of older people. The health service throughout the UK is largely a service for those in later life, yet its organisation, including the education and training of its staff, does not reflect this reality. It struggles every day to deal with tens of thousands of patients with dementia and a range of other long-term conditions – sometimes even struggling to be kind and compassionate. We know standards vary, some care is excellent, much is good, but some is unacceptable.

If health leaders can meet the needs of this group of patients, they will have dealt with the major challenge of our current system. The answer on the face of it is simple – create services that have safety and quality as their organising principle, embrace information technology and the transparency it brings, and develop and support clinical staff to enable them to champion and lead change. In most cases we know what works – we just have to do it.

In ten years' time, the NHS will probably not look very different from how it looks today. The health service now would be easily recognisable to the patient of 2003 and there is no reason to suppose the next ten years will produce such radical change as to upset that pattern. After all, the vast majority of those working for the NHS today will still be working for it in ten years' time, and many of the new professionals are already being trained.

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That said, it is possible that the digital revolution will precipitate a tipping point which could transform the way services are organised and even the relationship between professionals and patients. Already the clunky way in which the NHS books appointments, uses and transfers data and knowledge, and listens to feedback is changing. This itself will drive further change,

exposing variation in care and encourage patients and relatives to demand much more responsive services. The consumer will not yet be king by 2023, but patients and their relatives will expect more and the NHS must surely adapt or fail.

In 2013 much has been said about the culture of the NHS and the obvious failings of care and compassion exposed by the Mid Staffordshire Inquiry – in any case we should ask future leaders whether they have created a culture where staff can raise concerns with impunity, where kindness and empathy are universal and where these qualities are valued equally with clinical skill and effectiveness.

In ten years' time we will know more about the performance of institutions, teams and individuals. Every doctor in the UK will be part of a system that assesses how well they are doing and which should ensure they are competent and fit to practise. If that system, called revalidation, works and develops we will be on our way to putting safety and quality first.

THE CONSUMER WILL NOT YET BE KING BY 2023, BUT PATIENTS AND THEIR RELATIVES WILL EXPECT MORE AND THE NHS MUST SURELY ADAPT OR FAIL.

For those running the service perhaps the greatest task then, as now, will be how to set professional staff free at a time when consistency and measurable standards are within reach – how to achieve results without micro-managing or over-regulating, by understanding that results come when staff feel good about themselves and what they do.

SIR ANDREW DILLON

Sir Andrew Dillon is Chief Executive of the National Institute for Health and Care Excellence (NICE). He joined the NHS in 1975 and has held a number of senior management positions, including General Manager of the Royal Free Hospital and Chief Executive of St George's Healthcare NHS Trust. He joined NICE as its founding Chief Executive in 1999.

The NHS in 2013? Well, it's bruised by reform and scandal, uncertain about how to deal with familiar problems, such as pressures on A&E departments and difficulties in discharging patients, together with some new ones, including how best to use new technology and how to take advantage of the skills and the investment that the private and third sectors bring, without them frustrating comprehensive, integrated provision. It understands the potential of rebalancing primary and secondary care, but it's no clearer now than it's ever been about how to apply on a national scale the knowledge and experience that exists locally about how to do it. It recognises that patients' experience of care can be anything from astonishingly poor to breathtakingly good, but struggles to push the average consistently closer to the latter. Nevertheless, and despite these pressures and disappointments, it's facing up to the challenge of reducing resources against a backdrop of rising demand; it's solidly competent at dealing with the majority of what we expect it to do; and it retains the admiration and affection of virtually everyone.

For the sake of its future, the people who run it need to engage its users in real debate about its potential and its limitations. They need to be honest about the changes that need to take place in its geography and delivery, and have the courage to see the changes through. They need to concentrate on enabling local change informed by the evidence of what works and avoid the distraction of structural reform. It's harder but ultimately more productive. They have to work at getting a balance between a nationally

articulated ambition, accountability through local transparency and a confident regulatory system, which holds the confidence and support of staff as well as users.

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In ten years, the NHS will still be under financial pressure, still subject to political accountability, inevitably exposed to periodic tragedies and failures, and almost certainly a routine source of media stories, good and bad. But it will also remain our premier national social asset; better at discriminating between innovation that does and doesn't bring improvements in outcomes, and quality improvements that do and don't save money; more transparent about its achievements and

its failures; more accessible and accountable to its users, through better communication and digital technology; still a flawed, but fundamentally precious resource; and still largely free at the point of delivery because that's the cheapest and most efficient way of providing health care, and the best way of securing equitable access, and because that's what its users want.

My message for our successors in ten years' time? Are you delivering better outcomes than we were able to? Are patients safer in your care than they were in ours? Are you better organised around the needs of your patients and clients, and are they more engaged and better informed than they were ten years ago? Well done, if you can answer yes to these questions. It's all anyone could have expected.

DR MICHAEL DIXON

Dr Michael Dixon is Chairman of the NHS Alliance. He is also Chair of the College of Medicine, President of NHS Clinical Commissioners, Visiting Professor at University College, London, Visiting Professor at Westminster University, and Honorary Senior Fellow in Public Policy at the Health Services Management Centre at the University of Birmingham.

For many, the NHS's 65th year will be regarded as yet another year of unnecessary reforms that are likely to be undone by a future government. For others, from the ashes and misery of yet another re-disorganisation, comes new hope. Hope that a clinically led, locally sensitive and primary care focused NHS will lead to a better and more financially sustainable NHS.

That is because the reforms of 2013 have an unarguable underlying logic. If you want frontline clinicians to contribute towards improving NHS services and maximising the use of resources, they need to be persuaded away from being jeer leaders on the touch line to becoming players and leaders in the main game. Unsurprisingly, many frontline clinicians are less than happy about taking on this role. Many clinical leaders regard commissioning as a public duty and social responsibility but many of their GP colleagues may regard this as yet another chore in an over-full working day, which is already packed with difficult decisions and moral dilemmas. Unsurprisingly too, the barons of the old system – centralist managers and powerful secondary care voices – are equally concerned that frontline clinicians are invading their pitch.

What is clear in 2013 is not only that the CCG leaders are enthusiastic and talented but also that their mission is urgent and necessary. An increasingly elderly population will need to be looked after closer to home, long-term disease will need to become the responsibility of communities not hospitals. As we devolve services from secondary to primary care, we will need equally to devolve services to individuals and communities, and away from

professionals and NHS services altogether. That will mean getting serious about self-care, helping individuals to improve their own health, and eventually and hopefully focusing on how we enable health-creating communities.

In 2013, the individual patient will not only be 'at the centre' of services (as is our current mantra), but will be equally central as a co-commissioner and co-provider of services and local health. As financial reality dawns and clinicians become the NHS's best solution rather than its worst problem, we will hear more about how CCGs are getting more for less rather than the perpetual lobbying by powerful professional and organisational interests for ever more professionals, extended training and resources.

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CCGs and local health and wellbeing boards will also capture a local focus, never previously witnessed by the NHS, which will see a new determination by frontline clinicians and local councillors and people to do their best for the local population rather than simply ticking the boxes from on high. There will be thorny issues around what to de-commission, trade-offs between quality, access and comprehensive provision, and eventually and inevitably some very difficult discussions about co-payment. Expect also to see the trench warfare between new market entrants and 'traditional' NHS providers as they move from the ideological to the pragmatic with the introduction of open account books for all NHS providers. It may seem radical but it is what taxpayers and patients deserve, and would introduce a level of financial transparency that will enable the new clinical commissioners to make the right decisions.

Inevitably, the centralists, the managerialists and those who see secondary care as the 'senior service' will fight back for their former territory now occupied by frontline clinicians. The former have had their day and the new shift of power and responsibility to frontline clinicians and their local population is unlikely to be undone.

PROFESSOR TIMOTHY EVANS

Professor Timothy Evans is Professor of Intensive Care Medicine at Imperial College London, and Medical Director and Consultant in Intensive Care and Thoracic Medicine at The Royal Brompton and Harefield NHS Foundation Trust. He is Vice Dean of the Faculty of Intensive Care Medicine and Lead Fellow, Future Hospital Commission, at the Royal College of Physicians.

The NHS in 2013 is in a state of unparalleled uncertainty, attributable to the need to save up to £20 billion from the NHS budget as directed by Sir David Nicholson, Chief Executive Officer of the service; coupled with massive clinical pressure on A&E services and significant current and projected shortages in the trained medical workforce. The publication of the report of the Francis Inquiry and the changes in administrative and governance structures consequent upon the Health and Social Care Act (2012) now being enacted are events with long-term implications.

Health service leaders now need to ensure the NHS remains viable and fit for purpose in a number of ways. First, they need to address the uncertainties surrounding the perceived fragmentation of community health care provision. This has particular relevance as primary care ‘gatekeepers’, who are not contracted to the rest of the service in a salaried and managed fashion, assume a central and controlling role in commissioning. The potential for conflicts of interest as CCGs award contracts to themselves or companies in which members of CCGs have financial interests represents a significant challenge and may prove to be the subject of a future inquiry.

Second, the NHS in England is driven by political expediency rather than service provision. A ‘top-down’ administrative structure (now answerable to NHS England) is at odds with the increasing diversity of what are largely autonomous health care providers, a paradox exemplified in 2013 by NHS foundation trusts seeking judicial review of Department of Health decisions.

Third, an endless round of reorganisation has left those who might be interested in exercising effective leadership disinclined to become involved in what are often short-lived bodies. The tendency towards short-termism in appointing trust chief executives, and reputation-damaging exchanges between nationally appointed clinical leaders and those they serve, have not assisted.

Fourth, the manner in which the service and parts of it (hospitals, A&E services, paediatric cardiac surgery units) are manipulated politically in defiance of rational and reasonable argument represents a further barrier to efficiency. Where national (for example 'Safe and Sustainable') and regional ('Shaping a Healthier Future') reviews have been conducted, the systems and processes employed have been flawed, or when results are broadly acceptable to patients, clinicians and managers, they are challenged because of political expediency.

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What is the way forward? Ideally, a decade from now the NHS will be fully integrated, with mental, social and clinical (primary and secondary) care sourced from a unified provider or collaboration of providers via a single point of entry. Patients would be directed towards the relevant portal (community clinic, A&E) or services provided at home (social or nursing support) employing electronic systems to make appointments, alert providers to their arrival or

need, and to transfer records and other material such as images. The smooth coordination of care between (enhanced) community-based services and secondary care would be assured. Working from community health centres, general practitioners would shift towards a significant role in public health, disease prevention and health screening; dispelling any remaining myth that they can supply emergency, seven-day community-based clinical care. Within the secondary care environment, a revolution in clinical leadership will occur. A chief of medicine in each trust will ensure that the responsibility for delivering compassionate, safe, effective

and reactive care is assumed by trained teams, and that the transition of care on a seven-day, basis is effective and complete. Individual members of staff will be rewarded in part according to their standards of 'citizenship'; an assumption of responsibility for safeguarding and caring for patients and their carers both directly and indirectly. The movement of patient data in a secure and protected fashion between social care providers, mental care providers, and primary and secondary care providers will be easy and effective. Financial restrictions will mean that the NHS provides a basic level of accommodation. Individuals will take out insurance or pay for enhanced hotel services.

