The future of health

Rt Hon Jeremy Hunt MP, Rt Hon Andy Burnham MP, Dr Diane Bell, Professor Paul Corrigan CBE, Sir David Dalton, Ian Dodge, Mike Fairbourn, Toby Lambert, Dr Arvind Madan, Martin Markus, Emil Peters, David Prior, Ian Wylie and Baroness Young
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Across the world, healthcare costs are rising faster than our ability to meet them. An ageing population and rising costs are stretching resources ever thinner while patients are expecting a better, safer and more modern service. The NHS is no different. Without significant reform to the way the NHS does business, NHS England has forecast a funding gap of up to £30 billion by 2020. The Five Year Forward View has given the NHS cause for optimism. Through radical change, innovation and efficiency the health service can narrow the gap. So far this Parliament has seen the emergence of powerful ideas and pioneers but there is still more to be done to put the health and care system on a sustainable footing. Reform is delighted to hold this pre-election conference to lay down the powerful ideas that will transform health and care in the next Parliament.

In the first session of the day, we will explore the productivity challenge facing the NHS. The next government of whatever political persuasion will be met with an annual deficit of around £70 billion, twice what we currently spend on schools alone. The fiscal envelope for the NHS has little flexibility and the NHS will have no option but to learn to live within its means. This Parliament has seen progress towards the Nicholson Challenge but through the “low hanging fruit” of tariff reductions and a pay freeze, not through the rewarding changes to the way services are delivered. A high value NHS is, however, in reach. Speaking for Reform at the start of 2014, the Harvard Professor Michael Porter reminded an audience of NHS leaders that more for less in healthcare is possible: “If you think about how we can restructure and streamline our care delivery process, what we’re finding is that cost reduction opportunities in healthcare over and over again are 25, 30, 35, 40 per cent.” As the Health Secretary has said in recent weeks, “good care costs less”.

The second session will consider progress towards a patient-centred NHS. There is broad consensus that the health and care of the future will not be built around institutions but around empowered patients with control over their care. Initiatives such as the Friends and Family Test and the roll out of personal health budgets represent real progress. Now the patient revolution must go one step further and harness patient co-production as a source of “renewable energy” to fuel the health service. And there is political appetite. The Health Secretary has called for a “technology revolution” where the NHS learns from other industries such as banking and airlines to harness the role of the consumer. Ed Miliband has called for a “people powered” health service, which he says is “essential if the NHS is to survive and improve in an era of tough fiscal restraint”.

The final panel will discuss the idea which has united politicians across the political divide: an integrated health and care system, centred in the community and focused on prevention and wellbeing not just incidents of illness. Since the last Spending Review, integrated care has been at the heart of the Coalition’s health policy, with the creation of the Better Care Fund and the “integration pioneers” giving new momentum to this agenda. The Opposition has also set out its own proposals for integration and “whole person care”, commissioning Sir John Oldham to explore new ways to join up physical health, mental health and social care. On the ground progress has been made. We have seen leading commissioners from Bedfordshire to Cambridgeshire developing outcomes-based contracts to join up services around the individual. England’s elite hospitals are eyeing up opportunities to takeover other services and form chains of providers. In some parts of the country public services are collaborating to make resources go further. In Jersey the postal service has joined up with their NHS to monitor the frail elderly in their home.

The challenge for the NHS is that innovation is not just about these new ideas but about how they are spread. In this the NHS falls short. As Simon Stevens said in his maiden speech as Chief Executive of the NHS, “The NHS needs to become the best at harnessing the best – whether spreading good ideas from within, learning from other industries, or cherry-picking from other countries”. The Five Year Forward View has given the NHS a radical blueprint for reform. Seeing this implemented successfully and with the urgency required will be the next challenge for the NHS and their counterparts in local government. The nature of this change is to be locally led but nationally enabled, and it is in this that politicians can play a crucial role. Not simply in addressing the national barriers which hold back the innovators, but by voicing the unambiguous call for change that we have heard in other public services this Parliament. They will find a receptive audience: a Reform commissioned poll by Populus this year found that almost two thirds of the public believe the NHS needs reform more than it needs more money. Now is the moment for politicians to build a public mandate for change.

Generating debate and ideas on the future of a high quality, sustainable NHS will continue to be at the forefront of Reform’s work. In the approach to the General Election, Reform will help set the agenda for health reform and feed into the thinking of new Ministerial teams and the Spending Review after it. We would be delighted to keep you involved in this work going forward.
Better treatments, new drugs and the latest technology means that people are living longer, which is undoubtedly a good thing. But our ageing population – as in many Western economies – does mean unprecedented challenges for our NHS, especially as many older people have complex, long term conditions and comorbidities.

The NHS is carrying out record numbers of treatments in rising to that demographic challenge. 50 per cent more people with suspected cancer are seen by the service now than in 2010. In the past four years, ten million people had an MRI scan and sixteen million people had a CT scan.

Which makes it all the more impressive that this has been combined with significant improvements in patient care. Hospital infections are at an all-time low, mixed sex wards are finally becoming a thing of the past, and the proportion of people who would both feel safe in an NHS hospital, and think they would be treated with dignity there, have never been higher.

I am proud of this Government’s commitment to the NHS. We protected the NHS budget, allowing us to hire 8,000 more doctors and 5,600 more nurses on our wards. And we have saved £20 billion by reducing waste and bureaucracy – money which has gone directly back into frontline services.

But as the way we use healthcare continues to change, the NHS must adapt accordingly. Nearly two months ago, NHS England published its Five Year Forward View, a document I welcome. The Government’s response – our long term plan for the NHS – has four pillars.

The first is funding for the NHS backed by a strong economy. Our NHS has an annual budget of £113 billion, and paying that bill is only possible when the government has a strong grip on the national finances. A failure to tackle their deficits meant Greece, Spain and Portugal had no choice but to cut their health budgets. We have been able to increase ours by £12.7 billion over the course of this Parliament.

The second pillar is integrated community care. The public doesn’t think in terms of primary and secondary care, but wants the system as a whole to work for them. Hospital care matters enormously, but we need a much greater focus on helping people to stay healthy and happy at home.

