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# Goldberg IV:
# The Challenge for the NHS

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# **Goldberg IV:**
# The Challenge for the NHS


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GGI exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will effect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions.

Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

GGI is committed to develop and promote the Good Governance Body of Knowledge

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# Foreword

"Modesty, propriety can lead to notoriety
You could end up as the only one
Gentleness, sobriety are rare in this society
At night a candle's brighter than the sun"[1]

In December 2012, when I sat down to write the forward to the first Goldberg Report, I sensed we were on the beginning of an interesting odyssey. The Good Governance Institute was then just three years old, had no staff, relied entirely on an associate model for its operation and considerable personal efforts from myself and Dr. John Bullivant to push our credo forward. Our credo then was that governance was good, and that healthcare in the UK needed to better understand the point of and benefits to governance, rather than just feed the beast with annoying administrative activities. Governance wasn't properly understood as the lubricant for the more efficient achievement of strategy and the organisational health of NHS bodies. Much of the work of GGI was around helping trusts and the then nascent Clinical Commissioning Groups achieve authorisations, rather than focus on organisational excellence.

Today much has changed. For GGI this means that we have a staff of 21, an office base in London and at any time are working with 20-30 organisations – and not just in the healthcare sector. Increasingly, universities, housing associations, third sector organisations and colleagues from the commercial sector are engaging with GGI. We are also at-scale purveyors of guidance and, I hope, thought-provoking debate through our publications, events and work with both national and local bodies. Our purpose too has broadened-out as we better understand the governance mission. It is nothing short of doing our bit to make the world a fairer, better place. Recognising that most of human activity is increasingly influenced by organisations rather than governments or religions, our mission is to play our part in ensuring that these are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions.

This has been a lot to achieve in three and a half years, and key to this has been the monthly visits to GGI from David Goldberg who has been making the long journey from Portland, Oregon to London and back again to work with GGI and our clients. As a colleague and as a friend, I have found David's support, counsel and friendship invaluable. Our clients too have benefited from his skills, somewhat unique approach and his experience gained from a long career advising and supporting healthcare organisations. But GGI has benefited too from his intellectual input into his series of Goldberg Reports, which have been a platform to take the experience of a lifetime of work, as mediated through David's special and direct character, and distil this into counsel for our healthcare systems here in the UK.

David is an American, born in the Bronx in fact. He grew up experiencing a very different healthcare system to today's NHS. New York and then New Jersey in the 1950s and 1960s, where David lived, must have been an odd prelude to his first experience of UK care services in the 1970s when he spent time in London undertaking social research, much of it in laundrettes, I understand! In his 40 years of working with healthcare organisations, across the UK, New Zealand and the USA David has remained both a fan and a constructive critic of the NHS. He believes in our publically-funded healthcare system, free at the point of care and available to all, based on need rather than the ability to pay. His opinion of how the NHS is run has both impressed and exasperated him. On his weeks in the UK, David and I share an apartment in Lambeth, and after the day's work is done we often discuss with both admiration and horror, in pretty equal measure, what we have been working on. His perspective is unique, shaped by his career, family and friends and where he started in life. This has been a wonderful asset to GGI as we have developed it over the years.

The publication of this last in the series of Goldberg Reports looks at the most pressing strategic question now facing the NHS. We all know the direction of travel that must be achieved for healthcare services to remain sustainable within the NHS model, but how to do this when hemmed in by decades of history and a nervous political class that watch the polls and plan within an electoral cycle? Taking a pragmatic stance, and starting from the point of what people in the system can themselves achieve now, David offers a perspective and advice to those leading the NHS, local authorities and our politicians in this latest, and the last, Goldberg Report.

1) Sting; "An Englishman in New York", from the album 'Nothing Like The Sun; 1988

I would like to make one final note, and that is to thank David's family who have lent him to us since 2012. David's wonderful wife Deb, daughter Becca and son-in-law Davis have all been the poorer these last years while he has been travelling on a monthly basis to London, but the arrival last year of granddaughter Sienna Lee has tipped the balance and David is returning home now to them all. So while this report is his swan's song with GGI, a new chapter opens up. JRR Tolkien readers would appreciate if we might call this next part of his journey 'Goldberg V: The Return of the King'.

**Andrew Corbett-Nolan**
Chief Executive
Good Governance Institute

April 2016

# Introduction

"The overall principles of this plan are:

- Prevention, early intervention and improving health, not just treatment
- Co-ordinated care where generalists work closely with specialists and wider support in the community to prevent ill health, reduce dependency and effectively treat illness
- Active involvement of the public, patients and their carers in decisions about their care and wellbeing
- Planning services at a community level of 25,000 – 100,000 people
- Prudent healthcare"[2]

The Five Year Forward View[3], Scotland 2020[4] and public statements by leaders of the Northern Ireland and Welsh health care systems envisage a reformed NHS where prevention and self-care are emphasised, there is better integration between health and social care, and where much of what is presently delivered in secondary care (hospital settings) will be shifted into community-based integrated primary care settings.

These aspirations are sensible and there is ample evidence for the benefits of integrated care in community settings in terms of lowering cost, improving efficiency, improving coordination of care, improving relationships between general practitioners (GPs) and secondary care consultants, improving patient safety and improving user convenience and satisfaction. Surely, however, the real goal is to have a sustainable, publicly funded NHS where sectors work together to improve the quality of coordinated care for the entire population throughout the local health and social care system.

The implications of these forward thinking policies for the various care sectors, particularly secondary and primary care, are dramatic and in my view, have been understated and largely ignored, resulting in confusion and the inability to effectively implement the vision. Instead of focusing on the wellbeing of an integrated and coordinated NHS, we have a classic zero-sum game wherein any resources provided to one care sector must come from another component of the health system, and with secondary care continuously attracting more and more resources. This has created strained relationships across the various local components of the NHS, including between providers and commissioners. It will not be solved without focused and clear guidance and substantive support from the NHS and from Government.

In my experience most relationships between Clinical Commissioning Groups (CCGs) and acute care trusts are adversarial and not sufficient to reform the delivery system. Sustainability seems to go only as far as the acute trust's front door. Each sector is more concerned about their financial wellbeing than how through working together, care can be improved. Further, organisational culture has been stoked by regulators who seem to be only concerned with the organisations they regulate rather than the wellbeing of a local health and social care economy and ultimately with the sustainability of the NHS.

