REFORM

How to run a country: Health and social care

Cathy Corrie
Leo Ewbank

June 2015

Contents

1	**Introduction**	
2	**A strategy to improve outcomes**	**2**
2.1	Integration and new models of care	2
2.2	Prevention and patient engagement	3
2.3	Competition	4
3	**High value care**	**5**
3.1	Productivity	5
3.2	Financing	7
4	**Priorities for the Government**	**9**
5	**Conclusion**	**11**

1. Introduction

Across the world, healthcare costs are rising faster than countries' ability to meet them. An ageing population and rising costs are stretching resources while patients are expecting a better, safer and more modern service. NHS England has made clear that without significant reform to the way the health service operates, the Government will need to find an additional £22 billion to fund the NHS by 2020.[1]

Reforms to the NHS and social care should focus not on increasing 'inputs' but on improving outcomes for patients. This is the only route to both a high quality and sustainable health and care service.[2] As Professor Michael Porter said for *Reform* in 2014, "Value for patients means delivering excellent health outcomes, hopefully improving health outcomes, on the things that really matter to the patient, and doing that very, very efficiently. It's the relationship between the outcomes we deliver and how many pounds we have to spend to deliver those outcomes that really represents the true north of any healthcare delivery system."[3]

This is a radically different way of thinking about the health service. As Professor Porter has explained, "Historically, the NHS has focused on measuring 'inputs' such as attendances, hospital admissions, and waiting times. These are easy to measure, but fail to capture whether the patient's care was good or bad, or even clinically effective."[4] Politicians continue to show their commitment to the NHS through more doctors or more money, not through better outcomes for patients. Only by re-orientating the health service around the outcomes that matter to patients and delivering them at the lowest possible cost can the Government and the NHS successfully deliver the £22 billion of savings required.

Achieving better health outcomes is a principal factor in improving not just the sustainability of public spending but individual wellbeing as well. Empowering individuals to live healthier lives promotes better social relationships, employment prospects and overall life satisfaction.[5] In light of the size of the budget and escalating projections of future costs, value for money in health spending goes a long way towards the sustainability of public spending and to protecting the wellbeing of future generations.

1 NHS England, *Five Year Forward View*, October 2014.
2 Michael Porter and Thomas Lee, "The Strategy That Will Fix Health Care," *Harvard Business Review,* October 2013.
3 Michael Porter, *Transcript: A Strategy to Fix Healthcare*, January 2014.
4 Michael Porter and Emma Stanton, "Why Outcomes Measurement Is the Key to Fixing Healthcare," http://www.reform.uk/reformer/why-outcomes-measurement-is-the-key-to-fixing-healthcare/, accessed on 8 June 2015.
5 Gus O'Donnell, Angus Deaton, Martine Durand, David Halpern and Richard Layard, *Wellbeing and Policy,* March 2014.

