Institute for Public Policy Research

THE NHS LONG-TERM PLAN

LESSONS FROM *THE LORD DARZI REVIEW OF HEALTH AND CARE*

Harry Quilter-Pinner

November 2018

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This paper was first published in November 2018.

The progressive policy think tank

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ACKNOWLEDGEMENTS

The author would like to thank Tom Kibasi, Clare McNeil, David Wastell, Florri Burton, Abi Hynes, Richard Maclean for their help in making this project happen. Thanks also go to Carnall Farrar, and in particular Toby Lambert and Sutha Satkunarajah, for their help on the analytics for this paper, and to ComRes, and in particular Rachel Phillips and Charu Agarwal for their help with the polling. With thanks also to Gilead Sciences - and in particular Dan Murphy and France Luff - for supporting this work.

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Citation
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Quilter-Pinner H (2018) *The NHS long-term plan: Lessons from The Lord Darzi Review of Health and Care*, IPPR. http://www.ippr.org/research/publications/the-nhs-long-term-plan

SUMMARY

1. **The NHS's funding deal is welcome – but is also incomplete**. Following the prime minister's announcement in June, NHS funding is set to grow at 3.4 per cent per annum for the next five years, resulting in an extra £20.5 billion of spending per year by 2023. This is welcome. However, it only applies to the NHS mandate,[1] which excludes crucial areas of spending including workforce training, capital budgets and the public health grant to local authorities. Meanwhile, the government is also yet to deliver a long-term funding settlement for social care which has significant implications for the NHS.
2. **The NHS long-term plan must re-double efforts to transform care in the NHS**. The NHS has been asked to produce a long-term plan to determine how this funding will be spent. NHS leaders must ensure that the long-term plan does not become a short-term plan to manage provider deficits. Instead it must focus on transforming the way care is delivered, looking at making it more accessible, joined-up, preventative and personalised. NHS leaders must ensure that the long-term plan does not become a short-term plan to manage provider deficits. This is crucial. Existing drivers of productivity in the NHS (such as wage restraint, and reductions in the tariff paid to hospitals) have run out of road: going forward, the only way of improving access and quality of care is fundamental reform.
3. **But reform should be about more than just making savings**. The 2020s will see England face a growing and ageing population, a rising tide of chronic illness, higher expectations of care from the next generation, and new treatments and technologies coming on stream. These are both challenges and opportunities – but regardless, they require the NHS to evolve in order to be fit for the 21st century. This is the task facing the NHS long-term plan. After all, in healthcare, to stand still is to fall back.
4. **The NHS long-term plan should not spend time re-inventing a vision for the future but instead focus on how to deliver change in the NHS**. There is a growing consensus that care will need to become more preventative, joined up, accessible and personal in the 2020s. But progress on delivering on this vision has been mixed. The long-term plan should not waste time re-inventing the wheel: it should adopt the vision set out in the *Five Year Forward View* and focus instead on how to drive change across the NHS.
5. **To achieve this, the NHS long-term plan should:**
   - **Make 'quality' the organising principle of the NHS** by re-launching the National Quality Board and tasking it with authoring and overseeing a new quality strategy for England with a focus on 'soft drivers' of quality improvement (such as staff and patient empowerment, leadership and culture change).
   - **Provide a 'new deal' for primary and community care** by making a commitment to increase funding for primary and community care as a share of NHS spending year-on year over the next decade, with new integrated care trusts (ICTs) created to manage these funds (as well as mental health and social care funding) and deliver integrated out-of-hospital care for whole local populations.
   - **Invest in the talent of the team** by creating a strong workforce planning function through the merger of Health Education England (HEE) into NHS

1 Only those areas delegated to the arm's length body NHS England rather than the whole Department of Health budget.

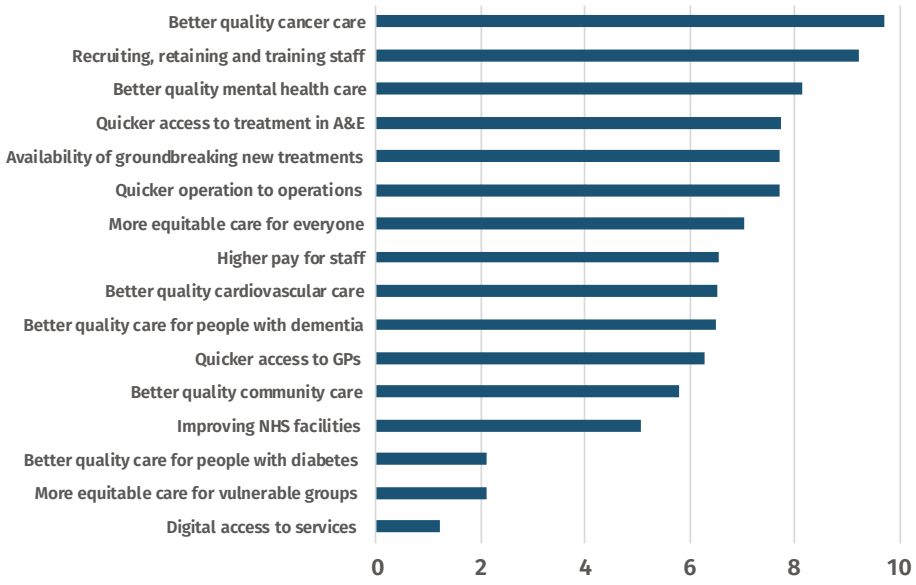
England and prioritising a workforce strategy for the next decade with the aim of ensuring that England is self-sufficient in the education and training of doctors, nurses and allied health professionals by 2030.

- **Make data and technology the driver of change** by ensuring that all NHS trusts have a chief technology officer at board level to manage IT change programmes and oversee the integration of datasets at a local level. This should be undertaken alongside a national effort to establish a new information governance system to replace Caldicott principles.

6. **These priorities broadly match those of the general public.** New polling undertaken by ComRes and commissioned by IPPR for this research paper shows that the public are most likely to prioritise new spending on better quality cancer treatment, recruiting, retaining and training staff, and better quality mental health care. Meanwhile, they consider digital access to services and more equitable care for vulnerable groups to be the lowest priorities (see figure S1 below).

FIGURE S1

Relative importance placed on spending priorities as determined by the MaxDiff score



Source: ComRes Polling

7. **The NHS cannot deliver on the potential of the NHS long-term plan in isolation: action will be required across government to make it a success.** Health is determined by a whole range of factors that sit outside of the NHS. Likewise, the NHS is impacted by the decisions of a range of other government departments. Only a coordinated effort across government will allow the NHS to deliver high quality care for all in the 2020s. This should include:

- **A long-term funding deal and reform plan for social care**, including the introduction of free personal care in England, to be funded out of general taxation. This should be introduced alongside reform to integrate health and care in terms of commissioning, provision and the workforce.
- **A radical plan for public health** including extending smoke free areas onto our highstreets and parks, introducing a minimum unit price on alcohol and extending the sugar tax to include milk drinks, cakes, biscuits and confectionary.

