

# Away from the past and to a sustainable future

How the UK's health and social care systems can be reformed to better align with the needs of today's society

## The authors



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His contribution to this pamphlet is solely in a personal capacity.



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Professor Smith was principal of the Faculty of Medicine at Imperial College London from 2004 and was chief executive of Imperial College Healthcare Trust since its inception, the largest such trust in the United Kingdom, with an annual turnover of £1 billion. The organisation was the UK's first academic health science centre (AHSC), launched in October 2007 by the merger of Hammersmith Hospitals Trust with St Mary's Trust and its integration with Imperial College, London.

His pioneering role in establishing the AHSC was recognised in the NHS Leadership Awards, where he was named Innovator of the Year in 2009. *HSJ* listed Professor Smith in its 2009 rankings of the top 30 most powerful people in NHS management policy and practice in England.

A gynaecologist by training, Professor Smith is active in research and has published over 230 papers on reproductive medicine and cancer. It was for his work in Cambridge on the complex gene pathways that regulate the growth of blood vessels in reproductive tissue that he was awarded his doctor of science in 2001. In addition to his academic and clinical work, he is a fellow of the Academy of Medical Sciences, the Australian Academy of Health and Medical Sciences, the Royal College of Obstetricians and Gynaecologists and the Royal Society for the encouragement of Arts, Manufactures and Commerce (RSA).

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## Introduction

A crisis is looming in health and social care in the United Kingdom<sup>1</sup>. The population is ageing, the prevalence of chronic ill health increasing, and demand is rising at the same time as funding falls. Parts of our system are already operating at crisis point, yet the pressures are only set to increase.

Health and social care systems have barely changed since they were founded in 1948. Society has changed hugely, however. The result is that we have a system badly misaligned with the needs of the society it serves. This is not a sustainable state of affairs.

This pamphlet explores the nature of this crisis, diagnosing the reasons behind this misalignment. It goes on to posit a solution: the introduction of integrated care organisations (ICOs) closely aligned to academic health and science centres (AHSCs).

ICOs will remove the artificial and unhelpful boundaries between different parts of the healthcare service, and between health and social care. They will meet the needs of a population which is living longer and with more chronic conditions, and move care away from our overwhelmed hospitals.

Through alignment of these organisations with academic health and science centres, meanwhile, it will be possible to improve clinical outcomes and deliver precision medicine – and to sustain the UK's position as one of the world leaders in genetic medicine.

There will be barriers to instituting such a change. Many are stubborn, and are the reasons why our system has been stuck in the past for so long. In these pages, we identify what these obstacles are. Importantly, we then explain how they can be overcome.

We have little choice but to take action. Unless we do, there is a real risk of catastrophic failure in both the NHS and the social care system.

### A note about references

References are listed at the end of this pamphlet. Wherever possible, a web address is given at which the cited source can be accessed. These addresses were accurate as of 3 June 2015.

# Section 1: The nature of the crisis

## The crisis in our care system

More people than ever before need our care system. The population is ageing and healthcare needs are longer lasting and more complex. These needs are not being met.

The introduction of austerity is such that there are more than 30 per cent fewer older people receiving social care now than five years ago<sup>2</sup>, rising to nearly 40 per cent when standardised for increased need<sup>3</sup>.

The precipitous fall in social care spending is occurring at a time when the population is getting older and co-morbidities and chronic diseases are increasing.

These cuts represent a false economy. They result in increased spending in the NHS as more people – especially the most vulnerable like frail older people – inundate the health system.

Hospital “bed blocking” is very expensive, costing from £1,750 a week up to over £3,000 for an acute bed<sup>4</sup> at end of life compared to about £800 to £1,000 for equivalent care in a nursing home bed<sup>5</sup>. Although worse in winter, it is a year-round issue. When he gave evidence to the House of Commons Health Select Committee in 2013, Mike Farrar – then chief executive of the NHS Confederation – suggested that an estimated 30 to 40 per cent of hospital beds are occupied by people who are there inappropriately<sup>6</sup>.

Moreover, inappropriate hospital stays for frail older people are dangerous and debilitating. The patient could receive the same or a better quality of nursing care in more appropriate surroundings, delivered by staff with specialist experience, and with less risk of hospital-acquired infections. This is not a sustainable or

desirable state of affairs. It is expensive, and it is not producing the quality of care patients deserve.

## The care system was a brilliant construct in 1948, but it is stuck in time

We do not have a system which is capable of giving us the care we need in the most appropriate setting. The main reason for this is that it is stuck in time.

