NHS
West Kent
Clinical Commissioning Group

# Agenda and Papers

for the

# NHS West Kent Clinical Commissioning Group Governing Body

To be held on

## Tuesday 27 August 2013
## At 1.30 pm

In

## The River Centre, Medway Wharf Road, Tonbridge, Kent, TN9 1RE

## Summary Financial Position

The CCG is reporting on plan for Month 4. Across the year as a whole the CCG continues to reflect the planned surplus of 1% (£4.66m).

In addition, the table adjusts financial performance for NR applications of funds. The principal item is the 2% Headroom reserve (£9.3m), together with a small amount of Non-recurrent expenditure items (£0.8m). Adjusting the planned in-year performance for these items produces an underlying recurrent surplus of £14.8m.

**A summary of the CCGs financial performance is shown in the Table below: £'000**

| | Year to Date | | | Full Year | | |
|---|---|---|---|---|---|---|
| | Original Plan per NHSE | Actual | Variance | Original Plan per NHSE | Revised Plan/Forecast | Variance |
| **Total Resource Limit** | 158,923 | 152,800 | 6,123 | 482,426 | 474,061 | 8,366 |
| **Total Programme costs** | (153,470) | (147,412) | (6,058) | (466,067) | (457,896) | (8,171) |
| **Total Administration** | (3,900) | (3,835) | (65) | (11,700) | (11,505) | (195) |
| **Total Expenditure** | (157,370) | (151,247) | (6,123) | (477,767) | (469,401) | (8,366) |
| **Net Surplus /(Deficit)** | 1,553 | 1,553 | 0 | 4,660 | 4,660 | 0 |
| **Non Recurrent Items** | 3,364 | 3,364 | 0 | 10,093 | 10,093 | 0 |
| **Underlying Surplus /(Deficit)** | 4,917 | 4,917 | 0 | 14,753 | 14,753 | 0 |

# Overall Financial Position

The CCG position reported for Month 4 is a surplus in line with planned levels.

Corporate running costs are performing below budget at the present time due to £65,000 underspend on pay costs year to date from vacancies and appointments due to start. The use of interim staff is eroding the level of pay under expenditure against budget and should the long term use of interim staff continue, this under expenditure could be completely eroded. The Acute Trust position for the CCG reflects the impact of MTW performance of a £1.25m year to date over performance which would project forwards to an over expenditure of £3.75m. The Governing Body should be aware that this position does not reflect the full extent of the Trust reported over-performance, and an assumption is included as to the impact of contractual challenges and contract efficiencies. The difference between the Trusts reported position and the CCG position clearly represents a financial risk within the local health system. This forecast position is currently being mitigated by the forecast deployment of contingency and reserves.

Remaining service line budgets are set to plan at this stage. In some instances where over-performance against issued budgets has been indicated, the CCG has available specific reserves, which are at this stage sufficient to offset any adverse position.

| Year To Date | Plan | Actual | Variance |
|---|---|---|---|
| **Overall Financial Position** | **152,800** | **151,247** | **1,553** |

| Year End Forecast | Plan | Forecast | Variance |
|---|---|---|---|
| **Overall Financial Position** | **474,061** | **469,401** | **4,660** |

| **Year To Date** | **Plan £'000** | **Actual £'000** | **Variance £'000** |
|---|---|---|---|
| Mental Health | 12,839 | 12,839 | 0 |
| Acute | 86,071 | 87,321 | -1,250 |
| Primary Care | 24,674 | 24,674 | 0 |
| Continuing Care | 10,220 | 10,220 | 0 |
| Community Health Services | 11,831 | 11,831 | 0 |
| Other | 3,265 | 527 | 2,738 |
| **Total Programme costs** | **148,900** | **147,412** | **1,488** |
| Corporate (Running Costs Allowance) | 3,900 | 3,835 | 65 |
| **Total Administration** | **3,900** | **3,835** | **65** |
| **Total** | **152,800** | **151,247** | **1,553** |

| **Year End Forecast** | **Plan £'000** | **Forecast £'000** | **Variance £'000** |
|---|---|---|---|
| Mental Health | 38,517 | 38,517 | 0 |
| Acute | 258,214 | 261,964 | -3,750 |
| Primary Care | 74,023 | 74,023 | 0 |
| Continuing Care | 30,659 | 30,659 | 0 |
| Community Health Services | 35,493 | 35,493 | 0 |
| Other | 25,455 | 17,240 | 8,215 |
| **Total Programme costs** | **462,361** | **457,896** | **4,465** |
| Corporate (Running Costs Allowance) | 11,700 | 11,505 | 195 |
| **Total Administration** | **11,700** | **11,505** | **195** |
| **Total** | **474,061** | **469,401** | **4,660** |

## Statement of Financial Position

The work to transfer balances from the former West Kent PCT into legacy organisations continues. The CCG has now received the transfers with respect to Fixed Assets (primarily IT related) - £500k, and still anticipating any legacy debtors/creditor balances where transactions have not yet been concluded. It is expected that this legacy programme work will continue through until the end of September. Progress is being made towards addressing the delays in processing payments, as measures are put in place to manage invoice validation in the context of new Information Governance rules. Finally, the level of cash balance at the end of July is higher than would be expected as part of managing the on-going position. CCGs have yet to be provided with a formal cash limit for the year. Once this is received, the level of cash drawings will need to be re-profiled and geared towards minimising the level of cash balances at the end of each month.