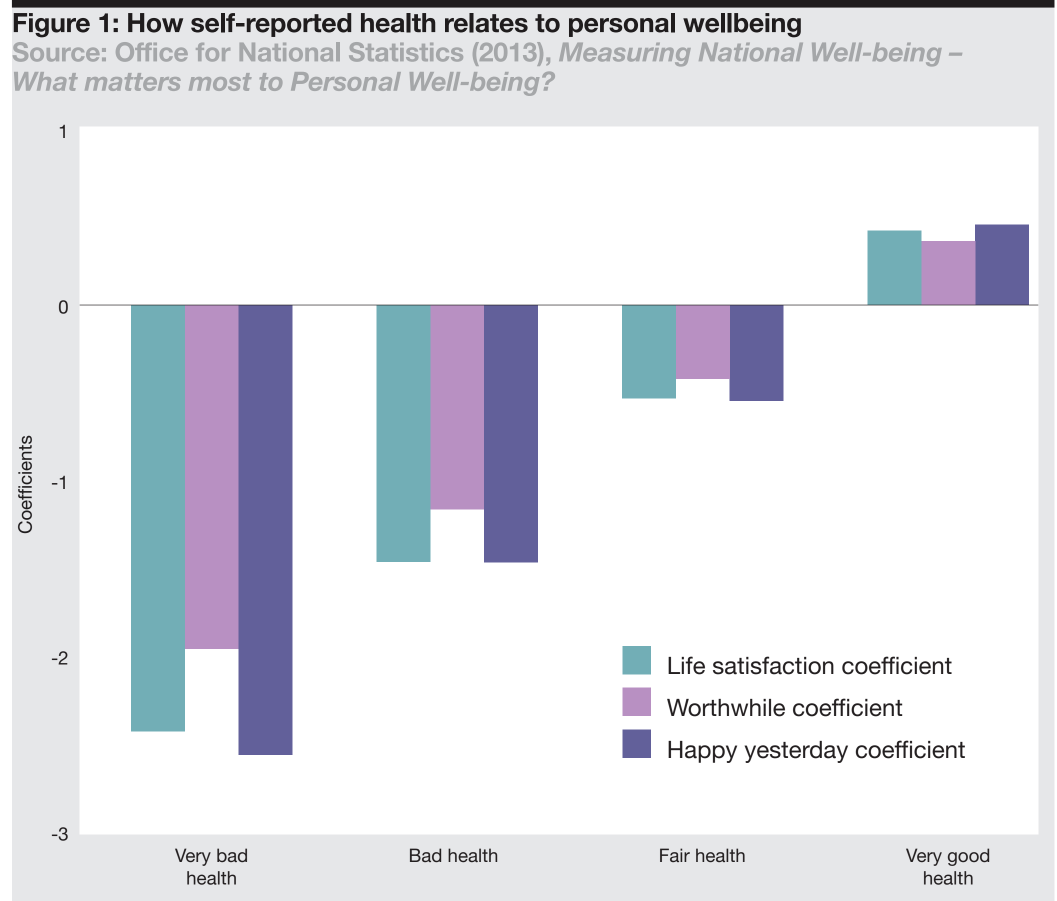


Figure 1: How self-reported health relates to personal wellbeing
Source: Office for National Statistics (2013), *Measuring National Well-being – What matters most to Personal Well-being?*

2. A strategy to improve outcomes

2.1 Integration and new models of care

As the population ages, individuals are living longer with one or more long-term conditions. People over the age of 65 account for 51 per cent of local authority spending on adult social care and two-thirds of the primary care prescribing budget, while 70 per cent of primary and acute care spending goes on people with long-term conditions.[6] How well services meet these needs depends on all parts of the system working together.

This means taking "decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."[7] The new models of care set out by NHS England are an important step towards redesigning care out of organisational silos and around patient pathways across whole health economies. In doing so care is tailored around the patient, not the providers or clinicians who treat them.[8] Integration at the individual level through personal budgets and integrated personal commissioning has the potential to give patients this choice and control over their care but has yet to achieve scale across health and care.[9]

Crucially the better coordination of care around the highest users of health and care services will require a shift in the default setting of care, from acute hospitals into more cost-effective and clinically appropriate community based and preventative alternatives.

6 Department of Health, *Long Term Conditions Compendium of Information: Third Edition*, 2012; Health and Social Care Information Centre, *Personal Social Services: Expenditure and Unit Costs, England, 2013-14 Final Release*, December 2014.
7 NHS England, *Five Year Forward View.*
8 Ibid.; KPMG, *Creating New Value with Patients, Carers and Communities*, 2014.
9 Chris Hatton, John Waters and Martin Routledge, *National Personal Budgets Survey 2013: Survey of Main Findings and next Steps*, 2013.

The majority of the NHS budget continues to be spent on hospitals and the proportion is rising.[10] Social care is a crucial part of a system which focuses on keeping people healthy and independent in the home yet it has been underfunded for a number of years in comparison to large spending increases on the NHS.[11] Since 2010 the social care budget was cut by 31 per cent while NHS spending was protected.[12] The Local Government Association (LGA) expects a funding gap of £4.3 billion by the end of the current Parliament.[13]

Table 1: NHS and social care spending in billions 1999-2009, 2009-10 prices
Source: Cawston *et al.* (2013), *Flat-lining: Lack of progress on NHS reform.*

	1999-00 (£bn)	2009-10 (£bn)	Change (%)
NHS	51.4	99.8	94.3
Social care	11.4	16.8	47.3
Total	62.8	116.6	85.8

Recommendation

The NHS should accelerate service redesign to better coordinate services and expand capacity beyond acute hospitals, including social care. It should extend the scope and uptake of personal budgets across health and care to give patients greater choice across services.

2.2 Prevention and patient engagement

It has long been recognised that by seeking to prevent illness, rather than just treating sickness when it occurs, the NHS can avoid preventable costs and manage demand on existing services. The landmark Wanless Review in 2002 argued that engaging patients and the public in their health and care was the only route to sustainable healthcare spending.[14] Yet 13 years since the review, progress has been limited, with improvements in public health marginal and in some areas, such as obesity, in decline.

Engaging patients and the public in the decisions that affect their health could help unlock this potential. An international body of evidence now shows that involving patients in their health leads to better outcomes and better use of resources.[15] There is real appetite to do more and in many cases patients already are. National patient surveys show that half of hospital inpatients and one in three people using GP services were not as involved in decisions about their care as they wanted to be.[16] Citizens already invest more in their health and wellbeing than ever before while 1 in 20 Google searches is health related. Tapping into this momentum could help the NHS realise savings of nearly £2 billion by 2020-21, according to *Reform*'s research.[17]

Considering the health and wellbeing of patients not just in moments of acute illness but in their daily lives places new importance on self-care. In light of the growing prevalence of long-term conditions, equipping patients with the tools to effectively manage their own conditions can improve health outcomes and reduce demand on services. As Simon Stevens outlined in his maiden speech as Chief Executive of NHS England, “At a time when resources are tight we are going to have to find new ways of tapping into…sources of renewable energy”, by “boosting the critical role that patients play in their own health

