

## Humber and North Yorkshire Integrated Care Board The Voice of Lived Experience - Workshop

Thursday 1<sup>st</sup> June 2023

### Purpose of event

To bring together the Corporate Affairs, Communications, Marketing and Engagement, Nursing and Quality and Healthwatch teams, to gain an understanding of what we are trying to achieve in relation to the Voice of Lived Experience.

A key challenge is to demonstrate the ICB is heavily influenced of its decision making based on patient experience.

### Hopes and expectations from the workshop

Participants set out what they hoped to achieve from the workshop session. People wanted to understand where we currently are as a system, bringing together the activities of all partners so that a plan of action can be put in place. People shared what is important to ensure insight can influence decision making and were keen to ensure they didn't leave the session without things being followed up.

- *Understand what insight we already have – "What do we already know?"*
- *Foundation starting point – what good looks like – principles / behaviours*

There was a need to look at the practical aspects of collecting and sharing insight data. People shared what they felt were effective ways to gather the insight of those with lived experience.

- *Triangulate information to influence decision making / make change happen*
- *Understand how we get balance between positive and negative*
- *Collate information, themes, trends, evidence all forms of feedback.*
- *Co-production – informs, values and truth*
- *Two-way conversation – feedback. Giving all stakeholders a voice.*
- *Consistency when reviewing policies and services*

Participants were keen to use the workshop to explore how everyone can work together to develop a wider bank of insight data.

- *Network with like-minded people and understand other perspectives. Gather and share. Collaborate. Right people here*
- *Joined up approach – shared insight*
- *Helping other partners influence change*
- *How we work in new model – multi agency approach a new architecture. Biggest opportunity for integrated working*
- *How do we join up across organisations? (ICS only part of the picture) Working together in partnership*

There was a clear desire to come away with a plan of action, to bring the voice of those with lived experience to the decision makers.

- *Action! – accountability / responsibility (who, what, when) clear actions and steps. A practical plan of action with flexibility*
- *Common language*
- *How we integrate Board and community voice and be bold and innovative. Statutory guidance. What will it look like for ICB?*

## What is the ambition?

Participants were asked what the ambition should be for hearing the voice of those with lived experience. A key theme was the need to have a common language when talking about involving people as we use many different terms to describe what we are trying to achieve.

- *Strive for a common language*
- *Patients and service users / lived experience*

The ambition is to collaborate and embed genuine engagement with people at the outset of pieces of work. There was a desire to make sure this is achievable within existing resources by working smarter.

- *By developing a greater understanding of what matters to people when accessing services. Utilise these insights to inform and drive the development, delivery, evaluation, and prioritisation of services for the population.*
- *Collaboration! Evolve*
- *Coordination / partnership*
- *Fundamental to service design at outset*
- *Maximise and harness resources*
- *Work smarter – not harder*
- *Clarity of focus*
- *Voice is captured in the system and used as intelligence – insight gaps*
- *Make every voice count*
- *Measure of success – increased confidence of the public in the NHS (annual satisfaction survey)*

One group showed the overarching ambition "*To have ICB/ICS priorities driven by our communities*" in a drawing which showed engagement and insight based on collaboration, triangulating data and co-production methods as the foundation. This is supported by the centralising of some processes, for example the shared use of consistent demographic questions, reporting structures and methods. Alignment of work priorities were fundamental to this where possible. This would be delivered through working with existing networks and forums, targeted groups, dedicated teams, VCSE and patch wide events. Reporting and closing the feedback loop were set out as the outcome.

## Challenges

Everyone shared what they saw as the challenges to achieving this ambition. Some of this was about ensuring meaningful involvement:

- *Treat public as equals – have honest conversations*
- *Not token involvement – a golden thread*
- *A power balance – not done to – valued, listened to the truth, co-produce*
- *How to achieve a culture change, a change in mindset to appreciate the positive aspects of listening to lived experience*
- *Focusing on both quantitative and most importantly qualitative insight to truly understand*
- *What resource can we identify to make it happen*

There is a need to agree a common language and scope for involvement:

- *Language – lived experience / expert by experience?*
- *Not one definition or a consistent language – need commonality of language and vision. Need to consider the ‘so what?’ and the learning*
- *Patients, residents, carers – what is the scope?*
- *How can we make sure we heard from many voices, not just those shouting loudly?  
- Role of ambassadors and advocates.*

There is a challenge around having a more proactive approach to involvement that isn't just to feed into the commissioning cycle:

- *What matters? – Voice influence strategy and not just operational/service change*
- *How do we reflect and pay attention to the voice of lived experience and make stuff happen as a result? Balance what going well / what needs to change.*
- *For ICB engagement has been linked to commissioning cycle – need a proactive approach now.*
- *Staff development*
- *Start a conversation without preconceived ideas*
- *Challenges – getting people to understand the importance of this*

The multi-agency approach needs developing:

- *Multi agency approach – ICS and Healthwatch only part of the picture*
- *Work together to get the best outcomes for people*
- *Healthwatch has the flexibility to follow the voice and hear experiences every day.*
- *How can we better harness work around engagement to make better use of resources and do something better?*
- *Accountability equal partners / responsibilities*
- *Onboarding of Local Authority / other VCSE / commissioners / BI – invite people who are missing around the table – get willingness to collaborate and share*
- *Unified purpose / ambition*
- *Align priorities – start with reviewing Place based (are these the ICS strategy?)*

### Getting the voice of lived experience to the Board:

- *Who are the subject matter experts? How can we help the Board to really understand what life is like for real people?*
- *What do communities want to inform the Board about – is two way communication?*
- *Be open and change perceptions of how things should be*
- *Fluidity and adaptability – response to what they are told. Challenge and break away from norm.*
- *Don't be afraid to look at controversial views*
- *Understand people's experience – not our view of it*
- *Patient voice heard at senior levels*
- *Board needs a temperature check / strategy insight to feed into decision making / a better feel for people*
- *Visibility of how the Board goes out into communities*
- *Bring outcomes of Board visits into public Board meetings*
- *Board papers to include mandatory element that has to give experience insight – emotive way, gives accountability*
- *Then – so what? Feedback loop and influence. Risk is monitoring and measuring impact*

There is a challenge around being open to hearing experiences and responding to these:

- *What is acceptable and unacceptable – manage expectation*
- *Vision needs to marry with practice – measure performance*
- *More than listening – reflect on insight and any actions*
- *What are we doing with what we have heard already?*
- *Look for improvement, not blame when there are issues etc. (a culture change)*
- *How do they influence? How do they enact and measure change? What are their priorities?*

Listening to the voice of lived experience was described as:

- *Actively listening and pushing for change to happen*
- *Not constructing our own views*
- *Listening to people with real life, first-hand experience of services etc. Important to listen to those who don't access or don't share*
- *Making sure we listen to needs of people to make sure services are commissioned effectively to meet goals, aims, outcomes and save money. Fit service to user. Patient first.*
- *Elevate voices that need to be heard*
- *Giving platform / equal voice*
- *“Really caring about our purpose”*
- *“Have the decision makers understand what its like to be the recipient of services”*

## What are the actions we need to take to achieve this ambition?

People felt that a baseline needs to be established by mapping what we are already doing at Place and the Collaboratives, picking out what are the things that only a specific team can do.

- *Experience – experience team plus*
- *Engagement – engagement team plus*
- *Co-production (true)*
- *Gap analysis and report*

*Consider who, what, when, why, how?*

- *Audit of experience data and mapping across system – flows of information. Identifying gaps – review of HW reports and what action taken, JSNA*
- *Map out what we already have and know what the gaps are and what is clearly whose remit (then putting in place the appropriate channels to feed up, including comms channels)*
- *Be clear on language and context in which intelligence / experience is gathered*
- *Become an ICP priority – ability to commission reports and receive appropriate analysis*
- *Making better use of existing data*
- *Clear on what we inform, consult on, engage on, co-design, co-produce. NEL as a building block*

There is a need to clarify the governance arrangements, to align strategies and procedures:

- *Forward plan of strategies and priorities - who is involved in this and who agrees it*
- *Mapping of practices, procedures and processes – what we gather, what we do, where we report, how we act / share / influence*

There is a need to establish a framework for capturing “the voice”. It was acknowledged that different organisations / directorates will be collecting insight in different ways and developing an overarching framework was compared to piecing together a patchwork quilt where everyone may be bringing slightly different elements. It was important to ensure the following were addressed:

- *Duplication*
- *Consistency and conformity*
- *Proportionality*

The group identified risks associated with establishing this baseline, around the scale of the task and the commitment this requires from all partners.

- *Too much information / irrelevant*
- *Resource to do this work*
- *Partners fail to contribute*
- *Timescale to undertake this – needs a deadline*
- *Clear process for review*

- *ICB to support education piece with commissioners of Healthwatch and engagement directorates on its role and value and potential in the system – wider system to get buy in into today's ambition and SLTs at ICP will then get that buy in*

- *Toolkit of methods of bringing patient voice – E by E, patient story etc.*
- *Toolkit that demonstrates difference made / mechanism used – links to mapping exercise - will then help determine what sits where and makes us question why we are doing it*
- *Patchwork quilt – who is this patchwork quilt for? People / Board*

How can we share the workload? It was suggested a collaborative approach could work involving all partners, with task and finish groups to ensure actions are completed:

- *Representatives from all relevant teams*
- *Share the workload*
- *Could be Place based then feed into overarching task and finish groups*
- *Resource to Healthwatch to support sustainability and also to enable system wide collective intelligence into the system*
- *Individual tasks – governance and reporting structures - RACI*

To allow the insight data to be managed across the ICS the group suggested an IT solution was required. It was suggested that BI could advise and review current systems and a task and finish group could implement.

- *Creating a repository / data observatory – will BI do this? Look at different existing systems and what other ICS use*
- *Can EPIPH&NY system that BI are using be developed?*
- *For wider partners – quant and qual data*
- *To develop capture data sharing agreement*
- *Development of a consolidated dashboard/barometer for ICB reports – mix quant and qual*
- *Investment in design and development of system that pulls themes and trends from each directorate – things in place that could be built on*

The group outlined the following risks to be considered with developing the required repository for insight data for all to access and ensure it captures qualitative and quantitative insight:

- *Appropriate system to collate insight data – bespoke system?*
- *Interoperability / compatibility between systems for reporting*
- *Are we missing insight - social media*
- *Where does FFT data get reported across the ICP?*
- *Make sure Healthwatch can upload to it, not just NHS*
- *Not able to contextualise the data – where it came from / what does it tell you*
- *Make sure that the contextual narrative goes with the data*
- *Working smarter – how we can integrate voice into existing mechanisms*
- *Review governance processes around receiving HW reports*
- *Accountability – who is checking we are meeting statutory duties?*
- *Who holds the ring to bring insight / info together?*



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## Understanding the Lived Experience of our LGBTQ+ Community in HNY

An estimated 3.1% of the UK population aged 16 years and over identified as lesbian, gay or bisexual (LGB) in 2020, an increase from 2.7% in 2019 and almost double the percentage from 2014 (1.6%). (ONS)

*And in HNY:*

5.5% of people over the age of 16 in York are LGBTQ+: 11.4% in Fulford, Heslington & University

3.77% of people over the age of 16 in Hull are LGBTQ+; 10.77% in University Newland North.