Through the Better Care Fund, we will see around 18,000 staff deployed in community roles next year. There will be an unprecedented joint effort by the NHS and local authorities to reduce hospital emergency admissions. It should see 163,000 fewer emergency stays in hospital for the most vulnerable and elderly, saving the NHS over £500 million in one year, and representing an historic first step in bringing about the integrated services successive governments have talked about for decades.

Innovation and efficiency make up the third pillar. The technological revolution we’ve seen in retail, travel and banking has not yet fully taken hold in healthcare.

Everyone should have online access to their medical records and be able to communicate with their doctor electronically. Hospital IT systems need to be effective and efficient, so that hardworking nurses can devote their time to patient care. Therefore I want the NHS to be paperless by 2018. Patients are more than consumers, of course, but they should nevertheless enjoy all the advantages of 21st century services.

Meanwhile, genomics and the life sciences promise to transform care and health outcomes, which is why the Government has championed them so passionately.

The final pillar – arguably the most important, but also the hardest to achieve – is cultural change. In the wake of Mid-Staffs, we have set the objective of becoming the most open and transparent healthcare system in the world. When patients are empowered to take decisions about their care, and where clinicians can compare their outcomes, performance improves. So we have launched myNHS – a first for any major healthcare economy. Patients will be able to look at the performance of their local hospital, GP surgery, care services and local authority.

Whether diabetes care, hospital food standards or the performance of a local surgeon, it can all be found on myNHS. Transparency and honesty means standards can be driven up not by yet more targets, but through peer review, learning and the natural desire of every doctor and nurse to do the right thing for patients.

And we have introduced the toughest inspection regime in the world, celebrating good care, but confronting incidences where standards aren’t what we would all expect. Patients will be able to see CQC risk ratings for GP practices, and we have already seen six of the eighteen hospitals placed into special measures turned around.

We are embarking on a journey. But our economy is growing, our NHS is rated the top-performing healthcare system in the world by the independent Commonwealth Fund, and NHS staff and their colleagues in social care are devoted to those they serve. I am completely confident the NHS will continue to blaze a trail in the years ahead.
As we approach the end of this Parliament, the Opposition is leading the wider debate about the future of health and care. By endorsing full integration of the NHS and social care, Labour has opened up an enticing possibility: a single service for the whole person, meeting all of their needs – physical, mental and social.

With “whole person care”, we can start where people and their families want to be – in their own homes – and build out from there. This is a big change from the 20th century when we thought of health in terms of buildings and institutions. In the 21st century, the home and not the hospital should be the default setting for care. Wherever possible, people should be supported by a single team providing high quality, personalised care with the aim of helping them get the most out of life. It will finally make a preventative service a reality.

Of course, this is some way from where we are today. England has a fragmented health and care system, where physical, mental and social needs are met through separate, disjointed services. This disempowers people and is wasteful of resources. People’s common experience is of a series of disconnected encounters with professionals, and the frustration of telling the same story to every person who comes through the door. As no one is accountable for the totality of one person’s care, people fall between the gaps and true accountability is hard to achieve.

A single service for the whole person opens up the possibility of a simple, but revolutionary, answer to this common problem: a single named contact for the coordination of all care needs. It is also one easy way to explain the difference that “whole person care” could make: for the increasing number of people in their 40s, 50s or 60s who live away from their parents and face the anxiety of making multiple phone calls to arrange their care, it will make a great deal of sense.

We need to look at powerful rights for individuals to pull the system towards a person-centred service, with more options for care in the home, with carers supported not ignored, and with equal value placed on mental and physical health.

The NHS Constitution already affords people some limited rights on waiting times and treatments. Various ideas have been suggested for how it could be updated. For example: the right to a single named contact for the coordination of all care; the right to an individual, integrated care plan agreed jointly between individuals, their families and professionals; the right for your carers to receive an assessment of their needs and to have respite care; and the right to give birth or to end life at home.

These ideas begin to illustrate the kind of changes that “whole person care” could make possible and what that might look and feel like to the public. And it also gets Labour’s focus where it needs to be – on services not structures. We don’t need new organisations; we simply need them to work together in a new way.

People will rightly question whether a system offering this degree of personalisation can be afforded. My response is that it is the status quo which can no longer be afforded. Today’s silo-based approach to the provision of public services is a luxury we can no longer sustain. Such is the medium term outlook for public spending that all professionals will need to open their minds to working differently and with fewer organisational boundaries. The simple premise behind “whole person care” and full personalisation is that the more we give people the support they are asking for – when and where they need it – the more likely it is to work and, therefore, be better value for money. It is providing care in an uncoordinated way that is so wasteful of public resources and is leaving increasing numbers of elderly people trapped in expensive hospital beds.

The biggest barrier standing in the way of Labour’s vision of a public, integrated health and care service is the Health and Social Care Act 2012. When the future demands integration, the Government has placed the NHS on a path towards fragmentation and privatisation.

The NHS is approaching a fork in the road. It either continues to embrace marketisation and fragmentation, with all the threats that entails; or it goes in the opposite direction and becomes more collaborative and integrated, so it can meet the challenges of the 21st century. The next election will decide which path it takes, and the decision will have irreversible consequences.

Rt Hon Andy Burnham MP, Shadow Secretary of State for Health @andyburnhammp
Professor Michael Porter and Dr Emma Stanton
Why outcomes measurement is the key to fixing healthcare

The solution to delivering more value in the NHS is not increasing budgets. Spending does not guarantee success, as demonstrated by the United States which leads the world in per capita healthcare spending, as well as the modest gains achieved despite the UK’s major increases in NHS expenditure since the early 1990s.

The only way to be sure that the NHS is truly delivering value for the taxpayer is to measure it. Value is the health outcomes achieved for patients relative to the cost of delivering those outcomes. Value cannot be measured for a hospital, a consultant, or an entire system. It can only be accurately measured by clinical condition, whether it be breast cancer or back pain.

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. There is no substitute for measuring the actual outcomes as well as the costs involved over the full cycle of care for the patient’s problem. Recent efforts to capture patient “experience” are useful, but are not the same as outcomes.

