The King's Fund

Ideas that change health care

# Written submission

## House of Lords Select Committee: long-term sustainability of the NHS

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

In line with the terms of reference for the inquiry, our response focuses largely on the NHS. However, it is not possible to consider the future health system without considering social care, so we have also highlighted issues relating to social care where these are relevant.

### Executive summary

- The health and social care system is facing unprecedented financial pressures and will require fundamental change if it is to successfully respond to the challenges it faces over the next 20 years, including the needs of an ageing population, the changing burden of disease and rising public expectations.
- As the Barker Commission recommended, a new settlement is needed that ends the historic divide between the health and social care systems by moving to a single, ring-fenced budget and a single local commissioner of services.
- While there is scope to improve productivity, if increased funding is not forthcoming, the growing crisis in health and social care will become much worse, with patients waiting longer for treatment, quality of care compromised and access to publicly funded social care further restricted.
- The UK spends less on health than countries such as Germany, France and the Netherlands, while public spending on social care will fall back to less than 1 per cent of GDP by the end of the parliament.
- As the Barker Commission recommended, the long-term aim should be to increase spending on health and social care to the same level as in other comparable nations.

- Increasing spending on health and social care is affordable and sustainable if hard choices are made about how to find the resources needed. The first step is for politicians to be honest with the public and to hold an open debate about how this should be paid for.
- Demand for the future health and social care workforce is likely to exceed supply. An effective workforce strategy will be needed to address these challenges, while staff will also need to work differently, increasingly working across current professional boundaries.
- New models of care, sustainability and transformation plans and the move to place-based systems of care offer significant opportunities to integrate care. However, genuine integration will be hard to achieve while the fundamental differences in funding and entitlements between the NHS and social care remain.
- Unhealthy lifestyles have a negative impact on health and wellbeing and cost the NHS and the economy billions of pounds a year. The weakness of the childhood obesity plan highlights the need for a much bolder approach to improving public health that recognises the role that regulation and taxation have to play.
- More needs to be done to strengthen the role of patients and service users as partners in their own care. The evidence shows that when people are involved in this way, decisions are better, health and health outcomes improve, and resources are allocated more efficiently.

## 1. The future health and care system

A number of trends and drivers will affect health and social care services over the next 20 years (Imison 2012). The most significant include:

- financial context: the NHS and social care are currently experiencing unprecedented financial pressures, and future projections suggest that these pressures are likely to continue
- demography and future patterns of disease: an ageing population will mean more people living longer and healthier lives but also increasing numbers of people living with disabilities and multiple long-term conditions
- medical advances: the pace of medical and diagnostic advances is rapid, offering great promise but with potentially significant implications for future spending
- information technologies: digital technology has the potential to transform the way patients and service users engage with services, improve the efficiency and co-ordination of care, and support people to manage their health and wellbeing but it is not certain that these opportunities will be grasped
- workforce: there are significant challenges in matching the skills of the workforce in health and social care with the changing needs of patients

and service users, and growing shortages in some key areas, driven by both training and budgetary constraints
- public attitudes and expectations: patients and service users increasingly expect modern, convenient and personalised services.

## 2. Resourcing

This Committee's inquiry is taking place at a pivotal time for health and social care. In the context of deficit reduction and significant cuts to many departmental budgets, the NHS received a comparatively favourable settlement in the 2015 Spending Review, and the pressures on social care were also acknowledged. However, the NHS is currently halfway through the most austere decade in its history, and NHS providers recorded their biggest ever annual deficit last year. Funding pressures can affect patients in a range of different ways, some of which are hidden (Robertson 2016); one of the most visible ways in which they are affected is by having to wait longer for treatment. Key performance targets for acute hospitals are now being missed all year round, general practice is in crisis and community and mental health services are under huge pressure (Murray *et al* 2016).

Six years of cuts to local authority budgets in the face of increasing demographic pressures have led to 26 per cent fewer people getting publicly funded care and support, increasing the burden on older and disabled people, their families and carers. The social care market is under unprecedented pressure, with increasing numbers of providers choosing to leave the market and going out of business. With a funding gap of at least £2.8 billion set to open up by the end of the parliament, it is clear that the social care system in its current form is unsustainable (Humphries *et al* 2016).