*“The evidence that LGBT+ people have disproportionately worse health outcomes and experiences of healthcare is both compelling and consistent.” NHS England*



## Hull LGBT+ Children and Young People's engagement- 2020 (HCC)

- 44% felt somewhat accepted by society.
- 19% felt they were not accepted very well by society.
- Only 11% felt completely accepted by society.
- 76% have been threatened, harmed or abused as a result of being LGBT+

## 'Stepping through the door' transgender needs assessment (East Riding of Yorkshire Council) - 2022/23

- **70%** of trans people have reported transphobia when accessing general healthcare (TransActual Survey 2021)
- **45%** of trans people said they didn't believe their GP understood their needs
- **57% of trans people have chosen to no longer go to a GP**
- Out of the 93 health and care staff in HNY who responded to the linked survey, **only 11** reported having had any training on supporting trans patients and/or colleagues.



## Humber Case Study: Trans male 2021

My name is **Ben** and I am a **trans male**.

I never truly felt that I was female growing up. I felt misplaced and out of place throughout my childhood and struggled with dysphoria. Whenever I was included in more masculine activities and masculine pronouns, I felt more myself.

I came out in 2016 which was quite a difficult time for me as family had trouble accepting it straight away.

In 2017 I began to socially transition and live my life as a male. This created both positive and negative experiences. I finally felt myself and this helped with my dysphoria. However, there were several challenges that I faced specifically around misgendering when accessing health services.”

“I have struggled with my mental health and accessed mental health services for some time now. My first experience of misgendering was when receiving support from a mental health practitioner. At the time I had not legally changed my name to Ben but one of my mental health issues stemmed from dysphoria around my birth name, and the service were aware of this. One worker in particular would continually call me by my birth name and use female pronouns. She never apologised for making the mistake and didn’t acknowledge or address the fact that my preference was masculine pronouns and the name Ben. The other workers in the service explained to me that ‘she doesn’t understand because she is older’ but that doesn’t feel right to me. This experience made me feel invalid and heightened my feelings of dysphoria. I was angry that I wasn’t being respected. I had changed my name and gender for a reason, and the service knew this. At the time I felt like I couldn’t voice my opinion and speak up about it because of feelings of anxiety and my mental health.”

“This was a few years back now, but I still face similar issues today. I have legally changed my name by Deed Poll and provided my formal letter to my GP to update my records. However, I recently discovered that my prescriptions are still placed in my birth name. I didn’t find this out until I received a text from my GP surgery with my birth name. Apparently, there had been a mix up with my documents not being handed over from my Dr to the pharmacy to let them know. Again, this brought up feelings of frustration and dysphoria- even more so because my name had now been legally changed. Just this morning I have had to submit my legal name change document to my Dr to start the process again. I am a much stronger person than I was when experiencing misgendering for the first time, but it still angers me that I must go out of my way to do it again and it just feels frustrating and brings up feelings I don’t want. Some people may think ‘oh well it’s just a small mistake and it’s only a name but for me...

It’s not just a name. It’s my identity. **It’s who I am.**”



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From data collected in 2022 (NHS Hull Pride in Our Health Survey), two main themes were present when people were asked why they don't access services when they need them:

- **People didn't know what support was available near them**
- **People didn't know where to find out what support is available near them**

In response, we have developed a digital hub as part of the Let's Get Better website for all things LGBTQ+ health and wellbeing.

On this hub, there is tailored information about:

- Mental health and emotional wellbeing
- Screening for LGBTQ+ people – e.g. cervical and breast screening information for trans and non-binary people.
- Sexual health
- Drug and alcohol services
- Eating disorder support
- Information around primary care e.g. how to change your gender marker on your medical record



The survey also told us that the key health issues LGBTQ+ people were worried about locally were:

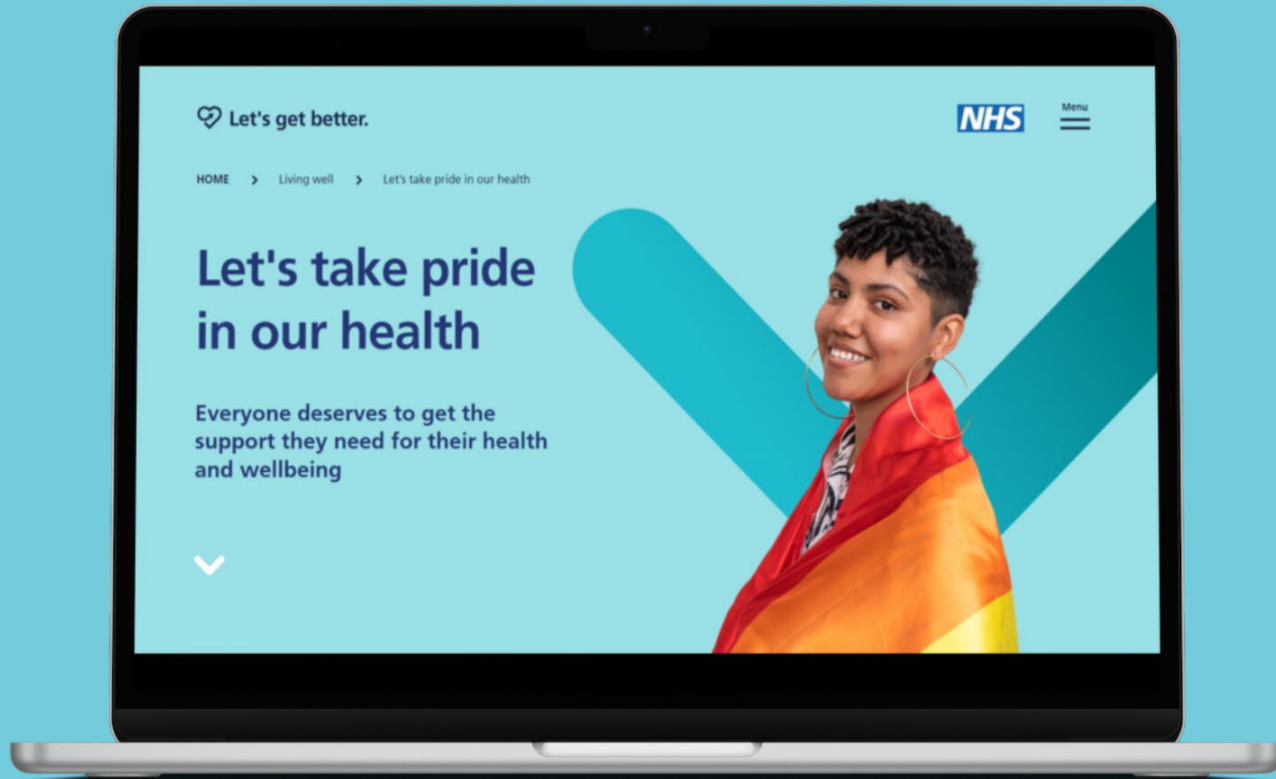
- **Cancer**
- **Mental health**

In response we have developed targeted social media and web messaging around screening and mental health and wellbeing.

By working closely with partners, we have been able to ensure the message is shared as far and wide as possible across Humber and North Yorkshire on social media, in the media, internal bulletins, websites and intranets.







[www.prideinourhealth.co.uk](http://www.prideinourhealth.co.uk)

### Mental health and emotional wellbeing

We all struggle with our mental health from time to time. But being part of the LGBTQ+ community poses its own unique mental health challenges.

It might not be easy, but you deserve to get the help and support you need.

[Find out more](#)



### Screening for LGBTQ+ people

NHS screening programmes do not discriminate against sexuality or gender identity. Be sure you know what screening you are eligible for and speak to your GP practice team to book an appointment.

[Find out more](#)

### Sexual health

It's important to create a space to talk openly and safely about practicing safe sex and what you expect from your partner to support you to enjoy safe sex.

Sexual health services in Humber and North Yorkshire are available to help you. They can help with things like testing, support to practice safe sex, and prescriptions for PrEP and PEP.

[Find out more](#)



### Drug and alcohol services

If you're worried about alcohol or drug use, there are local services that can help. These services can also help you to drink safely and responsibly.

[Find out more](#)



Humber and North Yorkshire Cancer Alliance

June 13 at 5:15 PM · 🌐



Just as you would tell your doctor about your age, occupation or ethnicity, it's a good idea to tell them if you identify as LGBTQ+. It makes it easier to discuss your life, relationships and health concerns and make sure you receive care that is tailored to the whole of you.

Find more LGBTQ+ health and wellbeing information here: [www.prideinourhealth.co.uk](http://www.prideinourhealth.co.uk)  
#PrideInOurHealth Letsgetbetter

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## Let's take pride in our health

Published: 14 June 2023 to 31 December 2028



*New one-stop-shop launches for all things LGBTQ+ health and care*

For the first time in Humber and North Yorkshire, knowing where to turn for health and wellbeing support as a member of the LGBTQ+ community will be at your fingertips. A new digital hub has launched to make finding support easier for people who identify as LGBTQ+.

Launched this Pride month, you can quickly find useful information, services, and support to help you to live a healthy life, as well as contact details for services near you.

Visit [www.prideinourhealth.co.uk](http://www.prideinourhealth.co.uk) to find tailored information on mental health and emotional wellbeing, screening programmes, sexual health, drug and alcohol use, and eating disorders. You'll also find information on how to register

## Let's take pride in our health



### Let's take pride in our health

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Follow [Let's Get Better on Facebook](#) for more tailored LGBTQ+ health and wellbeing information throughout June 2023.

We invite you to use the resources attached to promote Let's Get Better and celebrate Pride month.

## Let's Take Pride In Our Health!



From data collected in 2022 (NHS Hull Pride in Our Health Survey), two main themes were present when asked why people don't access services when they need them. The first, people didn't know what support was available near them, and the second, people didn't know where to find out what support is available near them, therefore, NHSE has developed a website for all things LGBTQ+ health and wellbeing, available here: <https://www.letsgetbetter.co.uk/living-well/pride/>.