Many individuals and organisations across UK healthcare are now talking about value – an encouraging sign. A few organisations are beginning to measure outcomes, which is a major step forward. For example, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) are amongst those exploring alternative delivery models for patient groups, and measuring outcomes. Starting with the frail elderly, they are seeking to measure the outcomes that matter to this population, such as whether a patient can walk to their local community centre and live at home independently. These things are what really matter to patients, not whether they were discharged from the hospital within four days. The outcomes framework has been codeveloped by clinicians, patients, carers and medical experts.

In a new contract recently tendered by Cambridgeshire and Peterborough CCG, a significant proportion of total reimbursement for care is based on results against these outcomes. Given the multiple health and social needs of many frail elderly people, this emphasis on outcomes will inevitably drive greater collaboration between health delivery, local authorities, and other services such as NHS 111 and the ambulance service.

Five CCGs across North Central London (Barnet, Camden, Enfield, Haringey and Islington) are also collaborating to adopt a value-based approach to commissioning care for frail and elderly patients with diabetes, and individuals with mental health problems. Their approach started with defining outcomes for these population segments via interactive workshops involving stakeholders from across the care cycle, including patients. Contracting models encompassing multiple providers are currently being evaluated, with the conviction that an outcomes-driven approach will drive service redesign for the populations served.

Outcomes-based approaches apply as much to mental health care as to physical health care. At the time of writing, Oxfordshire CCG is negotiating a fully compliant NHS standard outcomes-based contract with Oxford Health NHS Foundation Trust as lead provider together with voluntary sector providers across the care pathway including Oxfordshire Mind, Restore, Response, Connection and Elmore Community. Many of the outcomes that matter are best defined not just by healthcare professionals but also by adult social services, so that an outcomes-based approach is driving greater collaboration with Oxfordshire County Council.

The key challenge now is defining the outcomes that matter for each condition, and how to measure them. Efforts thus far in the UK and elsewhere have been bottom up and different across organisations and geography. There is a pressing need to develop standardised sets of outcomes by condition to enable comparison and learning, and put in place the infrastructure and tools needed to collect and measure them across the entire system.

We cofounded the International Consortium for Health Outcomes Measurement (ICHOM) in 2012, an international organisation seeking to define standard sets of outcomes that matter across multiple medical conditions. Through international working groups of leading clinicians in each field, together with patient representatives, ICHOM has already developed standard outcome sets and risk adjustments for low back pain, localised prostate cancer, Parkinson’s, cataracts, and coronary artery disease, with seven more on target for completion this year. Collectively these will address 35 per cent of the disease burden. Over the next three to five years, ICHOM will produce standard sets of outcomes for many more conditions.

ICHOM opened a London office earlier this year, led by Dr Thomas Kelley, to drive the adoption of ICHOM standard sets, by condition as the benchmarks across the UK. Bedfordshire CCG has been one of the early adopters of ICHOM’s standard sets as part of their recent musculoskeletal care contract with Circle Healthcare. The Lower Back Pain Set was incorporated into the five year contract, with annually demonstrated improvements in clinical and patient reported outcomes attracting financial rewards.

In the run up to the 2015 General Election, we challenge UK healthcare policymakers and commissioners to commit to the path of universal outcomes measurement by conditions across the full range of diseases in this country. This is the
single most powerful step that could be taken to drive rapid outcomes and value improvement for patients as well as for taxpayers. The UK should adopt globally vetted outcomes rather than bear the expense and inefficiency of reinventing the wheel in each local area, which also obscures comparison and learning. NHS England should become the central repository for outcomes from all entities in the NHS, with responsibility for ensuring the reliability of the outcomes reported, providing rigorous comparisons for clinicians and transparency for the general public.

Professor Michael Porter, Bishop William Lawrence University Professor, The Institute for Strategy and Competitiveness, Harvard Business School
@MichaelEPorter

Dr Emma Stanton, Chief Executive, Beacon UK
@doctorpreneur

Ian Wylie
The future of women’s health

The months before the General Election, and the end of the first fixed-term Parliament, are a crucial time to review and reflect on the past five years and take stock of how we all wish to shape the future of healthcare. As a Royal Medical College, we do not align ourselves to a political party and have always worked with governments to ensure that NHS women’s health services continue to be world class. This will continue to be the case post the General Election.

Like other organisations, however, we do try to influence the shape and direction of future health policy through a published manifesto in the lead up to elections. Here is a brief résumé of our key aims for the next five years.

For several years now, the Royal College of Obstetricians and Gynaecologists (RCOG) has made the case for the life-course approach in women’s health provision, a concept adapted from Professor Sir Michael Marmot’s Fair Society, Healthy Lives published in 2008. In his report, also known as The Marmot Review, he made the case to reduce health inequalities by focusing on the social issues which prevent good health. Policies should be developed to ensure that every child has the best start in life by helping them to “maximise their capabilities and have control over their lives”.

We support this view but would like to take it one step further by suggesting that early intervention should begin even before the child is born. It should come at the pre-conception stage.

This approach to health and social care is all the more urgent now. Over the last decade, we have experienced higher birth rates, increasing older mothers and raising levels of obesity. The general population is less healthy now compared to a generation ago (we lead more sedentary lives and consume more alcohol), and as the population ages, so does the prevalence of chronic illness. The stresses of modern life have also resulted in some diseases unique to the Western world. This makes for an explosive combination of variables since the lifestyle diseases that result will lead to more costly hospital treatment in years to come if we do not reverse the trend over the next decade.

We must think of ways to enable women to lead healthier lives before they become pregnant, and the government, working with organisations such as ours, has a role in developing policies that encourage women to lead healthier lifestyles. Previous successes include the introduction of the HPV vaccination programme among 12-13 year old girls and the ban on smoking in public places.

Our thesis is simple. In order to tackle future ill health, we must first empower the public by promoting good health from a young age so that they can go on to make the right decisions as adults. This is where universal Sex and Relationships Education (SRE) in schools can make a difference. Through the internet and their social circles, children are exposed to a range of ideas which can be potentially damaging to their physical and emotional health, and SRE can counter-balance these influences. The problems which many children encounter today – body image issues, bullying, gang violence and sexual abuse – are discussed within the SRE curriculum, and this is why it should be extended to all secondary schools.