10 Cathy Corrie and William Mosseri-Marlio, *Progress on NHS Reform*, March 2015.
11 Christine de la Maisonneuve and Joaquim Oliveira Martins, *Public Spending on Health and Long-Term Care: A New Set of Projections*, June 2013.
12 BBC Online, “Adult Social Care Firms Struggling for Staff due to Cuts,” 4 June 2015.
13 Local Government Association, *Adult Social Care Funding: 2014 State of the Nation Report*, October 2014.
14 Derek Wanless, *Securing Our Future Health: Taking a Long-Term View*, April 2002.
15 The Commonwealth Fund, *International Perspectives on Patient Engagement: Results from the 2011 Commonwealth Fund Survey*, March 2012; National Voices, “Prioritising Person-Centred Care: the Evidence,” http://www.nationalvoices.org.uk/evidence, accessed on 5 June 2015.
16 Care Quality Commission, *National Findings from the 2013 Inpatients Survey*, 2013.
17 Cathy Corrie and Amy Finch, *Expert Patients*, February 2015.

and care."[18] Technology has the potential to allow patients to do jobs previously carried out by clinicians, such as diabetics measuring their blood sugar and administering insulin. Other industries, such as banking and retail, offer relevant lessons for how technology and data can be used to harness the contribution of the consumer, such as self-checkout, and better understand customers' needs, for instance via loyalty cards.[19]

Recommendation:

The NHS should make prevention its core business. It should look to outside expertise and learn the lessons of industries such as banking and retail to accelerate patient engagement.

2.3 Competition

According to a poll by Populus for *Reform*, nearly 60 per cent of people believe it does not matter whether NHS services are public or private, as long as they are free at the point of use.[20] In this way the goal of better outcomes can and should allow for flexibility as to who delivers them. As Catherine Davies, Executive Director of Competition and Cooperation at Monitor, has argued, "I don't really see how a policy that discriminates in favour of a particular type of provider is the right way to get the best outcome for patients…What's most important is that you have someone who can provide the services that meet the needs of patients in a particular area."[21] Evidence from the OECD, IMF and others suggests that competition can be used "effectively to create a system that's responsive and to incentivise high quality and efficient care".[22]

Already commissioners are using competition to deliver integration. A growing number of Clinical Commissioning Groups (CCGs) have begun to use outcomes-based contracts to open up contracts to the provider best placed to coordinate care across a patient pathway, whether public or private. In Bedfordshire, Circle Partnership is coordinating services for patients with musculoskeletal conditions and in East Staffordshire, Virgin Care is doing the same for their frail and elderly population.[23]

This should be extended further to out-of-hospital care. Evidence from this country and abroad clearly shows that supporting patients to exercise choice between providers and GPs can enhance patient wellbeing and act as a powerful driver for quality care.[24,25] In general practice barriers to entry and exit have seen few new entrants in recent years. A recent survey by Monitor found that almost a third of patients think they do not have alternative GP practices to choose from and only 16 per cent of patients have considered using alternatives.[26] Already the private sector is going straight to the consumer to offer services not yet provided by the NHS, such as 'virtual' access to primary care.[27] Encouraging alternative providers from outside the NHS and giving patients meaningful choice could spread these kinds of innovations and improve access through better services, not just more GPs.

18 Simon Stevens, "Full Text of Simon Stevens' Speech," 1 April 2014.
19 Paul Corrigan and Mike Parish, *Going with Change: Allowing New Models of Healthcare to Be Provided for NHS Patients*, June 2014.
20 Michael Porter, "Two Thirds of Voters Oppose New NHS Tax," http://www.reform.uk/publication/two-thirds-of-voters-oppose-new-nhs-tax/, accessed on 8 June 2015.
21 Will Hazell, "Monitor: Role for Competition in New Provider Landscape," *Health Service Journal*, 28 November 2014.
22 Isabelle Joumard, Christophe Andre and Chantal Nicq, Health Care Systems: Efficiency and Institutions; Carlo Cottarelli, *Macro-Fiscal Implications of Health Care Reform in Advanced and Emerging Economies,* May 2010; Will Hazell, "Monitor: Role for Competition in New Provider Landscape," *Health Service Journal*, 28 November 2014.
23 James Illman, "Circle Named Preferred Bidder for Musculoskeletal £120m Contract," *Health Service Journal*, 12 August 2013; Shaun Lintern, "Revealed: Virgin Handed £280m Staffordshire Contract," *Health Service Journal*, 26 March 2015.
24 Zack Cooper, Stephen Gibbons, Simon Jones and Alistair McGuire, "Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms," *The Economic Journal*, vol. 121, no. 554 (August 2011).
25 Valentina Zigante, *Consumer Choice, Competition and Privatisation in European Health and Long-Term Care Systems,* 2013.
26 Monitor, *Improving GP Services: Commissioners and Patient Choice*, June 2015.
27 Corrie and Finch, *Expert Patients;* James Illman, "Parsa Launches New 'virtual Health Service' App," *Health Service Journal,* 28 April 2014.