| | Actual | Notes |
|---|---|---|
| | £k | |
| Property, Plant and Equipment | 0 | |
| Intangible Assets | 0 | |
| Other Assets | 0 | |
| **Receivables** | | |
| Inventories | | |
| Trade and Other Receivables | 2,328 | |
| Cash and Cash Equivalents | 8,052 | |
| Non Current Assets Held for Sale | 0 | |
| **Payables** | | |
| Trade and Other Payables | (25,165) | |
| Borrowings | 0 | |
| Other Financial Liabilities | 0 | |
| Provisions | 0 | |
| Other Liabilities | 0 | |
| **Payables greater than 1 year** | | |
| Provisions | 0 | |
| **TOTAL ASSETS EMPLOYED** | **(14,785)** | |
| **Financed by:** | | |
| Public Dividend Capital | 14,785 | |
| Retained Earnings | 0 | |
| Surplus/(Deficit) for Year | 0 | |
| Revaluation Reserve | 0 | |
| **TOTAL TAXPAYERS EQUITY** | **14,785** | |

| | Plan | Full Year Forecast | Variance | Notes |
|---|---|---|---|---|
| | £k | £k | £k | |
| Property, Plant and Equipment | 873 | 582 | (291) | |
| Intangible Assets | | | 0 | |
| Other Assets | | | 0 | |
| **Receivables** | | | 0 | |
| Inventories | | | 0 | |
| Trade and Other Receivables | | 799 | 799 | |
| Cash and Cash Equivalents | | 15,118 | 15,118 | |
| Non Current Assets Held for Sale | | | 0 | |
| **Payables** | | | | |
| Trade and Other Payables | (23,683) | (12,339) | 11,344 | |
| Borrowings | | | 0 | |
| Other Financial Liabilities | | | 0 | |
| Provisions | (6,767) | (6,767) | 0 | |
| Other Liabilities | | | 0 | |
| **Payables greater than 1 year** | | | | |
| Provisions | (626) | (626) | 0 | |
| **TOTAL ASSETS EMPLOYED** | **(30,203)** | **(3,233)** | **26,970** | |
| **Financed by:** | | | | |
| Public Dividend Capital | (34,863) | (7,893) | 26,970 | |
| Retained Earnings | | | 0 | |
| (Surplus)/Deficit for Year | 4,660 | 4,660 | 0 | |
| Revaluation Reserve | | | 0 | |
| **TOTAL TAXPAYERS EQUITY** | **(30,203)** | **(3,233)** | **26,970** | |

## Activity

The following activity data is provided by NHS England and is in the process of being validated by the CCG. The CCG is over plan YTD within Electives (Daycases) and Outpatients, further analysis has been provided within the Activity Analysis part of this report. The CCG is forecasting to be on plan for the year. The data below is presented as follows - actual for April 13 and May 13 and forecast for June 13 and July 13

The Governing Body should be aware that the Kent & Medway Commissioning Support Unit has identified some specific areas where changes in pathway/processes initiated at MTW have contributed towards the apparent increase in reported activity.

The increase in first outpatient reported activity is particularly significant and is a key focus area for further examination.

| **Year To Date** | **Plan** | **Actual** | **Variance** |
|---|---|---|---|
| **Total Activity** | **72,681** | **80,582** | **7,901** |

| **Year End Forecast** | **Plan** | **Forecast** | **Variance** |
|---|---|---|---|
| **Total Activity** | **294,630** | **294,630** | **0** |

| **Year To Date** | **Plan** | **Actual** | **Variance** |
|---|---|---|---|
| Elective | 10,233 | 11,323 | 1,090 |
| Non-Elective | 9,304 | 8,870 | -434 |
| Outpatient - First Att | 24,821 | 30,674 | 5,853 |
| A&E Att (Avg) | 28,323 | 29,715 | 1,392 |
| **Total Activity** | **72,681** | **80,582** | **7,901** |

| **Year End Forecast** | **Plan** | **Forecast** | **Variance** |
|---|---|---|---|
| Elective | 41,927 | 41,927 | 0 |
| Non-Elective | 37,319 | 37,319 | 0 |
| Outpatient - First Att | 102,093 | 102,093 | 0 |
| A&E Att (Avg) | 113,291 | 113,291 | 0 |
| **Total Activity** | **294,630** | **294,630** | **0** |

# Budget Breakdown

| Year To Date | Plan | Actual | Variance |
|---|---|---|---|
| Overall Financial Position | 152,800 | 151,247 | -1,553 |