The model of care was created in 1948 when the epidemiology of disease, social policy and people’s lives were very different from today. In that year, someone aged 65 would have had a life expectancy at birth of 44 years for men and 48 years for women.<sup>7</sup> People died quite suddenly, most of the time within six months or less of contracting a disease.

The NHS was therefore founded on an acute care model, based on district general hospitals – which at the time performed relatively simple clinical procedures – and GP surgeries handling minor ailments. Social care was not a large part of the system.

The model has barely changed since. Our society has, however. For babies born between 2011 and 2013, life expectancy is 79 years for men and 83 years for women<sup>8</sup>. Today’s population ages slowly, living with chronic disease, and with co-morbidities. Men aged 65 today have a seven in 10 chance of needing some care before they die; women aged 65 nearly a nine in 10 chance<sup>9</sup>. An estimated two-thirds of those who have reached pensionable age have at least two chronic conditions<sup>10</sup> and 850,000 people in the UK are living with dementia.<sup>11</sup>

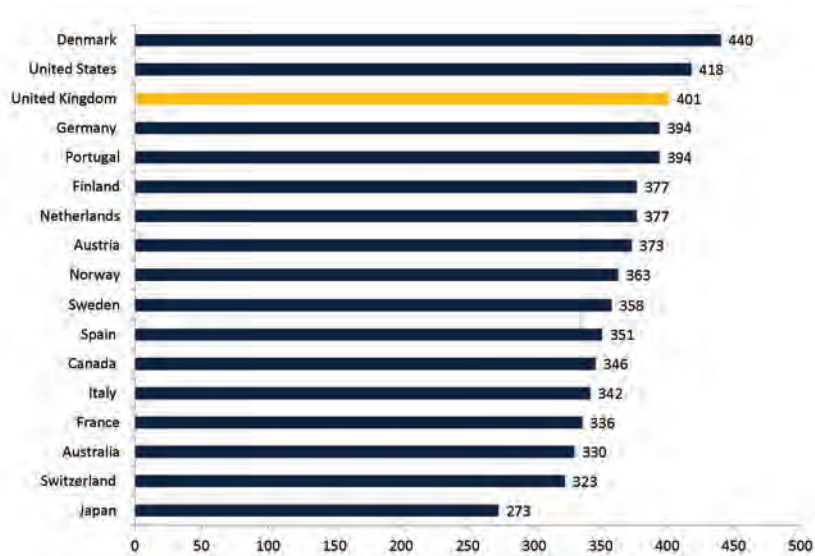
These chronic diseases are often related to lifestyle

## The vicious circle of a broken down health and social care system



(Ian R. Smith 2014)

### Mortality from non-communicable diseases (including cardiovascular and cancer) in 17 peer countries, 2008



Organisation for Economic Co-operation and Development (OECD) data cited in Woolf, S. and Aron, L. (eds.) (2013) *US Health in International Perspective: Shorter Lives, Poorer Health* Washington, DC: The National Academies Press

issues. Obesity, for instance, represents a widespread threat to health and wellbeing in this country: a total of 61 per cent of adults are either overweight or obese.<sup>12</sup> This is driving rises in conditions such as diabetes. In 2011/12 there were 2.6 million people aged over 17 diagnosed with diabetes in England<sup>13</sup>. By 2030, it is estimated that there will be more than four and a half million people aged 16 or over with the condition<sup>14</sup>.

This is a very different context from that of 1948, and we need a different care system as a result. Lower spending and higher need in social care, placing greater stress on the NHS, is a vicious spiral.

It is no coincidence that the United Kingdom has some of the worst health and social care outcomes in the developed world. For age-standardised deaths per 100,000 people for non-communicable diseases, the UK ranked 15 out of 17<sup>15</sup>.

#### What we need now

These demographic trends require a care system that offers a broad yet personalised service out of hospital, and consolidation of clinical units with scale in scientific discovery in hospital networks.