We need more of the public health approach in the way we care for the individual so that as soon as a problem is identified, a plan can be drawn up by a multidisciplinary group of professionals to support the individual. Our doctors sometimes see women in their clinics with complex social circumstances that compound their illness. The NHS is very good at treating diseases but more needs to be done to link with a patient’s mental health and social needs so that better, more comprehensive care can be provided. This requires working with local authorities and social services so that these women are followed throughout their journey. The right structures in the NHS are needed to enable this to happen.

We are encouraged that NHS England’s Five Year Forward View, published in October this year, gives much more weight to these key issues than previous planning documents. As a UK centre for excellence in women’s health, the RCOG looks forward to working with all those who wish to engage in developing high quality women’s healthcare.

Ian Wylie, Chief Executive, Royal College of Obstetricians and Gynaecologists
@RCObsGyn

#reformhealth @reformthinktank www.reform.co.uk
The fact that for many years the NHS has been treated, in the words of Nigel Lawson, as “the nearest thing we have to an established church or a national religion”, partly explains why the vital improvements that today’s patients need have been so difficult to make and so frustratingly slow. The CQC’s primary role is to shine a bright light into these holy places, to celebrate great care, to expose bad care, and to give a voice to its congregation (to continue the metaphor). That will enable them to become more powerful and informed consumers, rather than grateful supplicants.

We will do this with the help of risk based intelligent information, expert clinicians, comprehensive inspections, announced and unannounced, and greater enforcement powers. Our focus is on culture and behaviour not narrow and sometimes politicised measures of success. We have to be independent for our judgements to be credible and trusted. We will publish our inspection reports and give an aggregated rating (and a rating by service lines, locations and population groups where appropriate) to all hospitals, care homes and GP surgeries. Intelligent transparency will facilitate and enable change to happen; it will help drive patient choice and clinical benchmarking. Our role is both to ensure minimum standards are maintained and to encourage improvement.

But we cannot and will not restrict ourselves to inspecting the existing system. As stated in The NHS Plan published in 2000, we have “a 1940’s system operating in a 21st century world”. This is a theme eerily echoed in NHS England’s Five Year Forward View published in October this year, which demands “a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment”. The two documents could almost have been written by the same person.

The existing system was not fit for purpose in 2000 and as every year goes by it gets less fit. The power of medicine and surgery to prolong and enhance life has grown hugely but it has not been matched by the capacity of the system to care properly for the millions of elderly people living with long term conditions. The CQC inspects and regulates primary care, community care, mental health care, adult social care and acute care. We have a duty to see that the health and care system is joined up so that people are treated in the best possible settings for them. The typical patient in 2015 is very different from 1948. Our demography and disease profile have changed fundamentally. Today, many patients will be over 75 years old and suffer from a number of complex, hard to manage, long term chronic conditions. Frighteningly, between 30 and 40 per cent of patients in acute hospitals have dementia, and almost five million people suffer from three or more long term conditions.

The current system treats far too many of these people in acute hospitals and their admission process could hardly be worse: “blue lighted” in an ambulance into a busy, over stretched A&E department, thence to a ward often determined by bed availability, not clinical suitability. This in turn can lead to cancelled operations as surgical beds fill up with medical patients.

The discharge process is not much better, with too much delay, especially in the interface between NHS funded and local authority funded social care. The current payment structure, some of the targets, and the lack of capacity in primary and community care, have had the unintended consequence of driving resources and patients into inappropriate acute settings (poor care at high cost).

We must look after and manage the conditions of these people in their own homes whenever possible or in settings outside the acute hospital, for example in day centres, nursing homes or community hospitals. Acute hospitals cannot provide high quality, personalised long term care, they are not designed to do so and they are also very expensive. Most importantly, the system must be incentivised to work for the best interests of the individual not the best interests of the existing institutions. The artificial divisions within healthcare and between health and social care must be buried, fast.

These changes will not be easy. They were not achieved in 2000 at a time when the NHS received huge increases in funding. They have now got to be achieved at a time of austerity, at pace and scale. They will not be pain free; change never is. Politicians need to be honest about that. The drivers of change are both affordability and better patient care. We need an affordable care system designed for people living today not in 1948.

David Prior, Chairman, Care Quality Commission
@CareQualityComm

Sir David Dalton
Be optimistic – be bold

There can be no doubt that providers of NHS care are facing challenging times. I have heard many gloomy predictions about the future, and I of course recognise that resources, previously used to lubricate the delivery of change, are no longer as freely available. I would, though, like to offer an optimistic outlook based on involving staff,
developing a new entrepreneurial spirit and creating a new focus for population health improvement, all of which will offer greater value to the patient and the taxpayer.

I have confidence in the abilities of NHS staff. I know that the ideas for change and improvement are to be found deep inside the organisation. At Salford Royal, we encourage staff to test and measure whether a change in a practice results in an improvement or not. If it does we seek to replicate it and then measure to see if we can achieve the same improvement elsewhere. If we can, then we “reset the system” and every ward or department adopts the change package which we audit regularly to prevent regression. Our systems are now being regularly tested and changed by staff themselves using a disciplined methodology.

It is my view that staff empowerment, encouragement and support is crucial to how an organisation can find better ways of improving its care and its costs. The difference in outcomes and productivity between an engaged and a disengaged organisation is considerable, some say up to 20 per cent. We know that staff discretionary effort cannot be commanded; it has to be freely given. Creating this culture requires leadership attention, and a fundamentally different approach in many organisations, but the results can be significant. Leaders must make sure that they minimise the disconnection between themselves and staff, and that they achieve real alignment between the goals and values of an organisation and the individual contribution of each member of staff. This is the fundamental cultural requirement which will deliver success over the next five years and beyond.

Many European countries have pursued the standardisation of best practice; of back office functions and procurement; of care pathways, enabling standardised workforce redesign; of rapid adoption of innovative technologies, and of deployment of improvement methodology. All of these have enabled delivery of services at a lower cost overhead. It is perplexing that this approach has not been pursued at scale in England. It’s time to change the NHS leadership mindset and to think beyond the current ways of doing things.

Leaders of successful organisations should be “system architects”, using their social entrepreneurial spirit to develop innovative solutions to their challenges, and to codify and spread their success so that the best standards of care can be available, reliably, to every locality in the country. I very much hope that boards will be aspirational and develop an “enterprise strategy”, utilising innovative approaches for growth to deliver better care for patients.