This paper will explore the challenges facing this critical shift of resources from secondary to primary care and will make recommendations to encourage the implementation of these policies.

2) Mark Drakesford; 'Our Plan for a Primary Care Service for Wales up to March 2018'; NHS Wales; November 2014
3) 'Five Year Forward View'; October 2014. Joint policy paper from NHS England, Public Health England, The Care Quality Commission, Monitor, The Trust Development Authority and Health Education England
4) Scotland 2020 Vision; The Scottish Government; 2011

# Context

"The fragmentation and diverse nomenclature of urgent care services across England causes confusion amongst patients and healthcare professionals in terms of services offered. This can lead to patients presenting at services that may not best suit their needs."[5]

The NHS is not a 'designed' health system. Rather, it grew from its inception in 1948 with various sectors (siloes) evolving and reshaping, based on national priorities and government policy shifts, regulator guidance, local leadership and local relationships. In many ways the needs of the public and the service user have been secondary to the maintenance and growth of each of the disconnected separate components of the NHS. This has resulted in a very complex collection of disparate loci of care where providers have great difficulty sharing patient records, where increasingly GPs have little if any relationship with secondary care consultants, where conflicting financial payment schemes and incentives motivate each NHS sector differently and perversely, where collaboration and trust across sectors is difficult, and where the service user is largely left out.

The Five Year Forward View[6] (October 2014) is a refreshing, bold challenge for the NHS to change. It posits a number of critical strategic shifts, particularly in the nexus between primary care and secondary care. It states:

*"The NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally…" (page 3)*

*"The foundation of NHS care will remain list-based primary care. Given the pressure they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services..." (page 4)*

- *"Increasingly we need to manage systems - networks of care - not just organisations*
- *Out-of-hospital care needs to become a much larger part of what the NHS does*
- *Services need to be integrated around the patient" (page 16)*

*"In all cases however one of the most important changes will be to expand and strengthen primary and 'out-of-hospital' care" (page 18)*

*Multispecialty Community Providers (MCPs) - "these practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings" (page 19)*

These insightful policy statements are an important first step in instigating change. However, it is naïve to think that policy pronouncements will create local change. It is with great interest therefore that I read the new planning guidance for the NHS in England released in late December 2015[7]. It is curious that in the nine "must-dos" not one is specifically focused on the shift of care from secondary to primary care. Nowhere are there new targets or any demonstrable real shift of funding or care from secondary to primary care settings. There is no guidance for example that mandates the shift of 'X%' of care from secondary to primary care. This is not surprising given the dire financial performance of the acute care sector in 2015-16, but it is disappointing.

As poignantly analysed recently in his excellent blog[8] of 14th January 2016, Richard Murray, the King's Fund Director of Policy, explores the implication of the way the NHS views the £1.8bn new injection of funds for transformation and sustainability. Most of this new financial resource is frontloaded and targeted to cover trust deficits. Interestingly, rather than raising tariffs, it is a one-time injection of funds. The balance of monies can be used for transformation and sustainability on an application basis to be prioritised based on the quality of new plans required of all trusts and CCGs by NHS England. In a sense, instead of strategic change there are new NHS mandates to create yet more plans.

Without strong trusting relationships amongst health and social care leaders that allow a frank discussion of the necessary shift of care and funding and address the real impacts and collectively agree how these impacts can be mitigated, there will be no change – with or without new written plans.

5) NHS England, High quality care for all, now and for future generations: Transforming urgent and emergency care services in England, June 2013
6) 'Five Year Forward View'; October 2014. Joint policy paper from NHS England, Public Health England, The Care Quality Commission, Monitor, The Trust Development Authority and Health Education England
7) Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21, NHS England December 2015
8) Murray, Richard; "What is happening to NHS waiting times?'; King's Fund (blog); 16th February, 2016

The recent (March 2016) NHS governance and financial review – 2016 by Grant Thornton[9] offers some interesting insights:

*"We found 59% of trusts did not deliver their 2014-15 Cost Improvement Programme (CIP), compared to 48% in 2013-14. Of the 41% that delivered their 2014-15 CIP, 58% required non-recurrent schemes to do so. Overall, 77% used non-recurrent CIP schemes in 2014-15. 88% have demanding CIP targets for 2015-16, compared to 50% last year. A bleak picture especially if you couple this with nearly 3 in 4 survey respondents believing their organisation could either possibly or probably will be in deficit in 2020.*

*The recent central government bail outs are quite simply not enough. Rigorous financial governance at Non-Executive Director (NED) and Officer level is critical in the context of the downward trend on delivering recurrent CIPs. Greater scrutiny and challenge of underlying assumptions and innovative alternative CIP schemes is needed. Despite recent announcements on an additional £4 billion of central government funding significant funding gaps remain."*

It now appears that NHS Improvement (the newly combined regulator) will be primarily responsible for the financial turnaround of acute care trusts in England, a Herculean task even without contemplating the shifts of care away from the acute sector suggested in the Five Year Forward View[10]. How this will be done, with no real uplift in tariff, with increasing workforce demands that seemingly can only be met by expensive agency staff, and no clear guidance regarding demand management is a mystery. With so many trusts in financial difficulty and with the balance sheets of so many NHS Foundation Trust (NHS FTs) weakened by their need to spend cash reserves on 2015/16 operations, it is unclear where quick financial improvement can come from.

Nowhere in the December 2015 Planning Guidance[11] for either CCGs or for trusts is there a restated mandate requiring the shift of care from secondary to primary loci In light of the dire financial position of trusts, has the air come out of the will to transform the NHS to a more primary care centric system?

9) Modelling future care. The NHS under reconstruction, Grant Thornton, March 2016
10) 'Five Year Forward View'; October 2014. Joint policy paper from NHS England, Public Health England, The Care Quality Commission, Monitor, The Trust Development Authority and Health Education England
11) Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21, NHS England December 2015

# The Environment

"According to Professor Dominic Harrison, director of public health in Blackburn and Darwen and advisor to Public Health England, "Reductions in local authority social care budgets in England have particularly affected preventive care services that would normally provide one-to-one contact for elderly people."[12]

There is a general agreement that there will continue to be a significant increase in demand for NHS services from a growing and aging population; increasing numbers of frail elderly and a growing prevalence of individuals with multiple long term conditions. Add to this the recent draconian decreases in public social care funding which inevitably will create yet more Accident and Emergency (A&E) demand.

