REFORM

NHS reform at pace and scale

One Birdcage Walk
Westminster
London
SW1H 9JJ

Thursday 9 March 2017
08.30 for 09.00 – 12.40

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Contents

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Programme

08.30 – 09.00	Registration and breakfast	
09.00 – 09.10	Welcome and introduction	**Andrew Haldenby, Director, *Reform***
09.10 – 09.40	Keynote speech	The Rt Hon Jeremy Hunt MP, Secretary of State for Health, will deliver the keynote speech.
09.40 – 10.30	Panel one: Sustainability and Transformation Plans	The NHS is rethinking the way it delivers healthcare to citizens. The *Five Year Forward View* set forth plans to drive improvements in health and social care; restore and maintain financial balance and deliver quality standards. The vehicle for delivery are the Sustainability and Transformation plans. These represent an integrated approach whereby the local NHS and its partners make plans in line with national guidance but based around local need. This panel will explore the most innovative ideas and examples of best practice. **Jane Milligan, Lead, North East London STP and Chief Officer, Tower Hamlets Clinical Commissioning Group** **Dr Wendy Thomson, Lead, Norfolk and Waveney STP and Chief Executive of Norfolk County Council** **Dr Nigel Fraser, Chairman, Taurus Healthcare** **Nicola Sturt, Market Access Director, Baxter Healthcare** **Chair: Dr Kate Laycock, Researcher, *Reform***
10.30 – 10.50	Coffee break	
10.50 – 11.40	Panel two: Workplace health	In 2002, the Wanless Report suggested that the NHS could save tens of billions of pounds per year if it delivered better health prevention and public health. Dame Carol Black's work since then has emphasised the importance of workplace health. There are contradictions in the Government's policy at present. The *Five Year Forward View* spoke of financial incentives for employers. Recent increases in insurance premium tax may increase the cost of health products. This panel will consider how best the Government and employers should approach workplace health in both the public and private sector. **Professor Dame Carol Black DBE, Expert Adviser on Health and Work, Department of Health** **Danny Mortimer, Chief Executive, NHS Employers** **Professor Abhinay Muthoo, Professor of Economics at the University of Warwick and Dean of *Warwick in London*** **Mark Hamson, Managing Director, Corporate and Consumer, Simplyhealth** **Chair: Andrew Haldenby, Director, *Reform***
11.40 – 12.30	Panel three: Better care for less	The *Five Year Forward View* rightly argued that the NHS should become much more efficient, to deliver both new care models and financial sustainability. Very often, delivering "efficiency" actually means improving quality, for example through standardisation of process or though the greater access that follows from better utilisation of equipment. This panel will highlight examples of successful efficiency improvement in the UK and Continental Europe. Speakers will address the challenge of creating a value-for-money culture in health organisations. **Lord Carter of Coles, Non-Executive Director, NHS Improvement** **Sir David Dalton, Chief Executive Officer, Salford Royal NHS Foundation Hospital** **Dr Penelope Dash, Senior Partner, McKinsey & Company** **Dr Rowland Illing, Chief Medical Officer, Affidea** **Chair: Alexander Hitchcock, Senior Researcher, *Reform***
12.30 – 12.40	Closing remarks	**Andrew Haldenby, Director, *Reform***

The *Reform* team: setting the agenda

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After the so-called NHS "winter crisis", it may seem strange to say this, but I am more optimistic about the progress of health reform than at any time during *Reform*'s 15 years so far.

Interviewed in February, Jeremy Hunt rightly said that the solution to the problems of overcrowded hospitals is the Government's "plan", as he called it. The existence of the *Five Year Forward View*, and the breadth of its vision, is itself a great cause of hope. The NHS remains committed to a thorough reboot, shifting its centre of gravity away from acute hospitals towards much stronger community and primary care (and indeed care delivered online).

A great deal depends on the 44 Sustainability and Transformation Plans (STPs) being drawn up across England to deliver the *Five Year Forward View*. As recent *Reform* research showed, STPs have successfully led to new conversations between the different parts of the NHS and between the NHS and local authorities. They are taking forward existing plans to reshape services. The remaining question, for the first panel of this conference to discuss, is how to help STPs deliver the scale of reform envisaged in the *Five Year Forward View* before the end of this Parliament. That debate should include ideas to give STPs more executive power, even to the extent of giving them democratic legitimacy through elections.