| Year To Date | Plan £'000 | Actual £'000 | Variance £'000 |
|---|---|---|---|
| East Kent Hospitals University NHS FT | 1,910 | 1,910 | 0 |
| Medway NHS FT | 1,777 | 1,777 | 0 |
| Maidstone and Tunbridge Wells | 58,779 | 60,029 | 1,250 |
| Dartford & Gravesham NHS Trust | 377 | 377 | 0 |
| South East Coast Ambulance | 4,204 | 4,204 | 0 |
| Queen Victoria Hospital | 1,498 | 1,498 | 0 |
| East Sussex Hospitals NHS Trust | 613 | 613 | 0 |
| High Cost Drugs | 2,474 | 2,474 | 0 |
| Other SEC trusts (incl.contract exclusions) | 286 | 286 | 0 |
| **sub SEC acute trusts** | **71,920** | **73,170** | **1,250** |
| KCHT | 10,288 | 10,288 | 0 |
| GP Prescribing | 21,991 | 21,991 | 0 |
| Non GP Prescribing | 720 | 720 | 0 |
| Primary Care LES | 787 | 787 | 0 |
| Primary Care OOH | 1,177 | 1,177 | 0 |
| Other Community Services | 1,543 | 1,543 | 0 |
| **sub community services** | **36,506** | **36,506** | **0** |
| Guy's & St.Thomas NHS FT | 2,831 | 2,831 | 0 |
| Kings College Hospitals FT | 2,033 | 2,033 | 0 |
| Barts & the London NHS Trust | 154 | 154 | 0 |
| Great Ormond Street Hospital NHS Trust | 82 | 82 | 0 |
| University College London FT | 330 | 330 | 0 |
| The Royal Marsden NHS FT | 372 | 372 | 0 |
| The Royal National Orthopaedic Hospitals NHS Trust | 340 | 340 | 0 |
| Royal Free Hampstead NHS Trust | 83 | 83 | 0 |
| St Georges Healthcare NHS Trust | 282 | 282 | 0 |
| Moorfields Eye Hospital NHS FT | 114 | 114 | 0 |
| Chelsea and Westminster NHS FT | 68 | 68 | 0 |
| Imperial College Healthcare NHS Trust | 139 | 139 | 0 |
| Royal Brompton & Harefield NHS FT | 169 | 169 | 0 |
| South London Healthcare NHS Trust | 1,913 | 1,913 | 0 |
| Other | 1,578 | 1,578 | 0 |
| **Non SEC Acute Trusts** | **10,487** | **10,487** | **0** |
| KMPT | 9,410 | 9,410 | 0 |
| CAMHS | 1,003 | 1,003 | 0 |
| Mental Health Placements | 1,186 | 1,186 | 0 |
| Other | 1,240 | 1,240 | 0 |
| **Mental Health Services** | **12,839** | **12,839** | **0** |
| Continuing Care Placements | 10,260 | 10,260 | 0 |
| Children's Placements | 180 | 180 | 0 |
| Horder Centre | 1,002 | 1,002 | 0 |
| Will Adams ISTC | 28 | 28 | 0 |
| BMI Hospitals | 366 | 366 | 0 |
| Spire Hospitals | 196 | 196 | 0 |
| GPwSI | 640 | 640 | 0 |
| Other independent sector | 1,236 | 1,236 | 0 |
| Other (re-ablement & transport) | 503 | 503 | 0 |
| **Non NHS Contracts** | **14,410** | **14,410** | **0** |
| Corporate | 3,900 | 3,835 | -65 |
| Contingency | 1,185 | 0 | -1,185 |
| 1% Surplus | 1,553 | 0 | -1,553 |
| **Corporate** | 6,638 | 3,835 | -2,803 |
| | | | 0 |
| **Total** | 152,800 | 151,247 | -1,553 |

| Year End Forecast | Plan | Forecast | Variance |
|---|---|---|---|
| Overall Financial Position | 474,061 | 469,401 | -4,660 |

| Year End Forecast | Plan £'000 | Forecast £'000 | Variance £'000 |
|---|---|---|---|
| East Kent Hospitals University NHS FT | 5,731 | 5,731 | 0 |
| Medway NHS FT | 5,331 | 5,331 | 0 |
| Maidstone and Tunbridge Wells | 176,338 | 180,088 | 3,750 |
| Dartford & Gravesham NHS Trust | 1,132 | 1,132 | 0 |
| South East Coast Ambulance | 12,613 | 12,613 | 0 |
| Queen Victoria Hospital | 4,495 | 4,495 | 0 |
| East Sussex Hospitals NHS Trust | 1,839 | 1,839 | 0 |
| High Cost Drugs | 7,423 | 7,423 | 0 |
| Other SEC trusts (incl.contract exclusions) | 857 | 857 | 0 |
| **sub SEC acute trusts** | **215,759** | **219,509** | **3,750** |
| KCHT | 30,864 | 30,864 | 0 |
| GP Prescribing | 65,974 | 65,974 | 0 |
| Non GP Prescribing | 2,160 | 2,160 | 0 |
| Primary Care LES | 2,360 | 2,360 | 0 |
| Primary Care OOH | 3,530 | 3,530 | 0 |
| Other Community Services | 4,629 | 4,629 | 0 |
| **sub community services** | **109,517** | **109,517** | **0** |
| Guy's & St.Thomas NHS FT | 8,492 | 8,492 | 0 |
| Kings College Hospitals FT | 6,098 | 6,098 | 0 |
| Barts & the London NHS Trust | 463 | 463 | 0 |
| Great Ormond Street Hospital NHS Trust | 246 | 246 | 0 |
| University College London FT | 989 | 989 | 0 |
| The Royal Marsden NHS FT | 1,115 | 1,115 | 0 |
| The Royal National Orthopaedic Hospitals NHS Trust | 1,019 | 1,019 | 0 |
| Royal Free Hampstead NHS Trust | 250 | 250 | 0 |
| St Georges Healthcare NHS Trust | 846 | 846 | 0 |
| Moorfields Eye Hospital NHS FT | 341 | 341 | 0 |
| Chelsea and Westminster NHS FT | 203 | 203 | 0 |
| Imperial College Healthcare NHS Trust | 417 | 417 | 0 |
| Royal Brompton & Harefield NHS FT | 506 | 506 | 0 |
| South London Healthcare NHS Trust | 5,740 | 5,740 | 0 |
| Other | 4,735 | 4,735 | 0 |
| **Non SEC Acute Trusts** | **31,460** | **31,460** | **0** |
| KMPT | 28,229 | 28,229 | 0 |
| CAMHS | 3,008 | 3,008 | 0 |
| Mental Health Placements | 3,559 | 3,559 | 0 |
| Other | 3,721 | 3,721 | 0 |
| **Mental Health Services** | **38,517** | **38,517** | **0** |
| Continuing Care Placements | 30,780 | 30,780 | 0 |
| Children's Placements | 541 | 541 | 0 |
| Horder Centre | 3,005 | 3,005 | 0 |
| Will Adams ISTC | 83 | 83 | 0 |
| BMI Hospitals | 1,097 | 1,097 | 0 |
| Spire Hospitals | 587 | 587 | 0 |
| GPwSI | 1,920 | 1,920 | 0 |
| Other Independent Secor | 3,709 | 3,709 | 0 |
| Other (re-ablement & transport) | 1,508 | 1,508 | 0 |
| **Non NHS Contracts** | **43,230** | **43,230** | **0** |
| Corporate | 11,700 | 11,505 | -195 |
| Contingency | 19,218 | 15,663 | -3,555 |
| 1% Surplus | 4,660 | 0 | -4,660 |
| **Corporate** | 35,578 | 27,168 | -8,410 |
| **Total** | 474,061 | 469,401 | -4,660 |