In my review, I recommend a system of “credentialing” for our best organisations. This new “kitemark”, beyond foundation trust status, would enable commissioners to identify those organisations with the capability and greatest likelihood of successfully spreading their systems into organisations that are in persistent difficulty. This can bring a new approach to reducing the variations we have across the country in standards of care and to do so at lower cost.

Much is being spoken about the benefits of integrated care models. I agree with this. However, imagining different care models, which can deliver value to patients and taxpayers, is quite different to delivering these new organisational forms. In Salford, we are comparatively well advanced in creating our “integrated care organisation”, and the crucial element is to be the inclusion of primary care practitioners and social care within a single governance system. I believe that the Foundation Trust, connected to its community through its public membership, can use its organisational scale and experience to lead a significant improvement to the health of its population.

Finally, I believe that a major impediment to achieving change is that boards have been more interested in winning for their organisation rather than winning for their patients. We know that most hospitals will be unable to meet the standards required of them for a consultant-delivered, seven-day service from their existing workforce pool. Yet they continue to try to appoint more consultants, ending up using premium rate staff to fill gaps in rotas, and they try desperately to be self-sufficient of their neighbouring hospitals, who are doing exactly the same. I believe a real solution is to create new joint ventures where workforce can be pooled across organisations, enabling some consolidation of services which will be in patients’ interests. Joint venturing can be a new approach, between organisations and between sectors, where risks and benefits can be shared, and where patients and communities can be the new winners.

**Mike Fairbourn**

**Partnership to standardise care**

The NHS has no sustainable alternative than to embrace new technologies in order to improve patient outcomes and, as a consequence, reduce the cost of healthcare delivery. This thinking goes to the heart of innovative medical technology companies who are investing for the future to bring solutions to market which will deliver health improvements and avoid costs of poor care.

The CareFusion Focus on Quality Care (CFQC) programmes help healthcare organisations to standardise evidence-based best practice and reduce the costly consequences of variability in the delivery of care.

The new emphasis from Government on improving patient outcomes in order to reduce the costs of providing healthcare is
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welcome. This change in emphasis is influencing suppliers of innovative technologies, like CareFusion, to think differently about their relationships with customers. However, the pace of change is too slow. A report by Frontier Economics published earlier this year estimates that the cost to the NHS of poor care is about £2.5 billion, and the Secretary of State for Health has stated that the variation in care which exists across the country and even within healthcare facilities is unacceptable.

There are countless examples where innovations to improve the quality of outcomes for patients fail to live up to the expectations demonstrated in randomised controlled trials. Part of the reason for this may be down to patient exclusion criteria in the trials but often it is because the innovative technology has not been implemented fully and in the way the manufacturers intended. This represents an opportunity for clinicians and suppliers to work more closely together to make sure that, once the decision has been made to introduce a new technology, a plan is agreed to implement fully and faultlessly.

The CFQC programmes themselves embrace new technology to support training, implementation and monitoring of compliance. Our focus is on two programmes currently: infection prevention and medication safety. The CFQC process helps improve effectiveness (doing the right task, completing activities and achieving goals) and efficiency (the best outcomes in the least expensive way). For CFQC to have the greatest impact it needs buy-in and endorsement from the Trust board and a level of trust on both sides. If we are to put value at the heart of the NHS, I believe we need to have much greater trust between NHS and industry, and CFQC is a controlled way to start to develop this.

The recent publication of NHS England’s Five Year Forward View (5YFV) has many implications for industry. The 5YFV states that innovation is going to be taken more seriously, with test bed sites being introduced probably via academic health science networks. Operational pilots will be introduced to generate evidence and outmoded legacy medical technologies will be decommissioned. Positive words for the industry and, I can only speak for CareFusion, we stand ready to work in partnership to help turn the words into reality. We have heard these fine sentiments before, of course, but I am convinced by the analysis and arguments that the NHS has no sustainable alternative. It must embrace new technologies to improve patient outcomes in order to reduce the cost of healthcare delivery, not just now, but for generations to come.

Mike Fairbourn, Vice President, UK & Ireland, CareFusion

Ross Carroll
Quality and value in a cost constrained NHS: making the “sustainability equation” work

The debate around how to improve quality and value within the NHS whilst ensuring its sustainability has never been more pressing or acute as it is today. As Simon Stevens recently set out in his Five Year Forward View, if things don’t change, the healthcare system we all value will find itself with a funding gap of £30 billion by 2020/2021.

Mr Stevens argues that more funding is required from politicians to partially close this gap, but states that this in itself is not enough to achieve healthcare sustainability. Neither is a simple equation of more funding and greater efficiencies – vitally important elements though they are.

For a truly sustainable healthcare system, “innovation” needs to be embraced, adopted and exploited, people living with illness need to be empowered to self-manage in the home and in the community, new models of care must be adopted and allowed to flourish, prevention must be a central objective, and integration of services to enhance patients’ experience of care must be the norm.

Achieving progress against all of these variables is no easy task. For the quality, value and sustainability equation to add up, I believe a culture of partnership working – a whole system approach – is required from every organisation and practitioner that plays a role in the improvement of health outcomes and experiences of care for people using the NHS. And I strongly believe that the pharmaceutical industry must be central to this solution-oriented approach. As an individual passionate about healthcare, I truly believe that companies such as AbbVie – and my industry more broadly – have a vital role to play in delivering quality and value to people living with illness, as well as their carers, within the context of a sustainable NHS.

Let me provide a few examples. Quality – as enshrined in law – means safety, clinical effectiveness and patient experience. Few would disagree with this. And to deliver quality will require a value-based approach, given that value is often defined as quality divided by cost. In a cost-constrained environment it is tempting to consider only cost, but to do this will undermine the necessary focus on quality. In May 2013, the Royal Pharmaceutical Society led a publication called Medicines Optimisation: Helping patients make the most of medicines which was endorsed by numerous organisations, including the Association of British Pharmaceutical Industry (ABPI), NHS England, the Royal College of Nursing, the Royal College of GPs and the Academy of Medical Royal Colleges – whole system endorsement.