It's important to remember that our LGBTQ+ colleagues are also patients and service users. The inequalities LGBTQ+ people face in society are mirrored within the workplace.



## Pride Month: New digital hub launches for all things LGBTQ+ health and care

Members of the LGBTQ+ community in Humber and North Yorkshire can now find tailored health and wellbeing support easily thanks to a [new digital hub on the Let's Get Better website](#).

Launched in conjunction with Pride month, the fresh content has been introduced as part of the Humber and North Yorkshire Health and Care Partnership's *Let's take pride in our health* campaign to make finding support in our region easier for people who identify as LGBTQ+.

The webpages, co-designed with members of the LGBTQ+ community and with other health and care partners, creates a comprehensive hub, allowing people to find information and contact details for local services.

The pages feature information on topics such as mental health and emotional wellbeing, screening programmes, sexual health, drug and alcohol use, and eating disorders. Users will also find information on how to register with a GP practice and how to change your name and gender on your medical record.

**Bonnie Gray, Vice Chair of the LGBTQ+ Staff Network at Hull University Teaching Hospital NHS Trust, said:** "As the Vice Chair, I am very excited to be working in partnership with local organisations to bring health and wellbeing information to the LGBTQ+ community.

"We know from research that members of our community are far more likely to experience mental health problems than non-LGBTQ+ people, as well as being less likely in general to access healthcare; this is even more pronounced within the trans+ community.

"The campaign *Let's take pride in our health* is about educating our LGBTQ+ population about what is available locally to give them a well-rounded picture of inclusive health and wellbeing support. It will live on after Pride in Hull and all other local Pride events have taken place and will hopefully be a one-stop-shop for our community to access a wealth of useful information."

**Anja Hazebroek, Equality, Diversity and Inclusion Lead for Humber and North Yorkshire Health and Care Partnership, said:** "I'm thrilled we have been able to launch this new digital hub that encompasses all health and care resources for our LGBTQ+ community.

## BBC news article:

<https://www.bbc.co.uk/news/uk-england-humber-65884309>





One of the most important things for us with this campaign is that it really spoke to members of the LGBTQ+ community.

We worked closely with LGBTQ+ staff networks across HNY, and local charities and partners to develop the campaign.

The feedback was fundamental to developing messaging that spoke to the community we are trying to reach.

We are sharing some of the positive comments we received, but we also received a lot of very constructive feedback which we used to adapt and develop the campaign.



I love the trans inclusivity of these posters. It's refreshing to see something supportive for a change and is something that I firmly believe the NHS and we as a trust should stand up against and provide support for.

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I think the images presented are wonderfully diverse and are a brilliant indicator towards our inclusivity work.



I think the key messaging is great – particularly the part about screening! I think it's so vital that people don't forget the importance of this.

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In recent years I often worry when rainbows are put on things that people tend to associate them with just the NHS, however these posters are clear and concise in their message that this is about Pride and the NHS.

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## What's Next?

### Hull Pride (29 July)

We are gold sponsors so have a large health and care tent, bringing local partners together under one roof.

Partnership approach to provide info and support on:

- Physical health, Primary care and screening
- Emotional wellbeing and mental health
- Sexual health and fertility
- Alcohol, drugs and smoking support
- Recruitment
- Engagement and involvement

**Further triangulation of data, insight and intelligence to inform the ICB's position and approach in supporting our LGBTQ+ community to live happy and healthy lives, and access services fairly.**



Humber & North Yorkshire  
Public feedback, Year  
Review & Forthcoming  
Priorities

**healthwatch**

# Public Feedback – Themes across Humber & North Yorkshire

## GP services

- Key issue is access– long telephone queues and long waits for appointments.
- Challenges of online systems.
- Appointments being issued at times people cannot do with no option to rearrange.
- When people are able to get an appointment, they are often happy with the quality of care.

## Dentistry

- Issues raised around access to NHS dentists with many on waiting lists for years.
- Practices are closing or only offering private treatment.
- Oral health crisis is having a secondary impact on people's mental health and wellbeing.

## Hospital care

- Long waiting times at A&E.
- Long waiting times for follow up appointments and test results.
- Despite the delays, often positive feedback about kind and caring staff.



# North Yorkshire & York

- Concerns around adult autism and ADHD diagnosis. New online 'Do It Profiler' is being piloted alongside official diagnosis, however, is being perceived as a replacement for official diagnosis.
- Repeated concerns regarding the failure to commission Dexcom 1 Continuous Glucose Monitoring – HNY now 1 of only 4 ICBs nationally to not have commissioned this, and reports of failures to provide annual health checks for people with Type 1 Diabetes.
- Issues accessing CAMHS services for children with autism and/or ADHD.
- Difficulties raised regarding wheelchair services; people having issues when trying to book repair and maintenance appointments.
- Positive feedback about accessibility at Harrogate Hospital– praise for the interpreter service offered for people who are deaf.





# Hull

- Lack of easy-to-read communications for people who have a learning disability. Written communications regarding appointments and important updates are being sent to people who are unable to read the correspondence, resulting in missed appointments and unnecessary delays (both hospital & GP).
- Poor communication with people whose first language is not English. Letters being sent in English to people who are unable to read them, or have friends and family interpret the letters, but not always accurately.
- GP reception staff providing people with medical advice, for example asking people with minor symptoms to take pain killers and call back in a few days if still unwell.



# East Riding

- Increasing frustration for those trying to navigate the system for a learning disability referral and diagnosis. No clear pathway, communication, or triangulation of services.
- Failed discharge process – lack of services available to support a successful recovery.
- Lack of communication regarding other methods of obtaining prescriptions and appointments from GP Practices.
- Cancer patients travelling long distances for medication and procedures.
- Scan results not delivered in a timely manner, with no clear pathway for who is reporting and how to obtain.



# North & North East Lincolnshire

- Concerns raised around the lack of support for people with long-term health conditions to prevent further complications.
- Healthwatch have been signposting patients who feel they have not had the correct information regarding their long-term health condition.
- Issues have been raised outside of health & social care e.g., housing issues.



# Past Year Review & Forthcoming Priorities



# Healthwatch York

- **VoICeS network** – continued to establish this network, bringing together the public with local providers to have their voices heard. Each meeting has a different theme, allowing people to have their say on issues that matter to them.
- **Cost of living review** – highlighted that people were no longer able to afford nutritious food, heating, and non-essential items. Healthwatch York findings presented to the City of York cost of living summit.
- **Mental health services and support for children and young people** – highlighted issues around inefficient administration, poor communication from service providers and lost opportunities for effective information and signposting.
- **Accessible Information** – In partnership with Healthwatch North Yorkshire challenged local providers on the accessibility of the information. Led to a commitment from providers to ensure they are compliant with the Accessible Information Standard.



# Healthwatch York 2023/24 Priorities

## **Navigating primary care**

Gain further insight into issues around primary care access and helping to find solutions to help the public navigate primary care services.

## **Mental health crisis care**

Build on the work and insight gained through the recently published report [Breaking-Point-Mental-Health-Crisis-Care-June-2023-updated.pdf \(healthwatchyork.co.uk\)](https://www.healthwatchyork.co.uk/wp-content/uploads/2023/06/Breaking-Point-Mental-Health-Crisis-Care-June-2023-updated.pdf) to drive improvements to mental health crisis care in the City of York.

## **York volCeS network**

Continue to strengthen and grow the network, allowing more people to come together with providers and commissioners to have their say on issues that matter to them.





# Healthwatch North Yorkshire

- **Digital Access** – produced a report on digital access to highlight the benefits and challenges that people face in using & accessing digital care.
- **Cost of Living** – Worked with Healthwatch England to highlight the affect that the cost of living crisis was having on people’s health and wellbeing across the County.
- **Oral health Crisis** – published a report highlighting the detrimental impact the oral health crisis is having on both the mental and physical health of adults and children across North Yorkshire.
- **Young People’s mental health** – gathered young people’s (16-24) experiences of mental health and well-being, including where they would go for support if they needed it.
- **Mental health services** – Healthwatch North Yorkshire worked with the North Yorkshire & York Leadership Alliance Board to understand what helps people’s mental health and wellbeing and how mental health services are being used by local people.



# Healthwatch North Yorkshire 2023/24 Priorities

- Continue to build on the work that Healthwatch North Yorkshire have already championed such as GP access, dentistry, social care and mental health.
- Expand reach and engagement with those communities who aren't always listened to or involved in their health and social care.
- Establish a people's voice network for North Yorkshire to ensure people are at the heart of decision making.



# Healthwatch East Riding

- **GP Access in Bridlington** – Heard from nearly 500 people in Bridlington regarding their challenges in accessing GP appointments.
- **Carers** – gathering the lived experiences of carers and provided advice on how to register as a carer and the benefits of doing so.
- **Dentistry** – continuously shared the voices of people who cannot access NHS dentistry and have contributed to the parliamentary select committee inquiry about this issue.
- **Neurodiversity** – In partnership with Healthwatch Hull, co-chaired the Neurodiversity stakeholder group, utilising service user involvement to help shape the new Front Door service.
- **Cost of Living** – worked with Healthwatch England to conduct a survey looking at the impact of the cost of living crisis on the East Riding Communities.
- **Young Adults** – worked closely with Colleges and Universities to understand the experiences and healthcare priorities of young people when accessing services.



# Healthwatch East Riding of Yorkshire 2023/24 Priorities

## **Coastal Communities**

Use the voice of lived experience to reduce health inequalities, particularly amongst children and young people in coastal communities.

## **Community Equipment services**

Obtain service user feedback on Community Equipment Services within the East Riding, to improve access to daily living aids for adults and children.

## **Reaching hidden voices**

Support more of our seldom heard communities to have their say on health and care issues in the East Riding.



# Healthwatch North Lincolnshire

- **'Every Voice Matters'** – brings together, those with lived experience of mental health conditions to have their voice heard and feed in to service redesign.
- **End of Life Pathway** – In partnership with Healthwatch North East Lincolnshire, investigated the experiences of those who were on the end of life pathway, and the experiences of their loved ones. This work has been used to inform the Northern Lincolnshire end of life steering group to help shape and improve services.
- **Community Equipment Service** – undertook targeted engagement with people who use community equipment services to inform the recommissioning process.
- **Youth Healthwatch** – established a Youth Healthwatch whose first area of focus on young people's experiences of sexual health services in North Lincolnshire, used to shape the recommissioning of the sexual health service.
- **NLaGPALS services** – Escalated feedback of difficulties people were having in accessing the PALS service, leading to a review by the Trust.