The *Forward View* rightly argued that prevention should be at the heart of the new NHS. The second panel will present ideas on the one of the most important contributions to prevention, via greater efforts by employers to promote the wellness of their own staff. Employees would benefit, together with employers (through greater productivity), together with taxpayers. The NHS can lead the way in this respect because it is the UK's biggest employer by far. A matter for discussion is how Government can support greater employee and employer activity. The *Forward View* spoke of "financial incentives", which could suggest tax relief to encourage employers. Such a programme may need, however, to avoid the "deadweight" cost of supporting employers who are providing for their staff already.

Value for money lies at the heart of the reform agenda. The Service remains committed to £22 billion of annual efficiency gains, to be achieved by 2020-21. Lord Carter of Coles has done so much to promote thinking on efficiency and I am delighted that we can engage with him on our final panel.

Some have called on the Government to supply emergency funds in the forthcoming Budget, but there is little reason to think such an idea will make a lasting difference. George Osborne provided emergency funds twice, in 2014 and again the following year. For the second of those, the Chancellor front-loaded the NHS spending increases for this Parliament, so that it received £3.8 billion extra in the current financial year. That very big increase did nothing to prevent the problems that have dominated the headlines at the start of this year.

The current Government is right to stick to its reform plan. Today's conference aims to help it deliver.

Andrew Haldenby
Director, Reform
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Keynote speech by Rt Hon Jeremy Hunt MP

Rt Hon Jeremy Hunt MP

Next year, the NHS will be 70. But the need for change and reform in the present day is every bit as urgent as ever.

My mission since becoming Health Secretary has been to change the fabric of the NHS to make it more open and transparent, and ultimately to help staff deliver the safest, highest-quality healthcare in the world.

This is about addressing the shocking conclusions of Robert Francis's Inquiry into Mid-Staffs, and is ingrained in the clinical imperative 'first, do no harm'. But it's also – in my view – the only route to long-term stability for the NHS.

Why do I say this?

Well, I look first at international studies, which show that 3.6 per cent of all deaths are avoidable in advanced nations, and that the equivalent of one in every five pounds spent is not used effectively in healthcare settings.

We have to assume the NHS is no different – indeed this is a point reinforced by Lord Carter's world-leading work on efficiency. We also know that variation in clinical practice is one of the big areas where we can make progress and save money.

In the acute sector, bed sores in hospital cost £2,500 on average per patient; someone falling in hospital adds a further £1,200 per case. All of these are avoidable errors, and so avoidable costs.

In primary care, we find a several-hundred-fold variation in the rate GPs refer patients for some diagnostics tests, and rates of elective tonsillectomies range from about 150 to around 400 per 100,000 young people. That cannot be right.

Furthermore, we know what good looks like. The Sepsis Six bundle, for instance, is bringing consistency and focus to how sepsis cases are identified and treated, showing that safer practices, when applied systematically, can transform outcomes and associated costs.

The challenge therefore is to establish best practice at a new scale.

That's why we're opening the new Healthcare Safety Investigation Branch from April. Modelled on the airline industry's pioneering approach to safety monitoring, it will help us capture and apply the lessons from mistakes made within the NHS in a more systematic way.

And it's also why I want hospital trusts to publish their avoidable-death figures later in the year – this will mark another step change in openness, encouraging the transparent and critical exchange of insights and analysis that is the hallmark of every industry that "does" safety well.

Most importantly of all though, this shared reform mission is why the NHS's best years lie ahead.

Rt Hon Jeremy Hunt MP
Secretary of State for Health
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Sustainability and Transformation Plans

Reform comment

Current ambitions for NHS reform rest on the success of Sustainability and Transformation Plans (STPs). The 44 STPs covering the whole of England are the main delivery vehicle for the *Five Year Forward View*, which aims to strengthen prevention and primary care, develop new care models that reduce the burden on acute hospitals and deliver much better value for money. These changes are also needed to deliver the financial targets agreed by NHS England i.e. to achieve £22 billion in efficiency savings by 2020-21, thereby needing no additional financial support from the taxpayer.

The idea of STPs is that local health economies, rather than individual NHS organisations, are best placed to decide together how to reform health and social care in their areas. STPs will encompass all health bodies – primary, secondary, tertiary, mental-health providers and commissioners – and also local authorities, who are responsible for social-care and public-health provision.

STPs should enable these different organisations to look beyond a 'fortress mentality', in which each acts in its own self-interest rather than in the wider population interest.