Recommendation:

The Government should promote diversity of provision to drive greater efficiency, innovation and choice for patients.

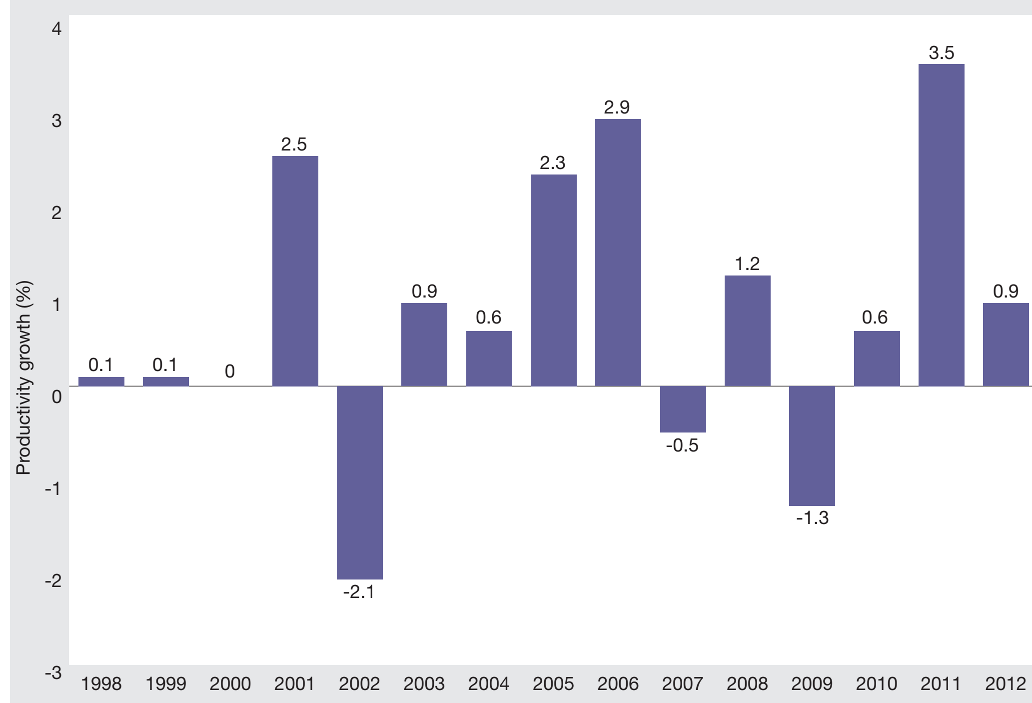
3. High value care

3.1 Productivity

Delivering better health outcomes for less cost relies on highly productive services. In this the NHS and social care have traditionally fallen short. Official estimates show annual UK healthcare productivity growth averaged 0.6 per cent from 1998 to 2008 and 1.6 per cent from 2010 to 2012, though data from the acute sector suggests this has since fallen.[28] This falls well short of the 4 per cent per year identified by the King's Fund and the Institute for Fiscal Studies (IFS) as necessary to close the gap between resource and demand.[29] Adult social care productivity has fared even worse, averaging at -1.4 per cent between 1998 and 2008, falling to -2.3 per cent between 2010 and 2012.[30]

Figure 2: UK healthcare productivity 1998-2012

Source: Office for National Statistics (2015), *Public Service Productivity Estimates: Healthcare, 2012*