At the same time the number and productivity of GPs is reducing. In commenting on a recent report from the Public Accounts Committee[13], Dr. Maureen Baker, Chair of the Royal College of General Practitioners said, *"GPs and our teams are making an estimated 310 million patient consultations a year – 60 million more than five years ago - to meet the increasing demand of our growing and ageing population, yet the number of family doctors over this period has remained relatively stagnant. The toxic mix of increased demand and plummeting resources is leading many established GPs to leave the profession, and not enough medical students are choosing a career in general practice to take their place."*[14]

So we have a perfect storm with increasing demand for NHS primary care services and a decreasing supply of providers of care. The only release valve is the A&E, and we know how clogged A&Es already are.

In my view, until a credible and sustainable alternative to A&Es exists in communities, the growth of A&E and hospital demand will continue unabated. I also believe that the next few years will see a palpable tension between CCGs wanting to innovate and move better care out of hospitals, and the financial sustainability of local hospitals. Clear guidance is needed from NHS England or this tension will likely be politicised.

12) Large 'jump in deaths' expert warns, 16 February 2016, BBC reported by Smitha Mundasad
13) 'Access to General Practice in England'; House of Commons Committee of Public Accounts; 9th March, 2016
14) Baker, Dr. Maureen; RCGP response to PAC report on access to general practice in England, Royal College of General Practitioners (press release), 9th March, 2016

# General Practitioners

"God and the Doctor we alike adore,
But only when in danger, not before;
The danger o'er, both are alike requited,
God is forgotten, and the Doctor slighted."[15]

Previous GGI reports have documented the growing shortage of GPs in the UK. Further, I believe that the partnership model of GP organisation is on its last legs in many parts of the country. Based on considerable work with CCGs and GPs it is fair to say that whilst I still believe the GP partnership model is failing, there are good examples where it remains a viable model for GPs. Yet many GP practices are so small, particularly in urban areas of greatest social disadvantage, that they have little scale to manage a shift of care from secondary to primary care. There are many examples of alliances and federations but these are still nascent organisations with little business capability. They have yet to demonstrate their ability to get membership agreement on a business plan of consequence. Further, the challenges of making real change by shifting care and services from the acute sector to primary care will be dogged by inherent conflicts of interest.

GPs must embrace working within teams of providers, particularly in their care of patients with multiple long-term conditions. GP-led teams of nurses, therapists, mental health professionals, social workers and secondary care consultants (such as geriatricians, endocrinologists and respiratory physicians) are necessary to manage patients in the community. It is very difficult, however, for GPs to have the time to organise such teams and frankly they have not been trained to lead teams.

Many have said that the most potent financial tool in the NHS is the GP's pen. The GP is the gatekeeper to secondary care referrals. Nothing should get between the physician and their patient. That said, the physician must be held accountable for the decisions they make. A referral is a powerful economic act that presently has no consequences to the referrer. Until financial incentives are aligned there is little reason to believe that behaviours will change. GPs are paid under a capitated model through which referrals have no financial impact on their practices. In fact, in a perverse way, making a referral out of a GP surgery to secondary care may be a "sensible" tactic in reducing demand in the GP practice.

Secondary care providers of outpatient and hospital services are paid on a tariff-based fee-for-service system where more activity means more revenue. Where is there an incentive or financial motivation for change?

Whilst the Five Year Forward View[16] seems to encourage the shift of care from hospitals to community-based alternatives, there are many obstacles in the way. Most GP practices are small with between one and five clinicians who are all very busy and whose surgeries are designed to meet only the needs of their GP services. There are very real estate limitations to what can be shifted from expensive and crowded hospitals to GP-based community settings. The estates challenge cannot be underestimated.

If existing and suitable GP premises are to be expanded to accommodate the shift of secondary consultant care into GP surgeries then new capital is required. If an existing community hospital, or other existing local real estate, can be used then there will likely be the need for remodelling capital as well as the need to buyout the GP surgeries that will consequently have to be vacated. Again, where will this capital come from? We believe an approach is to develop bespoke community health and social care community hubs. I will explore these later in this paper.

However, GP practices are by and large ill-equipped to take on more work. Organisationally, they are too small and under resourced in terms of management as compared to hospitals. To date, we have seen little real strategic thinking amongst GP practices other than to resist adding work to already harried diaries. There have been great improvements in "managing" independent GP clinical behaviour. Examples would be medicines management and, to some extent, referrals management. There is still far too much clinical variation and little consequence for outliers.

It is my belief that shifting ambulatory care away from hospitals into primary care makes sense in terms of cost, improved integrated care and quality of care and convenience to the user – the patient. Primary care electronic medical record systems are far superior to anything I have seen in the acute sector. Improved integrated care and coordination of care can only be enhanced with a single primary integrated patient record, ideally including detailed information on the social and housing situation of the patient as well. GP practices have long-standing relationships with their registered patients and families, and can better manage risk in the community.

15) 'The Difference'; Robert Owen
16) 'Five Year Forward View'; October 2014. Joint policy paper from NHS England, Public Health England, The Care Quality Commission, Monitor, The Trust Development Authority and Health Education England

# Clinical Commissioning Groups

"With CCGs as the main local commissioning organisations, GPs are, by definition, conflicted as they are at once referrers to secondary, community and mental health services and also commissioners of many of these same services and they are even, at times, contracted providers of some types of extended primary or secondary care."[17]

CCGs are maturing as organisations. As they approach their third year in existence, not surprisingly, we are beginning to see a turnover in senior executives. GGI has identified the loss of a chief executive and the non-existence of effective succession plans as perhaps the number one organisational risk for CCGs. The success of the transformation of services from secondary to primary care requires strong leadership and trusting long-term relationships within local health and social care economies. This is lacking in many areas. Further, many GP clinicians are deciding not to stand for re-election as CCG governing body members. This will further exacerbate the leadership vacuum and hamper transformation. GGI is increasingly witnessing pessimism among our CCG clients. There is a growing belief that in light of the grim financial condition of most hospital trusts, there is little political will to further "de-stabilise" the hospital sector by incentivising a shift of ambulatory care out of hospitals and into community settings.

Even if CCGs and their GP membership are able to shift care from secondary to primary care with substantial negative financial impact on local acute care trusts, I believe there is a high risk of anti-competition litigation based on the aforementioned inherent conflicts of interest in CCGs, which are designed and organised as GP membership organisations.