- **An immigration policy that recognizes the needs of the NHS** with exemptions for all NHS workers from the Tier 2 cap, an extended transition period for EU freedom of movement for health workers (six years) and the offer of British citizenship to all EU citizens currently working in the NHS.
- **Full implementation of the Life Sciences Strategy** including an increase in R&D spend to meet the upper quartile of OECD (around 2.6 per cent of GDP) in the next five years and a plan to increase uptake and access in the NHS including a restoration of NICE as the 'innovators gateway'.
- **A 'radical simplification' of the NHS** including the creation of a single NHS headquarters at the national level, five to 10 health and care authorities (HCAs) at the regional level to undertake strategic commissioning, and 44 local commissioners (at STP level), all with a statutory footing.

1. INTRODUCTION

The NHS is our most cherished national institution. For seven decades it has been there for all of us, offering care and compassion from cradle to grave. Earlier this year, on the 70th anniversary of the NHS, IPPR established the Lord Darzi Review of Health and Care. This celebrated the successes of the institution, but also took an honest look at the challenges it is facing in the years to come.

The final report of this review – *Better health and care for all* – was published in June and set out a comprehensive funding and reform plan to secure the NHS for future generations (Darzi 2018). The report helped shape the debate which led to a new funding settlement for the NHS – with funding set to grow at 3.4 per cent per annum for the next five years. This will see the NHS receive an extra £20.5 billion per year by 2023. The NHS is now authoring a long-term plan to determine how this extra spending is to be invested.

This funding boost is undoubtedly welcome. After eight years of austerity the NHS is severely strained: operations cancelled, staff under pressure and growing deficits. Furthermore, while the Lord Darzi Review (Darzi 2018) found that quality in the NHS has improved over the last decade, there is also evidence that we are approaching a tipping point, where the drivers of improvement will increasingly come up short against the pressures on the system.

But the truth is, the funding deal will not solve all of the problems facing the NHS.

This is partly because, while the new funding deal is substantial compared to other areas of public spending, it still falls short of what is needed. The Lord Darzi Review made it clear that 3.5 per cent growth on health spending (as a whole) over 10 years was the bare minimum required to achieve a world class NHS over the next decade. By contrast, Theresa May's NHS birthday gift of 3.4 per cent growth per annum only applies to the NHS England Mandate. It therefore excludes a number of crucial areas of spending such as workforce training, capital budgets and the public health grant, and does not give the NHS certainty for the long term.

FIGURE 1.1

The Lord Darzi Review funding settlement versus government funding settlement

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Government funding deal	£122.6bn	£128.1bn	£132.4bn	£136.4bn	£140.4bn	£144.9bn
Lord Darzi Review funding deal	£125.6bn	£130.1bn	£134.7bn	£139.6	£143.8bn	£148.4bn

Source: Carnall Farrar Calculations

Meanwhile, the government is yet to come forward with a sustainable funding settlement for social care. Fewer and fewer people are now receiving state funded

social care despite an ageing population (Darzi 2018). This is morally problematic in its own right but is also inefficient for the NHS, with delayed transfers of care and unnecessary admissions to hospital costing the NHS money it can little afford. The government is due to publish a Green Paper on the future of social care later this year which may help address this problem, but many in the sector are sceptical that it will resolve what is a long-standing concern.

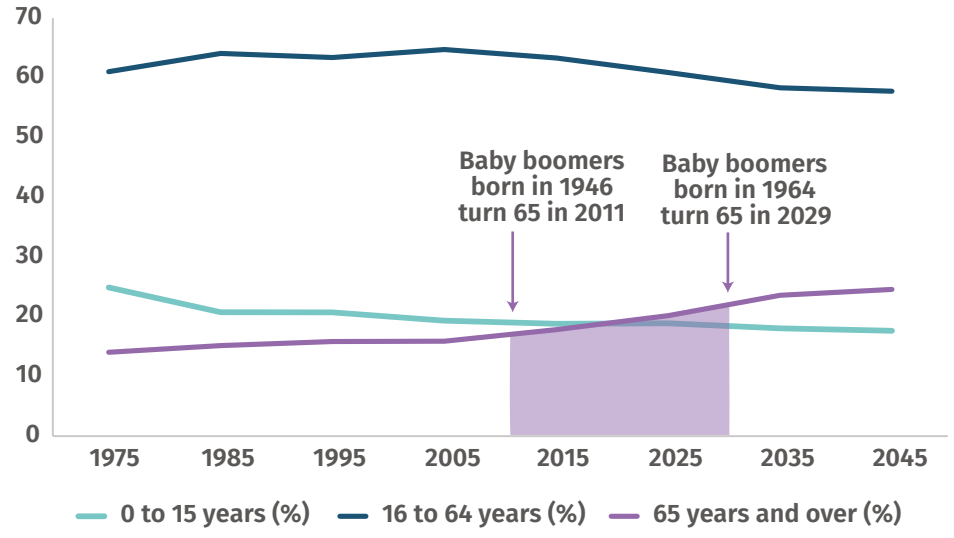
But regardless of its funding settlement, the NHS is in dire need of fundamental reform. The 2020s will be a decade of disruption with a growing and ageing population, a rising tide of chronic illness, higher expectations of care from the next generation, and new treatments and technologies coming on stream. These transformations require the NHS to evolve in order to be fit for the 21st century. After all, in healthcare, to stand still is to fall back. This is the task facing the NHS long-term plan: it must confront and overcome the challenges facing the NHS rather than duck them.

The NHS long-term plan must set out a bold plan for change. This plan must aim to return access to care to pre-crisis levels, improve the quality of care across England, and drive better, and more equitable, health outcomes. Achieving all of this will not be easy, particularly given that the funding settlement is less than most commentators believe is necessary to drive major improvements in care. But it is far from impossible. A pre-requisite will be maintaining or improving productivity levels in the NHS: indeed, this is an explicit condition placed on NHS England by the Treasury as part of the funding deal.

This will be challenging. Productivity in the NHS has grown by around 1.4 per cent a year on average since 2009 (and has outpaced productivity in the economy as a whole). This is well above the NHS's long-term average of around 0.8 per cent. However, the main sources of productivity relied upon over the last few years – in particular, holding down wages and reducing the tariff paid to hospitals for activity – are running out of road. This implies that future productivity increases will instead require more fundamental reform in the way in which care is delivered. There are no longer any 'quick fixes': maintaining the status quo in the NHS is simply not an option.