Long-term, financially sustainable improvements in health care are extremely unlikely while the NHS remains driven by politics rather than service. It is one of the few remaining areas, with education, in which politicians continue to enjoy a free reign. Depoliticising the system through empowering those at the level of service delivery would enhance its efficiency and secure its future.

MIKE FARRAR CBE

Mike Farrar CBE is the Chief Executive of the NHS Confederation. He was Chief Executive of the North West England Strategic Health Authority from May 2006 to April 2011. He was previously Chief Executive of West Yorkshire and South Yorkshire Strategic Health Authorities, Chief Executive of Tees Valley Health Authority and Head of Primary Care at the Department of Health.

We are seeing some worrying times at the moment. I'm optimistic. But there are things like the A&E performance going off. And when you look at the investment that we've been making over the last five years or so, we are putting more money through our acute work, rather than following a strategy of developing alternatives in primary and social care and in the community.

We're finding it very hard to pursue that kind of thing. The acute sector is a bit like the M25. You keep having to spend money on it, and more traffic will come. So we are finding it hard to manage the demand in the system with flat cash, despite the fact that people are saying we've done heroically. I think we have. But A&E is a worrying indicator that it's starting to creak.

We know also that the financial difficulties of some district general hospitals have not been sorted and will deteriorate. My fear is that problems with emergency waiting will knock on to elective waiting and put hospitals under further pressure because their elective work is more lucrative than their emergency work – and this will spiral, and it will spiral in the wrong direction.

All that underlines the need to do something different to tackle these challenges. And the fact that we have had this recent report from the Royal Colleges, National Voices and ourselves [the NHS Confederation] – all on the same page – has been very powerful. If you look at the recent Nuffield Trust report on future spending projection and we don't make the changes that are needed, then I think we will be in serious difficulties in protecting the founding principles of the service.

Looking back, I think the big question over the last decade is ‘when we had the money, did we use it wisely, to future proof the service?’ I think for the first part of the decade, the big priority was waiting times. That was killing people because they could not get access to the service quickly enough. So it was absolutely right to spend the money on that.

In the second half we were learning the science of handling patient flow so that you could become more productive without having to throw money at it. At that point we should have been using the extra growth to really transform services. The question is did we really do enough at that point? And I don’t think we did. So now we are having to do it without the money.

There are three aspects to the reconfiguration discussion. There is reforming urgent care, getting the right size and scale for A&E, for example. There is concentrating specialist centres for more complex conditions. But right in the middle of that are the 20 per cent of people who are the frail elderly, often with dementia, for whom hospital is not a great place to be, and where we are getting delayed discharges.

But if you are talking about the need to take 20 per cent to 30 per cent of general medicine out of district general hospitals and into the community, you are undermining the economic business model we have for hospitals. So the secret is not to compromise the best care for patients by saying we have got to carry on putting the resources through the hospital. It is to find financial flows from the rest of the system that support hospitals to do residential care and support patients in their own homes or residential care. You need to give them a decent business model that can handle the transition. At the moment, the business model is not designed for that at all. It is designed to generate more acute activity.

There are some really interesting options. Where you have a really good-quality provider like Salford, they could do the community services. There are some really brilliant and innovative community trusts, like Leeds. Some mental health trusts have picked up the

community services really well. But we have got to find a model that achieves all this while supporting the hospitals.

We have to solve this problem. To do that we need more honesty with the public about its nature. Even if the press want to create the interest by saying this is about closing hospitals, that's better than nothing, because it starts to get a debate about what do you do with the money we've got?

I think you've got to put the budgets together. But that's a problem because the Lansley reforms really fragment input. So why have primary care spend separate from the community and the hospitals? That's a really dangerous split.

Most people talk about integrating spending on health and social care. But what they talk about is integrating health and social care community budgets, not about having primary care spend in there.

That goes through the primary care budget. And that is difficult because GPs get paid through it. It is their livelihood, not an institution's budget.

So we have to find a way of bringing them through too, where they can see that it is in their interests. The good news is that

THE ACUTE SECTOR IS A BIT LIKE THE M25. YOU KEEP HAVING TO SPEND MONEY ON IT AND MORE TRAFFIC WILL COME.

their business model is starting to creak as well.

So GPs can't get equity partners, recruitment is starting to dry it up, and the drawings for equity partners have gone down by, I think, 12 per cent in the last three years. So I think there's more of an appetite for change in general practice. And

I do think you can get general practice to think

about changing, without having to challenge it through the BMA, and ending up in a big war with them.

So getting the budgets together and then saying 'well, how do we get these flows right to sustain all of this' is really important.

It does beg a question about having a commissioner/provider split. I'd be interested to look at places like Wales, the accountable care organisations in the States, and what is happening in Scotland. Whether, if you want to operate with a single pot and deploy it rather than commission it, does that help? Let's evaluate that.

LOOKING BACK, I THINK THE BIG QUESTION OVER THE LAST DECADE IS 'WHEN WE HAD THE MONEY, DID WE USE IT WISELY, TO FUTURE PROOF THE SERVICE?'

The one thing about commissioning is you can use it to organise care across boundaries and it can put some grit into the system around payment incentives and potential competition. I don't think we should lose that. But how we operate with a single pot should again be debated, and you could have some whole system pilots to see how well it worked.

And I'd like to have a real go at community budgets – the Total Place approach. We've been doing some work with the World Economic Forum and one of their key conclusions after looking at five countries is that you should spend your money with a sense of place, not in silos. Have a single locally driven pot which would bring in education, the under-fives, housing, leisure, fuel poverty among older people and so on.

Can the NHS remain largely free at the point of use? I think there might have to be some conversations about the extent of the offer. But we have prescription charges and no one says the fundamental founding principles of the NHS were destroyed by that.

I do think there is a real opportunity for the NHS to join with equity providers to capitalise on some of its innovation and sell it on, so that we don't have to rely just on the taxpayer. If we were smart about that we could generate some money that would help support all of these changes.

DR CLARE GERADA

Dr Clare Gerada is Chair of the Royal College of General Practitioners. She has held a number of local and national leadership positions including Director of Primary Care for the National Clinical Governance Team and Senior Medical Adviser to the Department of Health. She is the Medical Director of the PHP Programme. She has been a GP since 1992.

The NHS is struggling and general practice is one area bearing the brunt of the pressure to meet increasing, and changing, patient needs.

We have a growing and ageing population in the UK. From a GP's point of view, we are seeing more patients than ever before, making up to 70 patient contacts a day, which previously would have only been seen in exceptional circumstances, such as a flu pandemic. And these patients are often presenting with complex, chronic and multiple conditions, both physical and mental.

Additionally, another round of structural changes has meant confusion over who is in charge and who should be taking responsibility for and making decisions about crises across the NHS. This is having a terrible effect on patient safety and confidence in the care we provide.

Instead, decision-makers and policy-makers are embroiled in a blame culture, attributing problems in the NHS to one group one day and another the next instead of taking responsibility, working together and finding a solution in the best interests of patients and the health service.

The Secretary of State for Health, health ministers and think-tank leaders must recognise the need for investment in general practice. General practice is the most cost-efficient arm of the NHS, currently providing 90 per cent of care in the NHS but only receiving nine per cent of the budget; this imbalance needs to be redressed.

However, funding in general practice is actually decreasing. The Royal College of General Practitioners (RCGP) figures suggest that if current trends continue, funding will decrease by £200 million in the next three years.

Investment in general practice needs to be two-fold. First, we need more funding and resources – including more than 10,000 more GPs, and more GP nurses. This will allow them to spend longer with their patients, within their communities.

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Second, we need investment and support for extended and enhanced GP training in order to meet the increasing health challenges presented by our growing population.

Only with this investment in general practice can we ensure a sustainable health service, which continues to provide excellent patient care to all.

Hopefully in ten years' time, at least 50 per cent of all clinicians will be generalists. General practice is a cornerstone of the NHS and will continue to be essential in the NHS of tomorrow.

The RCGP's vision, *The 2022 GP – A Vision for General Practice*, sets out a future for general practice as the patient's medical home with GPs working in community-based, multidisciplinary teams to provide patient care in and out of hospital. This will involve a hub-and-spoke model of integrated primary care and social care providers including specialist teams located in concentrated sites.

Working together across federations of practices would also lead to better out-of-hours responsiveness and allow us to develop different models that are able to address the needs of different populations of patients, such as the frail elderly.

Our vision is of greater personalisation of care with patients being able to talk of 'their team' or 'their practice' and a focus on prevention as opposed to cure.

We also envisage a greater use of technology, to increase the efficiency of care and provide it in a more accessible way.

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Without these things we risk moving towards a more chaotic NHS that is more expensive, more fragmented and unsustainable.

The NHS must remain free at the point of use. Any alternative is simply inconceivable for the future of health care in the UK.

PAUL JENKINS OBE

Paul Jenkins OBE has been Chief Executive of Rethink Mental Illness since 2006. He has over 20 years' experience of management and policy-making in central government and the NHS. In 2002 he was awarded an OBE for his role in setting up NHS Direct.

Despite the many and varied achievements of the NHS over the last 65 years, it has failed to give people with mental illness the same level of care and treatment that it provides for people with physical health problems.

It's hard to argue with this conclusion when you look at some of the startling facts. People with severe mental illness are dying 15 to 20 years earlier than the general population. Just one in ten people with schizophrenia are getting access to all the treatment recommended by NICE for their condition. The majority of people with common mental health conditions such as depression and anxiety get no treatment at all. There are still no minimum waiting times for mental health treatment or even an automatic right to treatment at all in the NHS constitution.

This must change, and not just for the sake of the one in four people in the UK who will experience mental health problems in any given year, but because failure to address this inequality will undermine the sustainability of the NHS. Only last year The King's Fund and the Centre for Mental Health estimated that the additional cost of treating people with co-morbid mental health problems was of the order of £8–13 billion. Joined-up care offers the potential for major savings and better outcomes.

Slowly this issue is getting the recognition it deserves. Last year, the Health and Social Care Act 2012 enshrined a principle of 'parity of esteem' between mental and physical health for the first time. This has also been reinforced in the NHS Mandate, but change will not be easy. The institutional bias of the NHS towards

physical health is endemic. This is shown in the dominance of large acute hospitals, the limited coverage of mental health in training and the disproportionate under-representation of mental health in research spending.

So might things be different in ten years' time if we are prepared to grasp this nettle?

WE NEED THE MEDICINE TO MATCH
THE NEEDS OF INDIVIDUALS, NOT
THE OTHER WAY AROUND.

Despite austerity, we need a greater proportion of NHS resources to be spent on mental health. This can help improve outcomes for those already in the system and increase access, for instance, to psychological interventions, for those currently receiving no help.

We need to make real progress in developing a new paradigm of integrated and whole-person care which can respond to the needs of people with multiple long-term conditions. In such a model, physical and mental health needs are addressed as well as wider non-clinical issues, which so often impact on health outcomes. Essentially, we need the medicine to match the needs of individuals, not the other way around.

Finally, we need to see fundamental changes in clinical philosophy and training to create a workforce able to deal with psychological issues as comfortably as physical symptoms. In 2023 it can no longer be acceptable for a medical student to spend as little as five weeks of their entire training on mental health.

In short, if we want an NHS which is fit for purpose in ten years' time, we need an NHS which can offer mental health patients the standards of care they deserve.