The principles underpinning medicines optimisation – perhaps unsurprisingly – are patient experience, the evidence-based use of medicines, safety and making medicines optimisation routine practice. The broad principles of quality in other words. The challenge is for those organisations that came together to create

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and endorse the principles of medicines optimisation to work in partnership again to ensure that it becomes part of routine practice in the NHS to deliver quality and value for the people living with illness who we all serve.

But what about speed of adoption across the healthcare system? When medicines optimisation does become part of routine practice, will people living with illness be receiving quality care quickly enough? There is extensive evidence which shows that, in a number of therapy areas, people in the UK receive slower access to innovative therapies than many other countries such as France, Germany, Italy or the Scandinavian countries. So are we really able to deliver true quality, and serve our people living with illness optimally, if their ability to access innovative medicines they would benefit from is routinely delayed? I believe not. However, I am encouraged by Mr Stevens’ commitment in the 5YFV to accelerate the adoption of cost-effective medicines and to improve testing of innovation using “test bed sites” through organisations such as the Academic Health and Science Networks (AHSNs), whilst committing to expand the Early Access to Medicine Scheme that has produced a report’s recommendations through pilot partnership to deliver a number of the outcomes through the use of medicine are now looking “beyond the medicine” to provide care solutions to support people taking their medicines to ensure medicines optimisation occurs, and that their health outcomes through the use of medicine are maximised. As an example, AbbVie partnered with the College of Medicine to produce a report on sustainable healthcare in June 2014, and we are now actively engaged in funding and working in partnership to deliver a number of the report’s recommendations through pilot programmes to demonstrate that the concepts work in a cost effective way. Yet there is much more that AbbVie and our industry can do, but it all starts with a spirit of collaboration and partnership working.

So in summary, it is clear that delivering quality and value in a sustainable way is not easy. But I truly believe that if all stakeholders embrace working in partnership through a whole system approach to deliver for patients, the quality, value and sustainability equation will add up. AbbVie is certainly ready to play its part in dealing with the critical healthcare challenges of our time.

Ross Carroll MRPharmS MBA, Corporate Policy Lead, AbbVie UK

This article is written as part of AbbVie’s co-sponsorship of the “Future of health” conference, hosted by Reform.

Notes

1 NHS England (2014), Five Year Forward View.
2 Ibid.
4 Richards, M. (2010), Extent and causes of international variations in drug usage.
5 NHS England (2014), Five Year Forward View.
6 Ibid.
7 Department of Health (2013), Pharmaceutical Price Regulation Scheme 2014.
8 ABPI (2014), Update from the ABPI Procurement and Distribution Interest Group.
9 Sustainable Healthcare Steering Group (2014), Patient, manager, expert: individual. Improving the sustainability of the healthcare system by removing barriers for people with long-term conditions.
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A patient-centred NHS

Professor Paul Corrigan CBE
Harnessing the value of patients

Over a decade in the struggle for NHS reform has taught me a number of lessons. One of the most significant is to be most afraid that nothing will really change in the NHS when everyone appears to agree about the direction of the change that needs to happen.

No one really argues against a “patient-centred NHS”. Indeed for many people in the NHS, they think it is already here. And for others it just needs a few tweaks in how we tell patients how to behave to bring about the changes that will put patients at the centre of the NHS.

And, as some point out, when you look at the patient satisfaction scores of many patients’ experiences of the NHS, you see scores that would make Apple very jealous.

So what’s the problem? And why will this decade see radical change when the previous six have not?

In 2014, the problem of the lack of patient-centredness has moved from a moral problem of “Why won’t the NHS organise itself around my life rather than its own organisational needs?” to an economic one: “Because the NHS excludes us from our own healthcare, it can’t afford to treat all the new sick people”.

This change has happened for two main reasons. First and foremost, the nature and the extent of the illnesses that the NHS has to work with has changed. Most resources are spent on long term conditions and the number of people with those long term conditions will increase in line with the ageing population. Second, whilst the extent of NHS resources will stay about the same, the number of sick people to treat will go up. Therefore the amount spent per sick person will decline.

This means that the NHS can no longer afford to exclude patients from playing a significant and efficient role in their own healthcare. Given that patients need to do more of their own caring, it is inevitable that patients need to be more central in the way in which the NHS cares for them. Or the old model NHS goes bust.

The fact that most NHS resource is spent on people with long term conditions means that most NHS effort is spent with sick people who have their sickness for a long time. Most people with arthritis, diabetes, heart and lung problems have had, and will have, these conditions for decades.

In any other service or industry, if the consumer of the service had decades of experience of a particular activity, the provider of the service would see this as a large resource to be worked with. They would be asking themselves the same question over and over again: “How can I turn this vast consumer knowledge and experience into an asset to help me deliver value within the service?”

To make any of that real, the service provider needs to recognise that the use of the consumers’ knowledge and experience as an asset will only be fully realised if we make sure that the service is delivered in the way that is most convenient to the user. To get them to add the greatest value they can, we must wrap the service round their lives.

One of the oddest things to hear the NHS say is that “we, the NHS, will introduce this patient to the idea of self-management”. This is absurd because patients with long term conditions do self-manage. For nearly all of their lives the NHS is absent. The NHS is in their clinic or hospital and the person with the long term condition is in their home.

For nearly all of the time, there is no doctor or nurse sitting at their bedside when they run out of breath or they are in chronic pain from their condition. For 5,800 waking hours a year, people with long term conditions face their condition with the family, their carer and their friends and on their own.

Patients self-care nearly all the time. They just don’t do it as well as they might. If the NHS could use the little time we have with patients to invest in improvements in their capacity to self-care, this would transform the outcomes of “healthcare”. Poor self-care leads to exacerbations which lead to emergency admissions into hospital beds. Very good self-care leads to fewer exacerbations which leads to fewer emergency admissions.

Recognising that patients are at the centre of their own healthcare, and moving them to the centre of NHS care, will change the value proposition for the NHS. Failing to do so will endanger its future.