FIGURE 1.2

Increase in the share of people over the age of 65 relative to younger groups



Source: Carnall Farrar Analysis

This is the scale of the task facing those authoring the NHS long-term plan. Delivering on its potential will not be easy, but neither is it impossible. This paper re-visits the Lord Darzi Review of Health and Care with the aim of supporting the NHS to achieve the best possible outcome from the long-term plan. It does this by answering two crucial questions:

1. What should the NHS long-term plan prioritise in terms of funding and reform?
2. What does the NHS need from the rest of government to ensure that the long-term plan is a success?

2. WHAT SHOULD THE NHS LONG-TERM PLAN PRIORITISE?

Money alone will not be enough to address the challenges facing the NHS. Bold reform is needed to ensure that our health and care system is fit for the 21st century. This is the main task facing the NHS long-term plan. This reform agenda must go beyond the way that the NHS is administered to how care is actually provided. More specifically, there is a growing consensus that care will need to become more preventative, joined up, accessible and personal. This vision was set out as part of the Lord Darzi Review and is presented below.

BOX 2.1: PRINCIPLES OF NHS REFORM

Care must become more preventative

This means intervening earlier to prevent ill health rather than waiting for people to get ill. It will require a shift from a paternalistic model of care where doctors are experts and patients are recipients to one where both work together to co-produce care plans that are led by the patient in the community. NHS and social care staff will need to 'make every contact count' in shaping people's behaviours and utilise all of the best practice preventative interventions available to them, including new science and technology, as well as peer support groups and social prescribing.

Care must become more joined up

This means treating the whole person rather than individual medical symptoms. Support for physical, mental and social health must be fully joined up, and the divide between people's health and social care must also be closed. Services will need to be provided in the community where possible. People will still want a single point of contact, but this must be complemented with support from a wide range of professionals – including community nurses, social workers, and community-based mental health teams as well as wider public services and the voluntary sector – with technology used to communicate and work together to meet the care needs of each individual.

Care must become more accessible

This means delivering care at the right time and in the right place. This is partly about reversing the increases in waiting times seen in the last decade. But it's also about changing where and how care is delivered. People with low intensity (one-off) needs will increasingly receive care remotely using new technologies (telehealth or telecare) or in person using easy access hubs which open out of hours to suit the needs of the patient.

Care must become more personal

This means tailoring care to the needs of the individual. It's about giving patients choice over what care they receive and where they receive it. It requires health and care staff to work with each patient – treating them as

an individual – to co-produce a care plan which speaks to their needs and wants. It means ensuring the heath and care service is professional but also relational. New developments such as genomic sequencing will also be a huge step towards personalisation. A universal service should be there for everyone, but not the same for everyone.

Source: Darzi (2018)

In some areas, the NHS has started to make progress on delivering on this agenda. Sustainability and transformation plans (STPs) have been published for 44 health and care economies, authored by partnerships of local health and care commissioners and providers. The most advanced of these are in the process of delivering new models of care (NMC) (Collins 2016) – sometimes known as the 'vanguards' – and becoming integrated care systems (ICSs) (Charles 2018).

Yet substantial progress on delivering more preventative, joined up, accessible and personal care is still the exception rather than the norm. Even a generous summation of the scale of the change programme finds that the number of people served by NMCs is less than half (approximately 48 per cent) of the population (Darzi 2018). Significantly fewer areas are in line to become an ICS, with just 10 localities set to proceed. Even the most advanced schemes are yet to deliver significant improvements in quality and efficiency at scale.

The task facing the long-term plan therefore, is not to re-invent the wheel but to build on this progress. This means deepening reform in those areas where it has begun to take hold but also mainstreaming it across the country. This will require the NHS to focus less on what the vision of the future is and more on how we go about delivering it. In doing this, the Lord Darzi Review of Health and Care holds four key messages for the NHS. These are set out below.

MAKE 'QUALITY' THE ORGANISING PRINCIPLE OF THE NHS

The first and most basic objective of all healthcare services is universal coverage and access to healthcare when it is needed most. As a goal, this is uncontested in every country. Once universal coverage has been achieved – as it has in the UK – health systems must shift their focus from the quantity of care being delivered to its quality and efficiency. This is ultimately what patients care about: is their experience of care positive and is it both effective and safe (Darzi 2008)?

Despite nearly a decade of austerity, quality in the NHS has been improving (Darzi 2018). From cancer to stroke, mental health to patient safety, things have improved since *High quality care for all* (Darzi 2008) a decade ago. This is testament to what can be achieved when quality is put at the heart of the system. However, the reality is that the NHS lags behind other developed countries in the quality of care it is able to deliver in areas such as cancer, stroke and COPD and in other areas like mental health, improvement has been for a low base (Dayan et al 2018).

The long-term plan must ensure that the progress made over the last decade is locked in, but it should also set out to meet or exceed the best performing health and care systems in a decade's time. This means recommitting to quality as the organising principle in the NHS. The Lord Darzi Review suggested that this could be achieved by **re-launching the National Quality Board – to be chaired by the secretary of state for health and social care – and tasking this body with authoring and overseeing the implementation of a new quality strategy for England**.