DAVID MOBBS

David Mobbs is Group Chief Executive of Nuffield Health. He has previously worked for Community Hospitals Group and Bupa. In his early career, he was a management consultant for Ernst & Young and a national management trainee in the NHS.

I think the NHS is in disarray. It's gone through the nth number of reorganisations, all of which look at changing the structure rather than addressing the health need. It's under immense financial pressure while facing the major global health care trends of an ageing population, an increase in long-term conditions and the combination of those two. And as yet I've not seen any clear plan from the NHS to address either of those key issues. It's more about how we can be more efficient at doing the same thing.

In terms of what it does, the NHS is incredibly good value. I think every now and then people should rebase the debate and say, actually we've got a health care system in the UK that's incredibly good value in terms of cost and broadly in terms of the outcomes that it provides. So why keep tinkering with the structure? Why aren't we looking at the key issues?

To keep the NHS viable over the next decade, politicians and health care leaders need to address those. Part of that is making sure the system that we've got continues to perform – and there's always room for improvement. But that isn't about structural issues, it is about practice, and evidence and outcomes. In addition it is about politicians paying attention to the root cause of the long-term conditions in the first place – and that is broadly the lifestyle issues, preventing ill health, and improving people's wellbeing. Now, I'm not asking for a state intervention in that area. I don't think this is about new government policy to create systems around this.

It is about creating an environment, creating a culture, where people are encouraged to pay attention to that, and employers are encouraged to pay attention to that. There are figures from Diabetes UK, for example, which say that this growing problem will eventually swamp the system. When you look at something like that, you realise that the solutions to these problems are outside the control of the NHS and the state. This comes down to creating an environment where people are engaged in their health – and none of the debate talks about that.

IF THE UK PUBLIC HAD A CHOICE OF A REDUCTION IN THEIR LEVEL OF SERVICE OR SOME FORM OF CO-PAYMENT, WE MAY BE ABLE TO GET THE POPULATION TO UNDERSTAND THAT THERE IS A DEGREE OF RESPONSIBILITY IN THE FORM OF CO-PAYMENTS.

One way to do that is through employers. I get quite frustrated with people in industry asking for tax concessions for private medical insurance. For me, that's allowing people to contract out of the system when they should be contributing to it in full. If we really want the government to provide some tax incentives, the best area they could apply that to would be to UK PLC – to the employer – to encourage the employer to take more responsibility for the wellbeing of their employees by encouraging health promotion and healthy lifestyles. Not by subsidising private medical treatment.

Can the NHS remain free at the point of use? I think a big debate needs to occur over the next couple of years in the lead-up to the next general election, because we are in a period of sustained austerity. Currently the NHS budget is ring-fenced. The question is can you continue with that ring-fencing without major detriment to other areas of government expenditure and other areas of society and community? And if you can't, then one of the options in a massive array of other options is to engage with the UK public about other forms of funding, principally co-payment.

We already have a precedent in the NHS for co-payment for dentists, opticians and prescriptions. And I think if the UK public had a choice of a reduction in their level of service or some form of co-payment – if the argument was explained without the usual political rhetoric and emotion that goes with it, and in an adult way – then we may be able to get the population to understand that there is a degree of responsibility in the form of co-payments. But clearly we'd have to make sure that whatever system was introduced would be able to provide concessions for those who have little means or are in poverty.

DAME JULIE MOORE DBE

Dame Julie Moore DBE has been Chief Executive of University Hospitals Birmingham NHS Foundation Trust since 2006. She is an Independent Member of the Board of the Office for Strategic Co-ordination of Health Research, a member of the MoD/DH Partnership Board and recently led the education and training work stream of the two NHS Future Forum reports.

The NHS is in pretty good shape on its 65th birthday considering all it has gone through in its life. The NHS at its best is comparable with the best health care systems in the rest of the world, but not every part of the NHS is the NHS at its best. We have seen recent cases where care has been shockingly poor and quality across the nation is too inconsistent.

The NHS has been and still is a wonderful institution providing health care free at the point of delivery to the entire population. Yet it cannot remain unchanged, fossilised in its original format. For it to survive, it must evolve and develop to meet the changing needs of society, the growth in medical knowledge and technology, an ageing society with more chronic diseases and fluctuating economic circumstances.

WE NEED TO LIBERATE THE NHS, ITS LEADERS, CLINICIANS AND STAFF TO BE CREATIVE AND INNOVATIVE, AND PREPARED TO TAKE APPROPRIATE RISKS.

We demand, rightly, that clinicians have an evidence base for the clinical practice they undertake. We have evidence of how the organisation of care can improve quality, yet we frequently do not use it. We know, for example, that complex care is best delivered by teams of clinicians who all undertake a minimum number of procedures. Yet too often services

are not delivered this way. We continue to allow services to limp along providing substandard care, when the obvious solution is to combine and consolidate. Why is it so difficult to achieve configurations that are so necessary?

The NHS is an emotive subject that evokes strong feelings in its local population, who readily accept the need for the NHS to change, just not its local services. We have evidence from this country and from abroad that where services are integrated and acute and community services are provided by one organisation, care is more easily shifted out of hospital and acute pressures are managed more readily. Finally, we must find a way of delivering urgent care, where patients have consistent services which are readily accessible and easy to use.

The job that politicians and NHS leaders have to do is to engage with the public in a debate about the best way to provide the best clinical services now and in the future, and then make the right decisions. Too often decisions are made on the basis of expediency and short-termism, not looking to the future.

At the Queen Elizabeth Hospital Birmingham, we have seen real improvements in the quality of care by the introduction of decision support systems supported by information fed back in real-time to clinicians. These have shown improvements not only in quality of care, but also in efficiency and lower costs. And yet very few hospitals in this country employ such systems.

Why is it so hard to introduce real change into our NHS? One of the reasons I believe is the approach we take to managing risk. We need to manage clinical risk very stringently, but take a different approach to financial or organisational risk. In other words, never compromise patient safety, but be prepared to try out new ideas around the organisation of care. But trying out new ideas means being prepared to fail. We have created a culture in the NHS of being averse to all risk and therefore it is very difficult to introduce any changes.

We need to liberate the NHS, its leaders, clinicians and staff to be creative and innovative, and prepared to take appropriate risks. This requires a very different culture and approach in all aspects of NHS life, regulation and rules, finance and reward, education and training and it demands real leadership in every part of the system.

MICHAEL O'HIGGINS

Michael O'Higgins is Chair of the NHS Confederation. He is the current Chair of The Pensions Regulator and is the former Chair of the Audit Commission, a position he held for six years before stepping down in September 2012. He is also a Non-Executive Director of Network Rail, a Non-Executive Director of HM Treasury and Chair of the Treasury Group Audit Committee.

In the most recent NHS Confederation members' survey, 61 per cent of NHS leaders thought that culture change in the NHS was vital if patient care is to improve. I want to unpack this and, based upon my experience in and advising a wide range of organisations, set out at least some of what this means for the NHS.

LEADERSHIP NEEDS TO BE VISIBLE
AND OUT THERE, DRIVING CHANGE
AND IMPROVEMENT.

It is now a commonplace to say that 'culture eats process for breakfast' but that does not make it any less true. Those newly trained nurses who went onto wards expecting to do the things they had been trained to do, and should have been doing, found that the culture of 'that is how

we do (or too often, fail to do) it here' was often too powerful to resist. What should have been unacceptable in both standards and behaviour had become the norm.

Culture, whether good or bad, is set by leadership from the top. People need to understand that there is a real and visible commitment to doing things well – in this case delivering high-quality and appropriate patient care. Otherwise, why would they go through the discomfort of change? My experience is that resistance to change does not usually come from the top of an organisation, nor from the patient or customer interface, but from the middle – from managers who have got used to doing things in certain ways, who do not want leaner or networked organisations as such organisations tend to mean fewer managers than traditional hierarchies.

Leadership needs to be visible and out there, driving change and improvement. One of the public sector organisations I saw that improved most radically had a chief executive who was personally and visibly committed to delivering change. When they had the staff awards, he was on the platform for the entire event, speaking about each award because he had been in the judging process throughout and had given a lot of his time to this, rather than delegating this.

Such leadership creates ‘followership’ – a critical ingredient in success. Followers in this sense are those who believe not just in what the leader is saying, but also in how they are doing it, and therefore behave like this themselves, therefore expanding the leadership capacity by themselves becoming leaders to a further set of ‘followers’. This consistency between expressed values and behaviours is critical – bullies who claim they will not tolerate bullying do not inspire confidence!

One of the best bits of advice I was given in my business career was ‘asking for help is a sign of strength not of weakness’. We need a culture where this non-macho approach to leadership permeates our organisations, where a learning culture is the norm.

There is a wonderful quote from Josef Albers, a Bauhaus artist, that goes something like ‘learning is better than teaching because it’s more intense; the more that’s been taught, the less can be learnt’. Good leadership in a learning culture means that more people will behave like the good leader, so we will end up with more and better leaders, so that people get the care they need and deserve.

DR MARK PORTER

Dr Mark Porter is a Consultant Anaesthetist at the University Hospitals Coventry and Warwickshire NHS Trust, and Chair of the Council of the British Medical Association (BMA). His previous roles in the BMA have included being the Chair of the Consultants Committee from 2009 to 2012, and Deputy Chair responsible for pay and conditions of service from 2006 to 2009.

One of Peter Cook's comic creations was a doddering grandee who had wasted years of his life trying to operate a restaurant serving only frogs and peaches, reflecting on whether he had learned from his mistakes: "I think I have, yes, and I think I can probably repeat them almost perfectly", he said.

The politicians in charge of the NHS not only repeat their mistakes, but define them rather differently than the rest of us.

Perhaps it all comes down to how you view the last 65 years. The vast majority of the public and professions see a service that has delivered remarkable outcomes for the money invested and that has somehow maintained founding principles of equity while the rest of society has become more unequal.

The politicians tend to see a service that has its moments, but is just one major reorganisation away from being perfect. The mistake, as they see it, is not to change the NHS more than they already have.

Previous anniversaries have been overshadowed by organisational change, but at 65 it is feeling akin to post-traumatic stress. And patients with this condition don't generally benefit from being repeatedly slapped around the face.

Instead of being allowed to emerge from the profound and deep trauma of the Health and Social Care Act, crises are being manufactured for political reasons. Conclusions are being manufactured before the evidence is gathered.

What has ever been achieved by the NHS being kicked around the parliamentary playground, other than demoralised staff and patients asking when the name-calling and meddling will stop?

But all is far from lost. Although many services are under enormous strain, they remain free at the point of delivery. This can and must remain the case. None of the alternatives would be better. Charging for NHS services would quite clearly bring back treatment based on the ability to pay. An insurance-based system brings with it an army of assessors trained to say 'no'. Means-tested charging would raise the spectre of minimalist state services for those who cannot afford private services.

And there is little or no evidence that charging for services would reduce the share of national wealth spent on health care – and good evidence that it would reduce service access to an unacceptably low level for some groups.

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Whatever is happening around us, it is important, as Nye Bevan did, to believe in a better future.

It is possible that those of us who are still working in the NHS in ten years' time will speak of a service where health care professionals have been empowered to base their services on the best evidence, both clinical and structural, where

the focus will be on quality and safety, and not on whichever organisational shape is in fashion, or the myth of the competitive market.

