Future Healthcare Journal 2019 Vol 6, No 2: 110–3

QUALITY IMPROVEMENT

The future of the NHS: Plan B.

Author: Nick Bosanquet[A]

ABSTRACT

The NHS for England now has future plans for the next 10 years: but the documents say little about the problems likely to be encountered. The paper outlines two main problems – the poor record for expanding services out of hospital and the crowding out effect of hospital spending – and it sets out some directions for future action to make sure that development continues in the out-of-hospital space.

KEYWORDS: NHS, future, 10-year plan, model of care

NHS plans

The *Five Year Forward View*,[1] in many ways a very sensible document, has been followed by the 10-year *NHS Long Term Plan* (10-Year Plan).[2] Both documents have a defect common to many government reports, a tendency to ignore problems – the Captain's chart tends to miss out the reefs.

The key theme is that of developing more care in the out-of-hospital space. The first call for this was made in 1956 by the Guillebaud report, 'By developing the home health services and integrating them more closely with general practitioner, hospital and welfare service … an efficient and integrated medico-social service would not only prevent illness, but would also ease the burden on hospitals generally.'[3] Later came the one successful attempt to raise the relative spend on primary care through the *Family Doctor Charter*. From 1978/79 to 1985/86 spending on general practice rose by 57.1% while spending on the hospital service rose by 4.5%.[4] Integrated care through a wider primary care team actually came into being – in Stockton and elsewhere.[5]

Later efforts to develop more out-of-hospital services have had less success. The *National Service Framework for Older People* set out very positive proposals in 2001.[6]

> *Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.*

In the absence of a Department of Health evaluation of this framework which might have led to earlier remedial action it was left to the Care Quality Commission annual report 17 years later to report on the outcomes.[7]

> *Access to intermediate care can have a positive impact for people – an audit in 2015 showed how more than two-thirds of people who used intermediate care after a hospital stay, did not ultimately need to move to more dependent care settings. Access to enablement and rehabilitation services can make a significant positive difference for people – there is wide variation in access to these services. Of those older people who received these services following discharge from hospital in 2016–17, 82.5% were still at home 91 days later. However only 2.7% of older people discharged from hospital received these services in the first place.*

This was only one sign of the neglect of services for older people, with a 40% reduction in district nurses and a 15% reduction in all community nurses. Many of the problems are blamed on a lack of integration but this may hide just how much the NHS has reduced the services, which it delivers itself. As well as the lack of integration, there has been a covert shifting of responsibility for care over to social services, increasing the scope both for rationing of services and for self-payment.

These developments are especially sad because of the very good programme that was set out in the *National Service Framework* 20 years ago. Most leaders in health professions participated in drawing this up and it reflected 30 years of improvement in services from 1970 onwards. If the recommendations had been followed through, it is likely that many of the hospital problems, both for the emergency department and for admissions pressure, could have been avoided. The NHS has used an ageing population as a powerful part of its plea for more funding but it has not actually spent more money on the specific problems of ageing. In fact, allowing for the reduction in real terms spending on social care, spending on community programmes for older people has fallen 15% in the last decade.

Initiative by general practitioners (GPs) had been a vital force for change and improvement, but the Quality and Outcomes Framework (QOF) contract replaced professional initiative with central control. The QOF contract introduced an activity focus of an extreme kind into general practice. General practice had been based on an implied commitment that family doctors would do their best for patients. Many of the QOF activities would have been carried out anyway. The QOF interest replaced the general commitment with specific activities. Ironically, this was only possible because of the local initiative shown by general practice

Author: [A]professor of health policy, Imperial College London, London, UK

in developing their information technology systems. GPs lost the freedom to plan their own use of time and to decide on priorities – the inevitable results were dissatisfaction and the loss of a sense of control, with reduced capability for out-of-hospital services.

The second hidden problem is that of reversing momentum towards more spending on the hospital service.

Political and media pressure combine with professional power to produce a decisive tilt towards hospitals. The share of NHS spending on hospitals rose from 46% in 1997 to 56% in 2017. Media coverage of patients nearly always featured hospital treatment. Most of the mortality gains since 1990 in reducing heart disease and stroke prevention were actually due to primary care not hospitals but these were not photogenic. By 2018 the NHS was in the position that the total budgets of the seven largest trusts in the London area were greater than the national spend on primary care.

Most of the increased spending has been on specialised services. Spending rose from £13.0 billion in 2013/14 to £17.2 billion in 2018/19.[8] Even since the commitment to fund investment outside hospital in the *Five Year Forward View* this expenditure has continued to rise much faster than for primary care. Funding for specialised commissioning rose by £800 million or 5% from 2017/18 to 2018/19 while spending on primary care rose by £100 million or 1% and further increases at 5% are projected for the next 2 years. Together with increased spending on activities, there has been a shifting of research towards the hospitals with much less research on new programmes or drug therapies for primary care. In 2016, the National Audit Office warned that 'Against a backdrop of increasing pressure on NHS finances, NHS England has not controlled the rising cost of specialised services. If specialised services continue to swallow up an increasing proportion of the NHS budget, other services will lose out.'[8]

There were some positive developments during the period of centralisation. Public satisfaction with the NHS rose from 30% in 1997 to a peak of 70% in 2010.[9] Access to services improved and outcomes continued to improve, although in cancer and heart disease they remain at much the same rates as in the 1990s; however, the negatives have left a legacy which mean great difficulties for the future of the NHS.