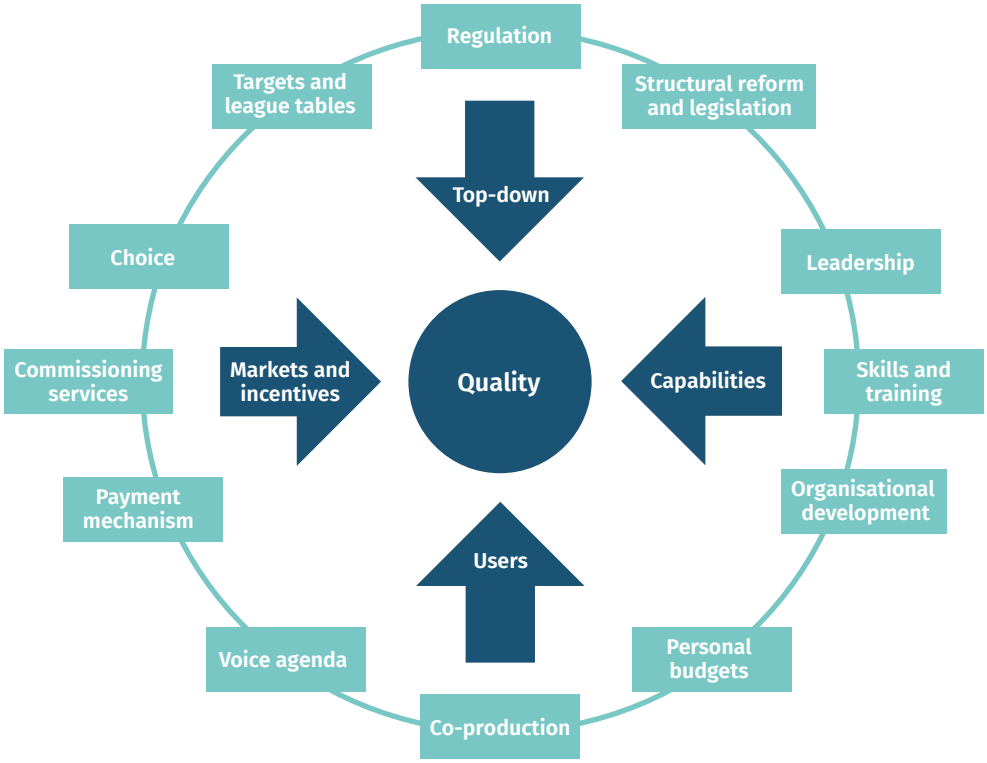
New polling commissioned for this report and undertaken by ComRes adds weight to the call for quality improvement to be the main priority of the long-term plan (see box 2.1 below). This polling shows that improving the quality of cancer treatment

is the public's top priority, while improving the quality of mental health treatment is the third highest. The latter is correlated to age: better quality mental health care is the top priority for those aged 18 to 24 (but is lower for those aged over 55).

Historically, policy makers have focused on 'hard levers' for quality improvement (Ham 2014) such as performance targets, league tables, regulation, competition and structural change. These can be effective but are limited: they drive compliance with a basic minimum standard but cannot deliver a culture of improvement that will move care from good to excellent. **The long-term plan should therefore drive 'reform from within' by focusing on 'soft levers' such as staff and patient empowerment and fostering leadership and culture change within NHS organisations** (Molloy et al 2016).

FIGURE 2.1

A framework for thinking about change in the NHS



Source: Adapted from Cabinet Office (2006)

DELIVER A 'NEW DEAL' FOR PRIMARY AND COMMUNITY CARE

Shifting care into the community and away from the acute sector has been a system objective for a long time. The case in favour of this change is well evidenced: healthcare systems that invest more in primary and community care are more likely to deliver better health outcomes – including lower mortality rates, fewer premature deaths, higher satisfaction with the healthcare system and a decrease in utilisation of hospitals and emergency departments (Macinko et al 2003).

One of the main barriers to achieving this has been that funding for primary and community care has consistently grown more slowly than acute funding and has rarely met the promises made by policy makers (Baird 2017). For example, the evidence suggests that the majority of the funding allocated for 'transformation and sustainability' at the start of the *Five Year Forward View* (NHS 2014) has been

put into acute providers to reduce deficits rather than used for delivering change (NAO 2018).

The long-term plan is an opportunity to reverse this trend. Without such investment in primary and community health services, the shift towards integrated, preventative and community-based care is virtually impossible. The long-term plan should therefore **make a commitment to ensure that primary care and community care both consistently grow faster than acute sector funding – and therefore increase as share of NHS spend – year-on-year**.

But simply shifting money around will not be enough: it will only lead to better outcomes if it enables a shift in the model of care delivered.

To deliver this, the Lord Darzi Review proposed **the creation of new integrated care trusts (ICTs) which would be responsible for the holistic care needs of entire local populations**. These organisations would build on the new models of care (NMCs) and specifically focus on providing better out-of-hospital care by bringing all local primary, community, mental health and social care needs into one organisation. They should be given the entire NHS budget for a local area with funding deducted from this budget (to fund the local acute provider) when the ICT fails to keep the patient in the community.

To enable this shift, the evidence is clear that transformation itself will need funding (HFKF 2015). Previous transformations have required funding for programme infrastructure, staff time away from day-to-day responsibilities, changes to physical infrastructure (such as technology, buildings and in some cases double running of services for a transition period). If the long-term plan really wants to driver a major shift in the model of care in the NHS **it should create a sizeable transformation fund (approximately 1 to 2 per cent of the NHS spend) to make it happen**.

Moving care out into the community is increasingly a priority for the public. New polling commissioned for IPPR and undertaken by ComRes shows that while overall higher, quality community care is not as important as other areas (ranking 12th out of 16 priorities), the older someone is the more important it becomes (sixth of 16 priorities for those over 55 years of age). This confirms existing evidence which suggests that older people have a strong preference to receive care and die in their own home.

INVEST IN THE TALENT OF THE TEAM

Around 1.2 million people are employed by the NHS in England. They are the engine of high-quality care. Our NHS depends on the talent and commitment of the whole team, whether nurses, doctors, porters or cleaners. The evidence that understaffing leads to poorer quality care – and puts safety at risk – is now well established. Likewise, poor leadership and demotivated staff are a pre-cursor to system failure. This makes the workforce trends experienced over the last decade all the more concerning.

Staffing gaps are large and growing (NHS 2017). One in nine nursing posts are unfilled (double the rate of just four years ago) (Molloy et al 2017). This trend is replicated across the whole service. Too often, morale is low, leading to poor retention of staff – while too few are joining the profession in the first place. This situation is exacerbated by the recent pay freeze, by a lack of training and development opportunities and by a lack of empowerment of staff (who feel unable to prioritise high quality care).

Underlying all of this is also a failure to undertake proper workforce planning. The NHS has over 40 organisations with a direct role in workforce recruitment, retention and development but no one organisation coordinates these efforts into a coherent

workforce strategy. The closest we have to a system leader is Health Education England but there is a growing consensus that it does not have the ability or the firepower to coordinate what is a very strong set of representative organisations into a joined-up approach bold enough to address the scale of the challenge (HoL 2017).

The long-term plan must address this: if it doesn't it will fail to deliver on its potential. **The long-term plan should join up Health Education England and NHS England (in a similar process to the one being undertaken between NHS Improvement and NHS England) to author a long-term workforce plan and make the case to the Treasury for further investment in training and staff development**. This strategy should aim to **ensure that England is self-sufficient in the education and training of doctors, nurses and allied health professionals by 2030**.

Polling commissioned for this research by IPPR and undertaken by ComRes finds strong support for bold action on the NHS workforce. Recruiting, retaining and training was the public's second highest priority and is the highest priority for those over the age of 55. Increasing pay for NHS staff is given slightly less priority, ranking eighth out of a possible 16 priorities. Together, this demonstrates significant public support for making investment in staff a major priority for the new NHS funding.