To get there, politicians have to end this obsession with NHS organisational form, each seeking to raze and rebuild their predecessor's work at enormous cost. Instead, they should talk to the patients, as we who work in the health service do every day, and to the staff. Listen to their voices, and use them to improve services for everyone, rather than an excuse for further reorganisation. There are so many ways the NHS could be made better, without needing yet another New Jerusalem.

DR KATHERINE RAKE OBE

Dr Katherine Rake OBE is the Chief Executive Officer of Healthwatch England. She was previously Chief Executive of the Family and Parenting Institute and the Fawcett Society, and a lecturer in Social Policy at the London School of Economics, where she is now a Governor. She has worked with the Prime Minister's Policy Unit, HM Treasury and other government departments.

The NHS is still the envy of the world and with good reason. It does a remarkable job in offering health care to millions of people every year, and overall our health as a nation is getting better. We live longer and healthier lives than any other generation, but this brings major new challenges.

The next ten years of the NHS will probably be the most difficult; dealing with the challenges of an ageing population at the same time as handling stretched budgets and significant system reform. More of the same or even less of the same is simply not an option. We need innovative solutions and a different type of dialogue with consumers and users of health services about our expectations of what should be delivered and how.

Since its inception the NHS has been built around the expertise of the medical profession. The system tends to treat disease rather than promote wellbeing, and as a result systems and budgets are largely focused on hospitals. Modern health care services that are affordable need to be designed around the patient or consumer, around our lives and needs.

This can sound quite scary, if you believe that patients or consumers have extravagant and unrealistic expectations. I don't believe this; in my experience – and all the evidence backs this up – when you involve consumers in developing services we are intelligent and responsible and the services improve. We understand tough decisions. You should trust us more to understand the big issues and come up with effective solutions.

One of the major issues to sort is the true integration of health and social care around people and the entirety of our health and social care needs. Keeping people well and in their homes and out of hospital should be our ambition. It's what we all say we want. It costs less to keep people at home than in hospital, which makes it hard to understand why it is so difficult to achieve. Politicians and policy-makers need to be brave and start shifting money and focus from hospitals to the Cinderella services of primary and social care.

POLITICIANS AND POLICY-
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To make this work, you need to put real power into the hands of the consumer and trust that when you give people power, we will also recognise our responsibilities. Take the issue of electronic records. Whose records are they? The patients? By giving people control of their own health information you will help us take some responsibility for managing our own health and wellbeing.

The challenge we have set ourselves at Healthwatch is to shift the balance of power towards the consumer. The difficult context we all operate in means it is imperative that people who use services help to shape them; identifying the most important things for service users, their families and carers and the best way to deliver them. It is the only way we can genuinely make the future NHS fit for purpose.

PROFESSOR TERENCE STEPHENSON

Professor Terence Stephenson is Nuffield Professor of Child Health at the Institute of Child Health, University College London, Chairman of the UK Academy of Medical Royal Colleges. He is Past President of the Royal College of Paediatrics and Child Health. He is a Consultant in General Paediatrics.

I have worked in the NHS for 30 of its 65 years and have never seen a private patient. So I and the NHS have much in common – free at the point of delivery, paid from direct taxation, care based on need not ability to pay, a utilitarian public service but a Kantian doctor–patient relationship. But both I and the NHS can do better.

The NHS changes constantly, mostly for the better, and sometimes we forget the huge strides made. In my 30 years, vastly improved survival for children with leukaemia and for preterm infants, eradication by vaccination of *Haemophilus meningitis* (and potentially measles, mumps and rubella), cot deaths reduced by two thirds, three times the number of doctors trained each year. And UK medicine has made great strides too. Ultrasound, CT and MRI are innovations of the last 30 years. Proton pump inhibitors have replaced gastrectomy for ulcer disease, angioplasty and stents have revolutionised cardiology and vascular surgery, and discovery of the BRAC gene allows a more precise approach to breast cancer. At the same time there continues to be, as a rule, extraordinary overall levels of staff commitment and dedication.

However, the NHS is often criticised for being a monopoly and almost synonymously therefore complacent, an organisation that would change and benefit from more competition. Hence the frequent reorganisations of the NHS between the ages of 45 and 65. But the NHS is not the only monopoly – I cannot practise as a doctor unless I pay £420 annually to the General Medical Council (GMC). So too the police, the fire service, ambulances and the army are monopolies. There is no alternative but is that a

problem? I am sure they all could be more efficient, the best can always do better, but presumably the downsides of competition outweigh any benefits? Budget airlines have driven down prices and maintained safety but what about quality? If I had dementia or needed heart surgery, would I click on the 'EasyNHS' option?

Among the greatest inhibitors of change in the NHS is the stifling of innovation. Some of this is public and political inertia – the 'nimbyism' of an MP looking to the next election when attempts are made to improve the quality and safety of hospital care for patients through reconfiguring services. Sometimes the inertia is within the NHS. E-prescribing has made prescribing safer in general practice for 30 years. Why is e-prescribing still not routine in hospitals? The results of tests can be overlooked because they are not automatically transmitted to the doctor who requested them. Why not have default alerts to the doctor's pager or smartphone as soon as the results are available? Would an innovator not jump at developing a secure instant messaging 'app' for exclusive use between the 1.4 million NHS staff, instead of hours wasted waiting on pagers and telephones to be answered?

Looking forward, in 2023 will the NHS at 75 be grey and wise or deep in senescence? My predictions for the NHS across the UK are:

- more care in the community
- more attention to prevention, especially of obesity
- more 'precision medicine' based on genotype as well as phenotype
- more consultants present seven days a week
- the longer training that GPs have requested
- fewer, better hospitals
- better IT
- an 'NHS & Social Care' combined service.

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Professor Terence Stephenson

Nuffield Professor of Child Health, Institute of Child Health,
University College London; Chairman, UK Academy of Medical Royal Colleges

PROFESSOR NORMAN WILLIAMS

Professor Norman Williams MS FMed Sci FRCP, FRCS is the President of the Royal College of Surgeons of England. He is Professor of Surgery and Director of Innovation at the Academic Surgical Unit of Barts and The London, Queen Mary's School of Medicine and Dentistry and National Centre for Bowel Research and Surgical Innovation. Previously he was President of the Society of Academic and Research Surgery and President of The Ileostomy & Internal Pouch Support Group.

Throughout my career in the NHS the service has stayed true to its founding principles in spite of the significant challenges that it has faced. Although there have been failings, the NHS in the main provides to all patients a safe and decent standard of care, which at times can be truly excellent.

The NHS should not be underestimated; it has ridden out many challenges in the past. However, a perfect storm of austerity and an ageing population with complex health needs means that in its 65th year real and sustainable change has to happen across the entire system.

I believe that politicians, clinicians, patients and managers can no longer sit back and prop up the system with piecemeal changes – the thorny issue of service redesign needs to be tackled. Too many reconfigurations have failed to win the support of doctors, nurses or the public. Consultations need to engage the public in a genuine conversation and must ensure they understand the substantial clinical benefits that can be achieved, while addressing their natural concerns.

Of particular concern to me as I look forward is the sustainability of our emergency care service. It is where some of the sickest patients in the NHS present and when it fails, it has an impact on doctors and patients across the hospital and indeed the whole community. Over the past few years, the development of the national trauma network has been part of the solution for the seriously ill. It shows what can be done – but we can't

spend another ten years discussing how we reform accident and emergency departments to make them fit for purpose.

In the coming decade the NHS must continue to focus relentlessly on mending the false divide between primary and secondary care. Integration must become a reality. Our A&Es are under enormous pressure primarily because many patients cannot be discharged back home after treatment, due to a simple lack of humane and thoughtfully planned care.

TOO MANY RECONFIGURATIONS HAVE
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There is also a cultural issue that needs to be addressed with a greater focus on the patient. Managers and trust board members need to concentrate more on quality and compassion than bureaucratic tick-box exercises and institutions need to be far more transparent.

All professional groups must be prepared to contribute to this agenda. I see our College's recent initiative of placing individual surgeons' data into the public arena as beginning this process, and would urge others to do the same. The data emanating from this initiative also underline the need to reshape services as they demonstrate the benefits of centralising complex surgical services.

As we mark the 65th anniversary of the NHS, we must grasp the opportunity to make clinically justified changes to the service so we can continue to offer the access and quality of services patients rightly expect. This is the time when patients, politicians, clinicians and managers must come together to support historic change in the NHS and create a long-lasting legacy.

Independent commentators

**INDEPENDENT
COMMENTATORS**

DR NEIL BACON

Dr Neil Bacon is the founder and CEO of iWantGreatCare, the UK's leading patient feedback service. He trained as a nephrologist at Oxford and Harvard before founding Doctors.net.uk – the world's largest online professional network of doctors. As well as leading iWantGreatCare, he is an adviser on ehealth and transparency to government and the EU.

A surgeon recently shared with me a story exemplifying a fundamental shift if the NHS is to remain viable and fit for purpose in a decade's time.

THE PATIENT EXPERIENCE, CAPTURED IN REAL-TIME, CAN BE A CORE METRIC USED BY REGULATORS, AS MUCH AS BY THE PUBLIC, TO MONITOR AND ASSESS THE SAFETY AND QUALITY OF CARE.

She was breaking very bad news – a terminal diagnosis to an elderly patient and his wife. As she was delivering the prognosis as gently as possible, the patient's wife leant across and touched her on the arm. She explained how much the couple appreciated her empathy and consideration in what was the most difficult moment of their lives. She then went on to say, "but we knew you'd be kind as that's what all your reviews said". Before their

appointment this 75-year-old lady and her husband had "googled" the surgeon and spent time reading the reviews and comments of other patients.

Such events are occurring with increasing frequency as sensitive, honest and insightful patient opinion is being shared by patients on the internet – about doctors, hospitals, dentists and nurses. In order for the NHS to remain viable and fit for purpose over the next decade, health care must finally embrace the power of the patient not only as an intelligent consumer of information, but equally importantly as a provider of a powerful and sensitive quality metric. The patient experience, captured in real-time, can be a core metric used by regulators, as much as by the public, to monitor and assess the safety and quality of care.

In almost every other public-facing, service industry, user reviews are accepted as fundamental to continued improvement and providing a high-quality service. The prevalence of online, independent, transparent customer feedback has made it impossible to continue to run a dirty hotel or an unhygienic restaurant. The same needs to happen within the NHS if it is to both improve and retain the trust of the UK public.

IN THE NHS'S 65-YEAR HISTORY,
IT'S HARD TO THINK OF A MORE
CHALLENGING AND FRAUGHT 12
MONTHS THAN THE LAST YEAR.

In the NHS's 65-year history, it's hard to think of a more challenging and fraught 12 months than the last year. A clear message emerging from the unnecessary deaths, buried reports and 'redacted' press releases is that the open, transparent opinion of patients and their families must be at the heart of health care. Change and

improvement will not come from managers, doctors or politicians: it is the voices of users, the 'wisdom of the patients' that can drive the improvement and total patient focus that is required.

Open, comparative patient feedback can be the most powerful driver of improvement the NHS has known, it will introduce informed choice and put pressure on organisations to continually improve.