There is significant scope to improve productivity in the NHS, ensuring the greatest value for patients from every pound spent on care. Estimates show, however, that productivity in the NHS as a whole improved at a rate of around 1 per cent a year over the past 35 years, some way short of the 2–3 per cent gains needed to meet the target of delivering £22 billion in productivity improvements by the end of the parliament. Many of the central policy levers used in recent years – in particular national controls over pay and prices – have reached their limits.

This means that further improvements will have to be delivered differently. Our review of the evidence suggests that there are significant opportunities to improve outcomes and deliver better value by tackling variation in the delivery of care through changes in clinical practice. Examples of overuse (when unnecessary care is delivered), underuse (when effective care is not delivered) and misuse (when care is poorly delivered leading to preventable complications and harm) of care are still common across the NHS (Alderwick *et al* 2015a). Realising these opportunities will require a sustained commitment to supporting

clinical teams, investing in the right kind of leadership and providing staff with skills in quality and service improvement (Ham 2014; Ham *et al* 2016).

The long-term trend has been for health spending to increase in real terms by 3.8 per cent a year (Office for Budget Responsibility 2016). In contrast, spending over the current parliament will increase by less than 1 per cent a year in real terms, as it did over the course of the last parliament. Given rising demand for services, this rate of increase is clearly unsustainable, even if the NHS can significantly improve productivity.

The pressures on the NHS have been recognised by the Office for Budget Responsibility (OBR); their recent report on fiscal sustainability and public spending on health concluded that, to maintain current policies in the face of the latest population projections, spending on health care will increase as a proportion of GDP (Office for Budget Responsibility 2016).

Longer term funding options should be informed as far as possible by regular detailed forecast and projections based on the latest data and modelling approaches – this more in-depth analysis could be carried out by the OBR. A priority for the Committee could be to produce some future spending scenarios to assess the range of possible spending paths.

In the short to medium term, if increased funding is not forthcoming, patient care will suffer, with longer waits for treatment and quality of care compromised. It is also inevitable that more NHS organisations will be forced to restrict access to certain services or dilute the quality of care they provide. This would raise significant issues of public acceptability. In the latest British Social Attitudes survey very few (3 per cent) respondents were willing to accept longer waiting times or raised thresholds for treatment (9 per cent) (Appleby *et al* 2016). A failure to increase spending and reform social care would result in a growing funding gap and an increasingly residual service that is only available to the poorest and neediest.

Although the latest data from the Office for National Statistics (ONS) suggests that UK health spending as a proportion of GDP has previously been underestimated in comparison with other countries, it remains lower than countries such as Germany, France, Netherlands and Sweden. Public spending on social care as a proportion of GDP will fall back to less than 1 per cent by the end of the parliament.

Increasing spending on health and social care is affordable and sustainable if hard choices are made about how to find the resources needed. As the government's decision to abandon the plan to deliver a budget surplus by the end of the parliament shows, there are political choices to be made about priorities, public spending and taxation. The first step is for politicians to be

honest with the public about the need to increase spending on health and social care and to hold an open debate about how this should be paid for.

To answer the long-term question about how to ensure adequate resources to meet future needs, The King's Fund established an independent Commission on the Future of Health and Social Care in England (2014). Chaired by the economist Kate Barker, the Commission was asked to consider whether the post-war settlement – which established the NHS as a universal service, funded through general taxation and free at the point of use, and social care as a separately funded, means-tested service – is fit for purpose.