# Healthwatch North Lincolnshire 2023/24 Priorities

## **Continence service**

Complete our work with the Northern Lincolnshire and Goole NHS Foundation Trust on the changes patients would like to see to this service.

## **Youth Healthwatch**

Continue the delivery of youth led initiatives aimed at tackling the issues most important to them.

## **Adults with Autism**

Understand the diagnostic pathway and support available for adults with Autism and bring the voice of lived experience to help influence change.



# Healthwatch North East Lincolnshire

- **Supported Living Accommodation** – the experiences of existing residents were gathered to inform providers and commissioners with future planning.
- **Seldom heard communities** – conducted targeted engagement at the Emerge Hub in Grimsby to understand the experiences and health and care needs of sex workers in the town.
- **Unpaid Carers** – investigated the issues that unpaid carers face when trying to access health and care services for themselves and those that they care for. A report was compiled and shared with service providers highlighting the good practice that takes place and the barriers that unpaid carers can encounter.
- **End of Life Pathway** – In partnership with Healthwatch North East Lincolnshire, investigated the experiences of those who were on the end of life pathway, and the experiences of their loved ones. This work has been used to inform the Northern Lincolnshire end of life steering group to help shape and improve services.



# Healthwatch North East Lincolnshire

## 2023/24 Priorities

### **Type 2 diabetes**

Using the voice of lived experience to tackle health inequalities for those with Type 2 Diabetes

### **Dentistry in care homes**

Understanding issues around access to dental care for people who reside in Care Homes

### **Mental health support in supported living**

Gather experiences from those that reside in supported living due to mental health issues





# Healthwatch Hull

- **Cost of Living** – carried targeted engagement within the City to understand the impact that the cost of living crisis was having on peoples' ability to pay for prescription medications. This feedback was shared with the Financial Inclusion Network to help shape the support on offer for the people of Hull.
- **Neurodiversity** – In partnership with Healthwatch East Riding, co-chaired the Neurodiversity stakeholder group, utilising service user involvement to help shape the new Front Door service.
- **Menopause** – Conducted targeted engagement around the menopause with feedback suggesting that there was a lack of professional knowledge around the menopause, an inability to access appointments to discuss symptoms and a lack of general support groups available. The Neighbourhood Network took the feedback on board to ensure that holistic support was available to support women through the menopause.
- **Communications Barriers** – worked with local providers to raise awareness of the barriers that are faced by people whose English is not their first language, to ensure that translation services are more widely available.



# Healthwatch Hull Place priorities 2023 - 2024

## **Tackling Health inequalities**

Using the voice of lived experience to tackle health inequalities further in Hull, particularly for asylum seekers, refugees, and those who face language barriers.

## **Rough sleepers and ambulance services**

Work with the rough sleeper population to understand their experiences of accessing ambulance services.

## **Housing Related Support**

Understand the needs of people who are in receipt of housing related support to shape the recommissioning of the new service.



# The NHS in England at 75: priorities for the future



A report from the NHS Assembly

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# Summary

**The NHS's 75th anniversary is an important moment to look back at where the service has come from; to consider where it stands today; and to look forward to how it needs to change to meet future needs.**

This report from the NHS Assembly draws on the feedback of thousands of people who have contributed to a rapid process of engagement with patients, staff and partners (the NHS@75 engagement – see page 6). It also draws on the huge breadth of experience within the Assembly itself.

The report aims to help the NHS, nationally and locally, plan how to respond to long term opportunities and challenges. It is not a detailed policy prescription. But it does set out what is most valuable about the NHS, what most needs to change, and what is needed for the NHS to continue fulfilling its fundamental mission in a new context.

## Where have we come from?

The NHS was born from hope. It was founded on the simple principle of providing universal care, based on people's need, not their ability to pay. Today, this resonates as strongly as it did in 1948. In opinion polls, 19 out of 20 people say they want the NHS to remain free at the point of delivery.<sup>1</sup> Those who responded to NHS@75 highlighted the underlying principles and values of the NHS as the most important feature to celebrate and retain.

It is striking how much the NHS has adapted to meet changing needs. Treatments for heart

attacks and cancer have helped dramatically raise life expectancy. Mental health provision has moved from around 100 Victorian 'asylums' to more humane and effective care provided largely in the community, although still not at the levels of provision needed. The NHS has also been at the forefront of innovations including helping pioneer hip replacements, the first test tube baby and new gene therapy treatments for childhood leukaemia. More than half of those who responded to NHS@75 celebrated these improvements.

At the heart of this history are the people who provide care: the NHS workforce of 1.3 million staff from over 200 different nationalities, alongside around five million unpaid carers who support their friends and family. Behind these numbers, our engagement highlights the diversity, daily resilience and adaptability of those who work in the NHS, despite the pressures they are under. The response to the COVID-19 pandemic is just the latest example of that.

## Where are we now?

Today, there is immense pride in how the NHS and its partners continue to develop services. For example, the recent creation of 9,000 virtual-ward beds to provide care at home supported by new technology and ways of working.

The NHS has enduring strengths, such as universal general practice, its links to science and research, and its education and training system. The service has recently made a big

shift to integrate the care provided by GPs, hospitals and community services, working more closely with local government, social care, the voluntary, community and social enterprise (VCSE) sector, and other partners, through the creation of Integrated Care Systems (ICSs).

There is also clear recognition in the NHS@75 engagement that, despite the best efforts of frontline staff, the NHS is not always providing timely access to advice, diagnostics and treatment to all those who need it. Waiting lists are at an all-time high. Public satisfaction is the lowest since the late 1990s.<sup>2</sup> The NHS, and social care, face very significant challenges of rising demand, constrained capacity and the need to recover from COVID-19. Taken together, this is a unique set of challenges in NHS history.

Although some of these challenges are partly a consequence of the pandemic, they also have deeper causes. Processes can often be too complex. There are too many vacancies for permanent staff. Growth in service capacity has not matched the rapid rise in the number of people with severe chronic health conditions and frailty. Inequality in access and health outcomes is too wide. The NHS's estate and digital infrastructure need investment and renewal.

The NHS will only thrive when wider economic, social and environmental conditions support good health and there are strong social care and public health services.

## Where is the NHS going?

The NHS is starting to recover from the long legacy of the COVID-19 pandemic. The feedback from patients and staff in NHS@75 highlighted the importance of continuing to improve access to treatment and making it easier for people to navigate and communicate with different NHS services. Supporting staff and investing in training the workforce of the future remain high priorities.

There is now also an opportunity to look to the longer term. The NHS has made a number of significant shifts in how it has delivered care in the past – tackling infectious disease in the 1950s, closing asylums in the 1980s and radically expanding treatments in the 2000s. These shifts succeeded when the NHS had a clear vision for transforming the way care is delivered, supported by the resources needed to implement new ways of working. Each vision has been rooted in an understanding of patient needs and local innovation and improvement.

Today there is a growing consensus around the need for three big shifts. Shifts that respond to the continuing rise of chronic ill-health and frailty, the need for people to have greater involvement in their own health and wellbeing, and the opportunities offered by new technology, data and modern forms of care.

The three shifts are:

- **Preventing ill health**

Shifting funding to evidence-based measures to prevent and manage coronary heart disease and other causes of poor health, such as smoking and obesity. Working far more effectively with others to reach those at greatest risk and using NHS insights to advocate for effective action in tackling the wider determinants of health.

- **Personalisation and participation**

Ensuring people have control in planning their own care, supported by a continuity of relationship with clinical teams and an NHS accountability framework giving greater priority to patients' experience and voice, particularly those who have been marginalised historically.

- **Co-ordinated care, closer to home**

Accelerating plans to strengthen general practice, wider primary care and community services in every neighbourhood. Universalising much better care for those with complex needs and frailty based on community teams and hospital at home services, supported by outreach from hospitals.

These are all developments which started some time ago and they must now be more firmly rooted, more quickly, in every aspect of healthcare.

This will require sustained transformation and long-term investment across a range of different elements, within the NHS, and across public health and social care:

- a thriving workforce and better supported carers, in line with the forthcoming Long Term Workforce Plan
- stronger partnerships with others, harnessing the opportunities from the creation of ICSs
- better use of digital technology and data
- a modernised infrastructure, particularly in primary care, supported by a long-term infrastructure plan
- maximising the value of care and treatment, alongside greater efficiency
- creating a well-led, learning, and self-improving service.

Above all, it will rely on strengthening the conditions for locally led innovation and renewing the mutual relationship of support and engagement between the NHS and the public. The lesson of the last 75 years is that when the NHS brings all these components together to support far reaching change, the service renews the way it delivers its fundamental principles for the next generation. This is the task the NHS once again faces.

## The NHS Assembly

The NHS Assembly brings together individuals from across the English health and care sectors at regular intervals to provide independent advice to the board of NHS England.

Its members are a unique group of NHS clinical and operational leaders, frontline staff, patients, unpaid carers and those who work for charities and community organisations. Members of the Assembly attend in a personal capacity, rather than representing organisations.

## The NHS@75 engagement process

75 years is quite a milestone, and the NHS belongs to all of us. So, we wanted to know how people felt about what the NHS has achieved so far, and what people want from it in the future. The NHS Assembly therefore reached out to those who work in the NHS and those who use the NHS, and wider partners. This was called the NHS@75 engagement process.

We received over 700 responses to our online survey, around 200 from organisations and 500 from individuals. Organisational responses often reflected the views of many people. In total the views of many thousands of people fed into this process. The NHS@75 engagement included specific contributions from key partners such as Healthwatch, National Voices, the Patients Association, Carers UK, the Race Equality Foundation, and networks representing particular groups, such as older people, people with a

learning disability and people with autism. We held interviews with NHS leaders and NHS clinical staff, and we benefited from the collective advice of a wide group of leaders.

We are very grateful for all those who have contributed to the process. A summary of the responses is published alongside this report, including more detail on the methodology.

### **This report**

This report is authored by Clare Gerada and Chris Ham, the co-chairs of the Assembly, with support from Eugene Yafele, Claire Fuller and Rob Webster and secretariat support from NHS England. It aims to reflect the themes from the NHS@75 engagement process together with deliberations of the NHS Assembly as a whole. It does not necessarily reflect the view of every Assembly member.



# Where have we come from?

1

## **The NHS was born out of hope and determination to build a better society after the devastation of the Second World War.**

It was established to end the gross inequity of access to healthcare being determined by your ability to pay for care.