Imagine this scenario:

*In a patch all of the independent GPs band together in an alliance or federation and approach their CCG with a business plan to save monies on the laboratory testing they order. Their plan calls for a joint venture between the alliance and an independent reference laboratory. Their plan lays out a business care to:*

a. *annually save the CCG (NHS) thousands of pounds on primary care laboratory testing*
b. *improve the laboratory service by providing onsite phlebotomy in GP surgeries*
c. *improve the speed that results are available*
d. *integrate results automatically into the GP electronic medical record system*

The major impact would likely be to decrease volume and revenue to local acute care trust laboratories. What would be the outcome? On the one hand the plan delivers better service for less money and shifts care from secondary to primary care. On the other hand it puts increasing financial strain on already challenged secondary care trusts.

I believe there would be much political engagement with local MPs and also a rise in anti-competition litigation, further eroding trust amongst local leaders of health and social care and among the general public. Frankly, the anti-competition litigation would be compelling because in reality we have all of the orderers of laboratory services aligning with their GP 'competitors' to develop market scale. Then these same aligned GPs get approval from the commissioning CCG, an organisation whose membership is composed of these same GPs. How can one argue that there is no colluding nor conflicts of interest in this very complicated arrangement amongst supposed competitors?

In my view, CCGs are too small as stand alone organisations. They were often formed to be co-terminus with local authorities and whilst this might make sense in more rural areas, it has resulted in a plethora of small commissioning organisations in London, for example. There is a whispered belief that CCGs should merge into larger commissioning organisations. At the same time it is our understanding that NHS England will not endorse CCG mergers. In lieu of mergers, CCGs have been clustered, or formed alliances and federations in order to get some economies of scale, more senior leadership, and a wider view of improving health and wellbeing for populations for whom local authority borders have little relevance.

17) Goldberg, David and Baltruks, Dorothea; "Goldberg III: Can the NHS deliver integration? Lessons from around the world"; Good Governance Institute; December 2014

The intense focus of CCG and Commissioning Support Units (CSUs) on contracting and transactions around trust performance against targets has significantly strained relationships between commissioners and trusts right at a time when they must work closely together to deliver credible and real Sustainability and Transformation Plans (STPs). The focus on performance details has caused all sorts of questionable behaviours, such as efforts to train consultants to document their care regimes in particular ways to enable and justify higher tariff codes. The current antagonistic focus on transaction details and compliance and the resultant fines seem very ill-advised in light of the real challenges around integration, managing a troubled workforce, and increasing demand. It is like worrying about sweeping the stairs of a building that is already on fire. Further, when deficits are ultimately covered, what is the point of fines other than to further strain the relationship between CCGs and trusts?

From an altitude of 10,000 metres looking down at commissioning, one must question the enormous attention to contracting and contract compliance that in my mind causes antagonism, strains relationships, and is wholly ineffective. Even when there are target misses and contract breaches, the resultant remedies (fines etc.) only add to trust deficits that are ultimately covered with new monies.  What are we doing?

# Acute Care Trusts

"A hospital is, of all social institutions, the one in which perhaps the greatest mixture of motives, the most incompatible ambitions and the most vexatious vested interests are thrown together."[18]

Much has been written about the dire financial condition of acute care trusts. An interesting blog on the King's Fund website states:

*"According to the King's Fund's latest survey of trust finance directors, 67% of trusts nationally are expected to overspend by the end of this year – including 89% of the acute care trusts...we estimate an overall budget deficit of £2.3 billion by March this year."*[19]

It should now be clear that with two-thirds of all trusts and 89% of acute care trusts projected to be £2.3bn in deficit for 2015-16, overall funding of the NHS to deliver services expected by the public is inadequate. Either additional permanent funding must be secured or rationing must occur. When such a high percentage of acute trusts are in deficit positions one cannot point to poor management. This is a funding and indeed control problem and strategically it is causing management to focus on the short term at a time when the big picture (e.g. Five-year forward view[20]) is necessary.

The downward trend of tariff in 2015/2016, cut by about 9% since 2010/2011, has had a devastating effect on trust financial performance. I believe the tariff pressure in 2015/2016 may have been motivated by the Treasury's intent to force NHS FTs to spend some of their accumulated cash reserves. It will be interesting to see whether in fact this occurred when Monitor publishes their next annual review of NHS FTs' financial performance and condition.

Anecdotally, we have seen cash reserves in NHS FTs have had a precipitous decline from the end of 2014/2015. Add to this the regulatory pressure to increase nursing staffing to meet quality guidelines, many of whom are supplied by expensive temporary employment agencies.

New funding in 2016/2017, much of which is frontloaded, seems to be intended to erase 2015/2016 deficits without increasing tariffs going forward. How trusts with the assistance of NHS Improvement can make a financial turnaround in 2016/2017 is the question of the day which most pundits, and indeed most acute trust CEOs and CFOs, consider in disbelief.

Presently in the NHS hospital A&Es are the only "one-stop" loci of care. Until a reliable and predictable community based alternative is developed and promoted, we will see little change in the use of A&Es, with a continued inexorable escalation of pressure on A&E departments.

There are many ways care can be shifted out of hospital settings into less expensive, more convenient ones with better integration with primary care. CCGs can de-commission outpatient and ambulatory care services from hospitals and commission the care from primary care organisations such as GP group practices, alliances, federations, etc. Acute care trusts can develop arrangements with local GPs and GP organisations to shift the location of care to GP based community settings, and at the same time lower the cost. Acute care trusts could also venture into primary care and employ GPs in the community and through these vertically integrated structures shift outpatient and ambulatory care into integrated community settings.

In order for any of the above to occur however there must be a mandate from NHS England, agreement from NHS Improvement, and a level of trust in local communities to enable change. It may also involve primary legislation. Further, there must be recognition that acute care trusts alone cannot solve the labyrinthine revenue and expense systems within the NHS. Presently, for example, all of the financial risk associated with Private Finance Initiatives (PFIs) accrues only to the acute care trust. If we want to reduce the size of secondary care and shift resources to community-based primary care, then it is reasonable to shift the repayment responsibility for local PFIs that were planned and funded under a different projected future, to the local health system - perhaps the CCG. This could eliminate some of the resistance to shift care out of hospitals into a coordinated primary care system in the community.