The Commission's final report, published in September 2014 suggested that the long-term aim should be to increase spending on health and social care as a proportion of GDP to the same levels as other comparable nations. The report concluded that:

- England needs a new settlement for health and social care that breaks down the historic divide between the two systems and better meets the needs of patients and service users
- this should be achieved by moving to a single, ring-fenced budget for health and social care with a single local commissioner of services
- the current maze of entitlements should be simplified by bringing Attendance Allowance within the new single budget
- entitlements to social care should be fairer, more consistent and generous, while entitlements to NHS services should be unchanged
- the settlement should be introduced in a phased approach:
    - first, care should be free at the point of use for those whose needs are currently defined as 'critical', ending the current distinction between NHS continuing care and means-tested social care for those with the highest needs
    - second, as the economy improves, free social care should be extended to those with 'substantial' needs
    - third, some limited support should be extended to people with moderate needs, with the expectation that they would contribute to those costs subject to a means test.

The Commission considered a number of different options for funding their proposals, including social insurance and increased user charges, concluding that the drawbacks outweighed the advantages in both cases. Instead they recommended that the bulk of the additional funding needed should come from the public purse. On the grounds of inter-generational fairness and equity, they recommended that the older generation and people nearing retirement age – who would be among the biggest beneficiaries of a new settlement – should make a significant contribution.

The Commission recommended a radical package of measures to pay for their proposals including:

- releasing resources by targeting some existing benefits more effectively (free TV licences for the over-75s and winter fuel payments)
- reforms to prescription charges to raise more revenue without increasing charges
- ending the existing exemption from employee's National Insurance once people reach state pension age (with a contribution of 6 per cent rather than the standard 12 per cent), increasing contributions for those aged over 40 by 1 per cent and for those above the upper earnings limit to 3 per cent
- a comprehensive review of wealth and property taxation with a view to spending all or part of the proceeds on health and social care.

Results from the latest British Attitudes Survey show that the public remain committed to an NHS free at the point of use (Appleby *et al* 2016). Other work we have done on public attitudes to paying for health and social care found that people strongly supported the principle that access to health care should continue to be based on need rather than ability to pay, and means testing was unpopular both in principle and for practical reasons (Galea *et al* 2013a). Some polling data also suggests strong public support for raising taxes to increase funding for the NHS (Ipsos Mori 2015).

## 3. Workforce

*Current pressures*

Problems with recruitment and retention are currently being experienced in both the health and social care sectors. The current approach to workforce planning and the general oversight of the health and care workforce have not worked well to date. Although recent data suggests there have been increases among key staff groups including consultants and nurses (Murray *et al* 2016), there was a shortfall in 2014 of 5.9 per cent (equating to around 50,000 full-time equivalents) between the number of staff that providers of health care services said they needed and the number in post, with particular gaps in nursing, midwifery and health visitors (National Audit Office 2016). Major imbalances between the supply and demand for nurses means that NHS trusts continue to rely on employing more costly temporary staff to fill the gaps (Dunn *et al* 2016).

Our research shows particular issues in general practice, community health services and social care.

- There are huge pressures on general practice, where rising demand and increasing workload has not been matched by growth in either funding or workforce (Baird *et al* 2016). Practices are finding it increasingly difficult

to recruit and retain GPs, and there are challenges in relation to other members of the primary care team. It will be challenging to deliver the government's policy objective to recruit and retain 5,000 more GPs by 2020.

- The number of nurses working in community health services has declined, with the number working in senior 'district nurse' posts falling dramatically over a sustained period and dropping by almost half between 2000 and 2014 (Maybin *et al* 2016). These pressures are having a deeply negative impact on staff wellbeing, with unmanageable caseloads common and risks that quality of care may be compromised. This is despite the longstanding policy ambition to provide more care in the community.
- Social care providers across the country have been struggling to recruit and retain good-quality staff (Humphries *et al* 2016). The care sector as a whole has a vacancy rate of 4.8 per cent (compared with a vacancy rate of 2.6 per cent across the economy). This rises significantly for qualified nurses, where the vacancy rate is 9 per cent; slightly more than a third of nurses were estimated to have left their role within the past 12 months (Skills for Care 2016b).