Many of the best examples of integrated practice come from areas with a long history of working together. Manchester, for instance, has all but joined up health and social-care spending and some regions have detailed memorandums of understanding to enable streamlined integrated working.

STPs are the right idea but as the recent *Reform* report, *Saving STPs*, outlined, they are unlikely to succeed within current constraints. Progress has been stifled by a lack of buy-in from local authorities, clinicians, the public and politicians. The fragmented payment systems across the NHS and social care prevent organisations working together, and STPs lack the executive authority needed to drive change.

The paper recommends that to save STPs, and their reform programme, Ministers should give them full control of the total NHS and social-care budget in their area. A single body in each STP area should commission all health and social care. In due course STP leaders should be locally elected in order to secure local buy-in for its proposals for change.

Kate Laycock
Researcher, Reform
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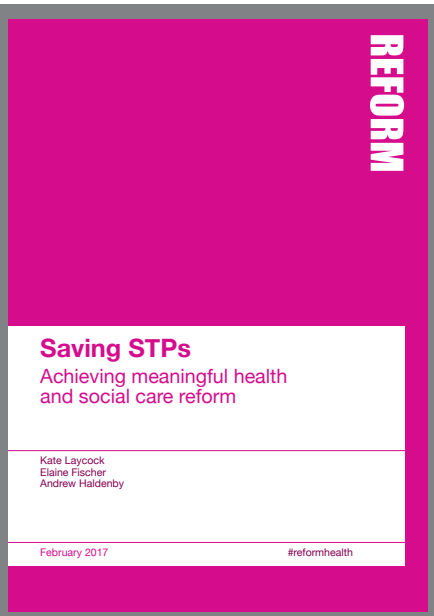
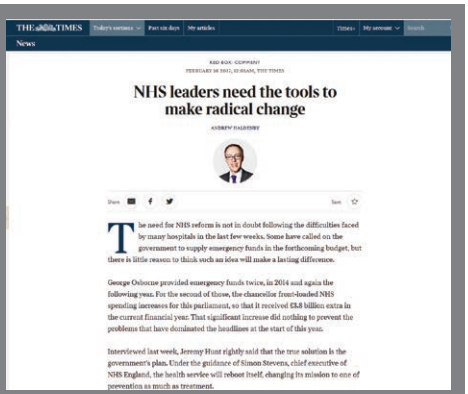
"If STPs fail to engage the public, politicians and those working within the health and social care sector, their work will be in vain" ***Saving STPs: achieving meaningful health and social care reform,*** **February 2017**

"In the medium term, a locally elected STP leader should take responsibility for the budget, whether a healthcare commissioner or a metro mayor" **Andrew Haldenby writing in *The Times,* February 2017**





Jane Milligan

North-east London is calling out for a new approach to health and social care to meet the increasingly complex needs of residents. Population growth of 18 per cent in the next decade, and more elderly and very young people, in an area which has some of the highest deprivation in the country, are providing unique challenges for services.

Our focus, in the STP for north-east London, is to develop strategic partnerships which enable us to utilise the resources we have to the maximum, as well as developing new approaches of delivering care that will be more tailored to the people we serve.

Access is too often through A&E, at a point of crisis. This is inconvenient for patients. It also ignores the value of people's homes: accessing care in a crisis through A&E means our solutions tend to be too much about providing care around a few hundred hospital beds, rather than care around the one-and-a-half-million beds in people's homes. The front door to the system should be people's own front doors, using digital technology and more self-care support to prevent crisis and maintain independence.

Working in this way also gives more autonomy to staff and releases them to innovate and provide whole-person care. Multi-disciplinary teams across health and social care, supported by the voluntary sector and our strong local communities can deliver this care. This provides new challenges and opportunities for the NHS's committed staff, who can work to outcomes, rather than following outdated processes. New training opportunities, roles and inventive ways of working will present themselves.

This will not happen through the will of one or two hospitals, however: the whole system needs to act. Fragmented commissioning processes currently prevent organisations from coming together to meet the multiple needs of patients with long-term conditions, who use different parts of the healthcare system to get help and treatment. The role of STPs is to change this – providing system-wide leadership, rather than working with an individual organisation focus.

One way to bring providers together is a place-based accountable care system. This supports self-care of long-term conditions and the delivery of care where it is most effective. Three areas in London are starting to do this: City and Hackney; Waltham Forest, Newham and Tower Hamlets; Barking and Dagenham, Havering and Redbridge.