The NHS was based on simple principles. A service for everyone, providing care from cradle to grave, free at the point of use, based on need, not ability to pay, funded mainly through taxation.

## **The enduring importance of the founding principles**

As a nation, we continue to strongly support these principles.<sup>2</sup> The NHS is the institution that makes us most proud to be British.<sup>3</sup> And the single biggest response to the NHS@75 engagement process was the importance of celebrating and preserving these principles.

## **A constantly changing NHS to meet changing needs**

When we asked people what the NHS has improved most, they highlighted how the NHS has constantly adapted over the last 75 years to meet changing disease patterns and needs.

In 1948, infectious diseases like tuberculosis and polio were the biggest killers, particularly in childhood. Antibiotics and immunisations changed all that.

## **Insights from our NHS@75 engagement:**

“The founding principle that anyone who needs care can get it free at the point of delivery is the absolute best thing about our healthcare service that should be celebrated and never lost sight of.”

“In 1948 the NHS foundation gave hope to people. It responded to an international disaster (War) and opened its doors to everyone. Sometimes it seems like that spirit has been obscured. I would like to see the NHS return to that spirit of hope, of trust, and of confidence.”

“Free at the point of delivery. A friend remembers what it was like before and only those with money or in an area with a “club” hospital got what they needed. My family would not be here if it weren’t for the NHS. I had cancer, caught early, and [as a result], have had over 30 years I would not have had.”

Now the biggest killers are cancer, heart disease and chronic respiratory diseases, many linked to lifestyle choices and the wider determinants of health. There is also significant growth in mental health issues.

In 1948 average life expectancy at birth was 66 for men and 70 for women.<sup>4</sup> Boys born in 2020 are now expected to live for 80 years and girls just over 83, and the risk of children dying before their first birthday is nearly 90% lower.<sup>5</sup>

Today this means that over 5.4 million of the English population are over 75 – when demand for healthcare is greatest – compared to under 2 million in 1948.<sup>6,7</sup>

The basic building blocks from 1948 – hospitals, GPs, and community services, alongside a separate social care system – remain. But a huge amount has changed: services and treatments; how and where care is provided; and the relationship between clinicians and patients. These have all been transformed.

### Changes in treatments

The range of new treatments developed over the last 75 years is astounding. Treatments for asthma, high blood pressure and psychiatric conditions and the arrival of the contraceptive pill have changed millions of lives.

New technologies have brought kidney, heart and liver transplants, joint replacements, and minimally invasive surgery. 1948's X-rays have been transformed into CT and MRI scans, revolutionising diagnosis and treatment.

The NHS has a proud, world leading record in developing many of these innovations – such as the world's first successful total hip replacement, test tube baby and vaccine against Group C meningococcal disease.

This record of innovation continues. In 2015, for example, the NHS was the first to use gene editing to successfully treat childhood leukaemia.<sup>8</sup>

## Changes in how and where we provide care

In 1948, 100 Victorian asylums looked after around 150,000 service users with mental illness, many compulsorily detained.<sup>9</sup> Today those old-fashioned institutions have gone, with more humane and effective care provided in the community, although there are still too many whose needs are not being met quickly enough. Care for common conditions such as diabetes, high blood pressure and heart disease, previously only delivered in hospitals, now takes place in primary care. This means around 100 million more GP appointments every year, a 50% increase compared to 25 years ago.

Children's services have also been transformed with care now predominantly in community settings, with a strong focus on development, education and prevention, rather than long stays in hospital.

The recent development of virtual wards, using remote diagnostic technology, means the NHS can now treat at home thousands of people previously treated in hospital beds.

A key theme of the NHS@75 engagement was the enormous pride in these improvements in treatments and care that the NHS has made possible.

### Insights from our NHS@75 engagement:

"There were a lot of diseases around in the 1940s/50s that have gone away with vaccination, a combination of Public Health and NHS resources, things that were not possible 75 years ago."

"We have seen vast improvements in patient care linked to new technology and medicines. This is leading to reduced length of stay in hospital and improvements in life expectancy. The NHS is now much better at how we manage long term conditions – caring for people at home to prevent them being admitted to hospital. This would never have happened years ago."

"Some of the technological advances have been phenomenal. You can do a CT scan and an MRI scan in a way that gives you incredible diagnostic detail. It has revolutionised how we can treat people. Similarly, advances in drug tech make a world of difference to patient care and survival rates."

## Changes in relationships between clinicians and patients

In 1948 “doctor knew best”. A paternalistic relationship that, at its most extreme, meant some doctors did not even disclose a cancer diagnosis to their patients.

Rising levels of education and social changes mean that today’s patients are much better informed. Clinicians increasingly share treatment decisions with their patients, with growing numbers recognising the positive impact of patient participation.

Today, over six in ten adults have signed up for the NHS App, enabling people to access their medical records and take much greater control of their own care. Last year, 1.9 million people measured their blood pressure at home and shared the reading with their GP, reducing the need for appointments and lowering their risk of heart attack or stroke.<sup>10</sup>

Another key theme from the NHS@75 engagement was the opportunity to go further in sharing responsibility with patients for improving their own health and wellbeing and using NHS services wisely.

### Insights from our NHS@75 engagement:

“[In] critical care – patients over 70 used to be sent away and not treated in ITU, but now we are working to get families involved in their relative’s care and treating people at older ages, including working to extend life where it may not be able to be saved.”

“Over the years, I have been able to get to know more and more about my own condition. I now feel like I can be in charge of my own care.”

“...the NHS is beginning to break through on issues like patient/doctor shared decision making but it still has a mountain to climb...”

## A single NHS

Being a single NHS has made the service an attractive partner for developers of new treatments, drugs and technologies, and helped stimulate our world class life sciences sector. And it has meant that the NHS is one of the most efficient health systems in the world,<sup>11</sup> for example negotiating single commercial deals for new drugs and treatments, a major cost for any health service.

Being organised as a single NHS has made it much easier to deliver important changes. For example, the shift from asylums to community care in mental health simultaneously required major changes to the NHS estate, and far-reaching transformation of clinical practice. More recently, national co-ordination has been central to delivering world-leading HIV and Hepatitis C elimination programmes.<sup>12</sup>

## The NHS workforce

The most important factor of all in making these changes has been the dedication, skill and professionalism of the NHS workforce. Respondents to our NHS@75 engagement were immensely proud of the NHS's 1.3 million staff.

They praised the resilience of the workforce. They highlighted how staff have changed the way they work to meet new needs. They emphasised the difficult decisions clinicians take every day, including identifying the right diagnosis and resulting treatment. And they stressed the important contribution that every

### Insights from our NHS@75 engagement:

"We must celebrate our staff and the teamwork that goes on every day in the NHS. It is the people that make our health service, and the NHS would be nothing without its staff. People feel very proud of staff and how adaptable, amenable, and resilient they are."

"Homage to and acknowledgement of the Windrush generation and all those who have come and are still coming from all over the world to care for us. NHS is training the nation in valuing diversity – a place where we meet people from all nationalities and cultures as they care for us or are our colleagues."

single member of staff – from pharmacists and porters to anaesthetists and accountants – makes to the NHS's success.

There was a strong emphasis on diversity. Respondents felt that the NHS has been a key contributor to diversity and equality in our nation. They highlighted the contributions of the Windrush generation of the 1940s and the south Asian cohorts who arrived in the 1960s, as well as their descendants.

Staff of more than 200 nationalities work in the NHS and social care,<sup>13</sup> reflecting the attraction of the UK as a place to work and train. This diversity has helped the NHS more effectively meet the needs of different communities and do more to tackle the health inequalities that the recent COVID-19 pandemic has highlighted.

## The NHS and the wider determinants of our national health

When proposals for a national health service were drawn up in the late 1940s, the NHS was just one of the measures needed to tackle “the five giant evils” that stood on the road to post-war reconstruction.<sup>14</sup> The others were better education, better housing, full employment and the abolition of poverty.

This is an important reminder, strongly echoed in the NHS@75 engagement, that prevention and treatment of disease are only two of the elements that determine the health of our nation. Disparities in the wider determinants of health – such as income, housing, education, employment – are also crucial, by some measures accounting for 80% of health outcomes<sup>15</sup> and account for many of the inequalities in these outcomes.<sup>16</sup>

### In summary:

- ▶ The enduring power of the NHS’s founding principles.
- ▶ The way the NHS has constantly adapted to meet changing needs, harnessing new technologies and treatments.
- ▶ Realising the advantages of being a single national health service.
- ▶ The central importance of the NHS workforce.
- ▶ The need to address the wider determinants of health and tackle health inequalities.

# Where are we now? What is our new context?



## What the NHS delivers

There is huge pride in what the NHS has achieved over the last 75 years. There is similar pride in what the NHS delivers today.

Those who participated in the NHS@75 engagement process often talked about the extraordinary response of the NHS to the COVID-19 pandemic. They also recognised just how much the NHS continues to deliver day in, day out.

## The challenges

But there was recognition, too, of the big challenges the NHS faces and where access and treatment need to be improved. Like every health system around the world, the NHS is recovering from COVID-19, the worst global pandemic in a century.

The NHS also needs to rise to the challenge of growing demand for healthcare driven by an ageing population with more complex needs and advances in medicine and technology.

The NHS@75 engagement highlighted six important areas where the NHS needs to do better or faces significant challenges.

Every working day in the NHS:

**1.3 million**

people are seen in general practice

**250,000**

people have an outpatient appointment

Nearly **67,500**

people attend an A&E department

**9,000**

A&E patients are transferred to hospital for unplanned care

**47,000**

have an episode of planned care like a surgical procedure

Around **60,000**

people have a diagnostic test

Around **285,000**

people are seen by a community health professional or therapist

One baby is delivered every **54** seconds

Over **7,000**

adults access psychological therapies

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## 1. Access and communications

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Many respondents to NHS@75 recounted stories of outstanding, compassionate care once they had accessed that care. But we know that recent waiting times for treatment in many key areas – cancer, accident and emergency, ambulance – remain at, or close to, the highest recorded in twenty years.<sup>1</sup> People are struggling to access NHS dentists. And despite the best efforts of frontline NHS staff, too many people are waiting too long for treatment.

The rise in waiting times is in part due to the legacy of the pandemic on delays in treatment and similar challenges are seen in other countries, such as France, Canada and Australia. But well before the pandemic, waiting times had been rising for several years as the gap between available capacity and demand widened.

A key message from the NHS@75 engagement is that issues of communication and service fragmentation matter almost as much as waiting times. There are too many instances where people cannot get through on the phone, receive confusing information, or must navigate complex and fragmented services.