Total transparency, not just of clinical outcomes and mortality rates but of patient ratings and detailed reviews, will highlight excellence and identify weakness within the NHS. Embracing such an opportunity, making the voice of the patient the 'smoke-detector of patient safety' would create an NHS meaningful, trusted and safe for the increasing challenges of a demanding society and an ageing population.

PROFESSOR PAUL CORRIGAN CBE

Professor Paul Corrigan CBE is currently an Adjunct Professor of Public Health at the Chinese University of Hong Kong and Adjunct Professor of Health Policy at Imperial College London. He has been special adviser to Alan Milburn and John Reid, and the Senior Health Policy Adviser to Tony Blair. He was also Director of Strategy and Commissioning at the London Strategic Health Authority.

A definition: A contradiction is a relationship whose two aspects will over time struggle against each other so that one side dominates and develops history into a new platform.

We are asked to say where we think the NHS is now and where it will be in ten years' time. But I need to explain why my view is that the NHS 2013 is both incredibly strong as well as very fragile. How this pans out will all depend on how the NHS works with the main contradiction between the NHS and the public over the next decade.

IT IS THIS BELIEF THAT HISTORY WILL IN SOME WAY ENSURE THAT THE PUBLIC WILL ALWAYS SUPPORT THE NHS THAT REPRESENTS THE BIGGEST WEAKNESS FOR THE FUTURE OF THE NHS.

Over its life the NHS has been created, sustained and developed because of very big political relationships between governments and the public. In 2013, those big politics mean that no political party with a hope of making up a government can hope to win that election by coming out against the basic principles of the NHS – services paid for out of national taxation, free at the point of need with equal access for all. We have yet to see what the saloon bar discussion of UKIP produces in the way of NHS policy, but

my guess is they like medical staff and don't like managers.

In 2013 we have seen a Conservative-led coalition cut the numbers in the army and the budget of the police forces while leaving the NHS budget alone. The positive passion that the public feel for the NHS places a strong lock on how any political party can challenge these basic principles when standing for election. This

will be the case in the 2015 election and, depending on how the contradiction I am talking about works its way through in the next seven years, is likely to do so in the election of 2020.

Politics places the NHS in a very strong position.

The problem for the NHS (the other half of the contradiction) is that most people in the NHS believe that this strong relationship with the public is secured and doesn't need constant work to redevelop it into a real contract. In 2001 to 2005 it was a constant shock to me that so many staff in the NHS didn't get how corrosive very long waiting times were for the public's view of the NHS. Too many people in the NHS believe that the public's passion for the NHS will always inevitably secure the extra resources that the NHS needs to keep up with demand. So while the rest of the public services are being cut, the NHS assumes it will always get more money.

This is a delusion that comes from the way in which the NHS takes public support for granted.

At the moment the right-wing press attacks the NHS, and its attacks slide off. But a couple more Mid Staffs, a few million regular experiences of very poor customer care, and this could change very rapidly. The NHS needs to learn from other institutions that had strong public support and see how this can be quite hollow unless it is worked on all the time.

It is this belief that history will in some way ensure that the public will always support the NHS that represents the biggest weakness for the future of the NHS.

If the NHS recognises that over the next ten years it needs to completely re-work its relationship with the public as patient and taxpayer, if it recognises that every patient is actually paying for the service they receive, then it might maintain and develop that strong public and therefore political support. If it takes it for granted, things will get very bleak for the NHS at some stage in the next decade.

ROBERT FRANCIS QC

Robert Francis QC has practised as a barrister since 1973 and is a specialist in medical legal issues. He chaired the Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, and chaired the subsequent Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of the trust.

The NHS is currently at a watershed in its development. Its basic concept of ‘free’ high-quality care for all is challenged as never before by technological advances, an increasing, more diverse and longer-living population, more assertive public expectations and greater financial pressures. As if this were not enough, it is in the middle of a politically driven, system-wide reorganisation, which aspires to provider autonomy, and public rather than political accountability. At the same time, the system is facing another round of reforms, changes designed to bring about culture change in order to prevent or pre-empt disastrous systemic failures of care such as occurred at Mid Staffordshire NHS Foundation Trust.

THE SYSTEM MUST BE OPEN,
HONEST AND TRANSPARENT ABOUT
WHAT CAN AND CANNOT BE DONE,
ABOUT ITS FAILURES AS WELL
AS ITS SUCCESSES.

It is therefore small wonder that many working in health care feel overwhelmed, pessimistic and fatalistic. Should such attitudes persist and become the default position of the service, there is a risk of serious deterioration in standards and of loss of public confidence. It will require a great deal of energy, commitment and persistence on the part of leaders at every level to maintain fundamental standards of care, the effectiveness of care and treatment provided to all who need it, and continuous improvements in the delivery of the service.

How is this to be achieved? Out of my experience of studying the issues arising out of the Mid Staffordshire disaster, I believe a number of objectives need to be kept firmly in mind:

- We must ensure the system is relentlessly *centred on serving its patients* and other users by being responsive to their needs, rather than seeking to fit those needs into what is on offer. The system must in that sense be led by its patients.
- The system must be *open, honest and transparent* about what can and cannot be done, about its failures as well as its successes, and thereby to allow the individual patients and the public generally to make informed and realistic decisions about the service they want as well as about the individual treatment choices available.
- We must develop, exploit and cherish the patient-centred values of medical *professionalism*, which need to be at the heart of the work done by all in the service, but doctors and nurses in particular, and re-engage their many talents, not only in the service provided to individual patients, but also in the formation and running of the service as a whole.
- Effective and inspirational *leadership* exemplifying and promoting this culture will be needed throughout the system, from the frontline to the boards of national organisations.
- Structural and individual *stability* is essential to allow cultural change to spread and be maintained.

I am optimistic that this can be done, but it requires political courage to allow the system to develop itself, independence of mind and initiative from leaders, commitment to patient-centred values on the part of all staff, and an acceptance by the public of their responsibility to take charge of their own service and their own health.

CHRIS HAM CBE

Chris Ham CBE has been Chief Executive of The King's Fund since April 2010. He has been Professor of Health Policy and Management at the University of Birmingham since 1992. He was Governor and then a Non-Executive Director of the Heart of England NHS Foundation Trust between 2007 and 2010. From 2000 to 2004 he was Director of the Strategy Unit at the Department of Health, where he worked with ministers on NHS reform.

The NHS has served the British public remarkably well over the last 65 years. Notwithstanding occasional and sometimes tragic failures, such as those at Mid Staffordshire NHS Foundation Trust, it meets the needs of most people most of the time, often to exceptionally high standards. The standing of the NHS with the public is demonstrated by survey data showing that more people identify the NHS as making them proud to be British than anything else, including the royal family and the armed forces.

If it is to thrive in the next decade, the NHS must reinvent itself as a health service, not a sickness service. It must do more to tackle the determinants of ill health by fully engaging the public in altering the lifestyles that cause sickness. It must act with other agencies in addressing the social, economic and cultural causes of health inequalities. And it must reorient to better meet the needs of an ageing population affected by long-term conditions, especially the needs of people with several conditions including dementia.

All of this has to happen at a time of unprecedented financial challenges. Unable to do more of the same because no extra resources are available, the NHS must find ways of doing things differently, for example by:

- empowering people to take control of their health and wellbeing instead of relying on health care professionals
- supporting people in their own homes to avoid inappropriate use of hospitals and nursing homes

- enabling people to consult GPs and nurses by phone and email rather than face-to-face
- delivering coordinated health and social care based on the needs of individuals, not the requirements of the system
- enabling people at the end of their lives to die in the place of their choice with support from health and social care services.

None of this will happen at the speed needed unless there is a willingness to challenge established practices and embrace innovations in care. This must include looking again at the post-war settlement that gave rise to divisions between health and social care. These divisions may have made sense at the time but they are increasingly anomalous in a society where far more people are living into their 80s and 90s, with needs that are both medical and social.

IF IT IS TO THRIVE IN THE NEXT DECADE, THE NHS MUST REINVENT ITSELF AS A HEALTH SERVICE, NOT A SICKNESS SERVICE.

It is for this reason that The King's Fund has set up a commission to review the post-war settlement and consider alternatives to current arrangements. Our decision reflects the urgency of examining whether the boundary between health and social care should be redrawn and different funding streams brought together.

Entitlements to care must also be reviewed to assess whether these should be aligned. Inevitably, this means asking how much should be spent on health and social care now and in the future, and where resources should come from.

These are all fundamental and difficult questions to which there are no easy answers. But they are questions that cannot be ducked if the NHS is to be reinvented and retain its standing with a population that has very different expectations from those that existed in 1948.

KAREN JENNINGS

Karen Jennings is Assistant General Secretary, Bargaining, Negotiations and Equalities, UNISON. She previously held lead responsibility for UNISON health policy, campaigns and the organisation of almost half a million members who work across the health care sector. She practised as a registered nurse for ten years, before becoming a researcher in health and social policy and then a national trade union official.

The NHS has come through a period of unprecedented upheaval and tremendous uncertainty over the past three years, since the bombshell of the ‘Liberating the NHS’ White Paper led to the Health and Social Care Act limping through Parliament, and a further year of transition up to April 2013.

Although the NHS and its workforce have, as always, done their best to weather these storms, the NHS has already entered dangerous waters. Waiting times are edging up, A&E problems show alarming signs of turning into a full-blown crisis, and there are other problems directly of the government’s own making, such as tampering with the successful NHS Direct and introducing a fragmented market of 111 providers. It should come as no surprise that satisfaction with the NHS has fallen since the all-time high of 2010.

The role of health care companies is expanding substantially, with a ten per cent increase in NHS money spent in the sector in the past year and analysts predicting a £20 billion ‘opportunity’ for companies through both provision and commissioning. The government’s botched implementation of the Section 75 procurement regulations has done little to convince clinical commissioners that they will be given the autonomy they crave, and which was ostensibly the point of the ‘liberating’ reforms. This direction is unlikely to change with the Prime Minister reaching out to right-wing think-tanks to staff his own health policy functions.

There is now a need for urgent repeal of the Health and Social Care Act, which has the potential to unravel much of what patients and staff know and love of our NHS. The N in NHS needs to be reasserted by getting rid of economic regulation, restoring the role of the Secretary of State, and insisting on a more rigid cap on private patient income.

Winding back the market also means saving money, which is likely to be a big issue for the foreseeable future. The transaction costs associated with administering the market are eye-watering, with the average cost of running an OJEU tender process estimated at £100,000.

THE 'N' IN NHS NEEDS TO BE REASSERTED BY GETTING RID OF ECONOMIC REGULATION, RESTORING THE ROLE OF THE SECRETARY OF STATE, AND INSISTING ON A MORE RIGID CAP ON PRIVATE PATIENT INCOME.

Integration is often cited as one means of making savings. This may be the case in the longer term, but the evidence base is currently patchy at best and too often staff have come to associate other buzzwords, such as personalisation, with budget cuts rather than improved quality – this must be avoided.

As recommended by Sir Robert Francis, but rejected by the government, safe minimum staffing levels are needed to provide peace of mind to patients and staff alike. Protection for staff terms and conditions is another area with knock-on benefits for those receiving care; an increasing body of academic research from the likes of Aston Business School and the National Nursing Research Unit points to a definite link between staff wellbeing and patients' experience of care.