# Financial Risk

The schedule of risks and mitigations has been re-assessed in light of the best information available. Compared to last month, the principal changes reflect the potential for excess performance at Acute Trust to be higher than envisaged, and a reduction in the scale of financial risk associated with changes to the new commissioning architecture – specifically specialised commissioning.

To mitigate the impact of these risks will require effective contractual management where it is evident that apparent costs increases are not in accord with contract rules, a focussed effort on the delivery of planned QIPP, and potentially the delay or cancellation of planned investments in order to achieve our financial duties.

| **Forecast** | **£'000** |
|---|---|
| Residual Financial Risk | 14,300 |
| Mitigated | 14,000 |
| Residual Risk | **300** |

| Prinicipal financial risks | YTD RAG | Forecast RAG | Total £'000 | Probability of risk being realised (75 / 50 /25)% | Residual value | Position | Explanation of Risk | Action if Risk materialises |
|---|---|---|---|---|---|---|---|---|
| Acute SLAs | | | 13,000 | 75% | 9,750 | Minimal data available to support position with regard to principal SLAs. | Relates to activity and case mix /coding impact. Initial M2 report from IPM indicates a net overperformance of SLAs . | |
| Community SLAs | | | | | - | | Block contract | |
| Mental Health SLAs | | | 1,000 | 80% | 800 | | No activity reports have been received in respect of Mental Health and Learning Disablity placements which are not deemed specialist commissioning | |
| Continuing Care | | | 1,000 | 25% | 250 | | Relatively low probability, as a result of further significant investment in continuing care placements | |
| Prescribing | | | 2,000 | 10% | 200 | | Relatively low probability based on actual performance to date issued by PPA and assumes that opening balances from WKPCT are secure | |
| HCD | | | 1,000 | 50% | 500 | | Details of impact of Lucentis replacement still to be factored in which is anticipated to reduce risk | |
| QIPP KMPT not achieved | | | 500 | 50% | 250 | | KMPT activity due to QUIPP non delivery through primary care mental health teams | |
| QIPP Not applied to SLA | | | 2,600 | 50% | 1,300 | Minimal data available to support achievement of QIPP on a Year to date basis. Concerns over capacity within commissioning team. | Past experience of QIPP achievement has been in the range 60% to 70%. | |
| Other - Running Costs | | | 1,000 | 50% | 500 | | | |
| Performance Issue - PTS | | | 500 | 50% | 250 | | | |
| Performance Issue - IVF | | | 500 | 100% | 500 | | | |
| Performance Issue - retrospective continuing care | | | | | - | | | |
| Movement to new commissioning architecture | | | 5,000 | 20% | 1,000 | Interim position agreed and adopted with South of England Commissioners. To be kept under review. Residual risk relates to Other NHS England Commissioners | Specifically relating to the possibility that the allocation deduction advised to to the CCG exceeds the level of cost reduction that will be achieved during 2013-14. See below. | |
| | | | | | | | | |
| **TOTAL RISKS** | | | **26,100** | | **14,300** | | | |

| MITIGATION | YTD RAG | Forecast RAG | Total £'000 | | | IMPACT | MITIGATION | NEXT STEPS |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| **Uncommitted Funds (Excluding 2% NR Headroom):** | | | | | | | | |
| Contingency Held | | | 2,330 | 100% | 2,330 | | | |
| **Actions to implement:** | | | | | | | | |
| Further QIPP extensions | | | 4,000 | 50% | 2,000 | | Identify additional measures to eliminate waste and avoid cost | To be discussed at Clinical Strategy Group, to agree list of schemes to extend current QIPP<br>Specific schemes to be worked up |
| Non-recurrent measures | | | 3,300 | 90% | 2,970 | | | |
| Application of discretionary reserves | | | 9,000 | 30% | 2,700 | | | |
| Delay / reduce Investment plans | | | 2,000 | 75% | 1,500 | | Specific schemes to be worked up | Range of options to be devised and brought to Clinical Strategy Group. |
| ***Others...*** | | | | | | | | |
| Renegotiate allocation transfer with NCB | | | 5,000 | 20% | 1,000 | | See key risk above. Assumes the ability to open up a dialogue with NHS England in the event of signficiant and material gaps between allocation reductions and expenditure change | |
| PH prescribing - recharge to Local Authority | | | 1,500 | 100% | 1,500 | | The CCG has identified a possible anomaly within allocation adjustments made in respect of Public Health (Local Authority ) adjustments, which it intends to pursue | |
| **TOTAL MITIGATIONS** | | | **27,130** | | **14,000** | | | |

