CURRENT ISSUES FACING THE NHS: LUNAR SOCIETY DINNER DISCUSSION, 14 SEPT 2016

Rt Hon Jacqui Smith, Chair of University Hospitals Birmingham and Heart of England Foundation NHS Trusts (UHB and HEFT) spoke to an audience of 35 Lunar Society members and guests at the start of the dinner, points and questions were gathered up during the meal and used to structure a lively discussion as the meal came to an end. While Jacqui Smith's introduction is (with her permission) summarised, the discussion was conducted under Chatham House Rules, so views are not attributed to individuals.

Jacqui Smith's Introduction

UHB and HEFT have a combined annual budget of about £1.5 bn, and are major components of the city's healthcare and its economy. Since its foundation in 1945, the central principle of the NHS has been provision of healthcare on the basis of need, and this has long been celebrated as a matter of national pride. But pride, nostalgia and gratitude are not enough: the widening gap between demands and resources means we need to take serious thought about how to sustain the NHS in future.

Funding the NHS – recent history and current challenges

In 2000 the Labour Government pledged to increase healthcare resources to the EU average as % of GDP. Though not quite reaching this level there were increases up to 2009, since when it has stalled leaving a widening gap with needs because of the combination of an ageing population and more sophisticated and expensive treatments. In spite of this, according to the US-based Commonwealth Fund the NHS does well in international comparisons of overall outcomes and efficiency.

Charging for services incurs high collection costs, and would be a radical break with the NHS principle of 'free at the point of use'. There is a clear need to consider other ways of achieving improvements, such as:

- greater involvement of patients in their own care (eg through apps to monitor their condition remotely);
- better targeting of drugs through genetic profiling, plus better understanding of links between diet and health (but ethical issues about access to personal data remain to be resolved in both cases);
- helping people to remain healthy through better-informed lifestyle choices;

These kinds of change would need a clear demonstration of safeguards and benefits, and engagement and discussion to secure broadly-based consent.

Health and social care

The health/social care split is a major problem because of differences in principles, standards and institutions. The Commonwealth Foundation contrast good UK performance on healthcare with our unhealthy lives:

- 20% smoke, 1/3 drink too much, 2/3 overweight or obese, and poor mental health;
- Locally, more Birmingham babies die prematurely, and health improvements are slower than nationally

Obesity requires a much bolder strategy than has been proposed nationally. Devolution is potentially a big opportunity for progress, not just on this, but on a wider range of public health and health integration issues.

Discussion

Initial questions focused on Post-its prepared during dinner, but quickly widened out into more general discussion. This summary brings together the points and questions raised with Jacqui's responses.

Staff, recruitment and training: the initial focus was on the connections between training, morale and recruitment. Budget pressures combined with Brexit and the proposed junior doctors' contract have brought these issues to the fore.

- Greater use of systems that by-pass staff (eg diagnostic systems, robotics) might help reduce unit costs, but it would require brave politicians to tackle the medical 'guilds'.
- Contrary to received wisdom, time spent by doctors on research is generally good for their patients.
- Recruitment and retention of staff is central to quality: in this connection staff perceptions are as important as reality, hence the significance of Brexit.
- An apprenticeship levy might be regarded as a tax on training, but could offer a recognised route into more healthcare occupations and professions, alongside academic pathways. Australia abandoned their 'shambolic' scheme, suggesting that an apprenticeship scheme needs to be well-structured, but the NHS should consider apprenticeship pathways to degree level qualifications.

- Birmingham is a very young city, with up to 1/3 of young people not in employment, education or training (NEETs). This is implicated in poor health which is becomes a further barrier to attainment. Pathways to higher levels may also be blocked by over-rigid standards which become barriers.
- Some Trusts find it very difficult to recruit staff, forcing excessive dependence on expensive agency staff. While targets have been set to limit this response, it arises because of sector wide shortages in training provision, which successive governments have not addressed at national level.

Funding health and social care: there was general agreement that health and social care need to be better aligned, but less on how increasing needs should be funded.

- There needs to be much clearer recognition of the relationships between the budgets for NHS, Public Health England (PHE) and Health Education England (HEE): cuts to PHE and HEE inhibit strategic approaches to a financially sustainable NHS.
- A radical approach to the problem of funding elderly social care would be to tap rising house values by earmarking funds from a lower inheritance tax threshold for a 'National Care Service'. The effect would be to pool risks and benefits across social groups, which at present are very unevenly borne.
- While almost all would prefer to die at home if at all possible, 50% of deaths are in hospitals and only 5% in hospices. There is a rationale for hospices to take more of the strain (where home is not feasible), and receive more NHS support.
- Spending on chaperones was queried as an odd priority, but it was pointed out that this was insurance against unjustified complaints which can have catastrophic (and costly) impacts on professionals.
- In New Zealand medical compensation is limited to fixed amounts for particular conditions. This has encouraged a culture of openness in reporting incidents, and less money going to lawyers.
- In Australia GP-supervised Health Care Homes help keep chronically ill patients in the community (see link below). Are there things we could learn from Australian policies and models?

Public involvement and support for change: there was widespread recognition that the key problems are political. The NHS was created as a bold political act – adapting it to future circumstances may require equal boldness.

- We fear political backlash against necessary changes (perhaps nostalgia-driven), but public opinion does not necessarily conform to tabloid stereotypes. The public are 'experts' on what they experience as problems, their aspirations, and what trade-offs they are prepared to make. Better understanding of public opinion in these regards can lead to acceptance of robust policy change.
- The public need to take greater ownership of their own health: early years education is more important than the kind of economic 'nudges' that are the basis of much present policy in this area.

Report by Alan Wenban-Smith, Chairman

21 September 2016