And we heard that the NHS is often not good enough at listening to people about what matters to them most. This means that NHS staff are not able to make the best use of their time and skills, a point which can add to staff frustration.

### Insights from feedback collated by Healthwatch England

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Healthwatch England has looked at trends in sentiments (that is, how people feel about services) using 75,663 pieces of feedback shared with them by local Healthwatch branches between April 2019 and March 2023. The work highlights the biggest areas of concern as:

- access to GPs and dentists and, more widely, delays for treatment remain the most cited public concern
- last-minute cancellations and a lack of personalised information.

In addition, the NHS@75 engagement process heard from charities and patient groups around their specific experiences.



**Insights from our NHS@75 engagement:**

“No-one should have to call 50 times to get through when a GP practice opens to be told there are no appointments then have to call another number.”

“[We should] cut waiting times so that patients are treated before their conditions become chronic and life limiting.”

“The pace is too quick. We can't give the patients the time they need because we're so busy. We're seeing hundreds more patients every week. Some patients slip through the net.”

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## 2. Supporting the NHS workforce

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The second very clear message from NHS@75 is that more must be done to support staff in both the NHS and social care. Respondents highlighted the commitment and dedication of frontline NHS staff and their sense of vocation.

But staff reported that there were too many occasions when they faced difficulties in performing to the best of their abilities in the face of intense workloads and a lack of time to recover and reflect. This has given rise to concerns around burnout, early retirement and staff leaving due to ill health.

Respondents pointed to the importance of ensuring each member of staff has a reasonable workload, they are rewarded appropriately and they can work more flexibly and have appropriate time for training and development. The NHS needs to fill current vacancies and reduce the inefficient use of locums and temporary staff. And it needs to create an inclusive workplace that tackles bullying, harassment and discrimination and improves opportunities for Black, Asian and minority ethnic staff.

Without action, shortfalls in staff will continue to grow. For example, in 2021/22 there were 4,200 GP vacancies and some forecasts suggest that, without action, this will grow to 8,800 by 2030/31.<sup>17</sup>

### 3. The rise in chronic disease, multimorbidity and frailty

Our population is living longer – a cause for celebration. But this means the numbers living with chronic conditions, and more than one of them, is rising rapidly. These conditions can be controlled, but rarely cured. Need is most acute among the rapidly rising number of

people in advanced old age. Analysis by The Health Foundation suggests that with current models of care, this growth in frailty and chronic ill health is likely to require between 20-40,000 more hospital beds by 2030/31.<sup>18</sup>

In addition, it appears that growing numbers of younger people are unable to work because of ill-health.

**The rise of chronic conditions:**

|   |  |
|---|--|
| <p>It is likely that over <b>5 million</b> people in the UK are now living with diabetes, including 850,000 who are not yet diagnosed, compared with fewer than 4 million in 2015. Prevalence is increasing in people under 40.<sup>19 20</sup></p> | <p>Around <b>15.5 million</b> people in England, 34% of the population, are thought to be living with chronic pain.<sup>23</sup></p>                                       |
| <p><b>2.25 million</b> were living with and beyond cancer at the end of 2020.<sup>21</sup></p>  | <p>By 2030, over <b>1.1 million</b> people are projected to have dementia, affecting one in two of us either directly or through caring responsibilities.<sup>24</sup></p> |
| <p>Around <b>7.6 million</b> people in the UK live with heart or circulatory disease and 1.4 million have already survived a heart attack.<sup>22</sup></p>   |  |

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#### 4. Inequalities in access, experience and outcomes

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The higher death rates among people already disadvantaged during the COVID-19 pandemic illustrated starkly how far, as a nation, we still have to go in tackling inequalities in access, experience and outcomes, which is a long-standing problem. For example, men with a learning disability are likely to die 14 years earlier than those without, often from conditions that are treatable if identified. For women the gap is worse – 17 years.<sup>25</sup>

Black women are up to four times more likely to die during pregnancy or childbirth compared to their white counterparts, and Asian women twice as likely.<sup>26</sup> Although women in the UK live longer than men, they spend a greater proportion of their lives in ill health or with a disability.<sup>27</sup> Health inequalities both reduce wellbeing and life expectancy for individuals and increase costs for society and the NHS.

The NHS also needs to consistently achieve Aneurin Bevan's ambition to "universalise the best", successfully tackling the current excessive unwarranted variation in outcomes from treatment.

Recent developments such as the NHS Race and Health Observatory;<sup>28</sup> Core20PLUS5, a programme to target the biggest causes of unequal health in the most deprived neighbourhoods;<sup>29</sup> and Getting It Right First Time programme (GIRFT)<sup>30</sup> have started to address these issues. But there is a lot more to do.

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#### 5. Capital investment

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Almost a fifth of the primary care estate (GP practices) was built before the NHS was founded and some mental health buildings date back to the 19th century.<sup>31</sup> Too many hospitals have leaking roofs, failing heating systems and too few diagnostic scanners.

The NHS also remains behind on technology, still lacking a fully interchangeable electronic health record, while just logging into the multiple IT systems in some trusts can feel like working in the 1990s. 14% of NHS trusts still do not have an electronic patient record (EPR) system.<sup>32</sup>

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#### 6. Wider determinants of health and wellbeing

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The nation's health depends on much more than just the NHS. NHS@75 highlighted that a more joined-up approach to tackling the wider determinants of health is needed.<sup>33</sup> It also highlighted the pressures on key partners such as local government, public health, social care and the VCSE sector.

The NHS will only thrive when wider economic, social and environmental conditions support good health and there are thriving and sustainable social care and public health services. And while the NHS relies heavily on around five million unpaid carers who support family and friends each day in England,<sup>34</sup> these carers need more support.

## The strengths and opportunities

The first 75 years of the NHS have shown the enduring strength of its founding principles; the adaptability of the service to meet changing needs, harnessing technological and medical advances; the advantages of a single national service; and the power of the commitment and professionalism of the NHS workforce.

The NHS@75 engagement exercise highlighted a wide range of further current strengths and opportunities the NHS can draw on to meet these challenges. These include:

- Universal general practice as a foundation for co-ordinating high-quality, continuous care within the NHS.
- The clinical and cost-effectiveness analyses of the National Institute for Health and Care Excellence (NICE), plus our national purchasing power, which helps ensure the NHS gets good value for its budget.
- The UK's world class education and training system and vibrant life sciences industry, working in partnership with both universities and the NHS.
- The NHS's unique database of patient interactions and records to draw on to improve care and outcomes and for trusted research.

- Recent innovations in automation and artificial intelligence that can free up significant time for staff and patients. Leading digitally enabled hospitals are now around 10% more efficient.<sup>35</sup>
- The NHS has, ahead of other countries, commenced an ambitious programme to become a net zero health system, making an important NHS contribution to reducing pollution and improving air quality.

The NHS also now has the organisational structure it needs to address the challenges it faces. 42 ICSs provide strategic leadership to bring all the previously disparate parts of each local health and care system together to plan and budget to improve the health of their populations.

Each of these systems also recognises the importance of integrating care services at both place and neighbourhood levels, supported by Primary Care Networks. Provider collaboratives are enabling all the NHS providers in a local area to work together to transform the pathways where they deliver care and improve efficiency by sharing clinical staff and back-office services.

Many of these strengths were illustrated during the COVID-19 pandemic. The pandemic showed that the NHS can rapidly achieve deep, transformational change by working differently:

- One in six staff took on new roles.
- Eighty per cent of outpatient appointments went online by June 2020.
- General Practitioners (GPs) adapted the way they delivered hundreds of thousands of appointments every day.
- Every hospital in the country took part in the Recovery trial aimed at finding a treatment for COVID-19. Dexamethasone has since saved over a million lives worldwide. The NHS COVID-19 vaccination programme saw the NHS working with local government, as well as hundreds of thousands of volunteers and thousands of VCSE organisations and businesses to provide vaccination not just at vaccination centres but also through community centres, churches, mosques and other venues.

**Insights from our NHS@75 engagement:**

“During the pandemic the NHS throughout the UK was able to alter to accommodate new urgently required streams of working. This involved local clinicians and avoided the usual multi-layer planning bureaucracy, particularly for commissioners of services. Many current service planning mechanisms serve to promote the status quo rather than allow change when it is necessary. The NHS has shown it can change quickly to meet needs when it needs to do so and this needs to be “built in” for the future.”

**In summary:**

The NHS faces major challenges: to improve access; increase workforce supply and support; meet rising demand and reduce inequalities; renew its estate and infrastructure; and work with others to address the wider determinants of health.

Meeting these challenges will require a major change. But the NHS has made big changes before, not least in its response to COVID-19.

What are the shifts required and how will the NHS make them?

# Where is the NHS going? Shaping the future of healthcare

# 3

**Beveridge's original vision for the NHS in the 1940s was for 'a national health service for prevention and comprehensive treatment available to all members of the community'.<sup>36</sup>**

Our NHS@75 engagement strongly reinforced the central importance of care that is easy to access and simple to navigate, provided by a compassionate and skilled workforce supported to work to the best of its abilities. The engagement also highlighted the ongoing importance of addressing health inequalities in access, experience and outcomes.

The response to NHS@75 also challenged those advocating alternative funding mechanisms or abandoning the NHS's key founding principles, for example by charging for services or introducing co-payments. Responses to NHS@75 and opinion polls clearly show that these changes are rejected by most of the public.<sup>37</sup>

Our engagement does, however, show that the NHS must now make a new set of shifts in how care is delivered – to address the acceleration in chronic ill-health and frailty we face in the coming decades.

## Three big shifts

There is growing consensus that three big shifts are now needed. These shifts are all already under way in many places and were featured in the NHS Long Term Plan in 2019. However, none are yet at sufficient scale or speed.

These are:

- 1) preventing ill health
- 2) personalised care and participation
- 3) from hospital care to coordinated care closer to home.

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## Preventing ill health

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There is widespread agreement that more could, and should, be done to support people to remain healthy through better and earlier intervention. Over the coming years the aim should be to improve healthy life expectancy and reduce inequalities in health outcomes, with measurable goals.<sup>38</sup>

Many of the factors that affect health are not within the NHS's direct control. Inequalities in employment, income levels, housing quality, green spaces, air pollution, diet and education all have a much greater collective impact on our health and wellbeing than NHS treatment of illness. The Government has a central role to play, through an integrated cross government strategy, including using action through investment programmes, public services and partnerships with business. Its key levers include taxation and regulation to moderate the impact of major risk factors, such as smoking, misuse of alcohol, gambling, and excess sugar and salt in processed foods. The challenges posed by obesity and excess weight, and their unequal impact in society, are a good place to focus.