# Index

| | |
|---|---|
| Foreword | 03 |
| The NHS belongs to the people: a call to action | 05 |
| How is the NHS currently performing? | 07 |
| What challenges will the health and care service face in the future? | 11 |
| Seizing future opportunities | 17 |
| What's next? | 21 |
| Conclusion | 24 |

# Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but we realise that even protecting the budget will not address the financial challenges that lie ahead.

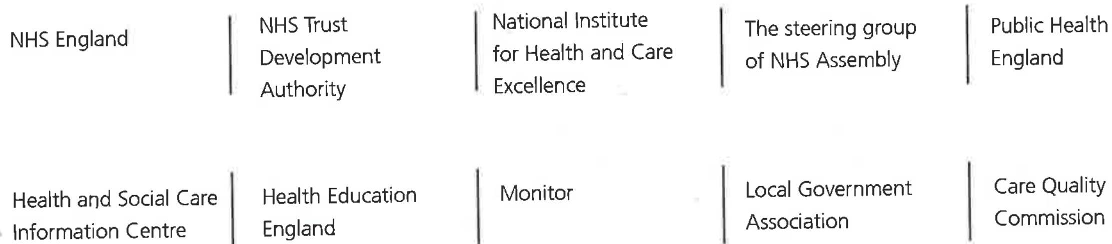
If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We know that we must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing illness rather than treating illness. And we also know that we need to do far more to help those with mental illness.

There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more heath and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association, the steering group of NHS Assembly, Health Education England and NHS England want to work in partnership to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the very process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves the current and future generations as well as it has served those in the past.



NHS England

# The NHS belongs to the people: a call to action

## Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.[1] There is still too much unwarranted variation in care across the country, exacerbating health inequalities.[2] As the Mid-Staffordshire and Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

[1] "UK health performance: findings of the Global Burden of Disease Study:, Christopher Murray et al, 2010, 23 March 2013.

[2] For example, unwarranted variation in common procedures and in expenditure. See "Variations in health care: the good, the bad and the inexplicable", John Appleby et al,King's Fund, 2011 and "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality", Department of Health, 2011.

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

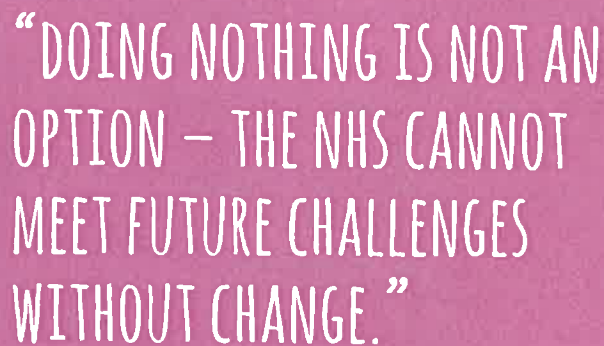
In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.



# How is the NHS currently performing?

## Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

### Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.[3] The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.[4]

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.[5]

[3] Office for National Statistics, 2011: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227587

[4] "European Health For All", World Health Organization http://data.euro.who.int/hfadb/

[5] "Global Status Report on Non-communicable Diseases", World Health Organization, 2010 (2011), p. 1: http://www.who.int/nmh/publications/ncd_report_full_en.pdf

## Enhanced quality of life for people with long-term conditions

Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.

Over 15 million people in England have an LTC. They make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England.[6] People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives.[7]

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management by patients will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

> "BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL."

## Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years, 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.[8] A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between, adult social care, community services and hospitals, accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.[9]

Different thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. The limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury, ensuring people have a positive experience of care, and caring for people in a safe environment and protecting them from avoidable harm.

[6] Long Term Conditions Compendium, 3rd edition, 30th May 2012: https://www.gov.uk/government/news/third-edition-of-long-term-conditions-compendium-published
[7] Fair society health lives, Marmot, 2011
[8] "Hospitals on the edge? The time for action", Royal college of physicians, 2012: http://www.rcplondon.ac.uk/sites/default/files/documents/hospitals-on-the-edge-report.pdf
[9] Hospital Episode Statistics, Health and Social Care Information Centre http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance]

This is why the first offer in Everyone Counts; Planning for Patients, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-day-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality including safety.

## Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study[10] of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. People from disadvantaged groups, including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

"EVERYONE WORKING IN THE NHS MUST STRIVE TO MAINTAIN AND IMPROVE ON THIS HIGH LEVEL OF PATIENT SATISFACTION AND EXTEND IT TO EVERYONE WHO USES THE NHS."



[10] 2011 Commonwealth Fund International Health Policy Survey http://www.commonwealthfund.org/Surveys/2011/Nov/2011-International-Survey.aspx

## Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,[12] of which 10,916, less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is vitally important as it helping the NHS to avoid more serious ones in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high Of those people who do experience adverse events a third of them experienced greater disability or death.[11]

## Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experience by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.[13] The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.[14] Health inequalities stem from more than differences in just income - education, geography, and gender, can all play a role.