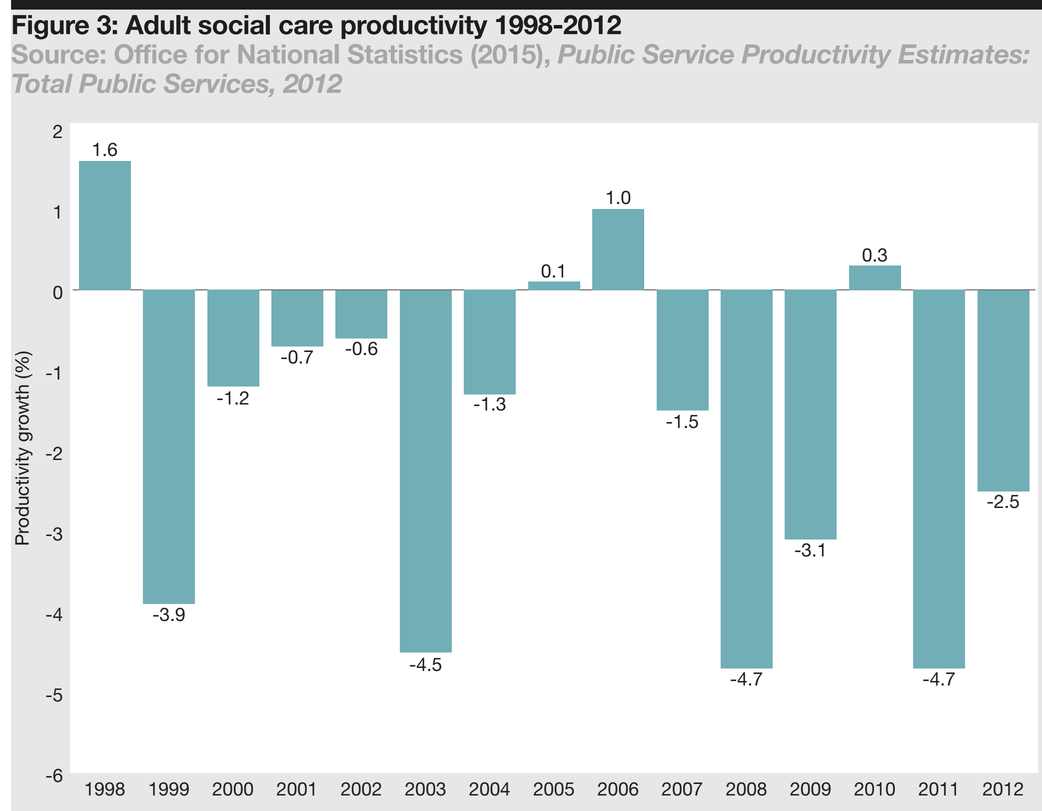


28 Office for National Statistics, *Public Service Productivity Estimates: Healthcare, 2012*, January 2015; Sarah Lafond, Anita Charlesworth and Adam Roberts, *Hospital Finances and Productivity: In a Critical Condition?*, April 2015.

29 McKinsey & Company, *Achieving World Class Productivity in the NHS 2009/10 - 2013/14: Detailing the Size of the Opportunity*, March 2009.

30 Office for National Statistics, *Public Service Productivity Estimates: Total Public Services, 2012*, February 2015.

Figure 3: Adult social care productivity 1998-2012
Source: Office for National Statistics (2015), *Public Service Productivity Estimates: Total Public Services, 2012*



While in 2010 the need for greater efficiency was recognised by the Government, in the NHS and social care the efficiencies made were not sustainable.[31] In the NHS, savings were achieved predominantly from short-term measures, such as reducing the tariff (the price paid to hospitals) and freezing staff pay.[32] As the National Audit Office (NAO) and the Health Select Committee have noted, underneath these short-term cuts, trusts have not changed the way they operate to become permanently more productive.[33] David Bennett, Chief Executive of Monitor, has criticised hospital savings plans as “not yet as stretching as they need to be”.[34] The result is a hospital sector with a deficit of £822 million in 2014-15, expected to rise to £2 billion this year.[35] In social care three-quarters of the fall in spending was achieved by reducing the amount of care provided. While this could have been in part through the prevention of the need for care, it is likely that this was largely the result of changes to eligibility or reductions in service, with less care provided to fewer people rather than changing the way services operate.[36]

As such, there is clearly an opportunity to extract greater value from existing budgets. In the NHS, the *Five Year Forward View* (5YFV) has pledged to achieve 2 to 3 per cent annual productivity growth this Parliament. This target can only be achieved by both eliminating variation between the worst and the best providers and fundamentally transforming the way care is delivered across the board.[37]

31 HM Treasury, *Spending Review 2010*, October 2010.
32 House of Commons Health Select Committee, *Public Expenditure on Health and Social Care, Seventh Report of Session 2013-14*, February 2014.
33 National Audit Office, *Adult Social Care in England: Overview*; House of Commons Health Select Committee, *Public Expenditure on Health and Social Care*.
34 Crispin Dowler, “Exclusive: Monitor Ramps up Challenge to FTs over Spending,” *Health Service Journal*, 29 May 2015.
35 BBC Online, “NHS Trusts’ Deficit Rises to £822m,” 22 May 2015.
36 National Audit Office, *Adult Social Care in England: Overview*.
37 Sarah Lafond, *Current NHS Spending in England*, January 2015.

Table 2: Scope for productivity improvement in the NHS

Area for reform	Potential savings
Reconfigure services	Consolidation of specialist services and reconfiguration of emergency care has been shown to improve productivity.[38] Hospital chains could see the sharing of back office costs.[39] Integration through new models of care will streamline patient pathways and reduce duplication, though the value is largely unquantified.[40]
Procurement	Variation in hospital procurement currently leads to the same materials being purchased at prices which vary by up to 50 per cent.[41]
Estates	350 surplus sites worth £7.5 billion. Estate rationalisation could yield up to £1.1 billion savings in the acute sector alone.[42]
Workforce	There is no consistency in productivity of consultants within and between hospitals. Wards of similar workloads often have unexplained differences in nurse-bed ratio of 50 per cent.[43]
Prevention and patient engagement	Patient engagement could realise savings of nearly £2 billion by 2020-21. Shared decision-making, self-care and personal budgets can reduce high cost interventions and reduce hospital admissions.[44]
Poor quality	Adverse (preventable) events cost the NHS £1-£2.5 billion a year. Poor coordination can cause costs through delayed discharges, readmissions, adverse incidents and medication errors.[45]
Data and transparency	Collecting data on the true cost of a patient's cycle of care drives better value care.[46] Transparency on cost is a key driver in identifying and eliminating variation.[47]