Professor Paul Corrigan CBE, Former Health Adviser to Prime Minister Tony Blair
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Is the system unsustainable?
A combination of factors conspires to make the current challenges facing the NHS perhaps the greatest ever. Reducing budgets, increasing complexity and rising patient expectations mean that general practice and urgent care are creaking under the pressure. Add to this the drive towards greater regulation, poor infrastructure and the recruitment crises and we have a system approaching breaking point. Meanwhile politicians bid for the public’s trust with their beloved institution. What is also becoming evident is that the hope being placed in initiatives such as federating, cross-organisational integration, or even the merging of health and social care budgets, is unlikely to bridge the emerging funding gap alone.

So what needs to change?
So we turn our focus to wellness, prevention and earlier intervention, all of which are the natural territory of primary care. But how does a system struggling to even be reactive become proactive? This involves a paradigm shift from commissioners’ current drive to measure and monitor slithers of activity, towards a focus on population based outcomes created through frontline innovation. This requires a permissive and supportive commissioning environment, tangible support for federated working and real terms investment in primary care. When many secondary care providers face bankruptcy, it takes a brave commissioner to see beyond the current crises. Following the earthquake in Christchurch, the healthcare system was required to respond quickly. The co-payment system prevalent in New Zealand was suspended within an hour and GPs were allowed to design the solutions. Whilst the journey had started before the disaster, the pace of change towards a more efficient and, ultimately more cost effective service was accelerated. Some of these answers are now being adopted internationally.

How do we respond?
The recruitment crisis in general practice has now reached the point of no return. The pain is starting to hit as practices around the country fail to recruit. This will inevitably get worse before it gets better, whichever initiatives are now adopted. So we have no choice but to explore the role of skill mix, centralised demand management and revisit what we tell our patients they can reasonably expect. The system evolves at times of stress but general practice is more fragile than ever and we are in danger of losing the magic that happens between doctors and patients in the consulting room. We press ever closer to the edge of most GPs’ discretionary effort and goodwill. We bear some responsibility for this, as we have failed to adequately explain the value of our place in the system, and face losing the space to make the real connections with our patients that change many of their outcomes. Meanwhile commissioners continue to invent more innovative ways to measure our processes.

The answers should come from within. How does general practice cope with delivering personalised care a million times a day? Our response has been to develop technology that allows us to safely manage and segment demand, giving us more time with patients who need our generalist skills and abilities to manage risk and the needs of our most complex patients. This is the real art of general practice and can never be automated. We trialled a new system using GP practice websites to allow patients to use symptom checkers, self-help content, sign posting to alternate resources and the ability to email their own GP using webforms on 100 common minor conditions. Our study of over 133,000 patients top-slices face-to-face demand and demonstrates better access, health outcomes, practice efficiency and commissioner savings, as fewer patients overflow into urgent care settings. Alongside empowering patients with access to their medical records, these are examples of how we bring scalable technological solutions to the frontline of primary care.

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General practice for the 21st century

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Emil Peters
Patient-centred care offers opportunity to achieve balance between quality and cost

Healthcare is too important to stay the same. That’s our motto at Cerner, and the underlying belief that drives our 30-year track record of commitment and innovation. As we work to help combat the industry’s ongoing struggle to simultaneously promote healthcare quality and decrease healthcare costs, patient-centred care has emerged as an area of focus for clinicians, administrators and solution providers alike. It is a model that offers promising potential to help a dedicated and compassionate industry make strides in meeting both critical goals.

The concept of patient-centred care is steadily gaining traction in practice. The strategy emphasises communication and collaboration between clinicians and patients, an approach believed to strengthen relationships and contribute to reduced utilisation of potentially unnecessary tests, medications, referrals and admissions. By involving patients more proactively in the planning and shaping of their own care, patients become more vested, involved participants who may achieve improved outcomes at a lesser cost. Engaged patients, too, are patients who express greater satisfaction with their healthcare experiences.

Through our decades of initiatives to help improve healthcare, we have always believed processes should centre on the person. That principle drove our development of the Cerner Millennium unified electronic medical record, which creates and maintains a single, comprehensive record for every person who undergoes a healthcare encounter and makes it available to complete teams – scheduler, nurse, doctor, allied health provider, pharmacist, and so on – independent of care venue.

Our next challenge – our next responsibility – was to provide solutions that link the person into the process, solutions that enable patient-centred care while continuing to foster a seamless path of information-sharing and communication that preserves efficiency and effectiveness. Members want additional points of contact with healthcare providers and easier access to useful health information. They want to take an involved role in managing their health online. We created HealtheLife to answer those needs.

With consumer-oriented solutions like HealtheLife, providers and their staff can improve communication and enhance patient relationships. This contributes to efficiently achieving optimal health outcomes. Such solutions promote patient-centred care with capabilities including:

- Sending appointment reminders
- Providing new patient registration forms
- Sharing lab results and EPR data
- Conducting asynchronous e-visits
- Sharing documents and images
- Incorporating technology solutions to link patients with providers strengthens their collaboration and offers efficiency and convenience. It is an approach that enables secure messaging, supports prescription management and facilitates appointment scheduling, and billing and payment. It is a healthcare strategy that streamlines care and administrative processes for patients, providers and administrators, fostering optimal outcomes at an optimal investment.

In keeping with Cerner’s longtime position on healthcare, patient-centred care promotes “whole person” care and patient empowerment. From communication and collaboration to coordination and compassion, it is an approach ripe for harnessing technology to increase access and smooth administrative functions in order to maximise the human touch so critical to effective healthcare.

We look forward to continuing to do our part in creating solutions that strengthen patient-centred care. We believe it is an approach our industry challenges currently demand, and we are excited to see it realise the potential we believe it holds.

Emil Peters, Vice President and Managing Director, Cerner Limited UK
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@CernerLimitedUK
Inform
- More Control of Their Own Health
- Understanding of What’s Happening

Engage
- Community
- Family
- Person

Empower
- Stay on Track
- Responsibility for Better Health

Support
- Culture of Health
- Manage Conditions in a Better Way

Partner
- Connected to Care

Involve
- Supervision of Long Term Conditions
- Improve Healthcare Outcomes

At Home

At Work

On Your Device

Delivering Better Person Centred Care.
With our partners in the Integrated Care and Support Collaborative, Monitor commissioned National Voices to develop a narrative for “person-centred, coordinated care”. The narrative includes “I” statements that can help to define what integrated care means for an individual, such as “I am always kept informed about what the next steps will be” and “I always know who is coordinating my care”. In the “extensivist” model of integrated care, a general care provider is fully accountable for a patient’s outcomes and overall budget, and care follows the person regardless of setting.