18) Langdon-David, John; Westminster Hospital: Two centuries of voluntary service, 1719-1948; J Murray, London; 1952
19) Jabbal, Joni; the story behind the figures: what NHS finance directors are telling us; King's Fund (blog), 18th February, 2016
'Five Year Forward View'; October 2014. Joint policy paper from NHS England, Public Health England, The Care Quality Commission, Monitor, The Trust Development
20) Authority and Health Education England

# Devolution

"Few would have predicted when Lord Darzi published his report a year ago (2007) that polyclinics would become a flashpoint between the Government, the profession and the Opposition. The BMA, having suffered one bloody nose at the hands of ministers last February over extended opening hours, resolved they were not going to suffer a second over polyclinics. They have mounted a successful "save our surgeries" campaign, claiming that ministers are bent on privatising general practice by bringing in commercial organisations. Ministers have responded by accusing the BMA of a "mendacious" campaign, deliberately misleading patients and spreading fear and despondency."[21]

Following the fascinating politics surrounding the Scottish separation vote last year, and the new devolved powers given to the Scottish Parliament, a number of large English cities pressed for a devolved NHS. 'Devo-Manchester' is leading this movement. It is still early days and unclear where devolution will lead. If it achieves nothing more than getting all parties to the table around designing, prioritising, and funding an improved and integrated health and social care system, then it will have proved worthwhile.

I see four significant issues with devolution of the NHS:

1. If the devolution of NHS funding goes to local councils then central government will effectively have a single funding spigot that they can turn to reduce future funding leaving the political consequences to the local councils
2. Shifting NHS funding to local councils, even with ring-fencing, will further politicise NHS funding and spending at the local level
3. If devolution is successful across the UK, the whole notion of a single NHS, free at the point of service, is compromised and we could wind up with many different local mini-NHSs
4. Finally, how will devolution solve the acute care trust financial crisis?
   Until a credible alternative to A&E is available and accepted by the public, little change can occur. We must start to build in the capacity of communities, such as larger GP practices, hubs, etc., to take on services that are better delivered outside of hospitals

What might a community based alternative to A&E units look like?

Presently, in the UK there are many confusing points of entry into the NHS for non-routine care - 999, 111, urgent care centres, walk-in centres, minor injuries units, GP out of hour services etc., etc., etc. A number of years ago GGI asked a board of a PCT what each would do if the arrived home at 19:00 and found their eight year old child had a fever over 39 degrees and had laboured breathing. We got eight different answers from those who, at the time, were the local health system leaders! The real insight from this exercise was that parents (service users) sought convenience and efficiency. They wanted to be able to get all of the care their child needed whilst having to park their car only once. Getting an examination by a doctor, having bloods drawn, receiving a chest x-ray and getting a prescription filled can only be done presently, across the vast majority of the UK, in a hospital setting. Little has changed since then.

The public is very used to having markets and services geared to their convenience. Supermarkets, shopping malls, and home DIY centres are examples of how businesses are meeting the public's need for one-stop shopping, extended hours, weekend availability, and all of this with free car parking.

So, in our view alternatives to A&Es must be developed and the public re-educated and re-directed to access care at these new centres. Let's call these new centres, Health and Social Care Community Hubs. These hubs could be located in the community in the heart of population centres. Ideally, all of the hubs would have the same opening hours (say 8 am until 10 pm, at least six days a week). Each hub would be the home for +/- 20 GP practices. With this scale, ancillary services such as phlebotomy and some minor laboratory testing, chest and plain x-ray, and a pharmacy would easily be justified. Add to this community nursing, social care, and a long list of services such as physiotherapy, podiatry, psychological therapies etc. and we have a community-based centre of care. Further, at this scale, traveling consultants, such as specialists in gynaecology, respiratory, endocrinology / diabetes, geriatrics, urology, cardiology, etc. can hold fully subscribed sessional clinics in the community. There is really little reason, except tradition, to hold clinics for ambulatory patients in hospitals that are some of the most expensive estates and are dangerous loci of care.

21) 'The Big Question: What are polyclinics, and why are doctors so angry about them?", The Independent, 12th June, 2008

When presenting the idea of community based Health and Social Care Community Hubs to CCG leaders and GPs during the past year, I was repeatedly asked whether this is step one in the development of polyclinics? Polyclinics have fallen out of favour. I remain a strong advocate of the development of polyclinics as I believe they offer the best chance to shift care out of hospitals, to speed the development of qualified clinical leaders, to enable clinician-led organisations to develop scale, and to better integrate clinical care into a single electronic medical record.

I believe that primary and secondary care clinicians co-located and working together as colleagues in a single organisation provide the hope of better, integrated patient-centric care. In order for this new model to work, these hubs should be standardised across the country so that when service users are in need of care and they are ambulatory, their first thought is to go to the hub rather than the A&E. Furthermore there needs to continued for support for service users.

# Conclusion and recommendations

"In the past several years alone I have witnessed strategy resources devoted more on the World Class Commissioning Assessment, the CCG authorisation and NHS Foundation Trust qualification than on any strategy that actually impacts quality and efficiency of care or improving the patient experience. The opportunity, indeed the pressing responsibility, is for boards to now focus on strategy that will be sustainable and make a difference."[22]

CCGs have been given the mandate to innovate and to shift care out of hospitals. However, their hands have been tied by a highly restrictive national contract and tariff structure. Why should financially challenged acute care trusts have any interest in losing services and revenue? What incentives are in place to facilitate the well-planned shift of care into the community, better integrated with primary care? Unless and until there is a clear national priority of transformation with tools and flexibility provided to CCGs to enable change and with some clear financial protection of secondary care trusts, I believe little will change.

**In my view, to make real progress in the shift of care from hospitals to primary care, several necessary steps must be taken:**