The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green-space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

[11] "Adverse events in British hospitals: preliminary retrospective record review", BMJ, 2001 March 3; 322(7285): 517–519

[12] "National Reporting and Learning System Quarterly Data Workbook" up to June 2012 http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153

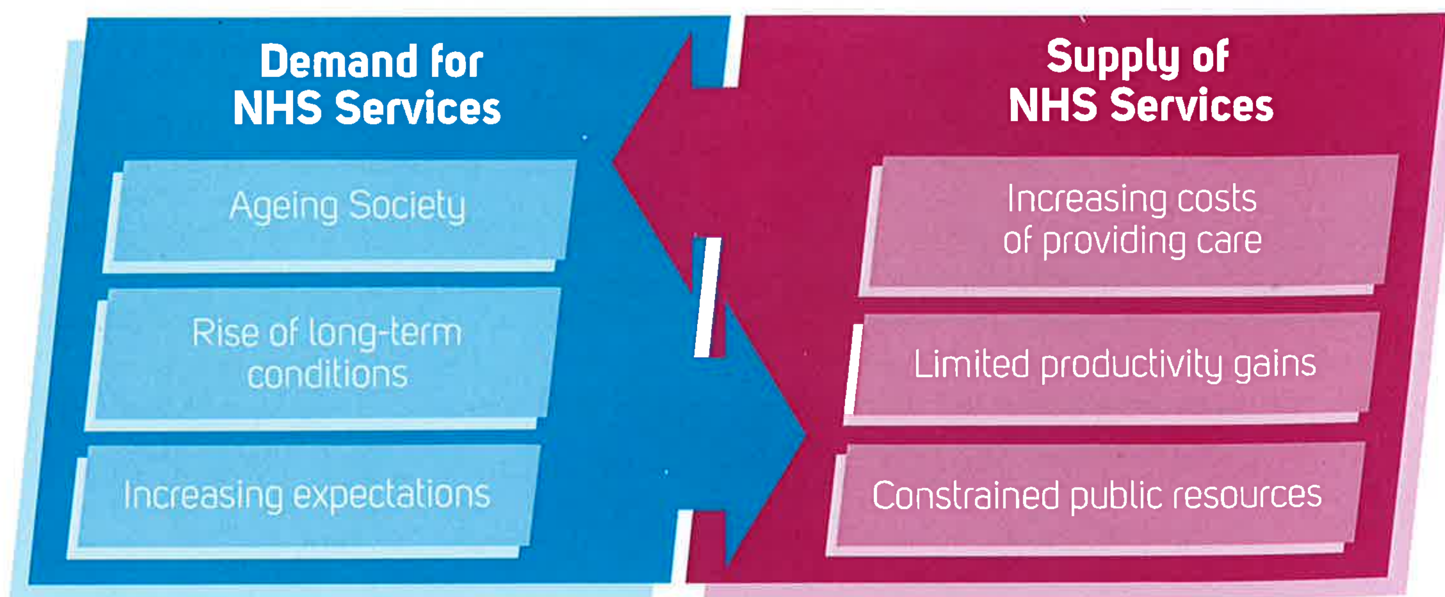
[13] Fair Society Health Lives (The Marmot Review), 2010 [http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review]

[14] Fair Society Health Lives (The Marmot Review), 2010 [http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review]

# What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service



## Changing Demographics

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70 per cent of hospital emergency bed days.[15]
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.[16]
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.[17]

Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.[18] The NHS is also about our children and young people. The national birth rate has increased by 22% in the past decade and pregnancy is now the largest single reason for admission to hospital.[19]

> "STUDIES SUGGEST THAT OLDER PATIENTS ACCOUNT FOR THE MAJORITY OF HEALTH EXPENDITURE."

### Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalization, bringing the potential for overall cost savings.[20]

15 "Older people and emergency bed use: exploring variation", Candice Imison et al, King's Fund, August 2011.
16 "Continuity of care for older hospital patients: A call for action", Jocelyn Cornwell et al, King's Fund, March 2012.
17 "Fairer Care Funding: The Report of the Commission on Funding of Care and Support", July 2011
18 "Understanding patients' needs and risk: a key to a better NHS", McKinsey, 2013
19 "Commissioning Maternity Services A Resource Pack to support Clinical Commissioning Groups", NHS England, July 2012
19 "Improving housing with care choices for older people: an evaluation of extra care housing", Netten A, Darton R, Bäumker T, Callaghan L., Personal Social Services Research Unit, University of Kent, Canterbury 2011.