Of course, this is just one model for delivering integrated care. Monitor aims to provide the flexibility needed to allow new care models to emerge and encourage provider innovation. Our assessment process can accommodate new organisational forms, such as integrated care organisations, as long as they are well led, sustainable, and meet legislative requirements that more than half their income is for NHS purposes. The design of new models of care is being given momentum by certain programmes we support. An example is the integrated care “pioneers” programme, through which local areas can share how they have used innovative approaches to deliver patient-centred and coordinated care.

We have made changes that allow for greater flexibility in payment. Commissioners and providers can now choose to use, and inform us of, their own payment mechanisms that are good for the patient. In this way the tariff is an aid to, rather than a barrier to, innovation. Monitor has also been supporting local areas to link patient datasets so that pricing can be more accurately calculated under new payment designs.

There is no inherent contradiction between the drive for patient choice and provider competition and greater integration; both have a role in improving care. Integration means bringing together different services that are not in competition with each other. But we are aware integrating different services, particularly at scale, is a complex task and reconciling integration, choice and competition can seem challenging. We are therefore, through competition supplementary guidance, advising the sector of the potential risks of planned approaches as well as highlighting the opportunities of adopting competitive processes. By ensuring patient benefits are always considered first and foremost, no tensions should ever arise.

The Royal Marsden’s “Coordinate My Care” initiative is one example of successfully integrated care without hindrance from competition rules. It centres on a care plan shared electronically between providers of urgent care. These include ambulance control staff, NHS 111 operators, GPs, out-of-hours GP services, hospitals, nursing and care homes, hospices and community nursing teams. There is undoubtedly more work to be done in strengthening the evidence base for integrated care, and in making it the norm. We were involved in choosing 14 pioneering integrated care services across England as beacons of best practice. Our “pioneers” are now helping us identify the local and national barriers to integration.

Because Monitor is responsible for several aspects of regulation in the health sector we are uniquely placed to encourage and support the integration of care. It is important for the patient and important for the health and care system as a whole as it strives to make best use of the available resources.

Toby Lambert, Strategy and Policy Director, Monitor
@MonitorUpdate

Notes
1 Department of Health (2013), Improving quality of life for people with long term conditions.
2 Department of Health (2013), Long term conditions compendium of information.
3 Such as the Department of Health, NHS England, Public Health England, the Local Government Association, the Association of Directors of Adult Social Services and the Social Care Institute for Excellence.
NHS England’s Five Year Forward View (5YFV) proposes a vision for delivering high value sustainable healthcare. There’s little debate over what’s needed: more focus on prevention and early intervention; greater control and engagement by people over their own health and healthcare needs, and fewer fragmented services to help people live the lives they want to lead. The 5YFV describes local models that could deliver this vision, based on strengthened primary care or redesigned hospital systems, supported by networks of specialist care. So far, so good.

The question of “how” is largely left to local economies to figure out. Quite right too: in complex environments such as healthcare, the centre is too distant to respond sufficiently accurately or nimbly to local issues. Although enablers of effective and efficient clinical care, such as tariff setting and technology development, can be facilitated nationally those changes will only be effective when translated into each patient having a better interaction with his or her local healthcare service.

Outcomes-based commissioning is a route through which the 5YFV’s vision can become a local reality. Working with communities to describe a set of outcomes that matter to them provides a bespoke mandate shared across the local silos of health (and care) services, underpinned by bringing previously fragmented funding and contracts together into a single capitated budget. Coupling this with a long contract duration further incentivises prevention, early intervention, and innovation. Thus, the “administrative” barriers that have previously stymied efforts of local clinical redesign working groups are removed.

But outcomes-based commissioning is not a panacea: it simply reframes system redesign to focus on collaboration between providers that, under an outcomes-based contract, are now working to the same stated aims. The negotiations between these providers, however, remain as circular as ever. Before hospital fixed costs can safely be removed, sufficient infrastructure must exist within the community for the care to be delivered there instead. However resourcing that infrastructure first requires funding to move out of acute hospitals.

This time, however, another party can break the deadlock: the patients themselves. With 21st century technology and relatively little expenditure – indeed whether we like it or not – patients can access more information than ever before on health and healthcare. Using advice on self-management, comparisons of experiences at different providers, and information on the pros and cons of treatment options, patients make their own trade-offs between different modalities of care. Evidence and experience show that when such information is harnessed and used systematically and consistently, patient empowerment can lead to reduced demand for specialist care, different choices of providers of care, and improved outcomes.

So, if the power of patients’ knowledge makes system reconfiguration eventually inevitable, how can providers best respond? The roadmap to the 5YFV’s nirvana includes three things:

- Skills and capability in population health management – not just risk stratification but segmentation, profiling and healthcare offered in the most appropriate format for each patient type.
- Revised provider organisational strategy in the context of their offer to the whole system – stopping delivery of some service lines completely so that they can be provided at higher value elsewhere.
- Knowledge and transparency about costs, with open-book accounting across the system and appropriate transfer of resources between providers.

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What stands in the way of this happening? The most common reasons are not related to regulation as some might imagine, but rather the sheer scale of trust, determination and altruism required between leaders of local providers. No wonder some health economies have tested the water first with smaller population cohorts (such as those needing musculoskeletal care in Bedfordshire, Bexley, and Sussex) and catalyzed the process through a prime provider model.

Cooperation between providers to deliver better value care has parallels with the development in the United States of “accountable care organisations” (ACOs). In England, we have the advantages of established primary care, recognised inclusion of social care, and a national mandate between government and the NHS already using outcomes as its currency. As with ACOs, we are learning from pioneers in the field. But it feels a fragile concept – still too easy to dismiss when facing problems hard to solve.

It was said in the US that an ACO is like a unicorn: everyone knows what it looks like but no-one has ever seen one. If the 5YFV describes our NHS unicorn – integrated systems delivering better health through high value healthcare – then it is the responsibility of us all, patients, clinicians and leaders, to carefully nurture these fragile and valuable beasts out of dreams and into reality.

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