## Section 2:

# A new type of organisation for a new time

### The need for integrated care organisations

In 1948, it made sense to have an acute healthcare system. In 2015, it does not. Instead, we need integrated care organisations (ICOs). These remove the boundaries between:

- **Health and social care.** The creation of separate funding and delivery structures for health and social care was an accident resulting from a post-war political power struggle in the Labour government<sup>16</sup>.
- **Acute and chronic medicine.** The patient journey through community care and within hospital is disorientating and confusing<sup>17</sup>. The concept of chronic disease management is well developed in countries such as the United States, but poorly developed here.
- **Generalist and specialist skills.** There is a growing separation of clinical expertise between those who can consider the “whole person” and specialists in increasingly narrowly defined disease groups.
- **Primary and secondary settings.** GPs play a vital role in the care system. However, traditional surgeries are not home to the range of technologies and skills that will allow GPs to reverse, for instance, the United Kingdom’s dismal record on early diagnosis of disease<sup>18</sup>.
- **Episodic and preventive interventions.** The rise of lifestyle diseases and personalised medicine means that preventive interventions – largely absent currently – are a vital ingredient of improvements in outcomes.
- **Physical and mental health.** In the mid-1950s, 150,000 people deemed to be suffering from mental health problems were housed in institutions<sup>19</sup>. By 2004/05 there were around 32,000 beds in England for those with mental health problems<sup>20</sup>. There has been little increase in community resources.

By removing these boundaries, ICOs meet the needs of a society living longer but with more conditions. This section explains the changes that will be needed if these organisations are to be created.

### Removal of the health/social care split

The 1948 separation of health and social care was a mistake. Responsibility for the two systems, and their budgets, should be merged immediately. It should happen from the top down to local care systems.

### A smooth, seamless patient journey

The ICO will manage best-in-class care pathways (eg from home to intermediate care facilities to hospital and

back home), with each patient having one appointed case manager who will navigate them through the system<sup>21</sup>. These pathways will be made possible by a rapid introduction of electronic patient records (EPRs) set within a connected digital network.

The implementation of ICOs and EPRs have been problematic in the past. However, there have now been sufficient successes to allow implementation without multiple additional pilot studies.

### A new distribution of skills

The changing epidemiology of disease means that there is a separation of expertise between two types of clinicians. There are generalists who can consider the “whole person” in their social setting – experts known as “extensivists” in the United States<sup>22</sup>. Within hospitals, advancing medical science and practice requires greater clinical specialisation. The ICO will need to be able to draw on a balance of the two.

### Changing health settings

The holistic approach that modern citizens call for cannot be practised in the traditional setting of the GP’s surgery. Larger health centres are required. These should co-locate GPs with social workers, mental health experts, pharmacists and diagnostic technology.

Intermediate care/skilled nursing settings, based on an upgrading of the UK’s nursing home estate, will develop as the ICO puts the individual patient’s needs at the core of the pathway.

The ICO would also streamline 999 and 111 services so that expert assessment services are available – linked, critically, to the EPR – to improve triage of emergencies and ensure that patients are sent along the most appropriate pathway.

### From treatment to prevention

The ICO is a necessary step in integrating the various strands of public health, and in delivering them in context. An important part of this shift from not only treating illness but also promoting health is a greater role for self-care.

### True parity of esteem between mental and physical health

Turning parity of esteem from a political slogan into a reality is one of the core features of the ICO.

The ICO will, over time, extend to the criminal justice system, absorbing the encouraging work that has been started in the UK on “troubled families”.

## Section 3:

# Linking the integrated care organisation to the academic health science centre

### The move to personalised medicine

The ICO will keep people out of acute hospitals if there is no clinical need for them to be there. This will take unnecessary pressure off acute hospitals, freeing them to focus on clinical excellence in sub-specialities.

This clinical excellence needs to embrace the dramatic advances in the practice of science and medicine. The molecular biological and information revolution of the past 70 years is now leading to the greatest transformational change in the practice, prevention and delivery of healthcare in history. Personalised medicine is becoming a reality<sup>23</sup>.

The new biology, and genetic medicine, make it possible to identify the unique DNA profile of an individual and to tailor preventative medicines and treatments for that individual<sup>24</sup>. Work in these areas is already under way in the best UK universities, such as Imperial College<sup>25</sup>.

### The role of the AHSC

In 2014/15, the United Kingdom had four of the top 10 universities in the world<sup>26</sup>, and all of them are global leaders in the discipline of biological sciences<sup>27</sup>. To retain that position, and to deliver personalised medicine, we again need a new type of delivery vehicle: the academic health science centre (AHSC). These unite acute healthcare providers and universities, bringing clinical practice together with research experience to make scientific discovery work for the benefit of the person on the street. They advance biomedical science, especially genetic medicine.

AHSCs consolidate clinical units. For many

conditions, there is already a strong clinical consensus that this improves health outcomes<sup>28</sup>. There will be fewer acute hospitals in the country, but there will be bigger centres of global clinical eminence spread across the United Kingdom, each of which will be a dynamic nucleus of innovation and performance.