The NHS must always put the care of its patients above all else; the profit motive has no role in a service based on the comparison and solidarity of those delivering and receiving care.

PROFESSOR JULIAN LE GRAND

Professor Julian Le Grand has been the Richard Titmuss Professor of Social Policy at the London School of Economics since 1993. From 2003 to 2005 he was seconded to No 10 Downing Street as Senior Policy Adviser to the Prime Minister. He is a Founding Academician of the Academy of Social Sciences, an Honorary Fellow of the Faculty of Public Health Medicine, a Trustee of The King's Fund and a Fellow of the British Academy. He is also Chairman of the Mutuels Taskforce.

An important lesson from the reforms to the NHS undertaken by the Blair Government was that a poorly performing NHS will not improve on its own. When Tony Blair came into office in 1997, many people (especially those working in the service) argued that the principal problem with the NHS was money, or rather the lack of it. All that was needed was a massive injection of resources and every problem would be resolved. But what became apparent was that, although extra resources were indeed necessary, they were by no means sufficient. In the first few years, although more money was injected, waiting times actually increased; and there was little sign of increases in activity, or improvements in efficiency elsewhere in the service. What I have termed elsewhere the 'trust' model of health care service delivery had failed.¹

Evidently, in addition to resources, some kind of external pressure was needed to drive up quality. The government initially resorted to exerting such pressure itself, through what was initially known as targets and performance management but was eventually dubbed targets and terror. Although this was widely regarded as rather successful, policy-makers became increasingly worried about the side-effects of the policy, including gaming and distortions of activity. So they supplemented it by another form of pressure: that from patient choice and hospital competition for patients. Again this proved to be rather successful, with The King's Fund concluding that 'the market-related changes introduced

1. Le Grand, J. (2007) *The Other Invisible Hand*. Oxford: Princeton University Press.

from 2002 by New Labour tended to have the effects predicted by the proponents and that most of the feared undesirable impacts had not materialised to any extent’ – though the review added that the improvements may not have been as great as those induced by the previous targets and performance management regime.²

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Has this lesson – the need for external pressure of some kind – been learned? Elements of one of the currently ruling parties in the Coalition Government, the Liberal Democrats, clearly have not understood it, with their continued attempt to eliminate the incentives for encouraging competition and to foster a version of the trust model involving cooperation and networks. But, following the enactment of the NHS Health and Social Care Act and the Francis Report on Mid

Staffordshire, it looks as though the NHS in the future will indeed be subject to a number of sources of external pressure, especially that from a myriad of regulators, including Monitor and the Care Quality Commission, with a Chief Inspector of Hospitals. There may also be pressure from what might be termed ‘reputation competition’, with the publication of hospital ratings and the post-operative mortality rates for surgeons in some specialities.

What are the implications of this for the NHS for ten years’ time? Heavy-handed regulation has many of the same drawbacks as command-and-control. Indeed, it could be regarded as a form of command-and-control, with the regulators replacing the Department of Health as the institution issuing the commands. And, as with targets and terror, excessive regulation can be demoralising and demotivating; it can stifle initiative and innovation. Reputation competition can work; but there is a danger that ratings, like targets, encourage a focus on what is rated, with a possible diversion of attention from other aspects of care.

2. Dixon A, Mays N, Jones, L (2011), *Understanding New Labour’s Market Reforms*. London: The King’s Fund. p.191

So, although the fact that, over the next decade, there will be some external pressures on NHS institutions to improve is welcome, I am not wholly convinced the pressures are taking the right form. There is a danger that what we might see in 2023 is an over-regulated, stagnant NHS – with a return to (regulator-led) centralised control, demoralised staff and disgruntled patients.

THERE IS A DANGER THAT WHAT
WE MIGHT SEE IN 2023 IS AN
OVER-REGULATED, STAGNANT NHS.

What I would prefer to see is a return to emphasising patient choice and provider competition. That would give the freedom for new kinds of provider to emerge – especially employee-owned enterprises or mutuals, new providers already driving innovation in community health and ripe for development into acute care.³ A quasi-market with choice and competition between mutuals could deliver the necessary incentives for quality improvement, without creating many of the adverse side-effects of the other prescriptions. Developing this should be the aim for the next decade of the NHS.

3. Mutuals Taskforce (2012) *Public Service Mutuals: the next steps*. London: Mutuals Taskforce.
<http://mutuals.cabinetoffice.gov.uk/documents/mutuals-taskforce-report-public-service-mutuals-next-steps>

Heavy-handed regulation has many of the same drawbacks as command-and-control... And, as with targets and terror, excessive regulation can be demoralising and demotivating; it can stifle initiative and innovation. Reputation competition can work; but there is a danger that ratings, like targets, encourage a focus on what is rated, with a possible diversion of attention from other aspects of care.

Professor Julian Le Grand

Richard Titmuss Professor of Social Policy, London School of Economics

ROY LILLEY

Roy Lilley is a former NHS Trust Chairman. He is currently a writer and broadcaster on NHS issues.

I was born before the NHS. My dad was a window cleaner and my mum a shop worker. He saved the equivalent of three weeks' wages to have a 'midwife' come and help his young wife through 12 hours of labour. No gas, no air and no prospect of going to hospital. Her first-born had died and she nearly bled to death. A woman at risk but determined to start a family.

WHEN THE 1948 NHS ACT CAME ALONG IT LIFTED, FROM THE SHOULDERS OF WORKING PEOPLE, THE ANXIETY OF SICKNESS, INJURY AND ACCIDENT. IT WAS A HEROIC PIECE OF POLITICS, BUILT ON BELIEF AND VISION.

When the 1948 NHS Act came along it lifted, from the shoulders of working people, the anxiety of sickness, injury and accident. It was a heroic piece of politics, built on belief and vision.

Today, that young wife is a frail widow being cared for, in her own home, by a hospital in-reach team. Her husband died years ago but his life was extended by an aortic valve replacement. It was innovative, new and must have cost thousands.

I started life without the NHS and I expect to meet my end without it. Today's politicians are driven by balance sheets, not beliefs. There are no visions or convictions, just focus groups and practicalities. The eagerness to get the NHS off the nation's books will become more urgent. The damage to the economy has hobbled the NHS and the grim economic prospects will cripple it. The NHS is running up the down escalator of time, costs and demand.

Can we learn or legislate to make fat people thin? Can we find a way to help old people remember who they are? Can we turn the feral into families? Probably yes; but we don't have the time or the money or the know-how.

Yes, the NHS has to be efficient and safe and clean, but it has to be central to a political desire to promote, encourage and endorse social medicine and its values. I judge it is not. If we want an NHS we have to pay for it. No politicians have the courage to ask for the money.

We can fiddle with technology, jiggle with data and lean care pathways but the truth is the NHS is about smart people with a strong sense of vocation. There is no shortage of them, but the places that can employ them will become scarce.

In ten years we will be well on our way to 20 giant hospitals, vertically integrated with privately run health and care shops in the high street. Basic services will be available, top-ups common and a major source of NHS income.

Nurses will provide their own uniforms, patients will buy their pills online and inpatients will pay for their meals. As maternity is a condition and not an illness, mums will pay for their deliveries – just like it was when I was born.

My message comes from the past, delivered in the present, but meant for the future: ‘We tried, we did our best but they wouldn’t listen. Not enough of us saw it coming and too few saw it going. I’m sorry’.

ALASTAIR MCLELLAN

Alastair McLellan is Editor of *Health Service Journal* and Group Editor of *HSJ's* sister titles *Local Government Chronicle* and *Nursing Times*. He joined *HSJ* as Editor in 2002, leaving in 2007 to become Development Director during the launch phase of the government's patient information portal NHS Choices. Alastair returned to journalism 15 months later as Editor of *Nursing Times*, before rejoining *HSJ* in 2010. He has been a journalist since 1986. He was named 'Editor of the Year' in the 2013 Professional Publishers Association magazine industry awards.

Viewed from a distance the years between the NHS's 60th and 65th anniversary will be seen as a period the service turned into a policy cul-de-sac – from which it then had to reverse painfully before continuing its journey.

The Lansley reforms were not the dramatic new departure many believed them to be. Indeed, had they been introduced in a more evolutionary way in 2008 they would have seemed the logical conclusion of the New Labour reforms: improving clinical input into commissioning and providing greater independence for agencies and regulators.

But the last administration sat on its hands and the Lansley reforms, conceived in a time of plenty, were delivered to an NHS much more concerned with saving money. Confusion ensued.

In March 2012, in their first-ever joint editorial, the *British Medical Journal*, *Nursing Times* and *Health Service Journal* criticised the Coalition's health reforms for a range of weaknesses, but said that its most worrying legacy would be the need to return to the drawing board in the near future.

And so it has proved.

The possibility of more disruption does – and will continue to – madden many in the reform-weary NHS. However, change is hard-wired into the organisation and delivery of health services. The key is not to avoid, but to get it right. A stagnating service

is every bit as enraging as one reconfiguring itself for the wrong reasons and in the wrong way.

It may come to pass that 2013 will be seen as the year that the strands of more sustainable and relevant health reforms began to emerge.

There is no master plan (probably a good thing) and change is driven as much by austerity as any high-minded goal, but things that sensible people in the service have long wanted are starting to happen.

THE POSSIBILITY OF MORE
DISRUPTION DOES – AND WILL
CONTINUE TO – MADDEN MANY
IN THE REFORM-WEARY NHS.

More hot air has been expelled extolling the need for NHS and social care integration than any other health service-related subject. But, there now appears a widespread recognition that it is an idea whose time has come. There are a number of competing proposed methods – and not all motives are the right ones (the Treasury primarily sees it as a way to save money). However, whether it proves to be Labour's shifting of the NHS commissioning budget to local authorities, Norman Lamb's regionally driven joint initiatives or Jeremy Hunt's push to improve the care of vulnerable older people, the likelihood is that the NHS will celebrate its 70th birthday more closely aligned with social care than at any time since its 30th. A time incidentally when *HSJ* was called the *Health and Social Services Journal*.

The will having grown, the way will be provided by an overhaul of the NHS's payment mechanisms. Payment by results (PbR) will be seen as an important tool in driving capacity where necessary, but one increasingly irrelevant to more complex outcomes. PbR will become a spanner to loosen some stubborn bolts, not the toolbox itself.

By the 70th anniversary of the NHS English versions of the accountable care organisation – responsible for a specific population and rewarded on outcomes – will be becoming firmly established. The purchaser–provider split, as understood for the last decade, will have blurred significantly around the edges.

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As a result, the English NHS will be able to maintain an ‘offer’ to the public very similar in scope to the one it does now, delivered – hopefully – at a higher quality and through greater engagement with its users.

GEOFF MULGAN

Geoff Mulgan is Chief Executive of Nesta. From 2004 to 2011 he was the first Chief Executive of the Young Foundation. Between 1997 and 2004 he had various roles in the UK government, including Director of the Government's Strategy Unit and Head of Policy in the Prime Minister's office. He has also been a lecturer in telecommunications; an investment executive; and a reporter on BBC TV and radio. His most recent book is *The Locust and the Bee* published by Princeton University Press in 2013.