1. In order to deliver on the promise of the NHS as outlined in the visionary 1944 White Paper[23] and address the relentless growing demand for care, additional national funding is required. The UK cannot deliver the promise and publically assumed entitlement to unlimited choice and care that is growing within the current budget for the NHS. The alternative is rationing.
2. NHS England must set clear expectations for the movement of services out of hospitals into community settings. In the short term, hospitals must be protected financially as services are shifted to primary care. The development and investment in hospital-based outpatient and ambulatory care services occurred over decades. It is unfair to expect the shift of outpatient and ambulatory care services out of hospitals to be able to occur quickly without substantial temporary funding. Otherwise, why should hospital leaders and boards agree to the loss of services? It is counter-intuitive to expect NHS Improvement to advocate the shift of revenue producing services out of financially strapped acute care trusts. Across the country, CCG leaders are struggling to get hospitals to collaborate on the shift of services out of local hospitals. The resistance is palpable and understandable. There is an interesting precedent in the European Union supported farming 'set-asides', where farmers were subsidised for a time to not plant certain crops in order to stabilise market prices and make farming financially viable and sustainable.
3. There is a need for substantial capital investment into local facilities (Health and Social Care Community Hubs) where integrated primary care and outpatient secondary care can co-exist. Small and out-dated GP surgeries must be bought out to facilitate movement of GPs at scale into bespoke hubs. GPs cannot be expected to bear this cost.
4. Technical support is necessary to encourage and support the physical integration of existing GP, community, social care and indeed voluntary sector services locally. The form of this integration will vary from simple co-locating existing GP practices to these new Health and Social Care Community Hubs to full-scale mergers into single provider organisations.
5. CCGs must have greater flexibility to contract differently with acute care trusts away from the fee-for-service tariff system. Sessional funding, capitated funding and other approaches, locally determined are some options.
6. The importance of providing front loaded investment in electronic patient records in acute hospitals (in place in most GP surgeries since the late 1980s) and facilitation of sharing of patient records (already achieved across England for medications and allergies with the National Summary Record (SCR)), not just locally but regionally and nationally cannot be emphasised enough. Success in the full digitilisation of health records and pathways will transform practice, enable clinicians to work more efficiently and more safely, and help to ensure that we still have an NHS in 2048, one hundred years after it began.

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Oregon and London

April 2016

22) Goldberg, David; "The Goldberg Report: Strategy and the New NHS"; Good Governance Institute, December 2012
23) Ministry of Health; "A National Health Service; February 1944

# Endpiece: Looking across all the Goldberg reports

"Progress, far from consisting in change, depends on retentiveness. When change is absolute there remains no being to improve and no direction is set for possible improvement: and when experience is not retained, as among savages, infancy is perpetual. Those who cannot remember the past are condemned to repeat it." [24]

This is David's fourth report and, like those before, draws attention to some of the most pressing problems facing the UK health sector today. In each of his previous papers David has made a series of poignant, timely and reality driven recommendations targeted at those most responsible for the continued quality of the NHS, namely politicians, NHS England, regulators, CCGs, NHS trusts and Health and Wellbeing Boards. A number of previous recommendations are directly addressed in this report. Where they are not, in this section we reflect on the progress made since David's first report, Strategy and the NHS, published in 2012.

## POLITICIANS

**Recommendation: It is critical that the next British Government not undo the latest reorganisation of the NHS. Doing so would dampen the fire of commitment and enthusiasm that GP leaders of CCGs have shown across the country.**

- The re-election of the Conservative Party in 2015 included the pledge not to repeal the Health and Social Care Act, 2012 that created the current NHS structure. This has ensured that NHS structures and bodies have continued largely untouched. Without taking political sides in any way, we note that this stability at least provides the opportunity to allow CCGs and GP leaders to continue grow into their roles.

**There should be a clear continuance of a policy that encourages and rewards integrating social and health care without transferring health funding to the control of local politicians.**

- Much emphasis has been placed on moving the integration agenda forward by both healthcare leaders and politicians, and we have seen important steps taken in Manchester, Sheffield, Liverpool and across a range of CCGs. Particularly impressive is the 'Healthy Liverpool' programme which, in recognition of the extensive health inequalities in the region, seeks to improve wellbeing by fostering partnerships between GPs, schools, care homes and other providers. Over the last year GGI has worked with a number of Vanguard sites and we believe that these organisations offer a firm basis for innovation and progressive change. It is important that politicians continue to support these organisations and the drive for integrated services and not simply pay lip service to this ambition.

**Co-ordinated local and national prevention campaigns must be funded and promoted around personal responsibility, smoking cessation, moderate alcohol consumption, safe sexual behaviour, obesity and healthy diet and physical activity.**

**Look at tying together 'sin taxes' and the funding of health and social care. For example, consider a tax on 'couch potatoes', targeting sedentary activities such as television-watching and video games to fund recreational facilities or increased physical education in schools to address juvenile obesity.**

- We were both surprised and pleased to see a new sugar tax focusing on the soft drinks industry announced in the government's recent budget. This is an important and significant step in tackling the growing problem of obesity in the UK, where one in four adults is now obese. However, more still needs to be done by this government to promote healthy lifestyles across all generations, and particularly among younger people, and to promote and support coordinated local and national prevention campaigns.

24) Santayana, George; "The Life of Reason"; 1906

**Recognise mental health of children and teenagers as a major public health issue and put mental health education on the national curriculum.**

**Initiate public awareness campaigns about mental health concerns and ensure that support networks are adequately funded and embedded in integrated care networks.**

- In previous reports we have called upon the government to recognise mental health of teenagers as a major public health issues and to initiate public awareness campaigns about mental health concerns. We were therefore pleased to see the Prime Minister recently announce almost a billion pounds of investment to enhance the provision of mental health in England. This was the first time a UK Prime Minister had addressed mental health in a public speech and was undoubtedly a positive step towards recognising and tackling this important issue. Necessary improvements promised include 24/7 community-based mental health crisis response available in all areas, a mental health liaison service in every acute hospital A&E, and waiting time targets for children with eating disorders. Despite this, the profile of, and spending on, mental health must be raised further. In 2015, spending on mental health services for children and young people in England declined by £35 million[25], whilst an NSPCC survey published in October 2015 highlighted how more than one in five of those children referred to child and adolescent mental health services in England had been refused treatment.[26]

**Government needs to promote a campaign to raise the consciousness of the populace around planning for end of life care.**

- In 2015, the Economist Intelligence Unit reported, in its Quality of Death Index, that the UK had the highest quality end of life care in the world. Although this has been challenged by subsequent reports, such as Marie Curie's End of Life Care Audit which argued that, although services are much improved, there are still those who fail to receive adequate palliative care at end of life, it is a powerful reminder of the progress that has been made since the Liverpool Care Pathway was scrapped in 2013. However, we are not convinced that enough has been done to raise the consciousness of the public around the importance of planning for end of life care. Too often this topic is seen as taboo and yet advanced planning for end of life can relieve emotional stress on relatives who are frequently, and unfairly, left to take difficult decisions about the wellbeing of loved ones. Thoughtful and careful planning can also relieve well-documented pressures to our NHS including the significant financial costs associated with end of life care.