This consolidation does not mean closing hospitals: there is a symbiosis between the out of hospital ICO and the AHSC that means existing hospital buildings can be repurposed rather than closed down. The ICO needs new settings – such as intermediate/skilled nursing units and polyclinics<sup>29</sup> – that should be developed in existing facilities.

### The relationships between the ICO and the AHSC

The ICO is the nexus that wraps services and treatments around the individual patient, including that person's unique genetic profile. The anonymised aggregation of this information allows scientists and clinicians to discover links between the genome and disease. In turn this makes possible the determination of future outcomes and trends that allow for the implementation of population-wide preventive and treatment programmes and, sensationally, the delivery of these discoveries back to personalised therapies for the individual in the context of the ICO<sup>30</sup>.

Without the two delivery models of the ICO and the AHSC, the United Kingdom will suffer not only deteriorating health and social care outcomes relative to other advanced nations, but also an impoverishment of the country's prominent global position in biomedical science.

## Section 4: Identifying the barriers to change

### A long time coming

The costs of not reforming the UK's care system are very high. NHS England has written extensively about the need for integration in the *Five Year Forward View*<sup>31</sup>, and The King's Fund recently produced a very comprehensive paper on the topic<sup>32</sup>.

However, this is not a new desire for change. Consider this 1961 address to the National Association of Mental Health's annual conference:

"...a hospital plan makes no sense unless the medical profession outside the hospital service will be able progressively to accept responsibility for more and more of that care of patients which today is given inside the hospitals. It makes no sense therefore unless the medical profession outside the hospital service can be supported in this task by a whole new development of the local authority services for the old, for the sick and for the mentally ill and mentally subnormal."<sup>33</sup>

So why does the UK care system prove so resistant to change? What are the barriers?

### Supply side inertia

The NHS is a state-controlled, supply-side monopoly. Clinicians deliver excellent care on the ground but are often confounded by the workings of the system, and especially by the constant reorganisations and initiatives – pilots, pioneers, vanguards – that supply-side monopolies of any sort too often mistake for change. Demand-side, needs-based, mechanisms are lacking in the system.

### Who's in charge?

There is a paradox that – despite the accountability and responsibility that secretaries of state, ministers, senior civil servants and senior NHS managers feel – lines of authority are tangled and lack cohesion. The picture is often so muddled that at times it can seem that no-one is in charge<sup>34</sup>.

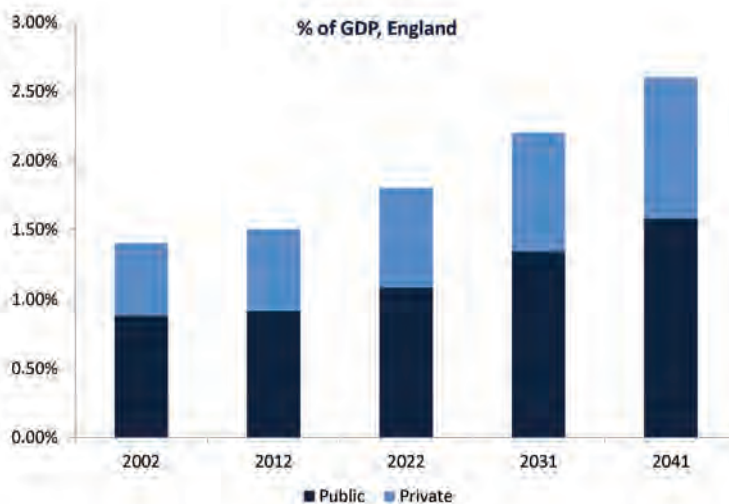
The many dysfunctional dynamics within the system make the task of management an exceedingly difficult one. The strain is compounded by a sometimes rancorous attitude towards management which is often equated with bureaucracy or unproductive overhead. This is not an environment conducive to implementing transformational change<sup>35</sup>.

### An under-supported workforce

The UK's clinicians and carers are amongst the best and most dutiful in the world. However, they are often not given the right skills, are severely under-resourced, and in many parts of the system they are underpaid. For example, despite the government policy of moving people with mental illness back into the community, primary care physicians, nurses and carers are insufficiently trained in delivering mental health therapies. Similarly, the UK takes far longer to diagnose dementia than other major European countries.<sup>36</sup>

There is a shocking national shortage of nurses. In 2013, The Royal College of Nursing reported a shortage of 20,000 nurses and a 15 per cent reduction in the number of student nurses being trained, combined with

### Long-term care expenditure projected to increase sharply



Wittenberg, R. et al (2006) *Future Demand for Long-Term Care, 2002 to 2041: projections of demand for long-term care for older people in England* [tinyurl.com/careexpenditure](http://tinyurl.com/careexpenditure)



an ageing workforce<sup>37</sup>. This issue continues to be dispiritingly unaddressed by government.