*Brexit*

Current problems could be compounded by the UK's vote to leave the EU (McKenna 2016). Both the health and social care sectors have benefited from the EU's policy of freedom of movement and mutual recognition of professional qualifications, with many members of the current workforce having come from other EU countries. This includes 55,000 of the NHS's 1.3 million workforce and 80,000 of the 1.3 million workers in the adult social care sector (Health and Social Care Information Centre 2015; Skills for Care 2016a).

Until the UK extracts itself from its obligations under EU treaties, the policy on freedom of movement remains unchanged. However, given the current shortfalls being experienced in both the health and social care sectors, we urge the government to clarify its intentions on the ability of EU nationals to work in health and social care roles in the UK, not least to avoid EU staff currently working in these roles deciding to leave to work in other countries.

In the longer term, we have argued that providers of NHS and social care services should retain the ability to recruit staff from the EU when there are not enough resident workers to fill vacancies. This could potentially replicate the recent approach taken by the Home Office, by adding specific occupations to the Migration Advisory Committee's shortage occupation list, which currently enables employers to recruit nurses and midwives outside the European Economic Area.

*Future needs*

Across the globe, the demand for health and social care workers is growing. However, the World Health Organization (2013) predicts that it will become increasingly difficult to recruit health workers, anticipating a global shortage of 12.9 million health care workers by 2035. Due to factors including an ageing nursing workforce, the international movement of health care workers and fewer people training to be nurses, the Royal College of Nursing has predicted that the number of nurses could fall by 28 per cent (100,000) by 2022 (Buchan and Seccombe 2011).

In social care, modelling suggests that if the workforce grows in line with demographic trends, 275,000 additional jobs will be needed by 2025 – an increase of 18 per cent (Skills for Care 2016c). Between 2010 and 2030 the number of people requiring informal care (unpaid care provided by friends and relatives) is expected to grow to 3 million, (Wittenberg *et al* 2011), while the number of people living alone and isolated from family support is growing.

Integration of care means that staff may be increasingly required to work across traditional organisational boundaries, and there will be a need to both facilitate and co-ordinate that care. Many of the clinical and professional skills required to support integration of care already exist within the workforce; however, as our research points out, they are often insufficiently available or inefficiently distributed (Gilburt 2016). There is therefore a need to consider the current skills and responsibilities of the workforce and how they can be deployed most effectively.

In recent years, organisations have sought to integrate care through the development of discrete multidisciplinary teams and, in some cases, of new roles such as care co-ordinators, case managers and personal assistants. While these have facilitated integration in individual areas of care, evidence to support their use more widely is limited and they have often proved unsustainable. Our research finds that successful integration needs to move beyond creating organisational forms and roles to deliver integration to supporting staff across the workforce to work in new ways. This will need a programme of training and ongoing development, supporting staff to build their skills and capabilities to deliver care across boundaries that is focused on meeting the holistic needs of patients.

*Workforce planning*

It should be obvious that the NHS and social care cannot function well without access to appropriately qualified staff. The complexity of the health care workforce, the long lead times in training new staff and the need to provide care now to those that need it mean that workforce planning is a critical and complex function (Addicott *et al* 2015). Addressing current and future workforce

challenges requires a workforce strategy that builds up from: the need for health care; the forecast availability of workforce now, in the medium term and the long term; and mitigation strategies where there is a gap.

Staff costs account for just under half of total NHS spending. Many assumptions made about future savings imply a smaller workforce (and therefore a lower paybill). This poses two risks:

- overly optimistic assumptions about efficiency and demand management can lead to workforce shortages
- training additional staff – for example, in mental health and community settings –will lead to more staff only if NHS commissioners commit sufficient money to providers to employ them.

Both risks can be reduced through a workforce strategy that links demand, affordability and the supply of staff. This should be done alongside a similar assessment for social care.

The Department of Health and its NHS partners also need to establish a balance between national, regional and local responsibilities for the workforce. For example:

- when developing new roles, there is a case for doing this beyond organisational boundaries as more standardised roles common across employers can increase the opportunities for career development and dedicated training
- there is also a case for regional or national co-ordination of overseas recruitment rather than expecting each individual employer to run recruitment campaigns in other countries
- each employing organisation should have the skills and capabilities to improve staff retention, with regional and national bodies limited to the provision of support and training.