As the Audit Commission and NAO have noted, there is scope to improve productivity in adult social care.[48] Indeed estimates of the social care funding gap by the LGA and ADASS are based on an assumption of 1.5 per cent productivity growth, tapering off to 1 per cent further on in the Parliament. As with health, this represents a significant step change to current rates.[49] Social services leaders and experts have identified a number of areas for further reform including better procurement, increased prevention, shifting activity to cheaper settings, stopping unnecessary services, increased personalisation and better use of technology by the workforce and in patient self-care.[50]

Recommendation

The Government should make sustainable improvements to health and social care productivity a priority.

3.2 Financing

NHS

Every health and care system is built on a mix of public and private funding, yet the NHS makes exceptionally little use of private contributions to the cost of care. Other countries have introduced charges across a broader range of services and across a broader section of the population. Across the OECD, all countries charge for prescriptions; two thirds

38 Ibid
39 David Dalton, *Examining New Options and Opportunities for Providers of NHS Care: The Dalton Review,* December 2014.
40 NHS England, *Five Year Forward View.*
41 National Audit Office, *The Procurement of Consumables by NHS Acute and Foundation Trusts,* February 2011.
42 Monitor, *Closing the NHS Funding Gap: How to Get Better Value Health Care for Patients,* 2013; Crispin Dowler, "Carter to Unveil Hospital Efficiency 'Index,'" *Health Service Journal*, 7 June 2015.
43 Ibid.
44 Corrie and Finch, *Expert Patients.*
45 Frontier Economics, *Exploring the Costs of Unsafe Care in the NHS,* October 2014.
46 Porter and Lee, "The Strategy That Will Fix Health Care."
47 Department of Health, *Better Procurement Better Value Better Care: A Procurement Development Programme for the NHS,* August 2013.
48 National Audit Office, *Adult Social Care in England: Overview*.
49 Local Government Association, *Adult Social Care Funding: 2014 State of the Nation Report*.
50 Steffan Torp, Elizabeth Hanson, Solveig Hauge, Ingun Ulstein and Lennart Magnusson, "A Pilot Study of How Information and Communication Technology May Contribute to Health Promotion among Elderly Spousal Carers in Norway"; *Health and Social Care in the Community,* Vol. 16, No. 1 (2008). ADASS, *ADASS Budget Survey Report 2014: Final*, July 2014.

charge for GP appointments and half charge for elements of hospital care.[51] By contrast, the OECD has noted that NHS patients benefit from an "especially high level of financial protection from the consequences of illness".[52]

Making greater use of private payment in the NHS could raise additional revenue and help manage demand on services. By introducing a financial charge, patients would be incentivised to use services more responsibly and to demand a more responsive, consumer friendly service in return. A survey commissioned by HealthWatch England found that nearly a fifth of people admitted to using A&E for a non-emergency issue while 20 per cent of GP appointments are taken up by minor ailments, such as the common cold.[53] While many have raised concerns that charging could deter those in genuine need from seeking medical help, robust exemptions as exist in other health systems can ensure that those needing advice are not wrongly deterred. For those with long-term conditions who would regularly use services, costs could be capped by a quarterly or annual limit, as the Prescription Prepayment Certificate currently does.

Changes to the level and base of prescription charges would be the simplest and most immediate reform to charging in the NHS. In the UK, approximately 60 per cent of the population is exempt from prescription charges and 9 in 10 prescriptions are dispensed free of charge. Not only does this raise little in the way of revenue but it is fundamentally inequitable; nearly 60 per cent of drugs are dispensed free to people over the age of 60 regardless of income.[54] As in other countries, policymakers could go on to examine the case for charges in primary and then secondary care. Some NHS services provided at the end of life could be subject to the same package of means-tested support used for social care to integrate those services.

Table 3: Summary of options for reform (2013 calculations)
Source: Cawston and Corrie (2013), *The cost of our health.*

Reform	Additional revenue
Reform to prescription charges	£124 million to £1.4 billion
£10 flat rate charge for GP consultations	£1.2 billion
£10 daily "hotel" charge for overnight hospital stays	£96 million to £193 million
£10 fine for missed outpatient hospital appointments	£55 million

Recommendation

The Government should raise the level of the prescription charge and reform exemptions. It should go on to consider charges for parts of primary and secondary care.