Meanwhile the drastic cuts in social care mean that, as of December 2012, more than 70 per cent of care workers were paid just £6.76 an hour<sup>38</sup>. This is only a fraction over the current minimum wage of £6.50, and considerably less than the pay for stacking shelves at Tesco. Poor wages are leading to high staff turnover and lack of care continuity.

### **The problems of regulation**

Regulation and inspection is fragmented and confusing. It is a patchwork of overlapping and often inconsistent regimes that include the Care Quality Commission, local authority inspectors and commissioners, Monitor, NHS England, and the Health and Safety Inspectorate. While the CQC, in particular, has made significant advances in the quality of its operations in recent times, the overall regulatory system is sometimes a distraction from real improvement in outcomes rather than supportive of them.

### **Constrained funding**

We are not spending enough on health and social care. That the system is largely tax funded means spending

per capita across the whole system will, due to the stringencies of austerity, fall over the coming years. Demand for healthcare is not going to fall. Social care funding has been at crisis levels for some time now. This too is set against a need that is rising rapidly.

A higher percentage of UK health spending is publicly funded compared to most other countries, and all of the public funding is drawn from the general taxation pot, unlike the more upwardly malleable social insurance system. This severely constrained funding means that the focus often has to be on carrying on, rather than on making the sort of fundamental changes that are needed.

### **The distraction of politics**

Politicians play a major part in the negative processes of launching reorganisations, tinkering with day-to-day operations, overloading the capacity of the system with policy rather than action, and pioneering eye-catching initiatives.

Damage is also done by using the care system as a political football to score points in an attempt to garner votes. The real differences between informed politicians is actually quite small, but the temptation to mould a distinctive political portrait means that concerted action is grievously disrupted.

## Section 5:

# The mechanisms for change

### Achieving momentum

The momentum for change will come from the staged introduction of demand-side mechanisms. These will pull through fruitful reform that forces the alignment of the system to the needs of the patient or citizen. This will confront the failure of supply-side inertia.

### High quality information on outcomes

The emphasis on outcomes and information is the first step in productive reform. It moves attention away from big reorganisations and small politics. It focuses everyone's minds on doing what is right for the patient. It is imperative that high quality information is made available to providers and consumers about which health and social care treatments and interventions work best for the individual (in terms of outcomes), the taxpayer (in terms of cost effectiveness), and the system (allowing it to learn and to innovate).

The data that such a shift will generate will be a major boost to the accumulation of learning and the spread of best practice. There is a tendency in any job for people to do what they have always done, in which case the work becomes task-driven and not outcome-oriented and patient/consumer-attuned. The process of enquiring into what works best and learning from others in the profession is expedited by this change from task- to outcome orientation.

### Guided choice

Guided choice is the process whereby UK citizens can choose to go to the best provider of health and social care outcomes rather than the only provider. The combination of well-publicised outcome data and the exercise of choice is a potent driver of change. To use an international example, there are 139 transplant facilities in the United States. The best of these transplant facilities is excellent – and has a 100 per cent one-year, risk-adjusted survival rate<sup>39</sup>. The worst facility has a 1 per cent one-year, risk-adjusted survival rate. It is clear what a citizen armed with information and a vote will do in these circumstances, and how that behaviour will take menacingly poor practice out of operation and animate the spread of best practice.

### Making the money follow the patient

Personal budgets, whereby people are given the money to which they are entitled and are able to spend it on the best provider, are now widely used and successful in social care. In the NHS currently, flows of money are to the same institutions – mostly hospitals and GP practices – as they were in 1948. There will be very limited reorientation of those services, then, until the money follows the patient.

### Accepting competition

Competition and the private sector, when applied to the NHS, have become toxic words. However, competition is vital if we are to get a service that provides the best care for people in the UK. The issue of the private sector is a red herring. Much of the competition to earn the right to deliver a service will actually occur in the public sector. Take, for instance, Great Ormond Street, which delivers the best paediatric care in the country (perhaps even in the world). If it can deliver better care than the paediatric units in other UK hospitals then why shouldn't it take on responsibility for those units?

### Expert commissioning

Individual guided choice can only go so far in reforming the system. Commissioners create the market landscape within which consumers can exercise their choice. It is the commissioners' knowledge of pathways, and their analysis of what produces the best outcomes, that creates the services that users/patients access. Commissioners then make that information available to everyone.