**Government should abandon the goal of reducing the cost of the NHS over the coming several years. This goal is dangerous at a time of increasing demand and an aging of the population. Please consider increasing NHS funding to better serve an aging populace with truly integrated high quality health and social care.**

- We have written before about the governments plans to deliver £22 billion of cost efficiency saving to the NHS by 2020, whilst increasing spending by £8 billion. We continue to be worried by this and believe that greater honesty and pragmatism is needed to ensure the sustainability of the NHS now and into the future. In particular, we would support increased spending on our health service to bring it in line with a range of European and more economically developed nations, including France, Germany and New Zealand. With an aging population, an increasing number of people living with one or more long term conditions, and ever greater demand and expectations placed on NHS services, the challenges facing the NHS are significant and growing, and bold leadership and action is required now more than ever.

25) YoungMinds; 'Widespread cuts in children and young people's mental health services'; July 2015
26) BBC, "Children turned away by mental health services", October 2015

NHS ENGLAND

**Re-focus efforts to enable the integration of patient care data where it matters the most – with the clinician who is at the time caring for a patient. Further, support the principle that patients own and control their medical information.**

**Recognise that the technology exists today to link patient data among GPs, secondary care, community and social care. Then invest and implement solutions now.**

- We have previously recommended that NHS England recognise that the technology exists to link patient data among GPs, secondary care, community and social care. Care.data is NHS England's (in partnership with the Health and Social Care Information Centre) response to this. Despite delays and teething problems, the project is now in its 'pathfinder' stage during which selected CCGs will trial the programme before it is implemented nationally. This technology is long overdue in the NHS but given its importance must be executed properly to ensure its effective application and adoption. Effective deployment will improve clinical effectiveness and enhance efficiency.

**Support co-commissioning wherein CCGs have the authority and responsibility over all primary care.**

- Primary care co-commissioning was one of the changes envisioned in the NHS Five Year Forward View. NHS England subsequently invited CCGs to take on the commissioning of GP services through three distinct models: greater involvement, joint commissioning and delegated commissioning. Based on feedback provided to NHS England, delegated commissioning appears to be the model which provides the greatest benefit to local people, including allowing for increased local decision-making and commissioning based on the best outcomes for patients. As with NHS England, we would encourage all CCGs to consider pursuing a delegated commissioning approach in future.

**Explore capitation as a means of purchasing services. In my experience, capitation (with appropriate and rigorous controls) offers a way to align financial incentives to provide the most efficient care. Capitation must come with real downside risk. Government or commercial reinsurance can be utilised to address outlier risks such as an influenza pandemic, or a run of poor neonatal outcomes.**

- We were pleased see Monitor explore capitation as a potential new payment model in a 2014 report.[27] The adoption of a capitated payment system would support integrated services deliver the best possible care - aligning financial incentives, ensuring that payment is contingent on outcomes and not activity and helping to ensure that emphasis is placed on patient wellbeing. We would hope that this model is explored further as a means of purchasing services.

REGULATORS

**Re-focus efforts away from meeting targets and onto how best to encourage and improve integration across health, community and social care. Make integration a requirement against which Trusts will be assessed.**

- The appointment of Jim Mackay as the new head of the provider regulator, NHS Improvement, should help push the integration agenda forward. During his time as chief executive of Northumbria Healthcare NHS Foundation Trust, the trust worked closely with social services and other stakeholders and he brings a huge amount of experience to this challenging role. There is no doubt in our mind that, with the sector facing unprecedented financial pressure, strong leadership is needed to drive innovative and practical solutions to issues such as the greater integration of health services.
- Monitor's (now part of NHS Improvement) integrated care guidance can also help support this push. NHS Improvement has powers to support the emergence of new models of care, to support local areas plan and deliver integrated care and to ensure that the sector does not obstruct efforts to deliver care in an integrated way.

27) Monitor; "Capitation: a potential new payment model to enable integrated care"; November 2014

**Encourage and enable the merger of Trusts where the goal is the improvement in the quality and safety of clinical services.**

- The Kings Fund report that "between 2010 and mid-2015, almost all of the mergers of NHS trusts and foundation trusts were initiated by regulators or administrators, with the aim of either helping NHS trusts to gain foundation trust status or rescuing providers from financial challenges."[28] They further argue that despite a large amount of money being spent, it is not clear the extent to which these are improving services or addressing the organisations core issues. As before, we would recommend that regulators seek the merger of trusts only when the goal is the improvement in the quality and safety of clinical services and system transformation.

CCGS

**GP shortages will be increasing into the foreseeable future. Develop robust workforce plans to address these shortages before they overwhelm local resources.**

- It is now well recognised that unless action is taken there will be a severe shortage of GPs in the near future, with many regions already reporting significant vacancy rates. Indeed, in 2015, one in ten GP trainee posts was left unfilled, and one in three GPs reported they were planning to retire within the next five years.[29]
- In April 2016, recognising that, "if general practice fails, the whole NHS fails"[30], NHS England announced a five-year plan to support GPs and to improve access to surgeries for patients, including an additional £2.4bn in funding per year by 2020. This significant step, funded by increases to the overall NHS budget, will support the commitment to grow the number of doctors in primary care by 5,000 and other primary care staff by 5,000 by 2020, and make greater use of the skilled workforce to provide seven-day access to effective care. Alongside this, it is important that the Government, as outlined in the strategy, works with doctors and their representative organisations to ensure that the GP role is an attractive one for future generations. The recent junior doctor contract negotiations, played out publically in the media, are a poor advert for the profession and are unlikely to encourage students to pursue a career as a doctor, nor encourage current junior doctors to pursue a career in the UK.

**Enable and fund appropriate "social" prescribing where GPs write prescriptions for diet counselling and daily activity promotion (even gym membership) for at risk patients where the GP believes behavioural change can be enabled.**

- In previous reports we have spoken of the need for CCGs to enable and fund appropriate social prescribing. We were therefore happy that one of the Secretary of State's commitments in the 'new deal' for GPs was to make 'social' prescribing "as normal a part of…[the] job as medical prescribing is today."[31] Since then, GPs have been using social prescribing to improve wellbeing and tackle inequality, as in London where GPs have referred more than 700 patients to walking clubs, ballroom dancing groups and lunchclubs.[32]

**Locate more mental health professionals in GP practice.**

**Foster integration of Children and Adolescent Mental Health Services with health and social care as well as the education sector.**

- CCGs are responsible for the commissioning of mental health services in England. It is important that these organisations are talking to the local Children and Adolescent Mental Health Service, health and social care services, and the education sector. Indeed, the Joint Commissioning Panel for Mental Health advises that, "mental health problems should be managed mainly in primary care by the primary health care team working collaboratively with other services, with access to specialist expertise and to a range of secondary care services as required."[33] Importantly, the government is working with the Royal College of General Practitioners to introduce minimum standards of mental health training for all new GPs. Similarly, many GP surgeries now have access to Community Psychiatric Nurses meaning patients are able to be seen at their local practice rather than in secondary care.