The creation of the NHS was a rare act of societal will. When the idea was first floated it appeared Utopian in the extreme. When it materialised there were innumerable reasons to believe it wouldn't work and wouldn't be affordable. Nevertheless it worked.

At its heart were ideas about rights (never precisely defined) and fairness, and, of course, a commitment to health for all. Those ideas show no signs of dating. But much of the architecture now looks ill-suited to the present; indeed almost everything other than the core values should be up for grabs.

What follows? I believe that the priority for the next few decades will be to make the NHS a true partnership with the public; to found it more explicitly on the best available knowledge; and to adapt the implicit social contract to a new mix of rights and responsibilities.

First, partnership. Health needs to be cultivated with patients and not just for them. There is a broad consensus that health needs to become more preventive, more holistic, more diverse, with greater self-management and peer support, all alongside a flow of ever more sophisticated and targeted treatments. At Nesta we've labelled this future 'people powered health' – mobilising the resources of the whole community and recognising that most care happens in the home and the family. Through pilots and projects we've shown what a health system designed around supporting ubiquitous care might look like – from consultations

to measurements and financial incentives and technologies that support horizontal networks rather than just vertical interactions. But much stands in the way – including professional habits and many hospitals which remain magnets of power and money.

THE QUID PRO QUO SHOULD BE
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IS USED FOR REBIRTH, NOT THE
BEGINNING OF RETIREMENT.

Second, knowledge. The glue of the future health system will be carefully managed and orchestrated knowledge – much of it open, and much of it highly confidential. The old NHS mobilised the best of professional skill and medical knowledge for use by the professionals. The next generation needs to mobilise knowledge in all its forms to support health decisions

wherever they're made – whether in the consulting room or at home, in hospitals or workplaces. That means going far beyond the consumerism of today's IT plans (although these are badly needed too – it's amazing how little serious information is available on GPs for example). We've advocated a 'Health Knowledge Commons' to organise and orchestrate knowledge, from the most thoroughly researched clinical knowledge, to experiential knowledge, and knowledge about promising but unproven treatments. The UK is uniquely well placed to bring this into being – we have the building blocks, from an integrated NHS to institutions like NICE, NHS Evidence, the BBC and the Open University. We're also uniquely well placed in the manipulation of big data sets.

Third, the social contract. A health aware population will demand that people aren't penalised for fate – the bad luck of genetic endowments that will become increasingly visible. That's why rights to health care, and care more broadly, will need to be reasserted and redefined. But a health aware public will also expect people to face the consequences of their own decisions. If they smoke, overeat or under-exercise, they cannot indefinitely expect the same rights as people who care for themselves.

The NHS hits 65 in ruder health than looked possible a few years ago, with extraordinary levels of satisfaction, a better record on value for money than the majority of health systems, and a pretty well-rewarded workforce. It now deserves to be protected from the endless shuffling of the organogram that has characterised the last 25 years. But the quid pro quo should be a raising of ambition so that the NHS's 65th birthday is used for rebirth, not the beginning of retirement.

DR PATRICK NOLAN

Dr Patrick Nolan is Reform's Chief Economist, where he focuses on welfare, health and taxation issues. He was previously a Senior Economist at the New Zealand Institute of Economic Research and Economic Adviser to a frontbench Minister in a Labour Government, and worked for the New Zealand Treasury in tax and regulatory policy.

As political parties prepare for the 2015 election they must think the unthinkable on the NHS. Population ageing and other changes are increasing costs just as the share of the population that is working aged and can pay the taxes required to fund the NHS is falling. This is turning the NHS's world on its head.

The NHS is the largest area of departmental spending and accounts for a growing share of the public services that families consume. For pensioner households, for example, spending on the NHS now accounts for around 95 per cent of the benefits in kind that they receive. This is not to say that more health spending is necessarily a bad thing. But the consumption of health inputs (for example, government spending) should not be confused with improved health outcomes. And the need to ensure the system remains financially sustainable should not be forgotten.

For decades real reform to the funding of the service has remained off the agenda and emphasis has instead been given to reorganising the service to improve resource use. Of course improving resource use is important and should continue (particularly given the potential of new health technologies). Yet the service will not be put on a sustainable basis without funding reform. Governments can no longer continue to introduce organisational changes in place of hard decisions on how the NHS is paid for.

Some steps have already been made in this direction. Since 2008 patients have been allowed to make financial contributions to their own NHS health care (top-up payments) without losing their NHS entitlement. It is necessary to go the next step and review broader arrangements for funding. As Professor Malcolm Grant noted in April 2013: “[a new charging system is] something which a future government will wish to reflect [on], unless the economy has picked up sufficiently, because we can anticipate demand for NHS services rising by about 4 to 5 per cent per annum.”

THE BEST WELFARE STATES
EMPLOY A MIX OF PUBLIC AND
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AFFORDABLE IN THE LONG RUN.

The first step in a new charging system should be to define the boundaries of free care (either as a positive or a negative list). The clarity this provides would encourage private spending and help create a market for insurance and other products to help manage these costs. This would bring the NHS into the international mainstream. On average OECD countries spend 2.7 per cent of GDP on health care privately. The UK spends 1.5 per cent. Indeed, as the OECD noted in 2009, UK residents benefit from an “especially high level of financial protection from the consequences of illness”.

There will be vocal opposition to any changes along these lines. But it is necessary to see the opportunities too. The best welfare states employ a mix of public and private funding. This reduces pressure on public systems and makes programmes more affordable in the long run. Mixed funding models also have important political effects, with greater private contributions helping build consensus that taking responsibility for your health is not just the job of the government.

BEN PAGE

Ben Page is Chief Executive of Ipsos MORI. He has worked closely with both Conservative and Labour ministers, and senior policy-makers across government, leading on work for Downing Street, the Cabinet Office, the Home Office and the Department of Health, as well as a wide range of local authorities and NHS trusts.

The NHS remains the closest thing the British have to a religion. No other country in the world would feature its health system at an Olympic opening ceremony. Even after raging debate over reform inside the medical profession, most people in Britain say it is one of the best health systems in the world, and public anxiety about it is far lower than a decade ago – and much lower than media headlines would suggest.

At the same time, people are anxious about the future, with over eight in ten saying they expect it to face a severe funding crisis. So although the principles it represents remain fundamental – it has changed dramatically since its inception, in terms of its aspirations and scope – it will have to change again. The proportion that agrees there need to be limits on NHS spending is up from 44 per cent in 2006 to 58 per cent now.

To me the NHS has three major challenges. The biggest is to achieve a huge cultural change in Britain – getting the public to take greater responsibility for their health. None of us would buy a car, never service it, and expect it to run faultlessly for decades, while filling it with any old fuel. Changing the NHS from an emergency/breakdown service to one that spends much more of its budget on prevention and routine, local care, and less on intensive episodes in hospitals is an enduring challenge for politicians and leaders. They have made relatively little progress in times of plenty – whether an ever tightening squeeze will allow it is another matter, but a potential social care crisis is already putting pressure on the system.

The second challenge is changing internal culture, and overcoming its “listening deficit”. Despite its revered status, 40 per cent believe the NHS should be better at listening to patients, and 36 per cent say it should be better at listening to staff. Last year Francis referred to a “tolerance of poor standards”. Nearly 30 per cent of the public think this happens in most or all NHS hospitals, with one in 20 thinking the problem is endemic. Building a much more responsive culture is the current aim of NHS England, but time will tell in terms of how much change they achieve.

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The third will be working out how to charge for some elements of care – the NHS currently provides much more, free, than Beveridge could have imagined. Across the Western world, governments are having to reduce social spending, and this will still be in train until 2020 and later. As part of getting people to reflect both on their rising life expectancy – and plan for it accordingly – will be making them take some more responsibility for it – if nothing

else in financial planning for care and support when they are older. A quarter of people do not have anything except the state pension to rely on – and will be living on less than they expect for longer than they seem to think.

So my prediction for 2023? The NHS will still be mostly free, it will still be seen as hugely important, and we will still be fumbling along with the transition to a wellness service.

To the people working in it in 2023 – many of whom already are working in it – well done for getting through the upheavals of the 2010s and congratulations on your ingenuity, determination and courage in changing the NHS to adapt to our rising life expectancy, and increased and diverse populations.

RANDEEP RAMESH

Randeep Ramesh is *The Guardian's* Social Affairs Editor. He studied Natural Sciences at Cambridge and Engineering at Imperial College. His first job was in the oil industry, which he left to write about jazz. Since then he's worked on the *Sunday Times*, *The Independent* and *The Guardian* as an investigative journalist, a news reporter, a leader column writer and a foreign correspondent.

Below is a fictional account of how a key component of England's health care, NHS London, might look in 2023 – and how it got to look that way.

When London's Labour Mayor Stella Creasy announced that the government had agreed to let the capital go its own way on health, it marked the break-up of the country's National Health Service. In fact the United Kingdom had long been operating with four distinct health systems in its constituent nations, but it was a fact rarely acknowledged.

Now, however, Parliament had conceded to break up the English NHS – allowing London to create an integrated care organisation overseen by a board headed by the mayor. Creasy had convinced the chancellor to devolve the budget for commissioning into her hands, partly by winning her second term on a platform of creating a Londoners' health service. What she ended up with was a tax-funded universal insurer and provider for a defined membership: the citizens of the capital.

However, Creasy's re-election – coinciding with Labour's landslide victory in 2020 – ensured both continuity and a break with their Coalition's health policies. Gone was the threat of the corporatisation of general practice – which the Coalition had wanted by allowing GP patient lists to be sold. Instead Labour forced family doctors to sit down with locally elected politicians to decide on health spending priorities. In London Creasy now sat atop a new London-wide health and wellbeing board.

This democratic mandate was crucial in explaining Labour's electoral victory. Since 2015, the Coalition had decided that non-health public spending would be kept at one per cent a year. That meant harsh benefit sanctions, a smaller army and continuing falling pay for public servants. Even then the NHS had to find £20 billion in cuts, something that only politicians able to sell change as hope could achieve.

To her credit Creasy did so. In 2016 Creasy, then a newly elected mayor, had focused on creating a mayoral response to the capital's health crisis. The young mayor resisted the imposition of patient charges – championed by health secretary Phillip Lee – something that won her support among the capital's 6,000 GPs. Creasy also took over public health budgets arguing that they had to be aligned with planning and education policies. She went further than the government had wanted in many areas – notably by transforming NHS trusts unable to reach foundation status into mutual enterprises owned and run by the staff.

Significantly, the mayor won her argument with NHS England that she should take health service cash and spend it on social care. It was clear a decade ago that the bulk of health spending in the NHS was on emergency medical referrals to NHS hospitals, mainly the elderly, and trauma services. Creasy working with London's GPs had proved that she could handle reconfigurations which located full services in a reduced number of large-scale hospitals.

Creasy's success was largely due to the fact she could show the elderly benefited from extra social care spending and from creating 'living wage' cooperatives which provided 'out-of-hospital' services in the community.

In doing so, she professionalised a cadre of medical staff who placed care alongside medical know-how. By casting a hospital shake-up as a job-creating policy, Creasy succeeded where others had failed. In 2023, health care in London employed ten per cent of the workforce – double that a decade ago. These new workers are a vital part of her political base for a 46-year-old politician who aims to become Labour's second female PM.