The ambition for integration should not stop at health and social care. Improving the wellbeing of citizens in north-east London (as well as any area in the country) requires health providers, boroughs and commissioners to work in a collaborative way with housing associations, the voluntary sector and local businesses.

Creating shared ownership and accountability for the delivery of care to deliver outcomes and incentivise collaboration is key; it will require roles and skills that span organisations and existing governance arrangements. We need to give people the space, tools and skills to help this and to do that we need to hold us all to account.

Jane Milligan
Lead, North East London STP and Chief Officer, Tower Hamlets Clinical Commissioning Group
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Nicola Sturt

The NHS is at a critical stage of reform. To achieve the £22 billion efficiency savings highlighted in the *Five Year Forward View* by 2020, momentum to drive new models of care needs to gain pace. With NHS demand growing by 4 per cent and current funding growth at 1 per cent, NHS organisations are under ever-increasing pressure to reduce costs. This is set against an ageing demographic and rising trend in prevalence of co-morbidities causing NHS costs to increase further.

The Sustainability and Transformation plans (STPs) are a key part of delivering the changes necessary for a sustainable future but implementing them can only be achieved if government, the NHS, the third-sector, industry and patients shift their thinking and work collaboratively. Difficult discussions are needed and re-configuring services has to happen. Doing things the way we do today simply is not possible.

We can only make the radical changes required to ensure the NHS is a world-leading organisation if, at the same time as commissioning new care pathways, we have courage to de-commission services that aren't fit for purpose to free up capacity.

Out-of-hospital care offers significant opportunities for efficiency savings and improving quality and safety of care. Home therapies can empower patients to take control of treatment, drawing on clinical and other support to assist their choices. However budgetary silos between different NHS organisations and local government are barriers to increasing out-of-hospital care. A joined-up, system-wide budgeting model must permit longer-term settlements for new treatment pathways – benefits of which may be realised over several years, but require initial investment. This can only happen where STPs are accompanied by an appropriate reimbursement system and alignment between commissioning and provider incentives.

Partnership working is important when working towards a shared goal of making the NHS a world-leading organisation. We are at the start of a difficult journey, but challenges can be overcome if we adopt a fresh approach to working collaboratively. Baxter Healthcare is a leading supplier of products and services to the NHS, supporting patients at all stages, from hospital admission to managing a long-term condition at home. We see ourselves as an integral partner to the NHS. We work with clinicians and patients to share our expertise on how to integrate and change patient pathways, driving efficiencies and improving outcomes.

There are examples of how Baxter can help deliver the NHS's out-of-hospital agenda, as set out in the *Five Year Forward View* and articulated in many STPs. An outpatient parenteral antimicrobial therapy (OPAT) service we set up, in partnership with St. George's NHS Healthcare Trust, enabling a carefully selected group of patients to receive intravenous antibiotics at home, has saved up to 2,700 bed days. OPAT reduces the length of hospital stays and allows patients to continue treatment at home, avoiding unnecessary hospital trips. In some cases, it can eliminate the need for hospitalisation. Baxter provides home delivery of medication, support to train patients to self-care, or nurses to infuse the drug as required.

Renal dialysis is another example where product innovation supports treatment at home, offering patients better clinical outcomes and improved quality of life. Baxter's cloud-based communication platform connects home dialysis devices to Renal Units enabling clinicians to monitor and manage patients daily. This simple technology has the potential to increase both patients' and clinicians' confidence in home treatment and reduce avoidable and costly hospital visits.

Nicola Sturt
Market Access Director, Baxter Healthcare
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Workplace health

Reform comment

Permanently reducing the stubbornly high incapacity-related benefit caseload – currently around 2.5 million people – means addressing the flow of people falling out of work due to ill-health or disability. With less than one per cent of claimants leaving Employment and Support Allowance (ESA) in any given month, the need for early intervention to prevent others from facing years trapped on benefits is clear. And since more than half of ESA claimants flow on to the benefit from employment, the workplace is the obvious place to start.

The business case for employers is also strong: improving health in the workplace would reduce the cost of sickness absence and recruitment, and increase engagement and productivity. Whilst there is evidence to suggest employers are concerned about the cost of workplace adjustments, the average cost is estimated to be just £75 per person. Employer-led occupational health provision and workplace adjustments are a sound investment.