28) The King's Fund; "Foundation trusts and NHS trust mergers 2010 to 2015"; September 2015
29) BBC; "NHS in £2.4bn funding boost for GP services in England"; April 2016
30) Ibid.
31) Jeremy Hunt; "Speech: New deal for general practice"; June 2015
32) GP Online; "How GPs are using social prescribing to tackle health inequalities"; October 2015
33) Joint Commissioning Panel for Mental Health; "Guidance for commissioners of primary mental health care services"; March 2012

**Provide data to track progress (real-time data where available and appropriate, retrospective data to assess trends).**

**Develop strategies to address clinical variation.**

**Improve data connectivity at the point of care.**

- The Secretary of State has used the terms 'intelligent transparency' and 'Patient Power 2.0' to describe a shift towards publishing data that is comprehensible to the public, claiming that "within the next five years our electronic health records will be available seamlessly in every care setting" helping to usher in "a radical permanent shift in power towards patients".[34]Near patient monitoring at all levels from smart phone apps to full home monitoring packages should be part of this. Although the timescales are perhaps unrealistic, the care. data programme being trialled across 104 GP practices in four CCGs should create a national database of GP-held records, allowing for improved analysis of health trends and better patient care. The publication of data may also help account for, and reduce, instances of clinical variation.

**Create an incentive scheme wherein GPs are rewarded for reducing A&E attendances by patients on their respective lists. This should involve the establishment of baseline data on the utilisation of A&E by GP patient lists and rewarding future reductions. This activity must be supported by enabling robust after-hour-care facilities and services promoted and co-ordinated with all local GPs, the 111 service, local A&Es and even the local ambulance service. We must reduce the glut of patients attending A&Es who can be more effectively and conveniently managed in the community.**

- Previously we had recommended that incentive schemes were looked at for GPs wherein they are rewarded for reducing A&E attendances by patients on their lists. In some areas we have seen this happen such as in Birmingham South Central CCG that has offered practices more than £11,000 to reduce new outpatient attendances, follow-ups, A&E attendances and emergency admissions by 1%, compared with 2014/15.[35] It is important that GPs are educated around the appropriate utilisation of A&E and that referral processes receive sufficient scrutiny so as to avoid any potential conflict of interest.

**Organise primary care (particularly for the frail elderly and those with multiple long term and mental health conditions) around the patient. Create listening forums where small groups of patients can provide guidance as to how to improve their care and lives.**

- NHS England has recently published National action for local change: Our Declaration Person-centred care for long-term conditions. This document highlights the significance of person centred care for those with long term conditions and should provide some further impetus for organising primary care around the needs of the patient.

**Recognise that acute care discharge planning cannot be only the responsibility of the local acute care trusts. It requires a focused and co-ordinated effort of community care, social care, local care homes, GPs working together with consultants and staff at hospitals.**

- More work needs to be done to ensure that responsibility for acute discharge planning is the responsibility of CCGs, and others, as well as the acute care trust with seamless transition from hospital to home. A good example of where this is happening is in Hull where the CCG, working closely with the local NHS Trust, has launched new transfer of care planning requirements to get patients home sooner and to help combat the growing pressures the acute hospital is experiencing, exacerbated by delayed transfers of care.[36]

NHS TRUSTS

**As major local employers develop robust employee assistance programmes (for staff and their families) around health promotion (smoking cessation, diet, physical activity etc.)**

- An increasing number of NHS trusts now provide materials and guidance for their employees on their health and wellbeing e.g. smoking cessation, diet, physical activity etc. As major local employers, and ones with a mandate to treat and care for the population of the UK, it is important that trusts and other NHS organisations set the tone with regards to the health and wellbeing of their staff.

34) Jeremy Hunt; "Speech: Making healthcare more human-centred and not system-centred"; July 2015
35) BBC; "GPs being paid to cut patient referrals"; October 2015
36) Hull CCG; "CCGs support new discharge planning to improve patient outcomes and pressures"; January 2016

**Instigate focused patient feedback to improve care. Trusts should bring together groups of patients who have received similar care into focus groups. For example, imagine the insights Trusts could gain by bringing together a representative group of patients who received hip replacements in the past six months. Enable them to discuss the outcomes of their care, failures of the care pathway, how the course of their care was perhaps different from what they expected. Gaining these insights could only improve the care of patients in future and better inform hospital clinicians.**

- It is important that trusts use patient experience feedback to help improve their services. Social media is a public forum that is changing the way in which patients are able to comment on the quality, as well as their experience, of care. Used properly, it can be a powerful catalyst for change and improvement and one which NHS organisations, including trusts would do well to harness. In some instances, this is happening already, for example, at Birmingham Children's Hospital where they have developed a smartphone app that allows patients and visitors to provide feedback on the quality of care they experienced on the wards.

HEALTH AND WELLBEING BOARDS

**Eliminate the silos that compromise good service to residents.**
**Build an understanding of healthcare services and the many issues the NHS faces with local politicians.**

- Health and Wellbeing Boards (HWBs), bringing together key health and social care leaders in a given area, are an important forum for improving the health of wellbeing of a local population. In the past, HWBs have been accused of being organisations with no teeth, with no powers to commission services and merely able to advise strategically and encourage the integration of health and social care. It is important that HWBs are able to fulfil their potential and act as a trusted advisor and catalyst for positive change in the areas they serve.

**Use the LHBs in Wales and the unified NHS boards in Scotland as examples of joint governance, commissioning and planning with representatives of health and social care providers, local government and the third sector. With sufficient funding and embedded in clear governance structures, Health and Wellbeing Boards in England could fulfil an equally enabling role.**

- We would continue to recommend that Health and Wellbeing Boards look at best practice from Scotland and Wales as a means of fulfilling their role. GGI have been working with Aberdeen City Health and Social Care Partnership developing their integrated governance arrangements. We believe there are lessons for Health and Wellbeing Boards, NHS Vanguard sites and accountable care organisations around partnership working and we will be publishing tools and guidance around this shortly.

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