Centralisation has also had a serious effect on financial stability and on financial information. The problem of trust deficits has been recurring and not just in recent times. There were deficits in 2006/7 after spending on acute hospitals had doubled in 5 years. After a bright start with budgeting information, NHS England has produced little on key topics. There has been no information on the spending and costs for specialist commissioning for 4 years and none on the Cancer Drugs Fund for 2 years.

Services out of hospital – improving on the record

Outstanding programmes in the NHS have shown a combination of national strategy and local initiative. A key example was the *National Service Framework for Coronary Heart Disease* showing how it is possible to align initiative for prevention, early diagnosis, active treatment and longer-term care and risk management.[10] This both managed risk factors and brought about a 40% reduction in mortality through active treatment. New lower cost programmes emerged using statins in primary care and stands for surgery. An area of care, which had been known for high tech surgery and long hospital stays, became highly efficient. As outcomes improved so costs per patient and total expenditure fell.

Programmes for acquired immune deficiency syndrome (AIDS) / HIV showed the same combination linking prevention, diagnosis and care programmes. Helped by strong links between patient led charities such as the Terrence Higgins Trust and the NHS, the service has developed though special clinics offering a total service such as those in Soho and in Brighton. Effective drug treatment has reduced admissions and 80% of patients are able to continue working. A service which, in the early 1980s, was expected to consume 20% of NHS resources now takes 2%. This is a striking example of how improving outcomes reduces costs.

The national strategy for cancer is already starting to show results with improved outcomes for hard-to-reach groups especially with lung and colon cancer. Further moves are expected towards earlier diagnosis with 10 rapid diagnostic centres planned and advertisements on the Doncaster cough were seen on the town's buses. Support for survivors and later stage cancer have also improved with hospices offering more services in the community and self-help groups for better fitness and lifestyle change.

The NHS needs a clear national strategy for integrated care out of hospital. The future is about delivering an effective personal service which will promote the total wellbeing of patients especially those with serious health problems. The future will be about partnership between patients and health teams drawing on experience of the HIV/AIDS and other services where there has been a very strong partnership with patient groups. The future is about an NHS which is more flexible and adaptable and which seizes opportunities for improving outcomes. In summary, it is an NHS which can reconnect with its patients and with local communities.

The future must be built from a recognition of how much patient needs have changed; not just in numbers but in complexity, long-term conditions and long-term illnesses. People have physical clinical symptoms but they also have cognitive and emotional problems. The illness may strike at their independent living and their security in life. The need for integration in services has been vastly increased by these changes.

The services now have a common template which has developed over the past 2 decades, notably though the *National Service Framework for Coronary Heart Disease* and this could be adapted to out-of-hospital care.[10] This is a four stage process: prevention, early diagnosis, active treatment and care support with risk management. Each of these stages has seen some progress but there is limited recognition of how they are linked. They can all contribute to better outcomes. The case for out-of-hospital care is not just about reducing pressure on hospitals. It is because each of these stages can only work with a strong service presence outside hospital. Notably it is only in primary and community care that it is possible to get to grips with the lifestyle issues which are so crucial for local population health.

What would be the key steps which would give the NHS this capability of using its resources more effectively and of adapting in a timely fashion? The 10-Year Plan sets out a long list of service improvements with much emphasis on new technology. Many of these changes are quite complicated and expensive. Many of the changes involve challenges to local management and commitment of staff time and resources. There is no estimate of whether they can be fitted into the likely level of funding in the next 10 years.

Reconnect with patients

Digital could improve staff and patient information on care pathways, improving patient access to personal care plans. The first essential step is the personal care record. This is essential to patient safety – some trusts do not share immediate information after transfer to primary care and with an increasing number of powerful drugs being used, often with side effects, this is highly dangerous.

This needs national action to set the standard then local action to deliver. More local action would be to set up networks within each Integrated Care System (ICS). For people with serious or continuing health problems, the high-risk patients would get a personal contact. They could also be enlisted as NHS lead patients who would get a short newsletter digitally every few months, setting out the latest news about the NHS in their area. They could be reminded by e-mail or text about medicines adherence. The Towards a Revolution in Chronic obstructive pulmonary disease Health (ToRCH) study showed over a 3-year trial with 6,000 patients that if they adhered to their medication, mortality was 11%: if they did not adhere it was 26%.[11] Primary care homes can also develop digital contact with patients as is rightly stressed in the 10-Year Plan. Digital could improve adherence and bring about faster response to changes and new preferences.