Commissioning will increasingly be based on a virtuous circle that identifies the best treatments, collects information to test outcomes and then adjusts the treatment regime accordingly. Commissioners ensure that all services are put out to tender regularly – in natural monopolies – or that sufficient competition is maintained to keep organisations honest.

They will manage economies of scale (building deep competence in treating specific medical conditions) and scope (taking this greater and safer competence to all parts of the country) in the interests of patients. Commissioners make sure that market failure does not interrupt service to the public.

## Section 6:

# Our recommendations for change

### Making the mechanisms work

As the previous section outlined, there are key mechanisms which can drive momentum for change. For these to be introduced, however, contextual changes will first be needed. These will address the longstanding barriers to wider change.

### Put managers in charge, and support them

It is a paradox that we need less centralised, especially politicised, intervention into the care system, yet one of the first things we are recommending is centralised intervention. This is a matter of timing. The system is currently mired in a particularly messy marshland of fragmented, overlapping and discordant organisations and jurisdictions.

The inertia is so inveterate and long-standing that clear and determined leadership is required to launch the market mechanisms that we have outlined, and to drive the twin engines of ICO and AHSC. This leadership needs to come from the very top, through consolidation of health and social care at ministerial level, and then be invested in the CEO of the NHS (adding the social care responsibility). It needs to be complemented by decentralised leadership in local health economies, and full integration of health and social care budgets and teams.

Managers deserve and require full-blooded support in the change process, and they need an explicit plan to which they can orientate themselves and their organisations.

Their leadership and managerial skills should be actively enhanced. As Jenny Priest has pointed out: “It has been established that effective leadership is required to facilitate integrated care. This is clearly felt by doctors: when asked to identify the barriers to achieving integration through joined-up care pathways, over half of doctors responding to our survey felt that a lack of managerial leadership was a key barrier. Almost 44 per cent identified lack of clinical leadership as a barrier.”<sup>40</sup>

### Boost the workforce, in number and skill

Workforce skills and numbers need to be increased. In the world of the ICO and AHSC, it is clear that clinicians need to be streamed depending on where they are going to deliver care. There will be more clinical specialists within hospitals, and more “extensivists” in a newly configured integrated system that breaks down the secondary/primary/social care distinctions.

GPs will need to further embody the extensivist concept, such that they can lead multidisciplinary teams in practices. These teams will care for complex patients and support a shift of care out of the acute hospital sector into the community – in nursing homes or in people’s own homes. Clearly the nursing workforce needs to increase.

Nursing homes should play a more important part in

this process: entry level carers should have a nationally recognised qualification that lies between senior care assistant and state registered nurse.

This elevation of the skill level of the 500,000 care home workers in the country will require improved funding so that the United Kingdom breaks out of the vicious spiral of low pay, high turnover, limited clinical training, and compromised care.

### Rationalise regulation

Rationalisation of the regulatory framework is urgent. Monitor and the regulatory functions of the TDA and NHS England should be closed down, and their activities should be integrated into a single regulator, the CQC, which itself integrated the regulation of healthcare and social care in 2009.

### Find more money

Many of the recommendations in this pamphlet will mean that money is spent more efficiently and effectively – such as the reduced inappropriate use of expensive hospital beds for frail older people.

However, more money will also be needed. The UK is not spending enough on health and social care. The fact that the system is largely tax-funded will mean that spending per capita across the whole system will, due to the stringencies of austerity, fall over the coming years. Social care funding has been at crisis levels for some time now.

The proportion of gross domestic product (GDP) spent on health and social care should rise at least to the average levels across the more advanced parts of Europe (in 2012, the UK spent just over 9 per cent of GDP on its health service, compared to almost 12 per cent in France and the Netherlands).<sup>41</sup>

It is quite appropriate that, as need and affluence increase, society will wish to spend more on health and social care. There is also a strong case for increased spending to maintain the UK’s global lead in biomedical science, which earns the country significant amounts of foreign earnings.