MAKE DATA, TECHNOLOGY AND INNOVATION THE MAIN DRIVERS OF CHANGE

Big data and technology are transforming society. Everything from how we shop to how we socialize, from how we bank to how we date is changing. But while our businesses and personal lives have been transformed, the NHS has failed to fully embrace the fourth industrial revolution. For example, 73 per cent of UK citizens have access to a smartphone and 90 per cent have access to the internet (ONS 2017), yet only 2 per cent of the population report any digitally-enabled transaction with the NHS (Imison et al 2016).

It is time for this to change. The opportunities are significant. From smartphones to wearables we can now get closer to patients and help drive healthy behaviours. Big data can combine with machine learning to change the model of care from 'diagnose and treat' to 'predict and prevent'. Soon whole populations will have their genome sequenced, allowing us to bypass 'trial and error' and provide medicine which is safer, more effective and more efficient.

Automation is a huge opportunity for the NHS. The Lord Darzi Review of Health and Care calculated that if all of the potential for automation of current roles were realized, there could be a productivity improvement valued at £12.5 billion a year (Darzi 2018). This is equivalent to 9.9 per cent of the NHS budget in England. This could help reduce staffing gaps in the service and release time for staff to care – something that would improve both patient outcomes and staff retention.

Likewise, the NHS has some of the richest datasets in the world. If properly integrated, it could be the major driver of co-ordinated care by providing all medical professionals with the same patient information – improving patient experience, making care both safer and higher quality and (in some cases) reducing the cost of care (Honeyman et al 2016). A few areas are already benefitting from this (Kent and Medway, Tower Hamlets and north west London) but for too many, data is fragmented and under-utilised.

Delivering these benefits calls for fundamental change: notably investment in the basic digital infrastructure and integration of datasets across the country. This will require all of the funding set out by the Wachter Review (Wachter 2016), some of which sits outside of the funding settlement provided by the government so far. However, **the long-term plan should first of all ensure that all NHS trusts have a chief technology officer at board level with the resources to begin driving change**.

Likewise, **the NHS long-term plan should also work with government to establish a new information governance system – to replace Caldicott principles – that better balances the need to deliver better quality, safer and more efficient care with privacy**. It should then **mandate every local health economy to create an integrated data set**, building on the work in Kent and Medway, Tower Hamlets and north west London. Our polling finds that the public do not want to prioritise digital health, but they do value high quality care: so where technology can help deliver this, it should be prioritised.

BOX 2.1: PUBLIC PRIORITIES: WHAT SHOULD THE FUNDING SETTLEMENT BE SPENT ON?

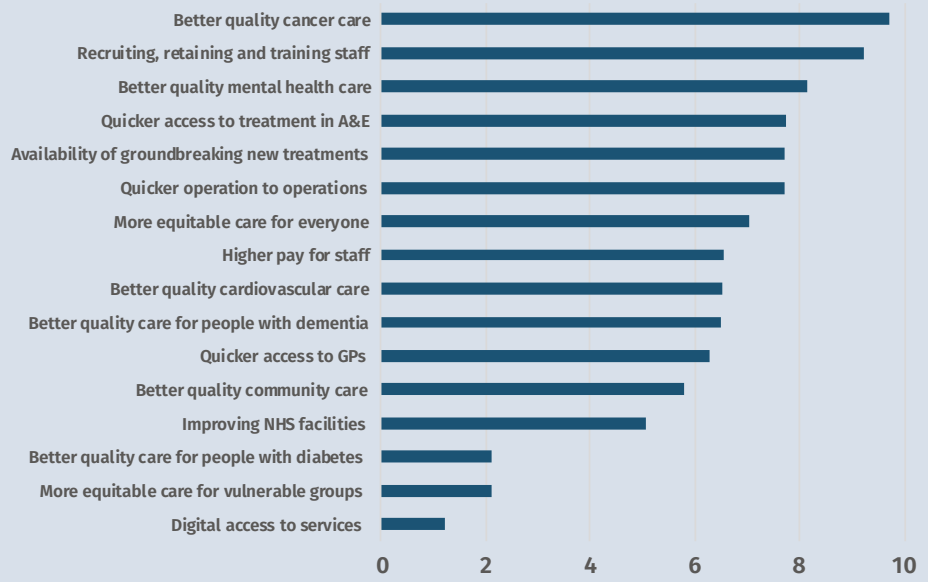
IPPR commissioned ComRes to interview approximately 1,800 adults (aged 18 and over) in England to understand how they would prioritise – and trade off – various areas of NHS spending. The exact question asked was: 'The NHS is set to receive an additional £20.5 billion over the next five years. From the list below, please choose the area you feel is the most important in terms of NHS funding, and which area is the least important.' A list of 16 options was then listed (see below).

MaxDiff analysis was conducted on the data to identify the perceived importance of each option relative to the others tested. This generates a relative importance score for each option. In the data, this is represented via a mean importance score between 0 and 100. These scores can be understood in terms of the proportionate distance between them. For instance, if option A has a score of 5 and option B has a score of 10, this can be interpreted to mean that the public are twice as likely to prioritise option B than option A.

The results show that the top three areas the public are most likely to prioritise in the NHS are better quality cancer treatment (9.8), recruiting, retaining and training staff (9.3), and better-quality mental health care (8.2). Meanwhile, they consider digital access to services (1.2) and more equitable care for vulnerable groups (2.1) to be the lowest priorities (see figure 2.2).

FIGURE 2.2

Relative importance placed on spending priorities as determined by the MaxDiff score



Source: ComRes Polling

There are significant differences in opinion between different population groups in England around how NHS funding should be allocated. For instance, NHS funding for better quality mental health care is the top priority for those aged 18–24 (9.7), but is much lower for those aged 55 and over (just 7.1). By comparison, the 55 and over age group are more likely to consider better quality community care to be a priority for NHS funding (6.9 versus 4.5 among those aged 18–34 and 5.8 among those aged 35–54). There are limited differences by age or by region of the country.

CONCLUSIONS

The main task facing the NHS long-term plan is to drive bold reform in the model of care delivered up and down the country. It should not look to re-invent the wheel: rather, the vision set in the *Five Year Forward View* (NHS 2014) – of a more preventative, joined up, accessible and personal service – stands the test of time. The challenge is delivering on this vision. To do this, the long-term plan should take heed of the main messages set out in the Lord Darzi Review of Health and Care by making quality the organising principle of the NHS, delivering a 'new deal' for primary and community care, investing in the talent of the team, and unleashing the power of data and technology across the NHS.