Set clear leadership for the development of out-of-hospital care.

This is a very difficult aim and needs much more concentration as a priority. Each ICS should have a chief executive who would meet the standard set by the Griffiths report all those years ago – they would be in charge of the area budget. The 10-Year Plan seems to envisage a structure of overlapping committees but unless there is one person with responsibility for this very difficult development, it is never going to happen. The chief executives would have aims in solvency and project development, and they would have a major communication role in getting across to NHS staff, social care and local communities about the new model NHS. It is here that the close links with local government can be made. They would lead on strengthening the research base for out-of-hospital care. The first priority would be, at long last, to develop intermediate care with much more access to reablement.

Stop further crowding out of spending and staffing

There has to be a clearer strategy developed for acute services. Much of the current resource base (and the local mind set) still reflects the Bonham-Carter report of 1969 which guided all hospital building in the next 2 decades around the concept of the district general hospital serving a population of 250,000 with a limited broad range of specialties with, as the ultimate luxury, two consultants in each specialty.[12] There has been no published strategy for these services since 1969, yet the situation is obviously vastly different and the pressures much greater, with more sub-specialties, more complex treatments and much higher costs. There have been some successful changes at the service level especially for severe trauma where concentration on 27 designated traumas have shown a 19% improvement in survival with further improvements likely as the teams gain experience.[13]

The strategy has to be one of concentrating high quality specialised services on fewer sites in order to ensure most effective use of teams and to lower cost per case. Such concentration is already beginning in orthopaedics with the *Getting It Right First Time* programme. If there is to be room for more funding and staffing in the out-of-hospital space, there must be reduction of the crowding out pressure from hospital services.

There could be much more information on relative costs especially in the area of specialist commissioning. There have been some hints in NHS England documents about the vast differences in costs between different centres for transplants. They comment on the lack of information on costs and where there was information there was great variability; 'In 2014/15 the price paid for a kidney transplant with a live donor varied from £13,000 to £42,000 across the eight centres providing this service.'[8] Long ago, the important Forest report on heart transplantation showed how the two centres had a 50% difference in costs because one centre discharged patients to a hostel for the follow on immune-suppressive treatment while the other centre retained them in hospital.[14]

Increased costs and the toleration of high costs make the rationing process much more traumatic as fewer patients can be treated for a given budget. Given that the budget for hospital services is likely be static at best this issue of cost management becomes crucial.

Conclusion

These steps would make it feasible to move forward on model of care set out in NHS 10-Year Plan with a more personal and even more reliable service. Unless we face up to the unrecognised problems of the extreme difficulty in expanding the out-of-hospital space and the crowding out effect of hospital spending, the reform process will come to a halt, with funding for community services diverted to pay for deficits and 'over trading' in the acute trusts. The NHS has a great resource in the staff that it already has – let us focus on improving their sense of achievement and job satisfaction and the capability of local teams to get value from the large sums being spent on the NHS. ■

References

1 NHS England. *Five Year Forward View*. NHS, 2017.
2 NHS England. *The NHS Long Term Plan*. NHS, 2019.
3 Ministry of Health; Guillebaud CW (chair). *Report of the committee of enquiry into the cost of the National Health Service*. London: Her Majesty's Stationery Office, 1956.
4 Bosanquet N, Leese B. *Family doctors and economic incentives*. Aldershot: Dartmouth/Gower, 1989.
5 March GN. *Efficient care in general practice*. Oxford: Oxford University Press, 1991.
6 Department of Health. *National Service Framework for Older People*. London: DH, 2001:41.
7 Care Quality Commission. *The state of health care and adult social care in England. 2017/18*. London: CQC, 2018:28
8 National Audit Office. *The commissioning of specialised services in the NHS*. London: NAO, 2016.
9 The King's Fund, Nuffield Trust. *Public satisfaction with the NHS and social care in 2018*. London: The King's Fund, 2019.
10 Department of Health. *National Service Framework for Coronary Heart Disease*. London: DH, 1999.

11 Vestbo J, Anderson JA, Calverley PM *et al*. Adherence to inhaled therapy, mortality and hospital admission in COPD. *Thorax* 2009;64:939–43.
12 Bonham-Carter D. *The functions of the district general hospital*. London: Her Majesty's Stationery Office, 1969.
13 Moran CG, Lecky F, Bouamra O *et al*. Changing the system – Major trauma patients and their outcomes in the NHS (England) 2008-17. *EClinicalMedicine* 2018:13–21.
14 Department of Health. *Report on heart transplantation in England*. London: DH, 1984.

Address for correspondence: Prof Nick Bosanquet, Imperial College London, South Kensington Campus, London SW7 2AZ, UK.
Email: n.bosanquet@imperial.ac.uk