Whilst the benefits of improving health in the workplace are clear, the Government's role in enabling this is more complex. Reform to Access to Work – by increasing awareness, efficiency and the ease with which employees can move their grant and equipment between employers – would be a quick win. Requiring more of businesses that are part of the Disability Confident campaign and setting an example by improving workplace adjustments in the public sector are other good places to start. Effectively disseminating good practice and overcoming more systemic issues of stigma and discrimination must ultimately, however, be driven from within businesses themselves.

Ben Dobson
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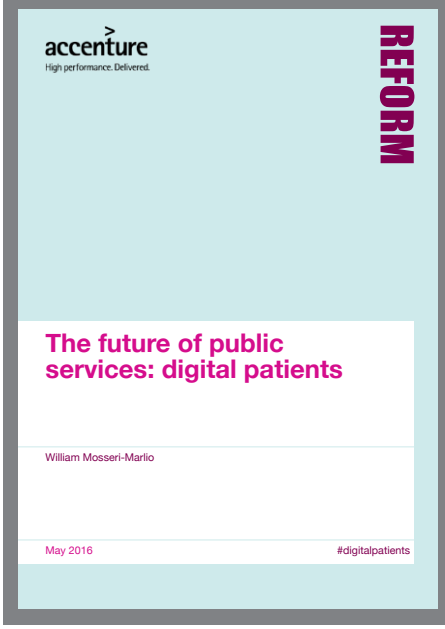

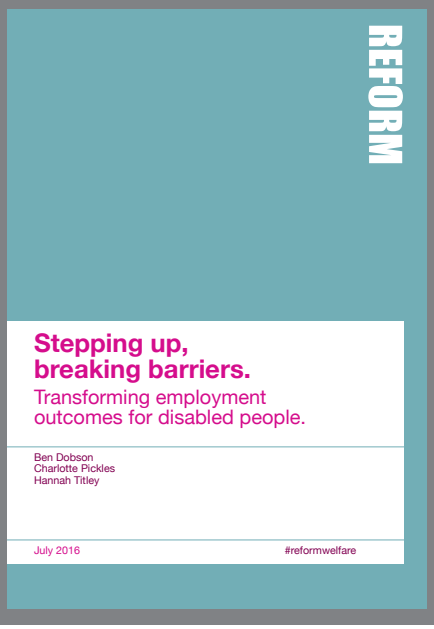

"The use of health apps in the UK more than doubled between 2014 and 2016; for wearables, usage tripled."
The future of public services: digital patients, May 2016

"Studies have also shown that retaining people who have become disabled, may be more cost effective than recruiting and training a new employee to the position."
Stepping up, breaking barriers. Transforming employment outcomes for disabled people, July 2016

Professor Dame Carol Black DBE

How do we maintain fulfilling and productive working lives in the face of ill-health or disability? The question covers the whole of working life – preparation for and entering work, support when sickness or injury supervene, return to work, and sustaining working life despite impaired heath – and is relevant for an ageing workforce.

Underlying the question is the conviction that everyone benefits from safeguarding the health of working-age people, and supporting them when they are not wholly fit.

This brings responsibilities to many agencies – in public health, in healthcare, in social care and other local-authority activities, on those who administer the system of welfare, and on employers. It places on individuals a personal responsibility for protecting and improving their health as far as they can.

There is a growing realisation of the need to support people in a personalised way as they enter and move through the health, social-care, welfare, and employment systems. This thought runs through *Improving Lives* – the recent work, health and disability Green Paper.

We now have a better appreciation of the impact of health conditions on the way we function in daily life. We also recognise the importance of appropriate work to maintaining health and wellbeing.

Importantly, these aspects have come to be accepted by health professionals as essential elements of clinical practice. That is why the fit note is important. Unlike the sick note that it replaces, the fit note gives a new emphasis to what someone who is not wholly fit can do if sufficiently supported and motivated. It offers an early opportunity to advise patient and employer on the ways to recovery, rehabilitation and return to work. Regrettably, I have to say that the potential of the fit note has yet to be realised.

Mental health is probably the most important – though often hidden – factor underlying sickness and disability. It is a major factor in continuing to work even when unwell.

Although factors outside the workplace come to bear on mental health, often before working age, it is clear that the working environment has a major impact.

A welcome shift in thinking has brought a much-needed emphasis on seeing physical and mental, not as separate domains, but as inseparable parts of health. Although common mental-health problems may exist alone, often they compound the effects of long-term physical conditions.