JEREMY TAYLOR

Jeremy Taylor is Chief Executive of National Voices, the national coalition of health and social care charities. Formerly a senior civil servant, Jeremy joined National Voices in 2009 to build its profile and impact as a major voice for patients, service users, carers and their representatives. He is regularly called upon as an adviser and speaker on patient voice and related issues.

We are in danger of losing our collective nerve over the future of the NHS. In 1948, in the midst of austerity and post-war national exhaustion, Britain created a comprehensive health service which offered care to those who needed it regardless of their means. It was a courageous idea whose time had come and it made compelling economic, political and social sense. It still does. In 2013 our far richer country can and should continue to embrace Aneurin Bevan's vision.

THROUGH A MIXTURE OF
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Of course we face very different health challenges to those of 1948. We live longer; there are more people with disabilities and long-term conditions; there are more very old people. More health care is delivered to more and more people. It has become eye-wateringly expensive. These, by the way, are largely the fruits of success: decades of rising prosperity and advances in public health, medicine, surgery, pharmacology and technology. Many millions of people have cause to be thankful. The NHS, as so vividly highlighted in the opening ceremony for the 2012 Olympics, has become woven into our national myth. Opinion polls consistently show it to be popular and well supported.

And yet in policy-making circles the prevailing mood in 2013 is one of gloom. People fret about 'rising demand' and the 'burden' of chronic disease. Hand-wringing about the sustainability of A&E services is the latest fashion as I write. A scandal in one

hospital in Stafford has prompted an unending spasm of inquiries, reviews and navel-gazing about the capacity of the entire NHS to deliver care safely and with compassion.

It has become fashionable to blame patients and the public for profligate use of the NHS. We are eating, drinking and slobbering ourselves to early graves at the taxpayers' expense, failing to 'self-care'; wasting GPs' time; and rolling up to A&E with trivial complaints.

And in this current economic slump it is becoming fashionable, for the first time since the 1980s, to question whether Bevan's settlement – a comprehensive service, free at the point of use – is sustainable and affordable.

Through a mixture of defeatism, lazy thinking and, in the case of some, malign intent, we are in danger of sleepwalking towards dismantling the NHS. Of course there is a lot that needs change and improvement. In ten years' time, a functioning NHS will need coordinated out-of-hospital services for the very old; it will need patients who are informed, engaged and when necessary stropic; and it will need a more social and less medical, less pharmaceutical model of care.

Before 1948, the great scandal was that your health care depended on the size of your wallet. In 2013, the enduring scandal is that the quality and length of your life depend on your postcode. To remove the appalling inequities in health that we have allowed to persist and worsen will need action on many fronts. The NHS cannot do it alone, but without a comprehensive health service, free at the point of use, we will never get there.

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Jeremy Taylor

Chief Executive, National Voices

MATTHEW TAYLOR

Matthew Taylor became Chief Executive of the RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce) in 2006. Prior to this appointment, he was Chief Adviser on Political Strategy to the Prime Minister, and Director of the Institute for Public Policy Research between 1999 and 2003.

The NHS right now could be described as ‘just about coping, increasingly creaking and possibly headed for the rocks’. The radical founding principles – which arguably seem even more radical today than 70 years ago – are still strongly supported, patient satisfaction rates remain high and there are steady improvements in key outcome areas. But as budget constraints bite deeper while needs continue to grow, the future on the current trajectory looks bleak. So what is to be done?

The improvement capacity of an organisation can be linked to three fundamental ways of thinking about and pursuing change: the hierarchical (leadership, strategy, rules and regulations); the individualistic (competitive, instrumental, market oriented); and the solidaristic (egalitarian, value-based). From this perspective the question is how much improvement capacity is generated through each channel and how well do the different aspects of change work together.

The recent history of NHS reform has in aggregate focused most on boosting the individualistic dimension of change by increasing the role of markets and contestability. At the hierarchical level, concerns about effectiveness and legitimacy led to greater target-based prescription under Labour Governments and then, under the Coalition, to devolve NHS management locally and put it at arm’s length from politicians nationally. Meanwhile both the ‘target culture’ and marketisation have been subject to the critique that they undermine the solidaristic impulse of the public service ethos.

Recent scandals involving neglect of vulnerable patients have led, for example, to accusations of a compassion deficit in the NHS.

The same conceptual frame can be used to look forward. The prospects for the NHS rely on reforming the key drivers and getting them to work together.

PERHAPS MOST IMPORTANT IS
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In relation to hierarchy, the argument continues to grow for greater integration of local commissioning, bringing together not just health and social care, but connecting health policy and investment to broader local strategies for wellbeing and economic renewal. In terms of markets and contestability, the focus should be on how unleashing their undoubted power can maximise the scope for innovation, but also encourage the right balance of competition and collaboration.

But perhaps most important is a re-imagining of the public service ethos of the NHS from one based on professional delivery to one which promotes a genuinely co-productive model of health and social care. The primary measurement of the effectiveness of public service interventions should be what the RSA calls 'social productivity' – the degree to which these interventions encourage and enable people individually and collectively to contribute to meeting their own needs.

Inevitably the imperatives and norms of hierarchy, individualism and solidarity will clash. Aligning them so as to produce 'clumsy' but effective solutions is the key task for policy-makers.

My message therefore is that the NHS's noble principles can survive and prosper, but only if we better marshal and combine the power of integrated local leadership, innovation and collaborative enterprise, and a new public service ethos of co-production.

STEPHEN THORNTON

Stephen Thornton is Chief Executive of the Health Foundation. He has over 25 years' senior health care management experience. He spent five years as Chief Executive of Cambridge and Huntingdon Health Authority and five years as Chief Executive of the NHS Confederation. He is currently the Deputy Chair of Monitor, an expert member of the Department of Health's National Quality Board, Vice Chair of the Eastern Academic Health Science Network and a member of the Nursing and Midwifery Council.

What could I possibly say about a national treasure? Stephen Fry, Helen Mirren, the real Queen or the NHS? Be positive and I stand accused of being sycophantic, offer mild criticism and to many I would be a pariah. And which NHS would I choose? The scandal-drenched one I read about in the newspapers, or the responsive, caring but mildly chaotic one I experience locally as a patient? So I will tread with care.

Fifteen years ago, as part of the NHS's 50th anniversary celebrations, I commissioned a set of scenarios to be developed, laying out different visions for what health care might look like 20 years from 1998. Would science rule the day? Would personal wealth be the determinant? Might public health get traction? Would the patient be in charge? In short, we can say with the benefit of hindsight that the answer to all these questions is 'no, not quite' as over the past 15 years the NHS has continued to 'muddle through'. So my big and perhaps rather boring prediction is that it will continue to do much the same over the forthcoming decade. Change in health care is glacial in its pace.

But that doesn't mean there hasn't been change or there won't be change in future. Today's NHS is immeasurably better than it was last century. The state of the built environment; outcomes for people with heart disease and cancer; access times and health care acquired infection rates; better crude and standardised mortality rates; new surgical, anaesthetic and diagnostic procedures; mental

health services delivered in community settings rather than from Victorian institutions; the recognition that much harm that occurs is avoidable; and a much greater degree of multidisciplinary team working, patient engagement and openness.

Yet deep-seated problems persist. Professional tribalism stymies teamwork; risk aversion brought about by fear of the personal consequences stunts innovation; vested interests keep the most radical possibilities off the agenda; and constant political piecemeal tinkering with regulation hampers effective oversight in favour of control.

MY ELDERLY PARENTS STILL
REMEMBER THE KNOCK ON THE
DOOR FROM 'THE DOCTOR'S MAN'
COLLECTING HIS DEBTS. LET
US NEVER RETURN TO THOSE
DEGRADING TIMES.

In this context I have just three pieces of advice for any future Secretary of State:

First, and most important of all, do not fall for the argument that we can no longer afford health care free at the point of use, provided on the basis of need not the ability to pay. My elderly parents still remember the knock on the door from 'the doctor's man' collecting his debts. Let us never return to those degrading times.

Second, resist all temptation to reorganise the management structure of the service. Such pointless displacement activity will eventually discredit you.

Meanwhile, third, get on the front foot when it comes to the reconfiguration of acute hospital services. Face up to the fact that the district general hospital as conceived by Enoch Powell in his 1962 Hospital Plan for England is reaching the end of its useful life. See this as an opportunity for some radically different delivery options rather than cowering in fear of public anger.

POLLY TOYNBEE

Polly Toynbee is a *Guardian* columnist and broadcaster and was formerly the BBC's Social Affairs Editor. She has won a National Press Award and has been *What the Papers Say* Columnist of the Year.

The NHS is in danger of sliding into serial crises, as it always does if it falls below at least two per cent real growth. Accelerating ageing as baby boomers retire is already pressing hard on GPs and A&E. The government wasted two years on a pointlessly disruptive reorganisation, where 90,000 moved jobs and many senior experienced staff gave up and left. Worse, it was designed for conflict and competition when austerity required maximum collaboration and sharing between acute and community services.

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It is unfashionable to say so, but more money is essential – and this time not wasted on bureaucratic change, but used as bridging funds to get from acute spending to community and preventative care. The risk is that a pre-election crisis will lead to a panic bung to ease politically embarrassing eruptions, with no plan. The strategic moment has been squandered. Even Sir David Nicholson, who obediently acquiesced, now says we need ‘integration’ – a bit late.

As commercialisation lets rip, stop it now before costs rise, NHS expertise atrophies and there is no way out of badly drawn contracts.

In ten years’ time the NHS will take a bigger slice of GDP, because the public will not allow ageing pressures to cause a worsening service for all. If current politics prevail, most of it will be privately delivered, managers powerlessly bound, costs

spiralling and private insurance surging, to everyone's detriment. If better policies prevail, money levered in will affect the big switch to good social and health care in one silo.

Voters will only accept minor health charges. Private insurance systems cost more for less care, less efficiently delivered. How much we want to spend on health will still be decided at the ballot box by taxpayers, more than by private pockets.

IF YOU EVER FORGET THAT A FREE NHS, IMBUED WITH A PUBLIC SERVICE ETHOS, IS PART OF OUR NATIONAL COLLECTIVE IDENTITY, TAKE ANOTHER LOOK AT THE OLYMPICS OPENING CEREMONY.

The better-off elderly could pay for their prescriptions. Blurring the line between health and social care could yield more capital from under-taxed property. Dilnot will be altered to make sure capital wealth accumulated by the old is released for their own care: use an up-front capital sum, or a lien on homes, at the point of retirement. Hypothecation of health spending is a more transparent and popular way to tax.

My message for future NHS leaders would be to dig up Lord Darzi's blueprint for polyclinics, if you haven't already discovered that intermediate care is the answer. Whatever it takes, bring GPs under greater direct NHS control to work in large clusters with diagnostics and specialisms on tap. Primary care is the efficient answer, but over-worked GPs in small groups can't satisfy demand that will go on growing. If you ever forget that a free NHS, imbued with a public service ethos, is part of our national collective identity, take another look at the Olympics opening ceremony.

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THE WISDOM OF THE CROWD

On 5 July 2013, the NHS reached 'retirement age'. To mark 65 years of the health service, the Nuffield Trust presents this compendium of essays featuring the views of 65 key people from the health sector and elsewhere on the current state of the NHS and social care system, and its future prospects.

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