3.
WHAT DOES THE NHS NEED FROM GOVERNMENT?

The NHS long-term plan presents a significant opportunity to deliver a fundamental shift in the way healthcare is delivered in this country. Get it right and we can improve access, drive up quality, deliver better outcomes and reduce inequalities. NHS England must do all in its power to make this a reality. But we must also recognise that the NHS cannot achieve this transformation on its own: it will require bold action across the whole of government to deliver high quality care for all, now and in the future.

This is partly because the majority of health outcomes are determined not by the health system (in this case the NHS) but by wider social, economic and environmental conditions. We need a 'health in all policies' approach in the 2020s to really address inequalities and deliver on the potential of prevention. But it's also because the NHS relies on partnerships with other government services to deliver its basic delivery functions (like social care) and is affected by policy decisions made in other parts of government (for example immigration policy).

Only by undertaking a co-ordinated approach to health across all government departments and being as ambitious across government as we have been on the NHS, can we deliver high quality care for all in the 2020s. In this chapter we therefore build on the work of the Lord Darzi Review of Health and Care and set out four key 'tests for government' that we believe will need to be met in order for the NHS long-term plan to succeed. These should not be seen as optional extras: they should be a core part of the government's offer to patients and the public.

A SOLUTION FOR SOCIAL CARE

By 2030, the number of people over the age of 65 is set to increase by 30 per cent (Darzi, 2018), with a corresponding increase in the demand for care. Funding for this care cannot come from existing local government budgets: already vital services are being cut (by 5 per cent per year since 2010), with people increasingly left to self-fund, rely on informal care or go without.

This is morally problematic – there is a case for further investment in social care in its own right – but it's also inefficient for the NHS. Nearly 2.3 million hospital bed days were lost to delayed transfer in 2016/17 (up from 1.4 million just five years before) though there has been a decrease more recently (Andrews et al 2017). Bed audits also show that four times this number of patients in hospital are medically fit to leave (ibid). On an annualised basis, this is costing the NHS around £3 billion (ibid).

Likewise, as it stands, around half of all deaths in England occur in hospital. Other countries experience much lower rates. This failure to shift care out of hospital is costly. On average, the last year of life costs around £10,000 per patient (aged 80–84) (Hazra et al 2017); this figure could be reduced significantly if end of life care was shifted into the community (for example, a move towards palliative care) (PHE 2017). But this requires investment in both community and social care.

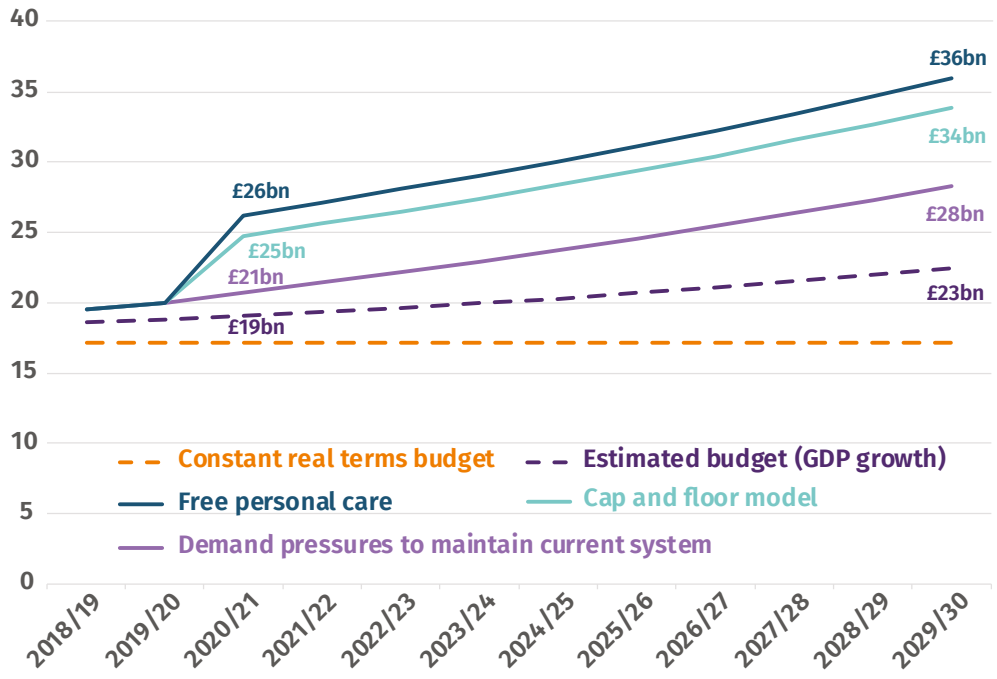
Whichever way you look at it, the case for comprehensive funding and reform of social care is unassailable. Investment in social care makes good sense. If social

care were a medicine, it would be NICE approved. Moreover, it is the right thing to do for elderly people and their families. The government has promised reform as part of its upcoming Green Paper on social care, but the sector is sceptical about whether it will deliver on its promise. The government must prove them wrong.

FIGURE 3.1

Social care will need significant funding increases in the 2020's

Social care funding gap (£billion) under various policy scenarios



Source: Bottery et al (2018), IPPR calculations using data from PSSRU

The Lord Darzi Review called for the **introduction of universal, free-at-the-point-of-need personal and nursing care for adults in England to be funded out of general taxation at a national level**. This would be costly (see figure 3.1) – assuming spending on social care were set to rise in line with increases in the tax base anyway, an additional £7.8 billion per year would be needed by the end of the parliament – but would drive savings in the NHS and deliver improved outcomes for older people (Bottery et al 2018). It is also popular with the public. **This universal care should be introduced alongside a greater drive to integrate health and care in terms of commissioning, provision and the workforce.**

PRIORITISING PUBLIC HEALTH

Close to half of the burden of illness in the UK is associated with four main unhealthy behaviours: smoking, excessive alcohol consumption, poor diet and low levels of physical activity (Buck and Frosini 2012). These behaviours are linked with significant numbers of early deaths in the UK each year: around 80,000 for smoking (NHS Digital 2017), 7,000 for alcohol (ONS 2015) and 30,000 for obesity (National Obesity Forum 2018). While smoking and excessive alcohol consumption has been declining in England, there is still much further to go. Meanwhile, the obesity crisis has been worsening (Darzi 2018).

These behaviours exhibit a clear social gradient: there is a strong correlation between income, education and class and the likeliness that someone smokes, drinks, has

a bad diet and/or lives a sedentary lifestyle (Buck and Frosini 2012). Evidence also shows there is a clustering effect: a large minority of people in England – around one-quarter – exhibit three or more of these behaviours simultaneously (ibid), increasing their risk. There is a strong moral case for intervention.