There is also fuller recognition of the fact that many common disorders fluctuate in their expression and impact. This is difficult to explain to employers. It may be even more difficult for employers to appreciate the impact and the kinds of accommodation that might be necessary to enable the employee to perform at their best.

It is almost expected that, as people age, long-term work-limiting conditions will develop. Experience shows that with the right support and sufficient workplace adaptation, most can maintain sustained and fulfilling work.

Naturally, employers seek to ease the burdens and costs of impaired health. Each organisation has a role in protecting and nurturing the health of its employees – to develop, one might say, a culture of health. Placing the employee at the heart of an organisation is key. It falls to the leading figures in the organisation to ensure this happens.

Professor Dame Carol Black DBE
Expert Advisor for Health and Work, Department of Health
@DameCarolBlack

Danny Mortimer

Health is not a simple linear entity – so many things can affect it. Any of us who have tried to keep a healthy lifestyle will know that it is a delicate balance of multiple things and that this balance changes. The same can be said when considering workplace health. If we see the workplace as a system, and consider how this system can be used to support the health of employees, we can address the areas where we should be taking action to achieve maximum impact.

The case for this focus on health in the workplace has been clearly stated by Dame Carol Black and others, and it is clearly in the interests of employers to ensure that employees are as productive as possible. In the NHS, we understand two benefits in particular. Firstly, our definition of productivity includes the outcomes and experience of those we care for. Secondly, we also understand that work is itself a benefit to health. We rightly focus on how our workplaces can carry risks to health, but we need to do much more to emphasise the real benefits that work brings to the health of individuals and communities. For healthcare, that brings the additional benefit of improving public health and reducing some of the demand for our services in the longer term.

Returning to our workplaces, we have identified a number of key success factors during our work in this area. Employers need to have the right infrastructure in place: good occupational health, interventions to support mental and physical-health issues – in particular, musculoskeletal problems. Employers need to look at their local needs, whether based on public-health data or analysis of the workforce's health data. This allows them to add interventions that are based on local needs – what is right for south-west London may not be what is needed in rural Suffolk. These interventions then complement the traditional performance management of absence, to instead focus on attendance and productivity.

However, none of this will work without two essential enablers: senior leadership and competent and confident line management. Senior leaders who invest time and resources in workplace health provide legitimacy for others in the organisation to engage with health in the workplace. Confident and competent line managers facilitate the local conversations about health, they know their staff and can engage in personal conversations, make links with what is important to their teams and, crucially, enable access to interventions.

Danny Mortimer
Chief Executive, NHS Employers
@NHSE_Danny

Mark Hamson

The NHS is facing a crisis. Unable to cope with the demands of an ageing population, critical and emergency care is not being delivered as quickly as necessary. We need long-term solutions to the current funding issues that will ensure the provision of sustainable and effective healthcare, and the role employers can play in this must not be underestimated.

Simplyhealth's health plans enable individuals across the UK to make regular contributions to a fund to cover the costs of their everyday healthcare, which includes dental treatment, optical treatment, podiatry and physiotherapy. Essentially, we help approximately 1.3 million people to receive the everyday healthcare they need, when they need it, to prevent the development of more serious conditions that could require increasingly complex treatment at the expense of the NHS.

Health plans are optional purchases that empower individuals to take responsibility for their everyday health. Unlike Private Medical Insurance (PMI), we do not discriminate against applicants on the grounds of their medical history, and our premiums tend to be much cheaper, making everyday healthcare affordable for more people. It is not surprising that many of our customers are employers who appreciate the importance of safeguarding their employees' health. This should be encouraged. Our work with the Chartered Institute of Personnel and Development (CIPD) confirmed that employers play a vital role in ensuring the physical and mental health of their employees, and that timely workplace interventions can promote wellbeing and reduce absenteeism. Workplace health plans give employers an extra level of security and reassurance, providing them with the financial means to seek specialised health solutions immediately when needed.

Unfortunately, the Government's approach to Insurance Premium Tax (IPT) – a tax applied to insurance products – is threatening the purchase and retention of everyday health cover, by causing the cost of monthly premiums to rise. When the increase announced in last year's Autumn Statement comes into effect this June, IPT will have doubled to 12 per cent in less than two years. As prices increase, individuals and employers will be forced to reassess whether they can afford to keep, or buy, health plans. Individuals who are "just about managing" will arguably be priced out of the everyday health funding market despite their willingness to take responsibility for their own health. This will inevitably result in lower take-up and cancellations of plans, with increasing numbers of people having no option but to call on the already struggling NHS for their everyday health treatment. We may see a rise in sickness-related work absences as employees are denied timely treatment.