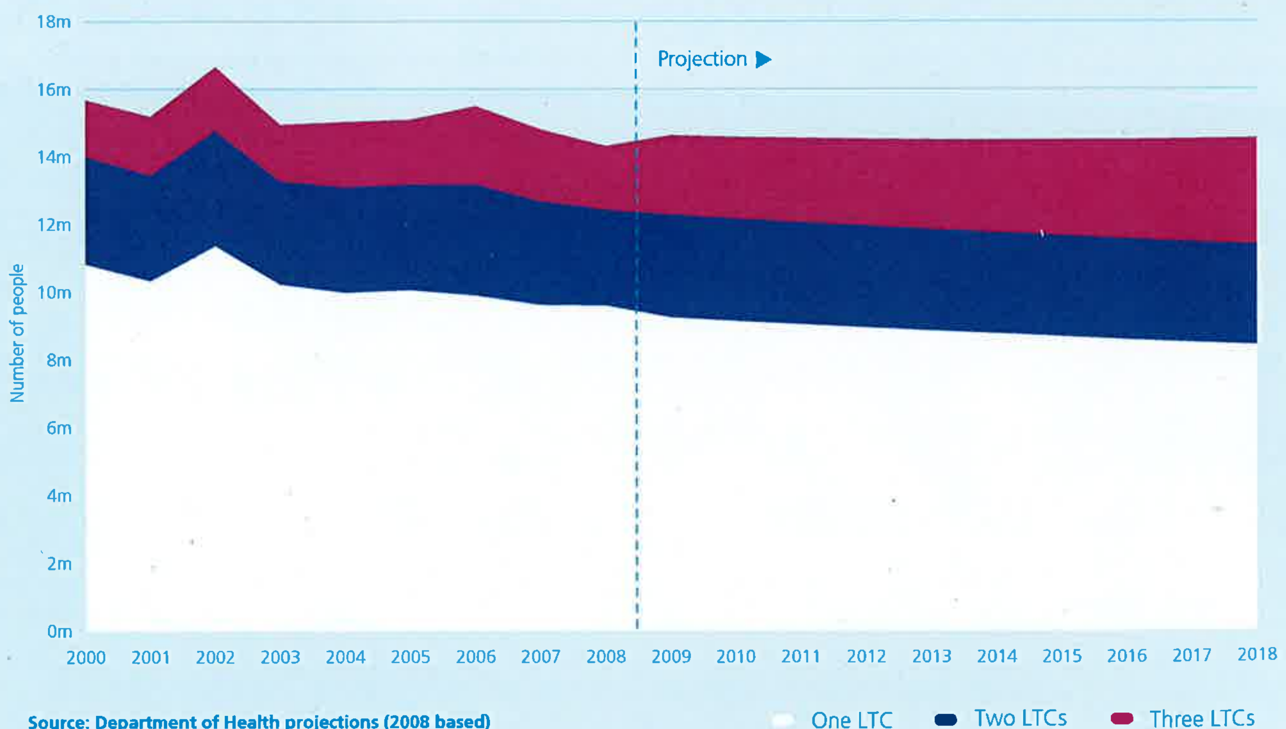
## Changing burden of disease

People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions already account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.[21]

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

> "THE 30% WHO HAVE ONE OR MORE (LONG TERM CONDITIONS) ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND"

### Actual/projected numbers with one or more long-term conditions by year and number of conditions




**Source: Department of Health projections (2008 based)**

[21] Long Term Conditions Compendium, 3rd edition, 30th May 2012: https://www.gov.uk/government/news/third-edition-of-long-term-conditions-compendium-published

## Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.[22]

## Lifestyle risk factors in the young

We know that the risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes and 400,000 additional cases of stroke and heart disease.[23] Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

## Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive–increasingly demanding access to latest therapies, more information and more involvement in decisions about their care. If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more information on their mobile telephones. Patients want seven-day access to primary care, provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

22 "A national challenge", Alzheimer's Society (2012), Dementia 2012, London

23 "Health and economic burden of the projected obesity trends in the USA and the UK", Wang YC, McPerson K, Marsh T, Gortmaker SL, Brown M (2011), The Lancet, vol 378, pp 815–25.

24 See for example "Fixing Healthcare: The Professionals Perspective", Economist Intelligence Unit, 2009.

## Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more expensive than the old technologies they replace - for example, the latest cancer therapies[25] which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

## Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and is adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme, the Government's recent spending review has severely constrained funding growth.

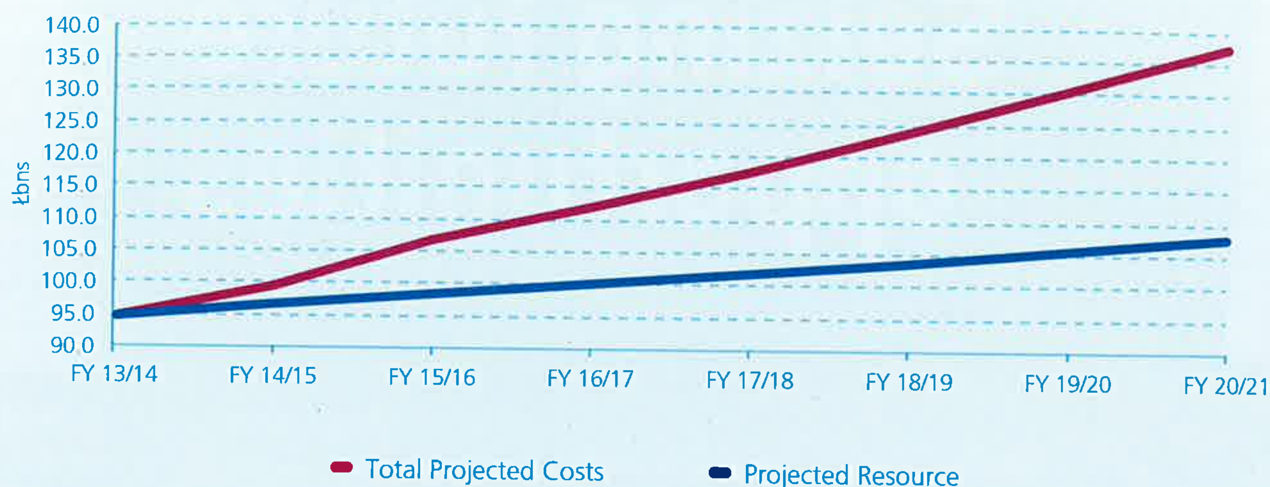
In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.[27] We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate are before taking into account any productivity improvements and assume that the health budget will remain protected in real terms.[26]

[25] "Delivering affordable cancer care in high-income countries", Richard Sullivan et al,The Lancet Oncology, Volume 12, Issue 10, Pages 933 - 980, September 2011.