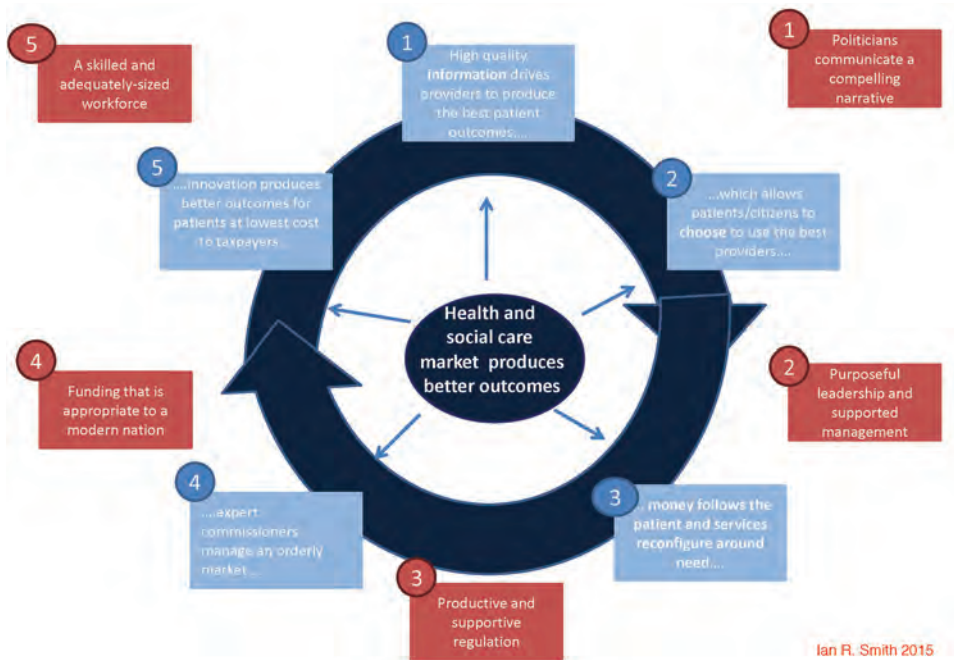
The constraints to an expanding share of GDP being spent on health and social care is the fact that the majority of funding is derived from taxes and allocated by government.

Funding arrangements need to balance the solemn need to protect the most vulnerable in our society with the rising cost of the service. In the first place, this cost needs to be slowed by preventing flippant use of the system.

For example, many people would support a charge on drunken and abusive people attending A&E – at weekends it is estimated that 70 per cent of attendances between midnight and 5am<sup>42</sup> are cases of drunkenness.

The austerity constraint to increased funding needs to be relaxed by placing more of the burden on those people more able to pay. In particular, the distinction

### The virtuous circle driving integrated care, clinical excellence and scientific progress



between means-tested social care and a free at the point of care NHS needs to be eradicated. It will mean the wealthier people paying more (“top-ups”) for healthcare, and more money flowing into social care. This flow is a vital part of making the integration of health and social care work.

Finally, the debate needs to be launched on the advantages and disadvantages of a social insurance system. This is a highly emotive topic, and often triggers fears of a hidden agenda that will obstruct accessibility and compromise affordability.

A social insurance system is a more appropriate funding mechanism than the unedifying sight of the NHS chipping away at a limited slab of anonymous taxes. It shares risk based on the most needy, it is something to invest in, and it allows for the targeted financing of integrated care and therefore outcome priorities.

#### A productive role for politicians

Politicians have an important role to play in the UK’s care system, but it is not the role they have traditionally played. The answer is to get the politicians out of the way of management and ban their often chaotic interventions. We need to say to our politicians what Dwight D Eisenhower is said to have commanded his meddling secretary of state, John Foster Dulles: “Foster, don’t just do something; stand there”<sup>43</sup>.

The appeal should go out to the public that says demand more from your politicians, demand that they do what we pay them to do: to lead the country to a place that better serves its citizens. Some 73 per cent of respondents in a recent Ipsos MORI survey believed political parties’ policies on the NHS are designed to win votes, not to do what is best for the NHS<sup>44</sup>. This is a very serious credibility gap.

## Conclusion

The care system in the United Kingdom has become seriously misaligned with the needs of the population in the 21st century. The NHS was a stunningly bold and appropriate system in 1948. Despite the skill and dedication of UK clinicians and carers, and despite the UK’s leadership in biomedical science, the structures of the NHS have barely evolved since they were formed in 1948. This cursed rigidity would be a major disappointment to the service’s major architect:

“We shall of course find from time to time that alterations and adjustments have to be made. We are not ridden by doctrine; we are a nation very largely of visionary empiricists, able to adjust things where necessary, and between us we shall have a standard of health service that will be the envy and admiration of the world.”<sup>44</sup>

It is time that all of us mobilised to deliver, finally, on Nye Bevan’s optimism and sense of duty.

# The route map to a better care system, through ICOs and AHSCs

The integrated care organisation (ICO) and the academic health science centre (AHSC) are the structures that will deliver better outcomes within the UK care system. Evidently, the fully formed organisations, mechanisms and markets will not emerge on day one. Rather, a transition will be required. At the start, it will be more managed. At the maturity stage, it is self-sustaining as the demand-driven mechanisms drive on-the-ground adaptability and alignment of the system with need.