There is also a compelling economic and fiscal case for investing in early intervention. Smoking costs our economy in excess of £11 billion per year, of which around £2.5 billion falls on the NHS (DoH 2017). Obesity is even more expensive, totalling £5.1 billion to the NHS every year, with the wider costs to society estimated to be over five times that amount (HoC 2015). And finally, alcohol consumption costs society as a whole £52 billion per year, around £3 billion of which comes from is to the NHS (PHE 2016).

The Lord Darzi Review of Health and Care was clear that progress on reducing smoking should be maintained by **extending smoke free areas onto our highstreets and parks alongside other public places**. England should also step up action to address alcohol consumption by **following Scotland's lead and introducing a minimum unit price on alcohol** (BMJ 2017). We must also act urgently to address the obesity crisis in England. We should learn from Australia, Finland and Norway by **extending the sugar tax to include milk drinks, cakes, biscuits and confectionary**, as well as **making changes to laws on advertising and including student's health in the OFSTED inspection regime**.

BREXIT AND THE WORKFORCE

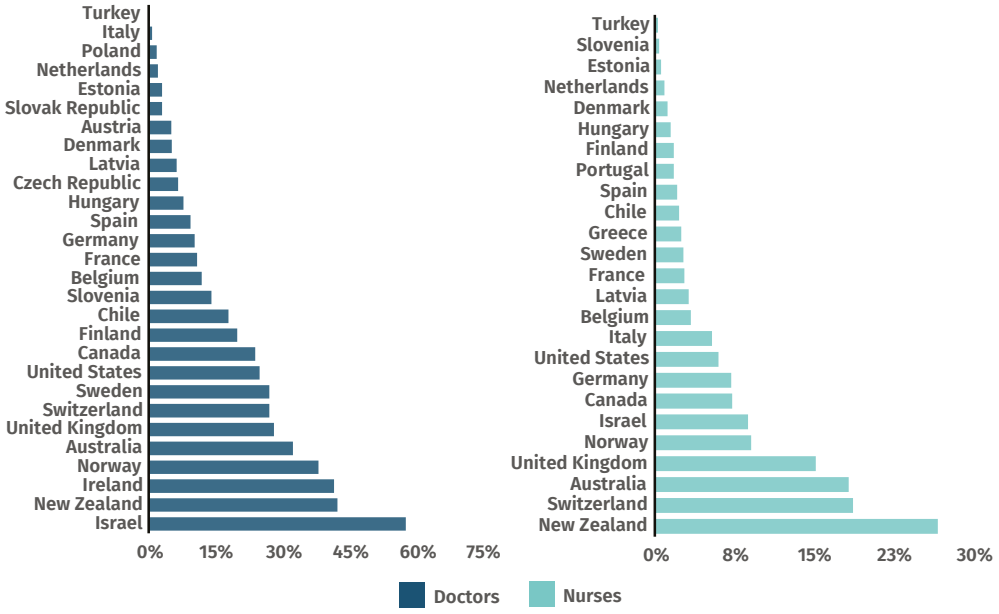
Brexit will have an impact on a range of areas of NHS policy. But the most concerning is the workforce. While the goal should be for the NHS to become self-sufficient with regards to health and care workers by increasing training and development opportunities over time, the immediate workforce shortages must be addressed through immigration. This is because it takes at least 10 years to train a doctor and three years to train a nurse.

Reliance on internationally trained staff has been one of the main policy responses to staff shortages over the last decade or so. While the UK has long been more dependent on doctors and nurses trained internationally than other countries (see figure 3.2), this dependency has grown of late (Molloy et al 2017). The EU in particular has become an increasingly important source of human capital for the health and care sector in recent years, making up 5.6 per cent and 7 per cent of NHS and social care workforce respectively (McKenna 2017).

An end to freedom of movement as a result of Brexit – without a corresponding increase in immigration from outside the EU – could significantly exacerbate staff shortages. Indeed, there is some evidence that the vote is already having an impact on recruitment: for example, the number of EU nationals registering as nurses in the UK has fallen by 96 per cent since the referendum according to the Nursing and Midwifery Council (NMC 2017).

FIGURE 3.2

Percentage of internationally trained nurses and doctors working in the UK, 2016



Source: Darzi (2018) using OECD data

The government should therefore ensure that they prioritise a Brexit deal and an immigration system that is favourable to health and care staff. This could be achieved by obtaining a Brexit deal that retains free movement of labour. However, given the current government's stance on Brexit, it seems more likely that we will have to prioritise a post-Brexit immigration system that gives preference to people with the skills needed to fill gaps in both health and social care.

As a minimum, **the government should exempt all NHS workers (and senior care workers) from the Tier 2 cap2, agree an extended transition period for EU freedom of movement for health workers (six years) and social care workers (three years), and offer British citizenship to all EU citizens currently working in the NHS**. Only by delivering on this will we be able to ensure that the NHS is properly staffed in the years to come.

IMPLEMENT THE LIFE SCIENCE STRATEGY

Healthcare operates at the limits of science, constantly pushing the boundaries of what is possible through new discoveries and breakthroughs. The UK is at the forefront of this scientific and technological frontier. As we enter the next wave of innovation – from robotics and AI to new treatments such as cell and gene therapies – it is crucial that we maintain or improve this position. This will require co-ordinated effort across government to promote the sector.

2 The immigration system currently operates very differently for EU and non-EU nationals. As it stands, EU citizens have a right to live and work in the UK with few restrictions, and so can be hired in the health and social care sector with no more bureaucracy than for UK workers. Non-EU citizens, on the other hand, typically have to be recruited through the Tier 2 system for skilled workers, which has become increasingly restrictive over the past decade. It requires employers to sponsor their prospective migrant employee, meet certain salary and skills thresholds, and pay a range of additional visa fees and charges. Tier 2 migrants are also subject to an annual and monthly cap.

Innovation in health and care is a major driver of improvements in our health. Some studies suggest that up to 50 per cent of the increase in life expectancy between 1960–90 is attributable to science, technology and innovation (Wang et al 1999). This is valuable in its own right but is also a driver of growth. As too is the life science sector at large, which already generates around £64 billion in revenue each year, employing a quarter of a million people nationwide (OLS 2016) – and it is growing.