[26] NHS England analysis.

[27] Research found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision was related to reductions in delayed hospital discharges and readmission rates. "Social Care Funding and the NHS: An Impending Crisis?", Richard Humphries, March 2011 http://www.kingsfund.org.uk/sites/files/kf/Social-care-funding-and-the-NHS-crisis-Kings-Fund-March-2011.pdf
"The Impact of a Tightening Fiscal Situation on Social Care for Older People". Forder J, Fernández JL (2010), PSSRU Discussion Paper 2723. London, Kent and Manchester: Personal Social Services Research Unit. Available at: www.pssru.ac.uk/pdf/dp2723.pdf (accessed on 11 February 2011).




## Limited productivity improvements

Measuring the productivity[28] of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.[29] Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.[30] This suggests that the NHS may not be using its capacity as efficiently as it could.

"BETWEEN 1995 & 2010 AVERAGE PRODUCTIVITY IN THE NHS GREW AT 0.4%, WHILST THE ECONOMY AS A WHOLE GREW AT A RATE OF OVER 2%."

NHS productivity remains an unresolved debate. However, the traditional productivity improvements will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to current 4% required efficiency in 2013/14.[31] Improvements such as better performance management, reducing length of stay, wage freezes or better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called "Nicholson Challenge" of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

[28] At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

[29] Public Service productivity Estimates: Healthcare 2010, Office for National Statistics.

[30] Public Service Productivity Estimates 2010, Office for National Statistics http //www.ons gov uk/ons/dcp171766_289768 pdf

[31] This is the challenge for the NHS after national action to constrain wages and other input costs In recent years these have typically delivered c 1% per annum benefit to the system which over this period modelling would equate to c £8bn.

# Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required. A number of opportunities are already evident and are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

## A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD average),[32] but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce to consider prevention part of the job will produce an entire service that is better prepared to support individuals in primary and community care settings.



32 "Public Health and Prevention Expenditure in England", Rebecca Butterfield et al, Department of Health, 2009

## Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care and treatment, they have better outcomes, are less likely to be hospitalised,[33] follow appropriate drug treatments[34] and avoid over-treatment.[35] Personalised care planning is also highly effective.[36] A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.[37] In kidney care there are great examples of self-care, shared decision making and personalisation to give patients more control.

### Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting insubstantial reductions in healthcare costs.[38]

## Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.[39] A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.[40] This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

[33] "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs", Hibbard JH Green J Health Affairs 2013;32:2207-14

[34] "Self-care reduces costs and improves health: the evidence", Expert Patients Programme, London 2010

[35] "Decision aids to help people who are facing health treatment or screening decisions", Stacey D et al Cochrane Summaries, 16 May 2011; and "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality", Department of Health, 2011

[36] "Care Planning: improving the lives of people with long term conditions", RCGP Clinical Innovation and Research Centre, 2011

[37] https://www.phbe.org.uk/

[38] Catalogue of Potential Innovation, NHS England, London: 2013

[39] Office for National Statistics, e-society (Social Trends 41), 2009

[40] For example Kaiser Permanente and the Veterans Administration, both in the USA

## e-Intensive Care: a Second Pair of Eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.[41]

> "DIGITAL INCLUSION WILL HAVE A DIRECT IMPACT ON THE HEALTH OF THE NATION, AND SO INNOVATION MUST BE ACCESSIBLE TO ALL, NOT JUST THE FORTUNATE."

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

## Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.



[41] Guy's and St. Thomas' NHS Foundation Trust: www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

## Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This mismatch suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

### Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive upstream services, only 36% of primary care resources were expended on these same patients.[42] This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Healthcare is becoming more personal in other ways too. Recent biomedical advances, suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

## Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity often delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.[43] This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.[44]

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,[45] and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

[42] "Understanding patients' needs and risk: a key to a better NHS", McKinsey & Co, London: 2013.
[43] "Sickness absence in the labour market", Office of National Statistics, London: 2021.
[44] Department of Health, Innovation, Health and Wealth, December 2011.
[45] Department of Health, Innovation, Health and Wealth, December 2011.

# What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

But we cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association and the Assembly Steering Group of clinical commissioning groups want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop a series of new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

## A Call to Action

A Call to Action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient- and public-centred, through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how it is anticipated services will improve.

"A CALL TO ACTION IS A PROGRAMME OF ENGAGEMENT THAT WILL ALLOW EVERYONE TO CONTRIBUTE TO THE DEBATE ABOUT THE FUTURE OF HEALTH & CARE PROVISION IN ENGLAND."

**The Call to Action aims to:**

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including leavers and incentives, for the next 5 – 10 years.

### What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England in relation to its direct commissioning responsibilities in relation to (i) primary care commissioning and (ii) specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal the service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. **Do nothing.** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. **Assume increased NHS funding.** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. **Cut or charge for fundamental services, or 'privatise' the NHS.** We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

## How will the Call to Action engage people?

The Call to Action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

### A digital Call to Action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

### 'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

### Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

### National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

# Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.