## Step 1: The journey of a thousand miles begins beneath one's feet

The objective in step 1 is to address short term but persistent problems that clearly exist within the UK system, and whose solution would have demonstrable benefits to UK citizens:

- Bed blocking
- Poor access to primary care
- The clinical inefficiency of sub-scale units in hospitals
- The absence of joined-up care pathways

Unless we can solve these problems, overcoming the detailed constraints to change – such as stand-offs between the NHS and local authorities on who pays once a frail older person leaves hospital – integration will remain a pipe dream.

## Step 2: Analysing data and introducing new pathways

The outcome-information exercise begins in earnest in this phase. Population data for cohorts are analysed, patterns identified and conclusions reached through inductive logic.

Personalised, integrated care packages and care pathways are introduced for “frequent flyers”: the people who are most frequently attending A&E and being admitted to the acute hospital.

These packages and pathways are managed by a case manager, who is responsible for instituting a robust crisis management procedure for the frequent flyers. Care pathways are measured for outcomes.

## Step 3: Creating expert commissioners

Existing clinical commissioning groups (CCGs) are too small to be expert commissioners. In step 3, lead CCGs are created by amalgamating existing bodies (incorporating existing, overlapping bodies, such as health and wellbeing boards).

By this time, there will be a growing body of data and evidence on what treatments and interventions work best. The lead CCG will be able to use risk stratification techniques to identify the most high risk/high cost individuals. These people can then benefit from integrated care plans, a case manager, funding agreed against assessments, a single point of crisis contact, and so on.

## Step 4: Managing the market and harnessing the power of digital

Lead CCGs start to actively manage the market and begin tendering for cohort management. The lead CCG will also begin to shape the choices that academic health science centres make about which clinical domains they will concentrate on to build national and global merit.

The lead CCG will elevate the paper-based integrated care plan into the first building block of an electronic patient record. This EPR will incorporate all data that currently exists on the individual, regardless of which system it is currently held in (primary care, local authority, hospital etc).

The lead CCG can start experimenting with new funding and charging approaches, such as financial penalties for abuse of the A&E system.

## Step 5: Effective electronics

Step 5 is engaged in getting the electronic platforms and records to work effectively. Once electronic patient records are available and there is reliable network connectivity, so the unique DNA profiling of individuals can begin, and links to the research organisations can be made more robust.

## Step 6: From illness to wellbeing

In step 6, the work of the ICO on illness can be supplemented by initiatives on wellness, including the encouragement of self-care.

## Step 7: The extension of cohort management

By this stage, cohort management has extended to all high risk/cost groups. This stage represents the culmination of background work to repurpose care settings (creating polyclinics and intermediate care centres). It is also the culmination of reshaping and reskilling the workforce so that it has the appropriate blend of skills and disciplines to meet the needs of patients.

## Step 8: To risk management

The data on which treatments and interventions are really effective and where the resources need to be spent to have the highest impact will be increasingly available and reliable. On this basis, it will be possible to extend the concept of the ICO so that it is a risk management operation and not just a service management operation.

## Step 9: Further erosion of boundaries

In this stage, the ICO extends to cover troubled families. It will take time to integrate health and social care, but eventually it will be possible to extend the concept to

include, especially, the criminal justice system. This will have a major impact on individuals and society – and also on the costs of the broader system, including the police, the prisons and the probation services<sup>46</sup>.

### Step 10: The virtuous circle

The UK care system is operating as an efficient market in which:

- Expert commissioning interacts with the deployment of high quality outcome information
- The outcome information allows individuals, who will be in possession of personal budgets, to discipline the system
- Services constantly reconfigure around the changing needs of the population, driven by the excellence and innovation that comes from competition

- Risk managed, individualised, whole person care is at the heart of the system

The Boston Consulting Group have said: “As more and more data about health outcomes becomes transparent... some stakeholders are taking on more of the risk associated with managing whole patient health. Because of the complexity of managing the entire health needs of a broad patient population, this is the most advanced version of competing on outcomes.

“Only players that have reached a high level of data sophistication, and that understand their patient segments well enough to minimize risk and to provide quality outcomes at relatively low cost, will be successful. Organisations that currently come closest to adopting the whole-patient-health approach are the single-provider integrated-delivery systems in the US, such as Kaiser Permanente, Intermountain Healthcare, and the Geisinger Health System.”<sup>47</sup>

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