Supporting individuals at risk of disease or worsening health – ‘secondary prevention’ – is an area where the NHS has a direct role. The NHS should seek to identify people at risk of premature mortality, building on existing work, including those at risk of cardiovascular diseases and certain cancers.

The NHS already has important tools to respond to risks, including vaccination, and support for people to stop smoking and manage their weight. The service has been developing these programmes in recent years and learnt from the targeted efforts during the pandemic.

The Assembly recommends that, over time, the NHS increases investment in evidence based preventative programmes. The forthcoming Major Conditions Strategy being developed by the Department of Health and Social Care is an important opportunity for taking the next steps.

The NHS also has a vital role to play in partnership with other agencies in tackling these wider determinants of ill health and inequalities. It needs to collaborate with local authorities, VCSE organisations, businesses, educational institutions and other stakeholders. Given rising ill health in the working age population and 2.5 million people not working due to ill-health,<sup>39</sup> there is a particular need and opportunity to work with employers to help improve the health of their staff. This applies to better supporting NHS staff too.

A high priority is to give children the best possible start in life, including supporting parents and guardians, by recognising the importance of the early years and the role of

### Insights from our NHS@75 engagement:

“We are too focussed on illness rather than prevention and promoting health.”

“Life expectancy is falling despite our best efforts. We still don’t focus sufficiently on prevention and there is significant under investment in public health.”

“We need to focus on prevention – including a series of public health measures (both nudge and legislation) to tackle obesity, sedentary lifestyle, alcohol use and smoking. Minimum alcohol pricing is effective. We can target a smoke free country. High calorie products should not be seen as food and society needs to be modified to encourage activity. The NHS should offer greater support to lifestyle modification.”

affordable childcare, nurseries and schools in making this happen. Early action is of particular importance for children and young people with learning disabilities or autistic children where access to assessments and support in the community fail to keep pace with demand.

NHS leadership in this area should include delivery of the Core20PLUS5 approach, which is designed to address inequalities in health outcomes in the population, as well as ICSS fulfilling their wider legal duties to address

health inequalities across services more broadly. Equally important, the NHS has a role in tackling threats from climate change, a global health emergency, by delivering commitments to reduce its carbon footprint.<sup>40</sup>

### What does the shift to prevention mean?

- i. Over time, spending more NHS funding on evidence-based preventive programmes to prevent coronary heart disease and other risks.
- ii. Reaching more people with the greatest risks through better outreach, by innovating in local partnerships with local government and the VCSE sector.
- iii. Supporting, and advocating for, concerted action across government, society and industry to address wider determinants of ill-health.

### Personalisation and participation

The delivery of care should be tailored to the mental, physical and social needs of different communities. And it should draw on the insights and priorities people have for their own care. Personalising care for those from marginalised and disadvantaged communities is essential for addressing health inequalities.

The value of personalised care<sup>41</sup> is increasingly understood, for example using personal health budgets in health and social care and offering choice of where and how treatment is provided, where appropriate. Shared decision making between patients and the clinical teams who care for them is rapidly growing. Advances in tailored medicines and genomics will become increasingly important as they enter clinical practice.

The use of healthcare technologies that enable people to monitor their health and exercise more control over their treatment should be accelerated. Services should be planned in partnership with patients and carers, and their experience should be actively sought and valued by care providers.

Those who responded to the NHS@75 engagement felt that too often, for example, inappropriate medical interventions take place towards the end of life. Patients and carers should be fully involved in decision making about treatment options based on an understanding of risks and benefits.

Throughout the NHS there should be a shared commitment to ‘nothing about me without me’ in the relationship between patients and those who care for them. The carers



and families of someone in ill health or with a lifelong condition told us they do not feel consistently listened to, respected or included. Every change should be assessed by asking, 'will it be an improvement for patients and carers and has it been planned with their needs in mind?'

Making a reality of these opportunities requires changes in culture and practice across the NHS.

Leaders should work with patients and carers to simplify how the NHS works and 'make the right thing the easy thing to do'. This is particularly important as the number of people with multiple conditions increases and patients seek advice and support from different teams.

Helping patients to navigate services and ensuring care is well co-ordinated is essential, with a lead clinician and team as the central point of contact a key foundation. That should extend to social care, given its importance in promoting independence.

Embracing technologies that enable patients and carers to make and change appointments more easily, order prescriptions online, monitor their conditions and receive advice remotely where appropriate is a further important building block.

The NHS should learn from other sectors at the forefront of transforming relationships with customers. Its accountability systems should give greater emphasis to patient experience and outcomes, rather than just the amount and timing of treatment delivered.

#### Insights from our NHS@75 engagement:

"My recovery started when my clinician asked me what I really wanted."

"We need to re-think care in the last year of life, currently resource intensive and heavily medicalised and often not in accordance with patients wishes. Frequent and early conversations with patients would establish their wishes, needs and priorities into the last phase of life. Care would improve and resources [would be] liberated."

"We are failing to have a conversation with our patients and the public about the values they place on healthcare particularly at the end of life."

### What does the shift to personalisation mean?

- i. Giving all patients a greater say, ensuring they can jointly plan their care and share in decision-making.
- ii. Every person requiring complex care has a continuity of relationship with a lead clinician or team.
- iii. Better measuring patient experience, engagement and outcomes in the NHS system of accountability for high quality care.

### From hospital care to co-ordinated care closer to home

As society faces an increase in chronic diseases, the focus of the NHS should shift towards providing support for mental and social wellbeing alongside physical needs. This includes considering the impact of deprivation and tackling the rise in mental health issues following the pandemic.

To achieve these goals, it is essential to allocate resources, including staff, closer to home. By bolstering general practice, wider primary care and community services, individuals can receive appropriate care in their own communities, reducing the need for hospitalisation.

The Fuller stocktake<sup>42</sup> outlined the future direction for general practices based on integrated primary care bringing together previously siloed teams in neighbourhoods. This includes adopting a holistic model of care, reaching out to those at greatest risk. It involves ensuring that primary care has the

digital and physical infrastructure, training opportunities and leadership capacity to fully achieve this blueprint.

The involvement of pharmacists and other staff is important in delivering this vision. It also includes strengthening community mental health teams and their relationships with schools and other services for children and young people. In the future, these services and others can be located in a new generation of community health centres, which can act as hubs for care and wellbeing.

A shift towards a more integrated, co-ordinated and community-centred approach to care means breaking down the historic artificial boundaries between different parts of the health system, especially between primary and community and secondary/hospital care. This includes better enabling discussions of individual cases between neighbourhood teams and specialists.

Virtual wards allow hospital nurses and specialists to monitor patients at home.

In many cases treatment can be adjusted without a hospital visit or stay. Around the world, such hospital at home services have been shown to achieve similar or better outcomes, at greater satisfaction and lower cost.<sup>43</sup> The NHS has recently established over 9,000 virtual ward beds. The potential is much higher still.

As part of this, it will be crucial to enhance the effectiveness of hospitals in delivering excellent treatments, and in their roles as hubs for specialist care, surgery and advanced treatment, and centres of innovation and research. This will play to their strengths and the institutional knowledge and capacity they have developed over recent decades.

Hospitals are community assets too. They are not only places for acute care, but also can provide preventive care, health education and health promotion. By enhancing a community-oriented approach, hospitals can better understand and respond to the unique healthcare needs of the populations they serve and become part of a larger network in their locality.

Care closer to home must involve closer collaboration between health and social care focused on supporting people to remain independent, avoid hospital admissions and to recover after treatment. In turn, that relies on a thriving and supported workforce in social care. With volunteers and VCSE organisations also playing a vital role alongside statutory agencies.

ICSs are now planning for each neighbourhood to have a multidisciplinary

#### Insights from our NHS@75 engagement:

"A significant amount of work is to be done to strengthen primary care, but the NHS is lucky to have outstanding primary care, especially pharmacy services with great accessibility."

"A culture shift – take the service to the patient more rather than expect the patient to come to the service."

"...patients as partners supported to prevent and manage illness close to where they live."

team able to use patient data to anticipate potential crises and intervene accordingly. And there is scope to further develop integrated community-based crisis response services, which includes close collaboration with the ambulance service.

The provision of a range of housing options for people with disabilities and those in their later years is also essential. Continued progress must be made to end long stays in hospitals for people with a learning disability and autistic people, working alongside local authority partners.

### What does the shift to co-ordinated care closer to home mean?

- i. Strengthening primary care and community services in every neighbourhood in the country.
- ii. Better integration with local government services, especially social care; fully implementing the Fuller stocktake; and building a new generation of community hubs.
- iii. Breaking down the historic divisions between primary and community and acute care; and enabling specialists and GPs to work together more effectively.
- iv. Accelerating the current growth of hospital at home services and virtual wards.
- v. Valuing the role of volunteers and VCSE organisations.

# Creating the conditions for change

# 4

**The history of the NHS shows that big changes only happen when a series of different factors enabling change are delivered simultaneously. Individual initiatives, by themselves, will not be enough.**

We have identified seven crucial enablers from our engagement. Each of these would benefit from a plan of action across the NHS, where they do not currently exist, and being part of NHS accountability frameworks.

## 1. Supporting those who provide care

The NHS is nothing without the 1.3 million staff who care for patients. Finding a resolution to the current pay disputes is crucial. All NHS organisations must value and support staff and tackle cultures that work against these objectives by delivering the NHS People Promise.<sup>44</sup> This means rewarding staff fairly, providing equal opportunities to learn and gain promotion and ensuring staff have a voice.

Staff need to be able to work flexibly in an inclusive, safe and healthy environment while supporting each other. We will not efficiently transform health and care outcomes without tackling workforce inequality.

The promised Long Term Workforce Plan should be a notable development to address gaps in supply in the medium term. The Assembly is pleased to have fed into the development of this plan, alongside many others. Those who responded highlighted the benefits of developing such a plan for social

care too. The NHS should also continue to support a significant expansion of volunteering – building on the 400,000 who stepped up to help during the pandemic.

A strong message from NHS@75 was that unpaid carers are the unsung heroes of health and social care and have faced many of the same pressures as staff during and after the COVID-19 pandemic. Better supporting carers is essential and any diminution in their contribution would place even greater burdens on an already over stretched health and social care system. Building on the work done during COVID-19, the NHS should aim to better identify and support unpaid carers, and the Government can increase its support too.