The *Five Year Forward View* highlighted the need to incentivise employers to promote good workplace health, and spoke of how greater preventative care could limit the development of avoidable illnesses. Health plans can help with the achievement of these aims and alleviate pressures on the NHS. Whilst the Government is candid about its use of IPT as a revenue-raiser, this strategy is short-sighted and fails to recognise the benefits of widening the accessibility of everyday healthcare. Instead of increasing costs, the Government should exempt everyday health cover from IPT so it is more widely affordable. Encouraging employers to offer health plans to their employees could reduce sickness-related work absences and NHS footfall, resulting in a healthier workforce and the development of a sustainable NHS that can comfortably meet demand.

Mark Hamson
Managing Director, Corporate and Consumer, Simplyhealth
@simplyhealthUK

Better care for less

Reform comment

Innovation is never easy; it's hardest when people's lives are at stake. But it is now the only option for the NHS. A population that is living longer, but not necessarily healthier, lives will push public spending to unsustainable levels. Jeremy Hunt has rightly called for a "revolution" in the way healthcare is delivered.

Revolution entails a break from the 1948 model of care. People with chronic conditions should receive care in the community or at home, not hospitals. Large primary-care providers – with patient lists of over 10 times the size of the current average – can deliver outpatient appointments and encourage self-management of conditions such as diabetes. Even those with emergency needs should stay out of A&E: urgent-care centres in new GP practices can save over £1 billion a year if applied nationwide. This is much more convenient and will allow ministers to focus on health outcomes, not waiting times.

New technology can facilitate this new model. Triaging apps on smartphones can provide advice for over 60 million GP appointments used by the 'worried well'. Video calls with clinicians are more convenient for patients, and 40 per cent quicker than face-to-face meetings, excluding waiting times. This can free time for clinicians to devote to those who would otherwise go to A&E – saving £600 million a year.

Accompanying this should be a new way to use the workforce. Using apps and online booking could replace the need for up to 24,000 GP receptionists, whilst 90,000 administrator roles could be automated in secondary care. Clinical staff can be used in more effective ways. Pharmacists and nurses are best placed to provide care for the 56 million GP appointments conducted for minor ailments. This simple switch would save over £700 million a year alone.

This represents not just a quickening of current processes, but a new culture of care: one that focuses on delivering better care for less. This is the innovation the NHS needs. Vive Hunt's revolution.

Alexander Hitchcock
Senior Researcher, Reform
@AlexJHitchcock
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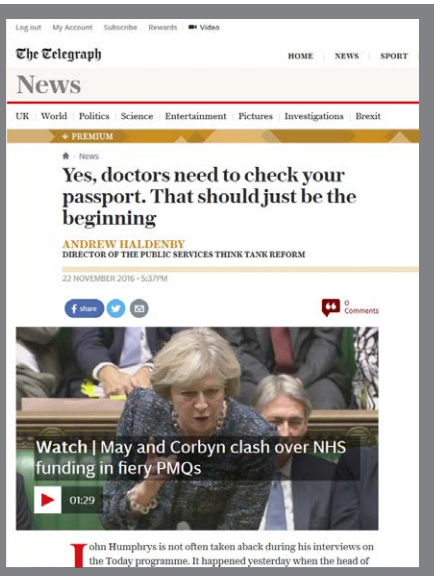
"While it may be controversial to some in politics, NHS leaders see their partnerships with external organisations from the independent sector as integral to their mission. They are a means to the end: better patient care."
Delivering the 2015 Spending Review objective of successful NHS partnerships with the private sector, June 2016

"Even after years of tight budgets, the NHS rarely behaves as if every pound matters"
Andrew Haldenby writing in *The Telegraph*, November 2016



Sir David Dalton

Quality, safety and reliability of services must be our organising principles. Yet delivering reliable services requires us to standardise the evidence of best practice and then organise to deliver this at scale. This is unlikely to happen whilst we have 238 trusts self-determining their own strategy for their limited catchment area. Inertia prevails when provider interests are put ahead of the interests of the population they should serve. New provider governance arrangements are described in the Dalton Review – such as single shared services, joint ventures, integrated-care organisations and groups/chains. Operating these arrangements at scale (c.1-million plus) allows a single system of governance for strategic decision-making and asset management to assure delivery of standards through pooling a service-line workforce across multiple sites.