*Supporting the role of volunteers*

In thinking about how to resource the workforce of the future, the potential for volunteers to play an important role should not be underestimated. Our analysis of the British Social Attitudes survey shows that around 1.7 million active adult volunteers in Britain already formally volunteer in the health and care sectors (Buck 2016a). In addition, half who do not currently volunteer in health and care services said they would consider it if asked – representing an untapped reserve for the sector.

In relation to the NHS specifically, volunteers perform an incredible diversity of roles (Galea *et al* 2013b), are highly regarded by patients, and have a positive impact on patients' wellbeing (Babudu *et al* 2016). Our 2013 survey found that

only half of acute trusts in England had a volunteering strategy, and there was little correlation between size of trust and number of volunteers (Galea *et al* 2013b). The NHS should do more to support volunteering and to make it easier for the 6 million people who say they cannot volunteer due to illness or disability.

## 4. Models of service delivery and integration

The need to improve the co-ordination of care around the individual requires services to be much more integrated. This might mean hospital specialists working much more closely with primary, community and social care colleagues in out-of-hospital settings (Robertson *et al* 2014), general practices collaborating in federations and networks to deliver extended services (Addicott and Ham 2014) and genuinely integrating physical and mental health services (Naylor *et al* 2016). However, providing more integrated services within the complex and fragmented organisational arrangements of health and social care services is not a simple task.

Since 2010, the government has introduced a number of measures to promote integrated care, including the Better Care Fund, integration pioneers, and a requirement for all areas to have achieved integration between social care and the NHS by 2020. Yet progress has remained patchy.

In 2015, 50 'vanguard' sites were selected by NHS England to test and implement the new models of care outlined in the *NHS five year forward view* (Forward View). Good progress is being made. However, while these initiatives offer significant opportunities to improve care, they are unlikely to deliver substantial financial payback in the short term. If they are to succeed, it is important that they receive the funding and support needed to build on progress to date, and to share and spread learning to other areas. Most importantly, they will need to be given the time to demonstrate results.

The King's Fund has set out practical proposals on what should be done to remove barriers to the development of these new care models, entailing the fundamental redesign of policies on commissioning, regulation and payment systems, as well as the support provided to NHS organisations (Ham and Murray 2015). Specific recommendations include support from national bodies for commissioners to implement new forms of commissioning and contracting, and support from commissioners for interested and capable general practices to operate at scale in the form of federations, networks and super partnerships. To ensure that the behaviour of the regulators facilitates the development of new care models, other recommendations emphasised the importance of developing a whole-system approach to regulation and intervention.

The variety and complexity of current payment systems reinforces the fragmented nature of NHS provision. These systems also contain conflicting

incentives. With NHS funding now tightly constrained, and the focus having shifted to how care can be better integrated around the needs of people with long-term conditions, much more emphasis needs to be given to payment systems that support this objective. To address this, NHS England and NHS Improvement should accelerate the development of new payment systems such as capitated budgets, pooled budgets and integrated personal commissioning.

Funding to support transformation is also essential. In previous work with the Health Foundation we made the case for a dedicated transformation fund for the NHS to accelerate change at scale and pace (Charlesworth *et al* 2015). We envisaged the fund operating as an active investor by providing proactive support to local areas, enabling them to invest in staff time, programme infrastructure, physical infrastructure and double-running costs. This year's Sustainability and Transformation Fund combines deficit support funding with money for transformation – as opposed to ring-fencing the latter – and the vast majority of the money will be spent on deficit reduction. If current and future transformation initiatives and programmes are to succeed, dedicated funds will be needed to support local areas to transform the way in which care is delivered.

*Moving care out of hospitals and into the community*

Policy-makers and service leaders aspire to a health care system that more effectively supports people to remain well and independent and cares for people as close to home as possible. To achieve this vision, strong general practice, mental health and community services are essential. However, these sectors are characterised by prolonged under-investment and weaknesses including a lack of data and oversight on the workforce, service capacity and quality of care (Baird *et al* 2016; Maybin *et al* 2016; Gilburt 2015).