As a result, there is the potential to create a virtuous cycle by simultaneously improving health and wealth in the UK. But there are a number of barriers in the way. Notably, the UK spends significantly less on investment in research and development (R&D) than other developed countries: 1.7 per cent of GDP in 2015, compared with 2.8 per cent in the US, 2.9 per cent in Germany and 3.5 per cent in Japan (Jacobs et al 2017). **The government must correct this by at least matching the upper quartile of OECD R&D spend – around 2.6 per cent of GDP – in the next five years.**

The UK is also relatively slow at implementing innovation across the NHS, and on some measures this is getting worse over time (OLS 2018). Government funding cuts have led to the introduction of a new affordability criteria for treatments (with up to one in five new medicines to be delayed despite being deemed cost effective). **This should be reversed**. In fact, the role of NICE should be expanded. As it stands NICE is not the default gateway for specialized medicines or devices. This should be change **with NICE given a remit over all innovation and powers to ensure its guidance is taken up at the local level.**

BOX 3.1: BREXIT AND INNOVATION POLICY

Brexit may make ramping up investment in the life science sector harder. The UK is a key contributor – but net beneficiary – of a number of EU medical research schemes such as Horizon 2020. While the UK government has said it will guarantee money won under Horizon 2020, this does not secure the biggest prizes of membership: eligibility for future funding rounds. **The government must negotiate continued participation in Horizon 2020 and other EU research programmes, potentially as an associate member** (Dayan 2017).

Brexit also poses a risk to access to medicines in the UK. We are currently part of the EU's systems of medicines regulation: this means regulation is coordinated centrally across Europe by the European Medicines Agency (EMA). A similar process is undertaken for medical devices through the CE marking scheme, which certifies compliance with relevant EU law (ibid). We need to ensure we retain these benefits post-Brexit. **The UK must negotiate to remain part of the European Medicines Agency and other health innovation regulation.**

A 'RADICAL SIMPLIFICATION' OF THE NHS

The health and care system has grown in complexity over the past 70 years, becoming ever more fragmented (Timmins 2012). This has been exacerbated by the Health and Social Care Act 2012, which: fragmented commissioning across primary care trusts, NHS regions, NHS England and local government; abolished local system leaders (most recently known as strategic health authorities [SHAs]) which used to lead local change programmes; and confused the national landscape with roles split between the Department of Health, NHS England, Health Education England, Public Health England, Monitor and NHS Trust Development Authority (now NHS Improvement), and the Care Quality Commission.

In other areas, the 2012 Act was merely the culmination of a 30-year experiment, further entrenching the internal market and the role of competition in the NHS. There is very limited evidence that this change led to improved outcomes or efficiency (Propper et al 2004, 2008a). Meanwhile, there is strong evidence that it has increased transaction costs (Paton 2014). Putting services out to tender usually results in NHS providers continuing to provide services but leads to significant costs, both direct (such as staffing commissioners) and indirect (like changeover disruption).

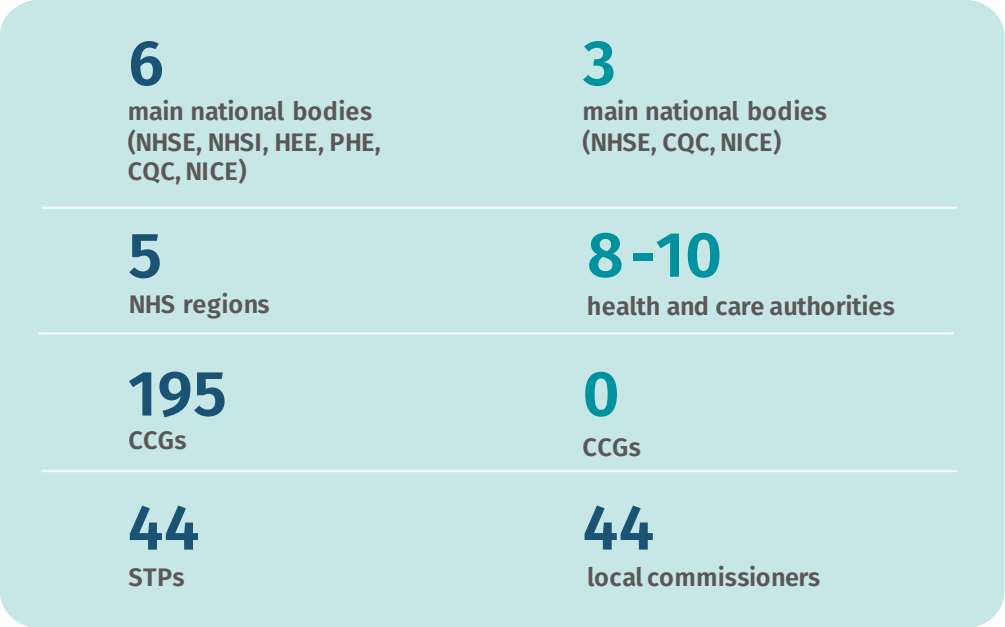
These changes have made delivering the transformation in care needed across the NHS more challenging. Fragmented commissioning invariably leads to fragmented provision. The lack of a local system leader makes co-ordinating change programmes and reform almost impossible, with the provider/commissioner split making this worse still. And this is further exacerbated by the fragmentation of national leadership functions, which often lead to conflicting priorities and instructions at the local level. All in all, it is becoming increasingly clear that if we are going deliver the change that we all agree is needed, we are going to need 'radical simplification' in the NHS. This will require new legislation and is therefore not within the gift of the NHS alone.

The Lord Darzi Review set out what this might look like. Firstly, at a national level, it recommended the **creation of a single NHS headquarters incorporating NHS England, NHS Improvement and Health Education England**, and the health protection and delivery functions of Public Health England.[3] Secondly, at **a regional level, all elements of the health and care system (primary, community, acute, mental health, social care and some specialised care) should be consolidated into five to 10 single health and care authorities (HCAs)**. Thirdly, at the local level, **STPs should be given a statutory footing and a role over both health and care**. And finally, we should **end the compulsory competitive tendering requirements for all services**.

3 The service delivery elements of health protection in Public Health England (the national screening programme, vaccinations and immunisations, addiction services, and sexual health services) should be transferred to the NHS headquarters. The health promotion functions should be delegated in full to local authorities, with the budget flowing directly from the Department of Health to local government. National policymaking for public health should continue under the chief medical officer of England in the Department of Health.

FIGURE 3.4

Proposed changes to the health and care structure



Source: Darzi 2018

CONCLUSIONS

The NHS long-term plan is a significant opportunity to deliver a fundamental shift in the way healthcare is delivered in this country. NHS England must do all in its power to make this a reality. But we must also recognise that the NHS cannot achieve this transformation on its own. Politicians must show equal ambition across all areas of government. In particular, for NHS long-term plan to succeed, it will require: a funding deal for social care; a plan for public health and the social determinants; an immigration policy that recognises the needs of the NHS; the full implementation of the life sciences strategy; and a 'radical simplification' of the NHS requiring new primary legislation. Without these conditions being satisfied, the NHS will struggle to deliver high quality care in the 2020s.

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