Social care

Containing social care spending as demand rises and costs grow means a balance between public and private contributions will have to continue. In the first instance, this means prioritising public resources towards a smaller cohort of people with the highest needs and the lowest means. This is far from unusual, with coverage being increasingly targeted towards health, nursing care and personal care and away from domestic care and practice help across the OECD.[55] It is important, however, that a range preventative services also continue to be delivered by local authorities to prevent the escalation of lower care needs.

51 Thomas Cawston and Cathy Corrie, *The Cost of Our Health: The Role of Charging in Healthcare*, November 2013.
52 Peter Smith and Maria Goddard, *The English National Health Service: An Economic Health Check*, July 2009.
53 HealthWatch, "Nearly a Fifth Confess to Knowingly Using A&E for Non-Emergencies," 4 March 2014; Gareth Iacobucci, "Fifth of Appointments Wasted on 'Worried Well', Leading GPs Warn," *Pulse*, 16 March 2010.
54 Health & Social Care Information Centre, *Prescriptions Dispensed in the Community: England 2002-12*, July 2013.
55 OECD, *Help Wanted? Providing and Paying for Long-Term Care*, May 2011.

Secondly, it should mean that housing assets play a part in funding long-term care.[56] The Dilnot Commission into the funding of social care sought to protect individuals from having to sell their home in the face of high care costs, regardless of their means.[57] This is unsustainable and inequitable. The value of housing wealth owned by people over the State Pension Age could increase by 40 per cent from £907 billion in 2009 to £1.3 trillion by 2030 (in 2009 prices).[58] Moreover much of this value has been unearned, with windfall gains from house price increases much greater than earnings or wider economic growth. The effect of the Care Act, which implemented many of Dilnot's recommendations, will therefore be to disproportionately benefit the better off; levying younger workers faced with an unfavourable housing market rather than asking elderly cohorts to contribute to the costs of care out of housing assets in order to address the growing funding shortfall.[59] This is neither inclusive nor sustainable.

Unlocking the housing assets held by older people will require an effective equity release market. People need to be able to use their assets to help pay for the cost of their social care, and to release money to adapt their homes (thus staying in their homes longer) and to support their incomes. While local authorities recognise the need for elderly people to be able to downsize their homes into suitable properties to remain independent at home for as long as possible, the housing stock is out of sync with this growing need.[60] This has knock on benefits for services. Providing adaptations to support an older person to remain at home for just one year, for example, can save £28,000 on long-term care costs and help prevent hospital readmission.[61] Yet while some schemes exist they are little used. Currently only 8 per cent of people who take out equity release use it to pay for long-term care.[62]

Recommendation

The Government should maintain means testing of long-term care funding and draw on housing assets, as well as income, to support this.

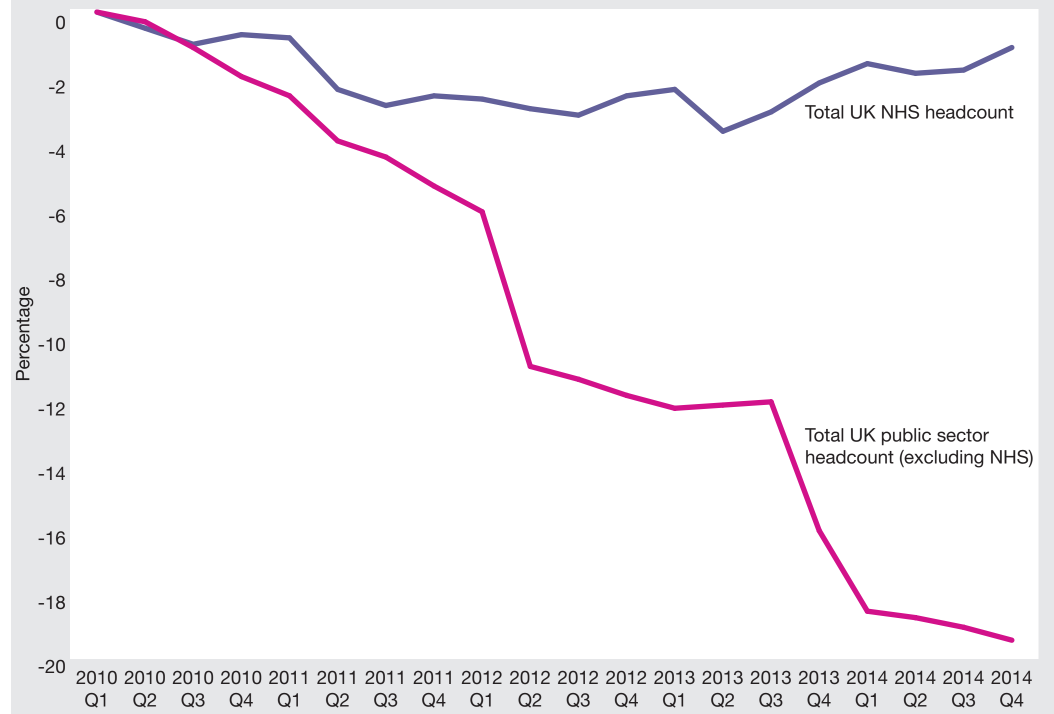
4. Priorities for the Government

The *5YFV* offers a radical vision of reform to address the financial and quality challenge through new more integrated models of care, a "radical upgrade" in prevention and public health, engaging patients in their care, and raising efficiency across the system. The challenge now is one of swift and successful implementation. Above all this means unprecedented change for the health workforce.