National targets and monitoring systems remain broadly focused on the acute sector, with A&E and referral-to-treatment commitments at the heart of the NHS Constitution. Similarly, the bulk of the additional funding provided through the Sustainability and Transformation Fund in 2016/17 is being used to tackle deficits in the acute sector rather than to support ambitions to move more care into the community and achieve parity of esteem between physical and mental health. Similarly, NHS Improvement's new oversight framework for NHS providers is heavily weighted towards oversight of acute providers.

These issues must be addressed if non-acute services are to play an increased role in future. We welcome recent attempts by the national bodies to address this imbalance through the Forward View in relation to mental health services and general practice, although there has not yet been a similar initiative in relation to community services. However, new care models and sustainability and transformation plans (STPs) offer an opportunity to redesign systems of care with a greater focus on these services.

*Integrating physical and mental health services*

The disconnect between care for mental and physical health has significant implications for both health outcomes and the sustainability of the health system (Naylor *et al* 2016). People with long-term physical health conditions are two to three times more likely to experience mental health problems. Similarly, people with mental illnesses commonly suffer from poor physical health for a variety of reasons, including the side effects of medication and high rates of smoking. Our research indicates that between 12 and 18 per cent of current NHS expenditure on long-term conditions is linked to poor mental health and wellbeing (Naylor *et al* 2012).

To be sustainable into the future, health services will need to be built on an integrated approach in which every contact with patients is used to support both their physical and mental health. This will involve developing new approaches to mental health in general practice; embedding mental health support in physical health care pathways; and making changes to education and training to ensure that all health professionals have the skills, confidence and support required to consider patients' needs in a holistic way (Naylor *et al* 2016).

*Integration of health and social care services*

Although integrated care has been a longstanding policy aspiration of successive governments, progress has been limited and patchy. This reflects fundamental differences between the NHS and the social care system in terms of funding, governance and accountability.

Building on the recommendations in the Barker Commission's report, we have set out recommendations to integrate commissioning in all parts of the country by 2020 (Humphries and Wenzel 2015). A key message from this work was that there is no one-size-fits-all solution and that CCGs and local authorities should agree locally how best to integrate commissioning, responsibilities and budgets.

*Working in 'place-based systems of care'*

The King's Fund has argued that further progress will depend on establishing 'place-based systems of care' in which organisations work together across geographical areas to improve health and care for the populations they serve. To support these systems to emerge, commissioners should become more integrated and strategic, defining outcomes to be delivered and measuring the performance of the system as a whole (Ham and Alderwick 2015).

We therefore welcome the work to develop five-year sustainability and transformation plans (STPs). These represent a significant change in the way the NHS plans its services – emphasising collaboration over competition between NHS organisations – and are an important opportunity to bring together health

and social care services to improve co-ordination and deliver better care for patients. However, for this collaboration to be successful it must be based on a realistic assessment of the services needed to meet changing population needs, the time it takes to transform these services to make them fit for the future, and the savings that can be achieved by reducing reliance on hospitals and strengthening services in the community.

Place-based systems of care should not just involve closer integration between the NHS and social care. Improving population health requires co-ordinated action across sectors and communities to address the wider determinants of health. Moving to a focus on population health will require NHS organisations to work more closely with a wide range of local partners. It will also require alignment at all levels, starting in central government (*see* Alderwick *et al* 2015b).

Overall, although considerable efforts are being made to integrate care across health and social care, genuine integration will be hard to achieve while the fundamental differences in funding and entitlements between the NHS and social care identified by the Barker Commission remain.

## 5. Prevention and public engagement

*The scale of the challenge*

Unhealthy lifestyles have an impact on the health and wellbeing of the population, as well as costing the NHS and the economy billions of pounds every year. For example, obesity costs the NHS £5.1 billion a year, with an estimated cost to the economy of £27 billion (Public Health England 2015) due to its effect on productivity, earnings and welfare payments. Despite this, the health system is still largely set up to provide episodic care in hospitals, treating people when they fall ill rather than preventing illness and supporting individuals to maintain active and healthy lifestyles.