We have a shortage of high-quality strategic leaders. I strongly advocate the development of groups/chains of providers where each provider in a group takes responsibility for delivering operational excellence and the group takes responsibility for three functions: strategic change, development of standardised systems and pathways and asset renewal. The benefits of scale will not be delivered quickly enough by current trust CEOs trying to reach mutual agreements amongst themselves.

Likewise, Clinical Commissioning Groups' (CCGs) responsibility for commissioning hospital services should be unified rapidly to commission for a c.1-million population and single-service commissions should be given for multiple providers covering a STP population footprint. The number of CCGs should reduce significantly.

Better care and improved outcomes have been delivered from consolidating cancer surgery, trauma and stroke care into regional centres. But the job has only just started: we should quickly consolidate inpatient surgery, especially high-risk surgery, into single surgical centres serving c.1-million populations with full 24/7 consultant access. Minimising the need for 'out-of-hours' surgical and anaesthetic presence at local hospitals will provide economic and outcome benefits.

We need to find a means that allows a capital spend over the next decade to be only 75 per cent or less of the spend over the last decade. This requires us to view the use of our estate differently and drives us to consolidate services into our best conditioned estate and thereby obviate the need for the same level of asset renewal. Again, this is best organised at scale.

Investment in 'digital' is a must. Electronic health records not only improve clinical decision-making and enable reliable communication with patients, but they allow better scheduling and management of patient flow. Digital provides the means to assure standardisation of best practice and enables access to elusive economies. Experienced organisations should be incentivised to manage the roll-out to other organisations.

The cost of labour and use of agency staff is a direct result of the tight labour market, where restrictions in supply have led to cost inflation with staff able to demand higher pay rates. New workforce supply strategies are urgently needed which can provide ease of access to the right skills and quantity of staff.

No other healthcare system has the number of performance targets the English NHS has. The sheer volume distorts real priorities and colossal expenditure is providing diminished returns. Instead locally selected key performance indicators, focused on the delivery of the NHS Clinical Standards, should be publicly reported on balanced scorecards.

Solutions to problems are most likely to be found from listening to and involving staff who will know the impediments which prevent them from providing the safe and reliable care they want for their patients. Their ideas must be encouraged, tested, implemented and spread to see sustainable change. Linking pay improvement to the contribution individuals and teams make to the goals and values of their employer must be pursued.

Sir David Dalton
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Dr Rowland Illing

The NHS is not alone in feeling financial strain. As an owner and operator of over 230 medical centres across sixteen countries in Europe and beyond, Affidea is keenly aware that European healthcare systems are grappling with the same problems of an ageing population, increasing costs and rising demand for higher-quality care.

To prepare for the future, the NHS must implement new models of care and improve its ability to roll out major change programmes. Future success relies on models of integration, co-ordination and leveraging meaningful analytics. Advances in technology, Big Data and personalised medicine can only be realised in this context.

Affidea has extensive experience of change programmes of this nature. The Magnetic Resonance Excellence Programme (MREP) is one such example. Although an excellent diagnostic tool, Magnetic Resonance is one of the most expensive and time-consuming imaging examinations. There is a large amount of variation in image quality as clinics typically work out their own protocols in isolation. Centres often spend many years optimising their own protocols, only for them to be rendered obsolete by changing technology or the requirements of the service to become more time-efficient.

Affidea uses technology and know-how to address this problem. Using the best-in-class technology obtained as part of a group-wide tender, each scan is performed under a standardised protocol set developed by an international group of experts. These protocols are available in an online platform, available in every Affidea centre, and are tailored for indication and vendor. An analytics tool has been developed that records data from the MR scanner in real time; time taken to scan, time between scans, adherence to the standardised protocol set and, crucially, image quality. These data are then shared in an online dashboard to allow transparent benchmarking. Protocols and processes can be optimised to increase the number of scans performed in any given time period, while improving image quality. Teleradiology then allows images to be moved between centres to balance workload and ensure that those with appropriate expertise review and report the scans.

The NHS perform a similar volume of scans to the Affidea group and have the same need to balance efficiency with image quality. The MREP highlights the key attributes which make Affidea the preferred independent provider in the geographies in which it operates – the scale of its purchasing power, standardised procedures, transparent outcome measures and a culture of quality improvement which transcends geographical boundaries. The NHS could benefit from the adoption of similar processes and mindset.

Rowland Illing
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ISBN number: 978-1-910850-05-3