There can be no sustainable NHS without a more productive workforce. The workforce is the largest cost to the health service, accounting for half the budget and two thirds of provider expenditure.[63] Recent years have seen unprecedented growth in numbers, with headcount rising by almost a third from 2000 to 2010.[64] While at the start of the last Parliament numbers began to fall, in the wake of the 2012 Francis Inquiry and concerns around quality of care this trend reversed. Between 2012 and 2014 the workforce grew by 2.2 per cent, in stark contrast to the rest of the public sector.[65] This is the principal factor behind the rapid deterioration in hospital finances.[66]

56 Partick Nolan, Lauren Thorpe and Kimberley Trewhitt, *Entitlement Reform*, November 2012.
57 Dilnot Commission, *Fairer Care Funding: The Report of the Commission on Funding of Care and Support*, July 2011.
58 Pensions Policy Institute, *Retirement Income and Assets: How Can Housing Support Retirement?*, 2009.
59 House of Lords Select Committee on Public Service and Demographic Change, *Ready for Ageing?*, March 2013.
60 All Party Parliamentary Group on Housing and Care for Older People, *Living Well at Home Inquiry,* July 2011.
61 LaingBuisson, *Care of Elderly People: UK Market Survey 2008*, 2008.
62 Patrick Nolan, *You're a Long Time Retired: Making the Most of Financial and Housing Assets at Retirement*, 2013.
63 Corrie and Mosseri-Marlio, *Progress on NHS Reform*; Lafond, Charlesworth and Roberts, *Hospital Finances and Productivity*.
64 Office for National Statistics, *Public Sector Employment, Q4 2014*.
65 Health and Social Care Information Centre, *NHS Workforce Statistics in England, Summary of Staff in the NHS: 2004-2014, Overview*, March 2015.
66 Lafond, Charlesworth and Roberts, *Hospital Finances and Productivity.*

Figure 4: Percentage change in total public sector and NHS workforces, 2010-2014
Source: Office for National Statistics (2015), *Public Sector Employment, Q4 2014; Reform* calculations.



Better quality care for patients will require "professionals to work in new ways."[67] The majority of clinical professionals continue to work in acute hospitals, with hospital consultants increasing around three times faster than GPs. Community based professionals and those working in areas such as learning disabilities and mental health are scarce.[68] Current terms and conditions have disincentivised out of hours working to the detriment of patients. The shift towards integrated delivery and seven day working means that traditional job roles and inflexible contracts will have to be challenged.

International health systems with workforce shortages have shown how changing the skill mix of the workforce can dramatically improve quality and value for money.[69] Hospitals such as Salford Royal NHS Foundation Trust have raised quality, improved financial performance and raised staff engagement through rigorous performance management and linking pay increments to performance.[70] Achieving this kind of reform to the workforce will be key to unlocking a high value NHS.

Recommendation

The Government should reverse rising workforce numbers by improving the productivity of existing staff. It should challenge traditional job roles and terms and conditions to ensure staff have the right skills in the right place for patients.

67 NHS England, *Integrated Care and Support Pioneer Programme: Annual Report 2014*, 2015.
68 NHS England, *Five Year Forward View*.
69 Cawston, *Aravind Eye Care Case Study: High Volume, Specialist Eye Care in India*, 2013.
70 Thomas Cawston, Andrew Haldenby and Nick Seddon, *Doctors and Nurses*, November 2012.

5. Conclusion

Reforming the NHS and social care is one of the defining challenges for the new Government. An ageing population and the rising cost of care is stretching budgets to their limits. In the long term it is the most significant threat to the sustainability of the public finances. The temptation remains for governments to pledge more 'inputs', whether more doctors or more money. What really matters to the wellbeing of current and future patients, however, is changing the service to deliver better outcomes and doing so at the lowest possible cost. This should mean a health and care service coordinated around empowered patients, focused on preventing illness as well as treating it. It should mean a radical new push on productivity and an honest conversation about the sustainability and equity of the financial foundations of the service. Flexibility as to who delivers these better value services should be encouraged.

In his first speech on NHS reform this Parliament, the Prime Minister recognised this need for high value care. Future success, he argued, cannot just depend on additional investment: "in return the NHS must step up. There is no choice between efficiency savings and quality of care."[71] This will mean difficult changes, most of all for the NHS employees whose actions, terms and conditions determine what the service can achieve. Last Parliament departments such as the Home Office demonstrated that better services could be delivered for less. The NHS and social care must now follow suit.

71 David Cameron, "Plans for a seven-day NHS," 18 May 2015.