NHS leaders recognise the impact of unhealthy behaviours on expenditure; the various funding scenarios set out in the Forward View were predicated on a 'radical upgrade in prevention and public health'. The 2012 reforms, however, meant that a significant proportion of public health funds and responsibilities were transferred from the NHS to local authorities, marking a clear distinction between the two. Although we welcome the transfer of public health to local government, this has weakened the onus on the NHS to take responsibility for public health.

*The rationale for investing in public health and prevention*

Although estimates vary, it is widely recognised that our health is influenced most strongly by the social, economic and physical circumstances in which we

are born, live and age. Our lifestyles are next, followed by the role of health and care services (The King's Fund 2013). Public health and prevention services can contribute to all three – the wider determinants of health (for example, through helping provide decent and safe housing), lifestyles (supporting behaviour change) or services (through preventive drug treatment).

*The criteria for assessment of public health interventions*

Public health efforts can delay demand for health and care services and in some cases may lead to long-term reductions in spending. However, it is important to recognise that public health interventions cannot eliminate costs entirely. The appropriate criteria against which investments in public health and prevention interventions are judged should be the same as those for NHS and social care interventions – that they are cost-effective actions that improve health while contributing to reducing health inequalities. Any further return on investment – for example, reducing demand for NHS services – should be seen as a bonus, not the purpose of public health and prevention.

Smoking cessation, for example, may delay costs in the short term, but ex-smokers will live much longer than current smokers and so will incur extra health costs over time. A similar picture exists for obesity (van Baal *et al* 2008).

The Department of Health, NHS England, Public Health England and local government should clarify these criteria for investment in public health measures. Without this, there is a risk that the 'invest to save' mentality focuses only on cost-reducing measures and ignores the cost-effective contribution to health and wellbeing that public health measures can make.

*Funding public health and prevention*

Around £4.8 billion was spent on prevention and public health through the Department of Health budget in 2015/16; around 40 per cent on NHS England functions (for example, health screening), the remainder on the current local authority grant and other functions provided or commissioned by Public Health England. This means public health accounts for 4.1 per cent of all health spending, although this does not take account of some activities in the NHS or the activities of other government departments that contribute to prevention (we know, for example, that better education improves health outcomes).

Despite the government's stated commitment to prevention, the 2015 Spending Review announced reductions to local authority public health budgets amounting to a real-terms reduction of at least £600 million in public health spending by 2020/21, on top of a £200 million in-year cut to the 2015/16 budget. This is a false economy – not only will these cuts affect a wide range of services including

health visiting, sexual health and vaccinations, but they will also have a knock-on effect on the NHS.

While we believe that more should be invested in prevention and public health, it is difficult to estimate the optimal level of spending in these areas. The public health reforms 'lifted and shifted' existing funding levels from primary care trusts (PCTs) to local government, but there was no estimate of the overall level of funding required. The responsibility for undertaking this analysis needs to lie with the government, and we support the recent Commons Health Committee's calls for a Cabinet Office minister with responsibility for driving forward strengthened cross-departmental working on public health (House of Commons Health Committee 2016).

*The NHS's role in prevention*

The NHS needs to maximise its own role in secondary prevention. While there have been welcome initiatives, the NHS remains underpowered in its response, particularly in tackling health inequalities. There is a host of evidence-based cost-effective action that, if delivered systematically and at scale, would narrow inequalities in health. Many of these lie in secondary prevention, such as cholesterol and blood pressure and smoking control. In the past these have been modelled by the Department of Health (2008) and assessed by the National Audit Office (2010) as being the most cost-effective actions the NHS can take. Often they are not new or novel initiatives, but they are essential and implementation remains patchy. NHS England needs to take the lead in rolling these out, co-ordinating with local government partners.

NHS England also needs to make better use of its existing spend. The NHS should be considered an important wider determinant of health, given its economic and employment footprint in all communities. Through better recognising its impact on social value, the NHS can help to tackle poverty (which is a significant driver of NHS costs (Asaria *et al* 2016, Bramley *et al* 2016)), as well as treating and paying for the consequences (Buck and Jabbal 2014).

*The government's role in supporting people to live healthier lives*

While individuals are responsible for their own and their children's health, the government also has an important role to play. The Wanless report (2004) made the case for government to try 'shifting social norms' using regulation, taxes and subsidies as well as health services and information. Regulation and taxation are powerful tools and have an important role to play in promoting healthier lives.

The government's childhood obesity plan is an example of where it should have gone further (Buck 2016b). It is widely known and accepted that obesity is not an issue that can be tackled through the selective use of one or two approaches,

instead requiring a cross-society, cross-government response with multiple levers deployed. Although the plan re-affirms the government's commitment to a sugar levy, its proposal to achieve product reformulation on a voluntary basis does not go far enough and has been criticised by leading voices in the food retail industry, who have called for mandatory targets and for the government to play a stronger, co-ordinating role.

*Key elements of a public health policy*

Public health policy requires balanced action across all of the factors that impact on our health – the wider determinants, healthy behaviours, health and care services and genetics – with a strong awareness of how they inter-relate. Given their central role in influencing the wider determinants of health, government policy on housing, education and across other ministries can do more to maximise their contribution to population health and wellbeing. This should include the potential role of regulation and taxation. This also applies to local government policy (*see* Buck and Gregory 2013). The NHS needs to accept and strengthen its role in prevention and public health as well as treatment, joining up the dots between integrated care and public health (Alderwick *et al* 2015b), but also acknowledge that it contributes to the wider determinants of health through its employing and economic power in local communities. Communities (including businesses) and individuals can also do more, but it is clear that individual actions on health behaviour are strongly conditioned by economic and social circumstances, so providing information and education to the population is not enough on its own to improve population health and reduce inequalities.

*The role of patients and service users as partners in their own care*

The idea that people should have a stronger voice in decisions about their health and care, and that services should better reflect their needs and preferences, has been a goal of politicians and senior policy-makers in health for at least 20 years. Despite this, and some small pockets of improvement, there has generally been a lack of progress towards fully involving people in their own health and care. The evidence shows that when patients are involved in their care, decisions are better, health and health outcomes improve, and resources are allocated more efficiently (Foot *et al* 2014, Hibbard and Gilburt 2014).

Options for increasing participation include making shared decision-making a reality, giving people the support and information they need for effective self-management, involving families and carers, giving people personal budgets where appropriate, and engaging people in keeping healthy.

## 6. Digitisation, big data and informatics

Digital technology has the potential to transform the way patients engage with services, improve the efficiency and co-ordination of care, and support people to manage their health and wellbeing.

Previous efforts to digitise health care have resulted in considerable progress being made in primary care – partly driven by the fact that, since 2007, most primary care IT systems in England have been centrally funded – while secondary care lags significantly behind.

Given the potential benefits, the government has rightly emphasised the importance of this agenda, setting out a high-level vision as well as goals for digitising the NHS. However, there is a risk that expectations have been set too high (Honeyman *et al* 2016). As with other innovations and medical advances in the NHS, new technologies should be introduced on the basis of robust evidence and evaluation.

Barriers to progress include:

- lack of clarity about funding available to support implementation
- the risk that progress on transforming care is crowded out by other priorities, not least stabilising performance in the short term
- there are few incentives for NHS leaders to attempt large-scale transformation involving digital technology.

Most importantly, progress in this area will require much more focus on engaging and upskilling the people (at all levels in the NHS) who are expected to deliver it, as highlighted by the recent review chaired by Dr Robert Wachter (2016). The importance of engaging clinicians in particular, and conveying the benefits associated with digitisation should not be underestimated.

Finally, data-sharing is essential for conducting research and improving patient care. Recent reviews present an opportunity to address legitimate public concerns about data-sharing in the NHS and ensure that information governance is not a barrier to progress.

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