### Insights from our NHS@75 engagement:

“[We need to] build up and support staff so that they can continue to work and do their jobs well, without sacrificing their own health and wellbeing.”

“Often the carers’ agenda is seen as a moral issue, but it’s actually economic. The NHS is doing more work than it needs to because it’s not supporting carers enough.”

## 2. Building partnerships

The NHS cannot achieve the three shifts we have advocated alone. This is why ICSs have such a key role in strengthening partnerships. Local authorities must be at the heart of these partnerships because of their role as community leaders and providers of a wide variety of key services, including social care and public health.

As statutory bodies, ICSs bring NHS organisations, local authorities and other local partners together to plan and deliver joined up health and care services to improve the lives of people in their area. They will need time to mature, but there are already good examples of progress in changing pathways; building partnerships with the VCSE sector and patients and carers; sharing budgets; creating single teams; and collaborating with leading digital innovators.

Partnerships with VCSE sector organisations must now become part of the mainstream to ensure that the best use is made of all assets in each community. This, combined with actively involving patients and carers in developing the health and care system, will ensure appropriate support for minority groups and that the voice of marginalised communities is heard more effectively. The NHS must also find ways of supporting the work of hospices, which play a key role in the provision of care at the end of life.

It is important to recognise the role of NHS and other public sector bodies as anchor institutions with considerable economic and

### Insights from our NHS@75 engagement:

“Operating through systems provides an opportunity for the local NHS to more clearly set out what it is seeking to achieve with cross-sector partners, including industry, and how it is delivering against those objectives... emphasis on delivering against this agenda will generate significantly more productive collaborations between the NHS, local statutory partners, patient organisations, voluntary groups, and the pharmaceutical and life sciences industries to improve patient outcomes and the effectiveness of NHS service delivery.”

“The voluntary sector [VCSE] is close to people and hears their concerns. The NHS improves when it shows humility and listens too.”

social leverage in their communities. Working in effective partnership with others can multiply the NHS’s beneficial impact in these communities and support economic growth and development.

Partnership working is essential for maintaining and accelerating the innovation in treatment and care which has characterised the last 75 years. The UK has a leading life science sector and growing expertise in digital health technology. The opportunity for the NHS is to create an environment which makes the UK the best research and innovation partner in the world, to the benefit of patients, NHS value for money and our economy.

### 3. Harnessing the power of digital and data

Healthcare provision is on the cusp of a data and digital technology revolution. The NHS has begun to take advantage of these opportunities but needs to go further faster.

The COVID-19 pandemic accelerated the adoption of digital and other technologies to enable patients to access care and support remotely. It also demonstrated how data can be used to improve population health in the NHS COVID-19 vaccination programme and in targeting support to groups at risk.

Digital and data are playing key parts in recovery from the pandemic and must be at the heart of how the NHS and its partners work to prevent ill health and meet the needs of people with chronic medical conditions.

Opportunities include creating a fully connected electronic patient record across hospital, primary and community care, with key elements visible to social care. More widespread use of the NHS App to enable patients to access their medical records and services is another important opportunity. Digital means of consulting with care givers needs to be accelerated. Investment is needed in information systems to help identify and respond to need, as well as to ensure interoperability between different systems.

We are already beginning to see how AI can help clinicians identify cancer earlier, make better referrals and identify healthcare risks across whole segments of the population.

#### Insights from our NHS@75 engagement:

“The introduction of virtual clinics is completely changing how people use and access planned services and reducing the need to travel to hospital.”

“The NHS is good at measuring effectiveness and using data, insights and learning to improve patient outcomes. Advances in clinical audit programmes has driven major quality improvements in care and services.”

The NHS in England, as a single national system, is well placed to adopt a strategic approach to the implementation of AI, including the management of risks.

There is a danger that some groups in the population may be excluded by lack of access to digital and other technologies. It is important that the NHS continues to offer choice in how to access care, alongside support to ensure that as many people as possible have access to digital communications and new technologies. Staff training in digital technologies is also critical.

Used effectively and wisely, digital and data are a powerful means of enabling patients and carers to take more control of their health and wellbeing in partnership with health and social care teams.

#### 4. Investment in infrastructure

The shifts to more personalised care closer to home with a much greater focus on preventing ill health can only be delivered in a modern infrastructure.

Building on the recent Government announcements for a rolling programme of capital investment in new hospital infrastructure, the Assembly believes that the NHS needs a long-term infrastructure plan. This plan would complement the Government's commitment to publish an NHS Long Term Workforce Plan.

As we set out in section 2, the NHS@75 engagement process highlighted the way that outdated buildings, equipment and technology are holding back better and more productive ways of working in general practice, community services, ambulance services and hospitals.

ICs are now developing single estate plans for their systems, and these now provide a good basis for a more developed national approach.

An infrastructure plan would include measures to address the current backlog in NHS maintenance, support the modernisation of primary and community care, ensure appropriate investment in modern equipment, and enable the NHS to fully harness the power of data and digital. It should give particular focus to facilitating the shift of care closer to home and to ensuring the NHS has the capacity to respond to shocks, such as a new pandemic.

#### Insights from our NHS@75 engagement:

"Estate improvements and the transition from old NHS estate into newer premises enables the benefits of new technology to offer more services and make primary care fit for the future."

"The level of funding in technology and infrastructure needed to manage the population profile changes created by the successes of the NHS's first 75 years is significant. Lots of our estate and equipment is aging rapidly."



## 5. Maximising the value of care and treatment

All healthcare systems, including the NHS, need to reduce waste and tackle unwarranted variations in care. As a taxpayer funded system, the NHS has a particular obligation to maximise the value of every pound spent. Freeing up resources in some parts of the system is also needed in order to fund greater investment in prevention.

The NHS spends 2p in every pound on administration compared to 4p in Germany, 6p in France and 9p in the USA.<sup>45</sup> But there is scope to improve efficiency further by reducing duplication between organisations.

NICE helps ensure that when new technologies are introduced into clinical practice, they are cost effective. But sustained action on unwarranted variation, for example through the GIRFT programme, has the potential to improve outcomes and release resources.

Poor communication and services that are difficult to navigate waste patients' time and are a poor use of staff time and NHS resource more widely. There needs to be sufficient management capacity to support simplification of services, with associated training. Maximising value also requires leaders being trusted to do the right thing more generally.

Maximising value means not allocating resources to care that provides little or no benefit to patients. Those who responded to the NHS@75 engagement shared concerns that there are areas of unnecessary treatment.

### Insights from our NHS@75 engagement:

"[We should celebrate the] development and implementation of systems, processes, procedures/policies and structures that enhance the effectiveness and efficiency of the NHS e.g. quality assurance, governance and accountability."

'We should consider the ways public funds are spent across some of the NHS organisations that exist. Do we need them all? Can we use our money more wisely?'

They recognised that, at times, less intervention can actually improve patient experience and outcomes, for example in care towards end-of-life.

One promising way of making progress is by involving patients in decisions on treatment options and alternatives. Shared decision making between people and their clinicians about their tests, treatments and support options leads to more realistic expectations, a better match between individuals' values and treatment choices, and fewer unnecessary interventions.

Above all, greater value hinges on investing in general practice, delivering more care closer to home, and intervening early to prevent the onset of ill health. By providing more care in lower cost settings, the NHS will be able to deliver better outcomes with the resources at its disposal.

## 6. Leadership and learning

To make a reality of the changes we have described, national and local leaders must be fully committed to the NHS becoming a more effective learning and continuously improving system. This means ensuring that staff and local leaders have the time, space and support to give priority to prevention and care which is personalised and closer to home. It requires trusting, valuing and training managers who play a vital role alongside clinicians and other staff.

Moving in this direction means acting on the recent report of the NHS delivery and continuous improvement review, now being implemented as NHS Impact.<sup>46</sup> The report put forward ten recommendations consolidated into three actions on how to support the development of a learning and improvement culture:

- Describe a single shared NHS improvement approach.
- Co-design with health and care partners a leadership for improvement programme.
- Establish a national improvement board to agree the small number of shared priorities on which NHS England, with providers and systems, will focus improvement-led delivery work.

These actions are aligned with the new Operating Framework for NHS England and the Hewitt Review, and they recognise the need to strengthen horizontal and bottom-up

### Insights from our NHS@75 engagement:

“Trusts and staff need to be empowered and supported not just to better manage day-to-day pressures but also to continually focus on how to improve the way they deliver care in the future. Within NHS organisations we need cultures of openness and transparency so that staff and patients feel empowered to raise concerns and are reassured that their concerns will be acted upon – while also needing to learn from when care goes right, rather than just learning from when things go wrong.”

“We don’t transform – we bolt an addition on. How do we change some of our models so that it’s true transformation, rather than just adapting a traditional model.”

approaches to improvement to enable the NHS to reform from within. Expertise in think tanks, royal colleges and other organisations should be harnessed in the delivery of NHS Impact.

The most advanced ICSs are actively progressing their efforts to enhance care within and between systems and strengthen collaboration. It is important to recognise that these developments are still in their early stages and will require time and perseverance to become fully ingrained.

As this happens, NHS England must demonstrate unwavering commitment to promoting learning and continuous improvement as the means of addressing performance challenges in all systems and organisations, including those facing the greatest challenges. The effectiveness of NHS Impact will ultimately depend on leaders embracing cultural change at all levels. At the same time, leaders should be leading all of the people all of the time, and yet we know that parts of the workforce often have poorer experiences in the workplace.<sup>47</sup> We must do more to increase accountability for inclusion.

Getting the basics right by supporting operational and clinical leaders to put in place and sustain established best practices in service delivery is essential. This includes work on admitting and discharging patients to and from hospital, managing demand for care in general practice, and tackling variations in clinical care described by GIRFT. Partners outside the NHS, for example in local government and the VCSE sector, have a key role to play in this work.

The many examples of change that occurred in the first 75 years of the NHS were possible because of innovation and research. There are multiple opportunities to do that now, working with universities and industry. In doing so, the NHS will make a positive contribution to economic growth.

## 7. A new relationship between the NHS and the public

Running through the changes we have described is a golden thread: the need to see people and communities as assets with a positive contribution to make in improving health outcomes and care. Instead of being passive recipients of care, the public should be supported to play an active role in their health and wellbeing and care. At a time when chronic medical conditions are becoming more prevalent, there is much scope for people to share responsibility for managing their own health, in partnership with health and care teams.

Shared responsibility is different from personal responsibility, which can fail to recognise that people's behaviours are influenced by the environment in which they live and work and the resources at their disposal. It challenges over dependence on health and care professionals by seeing people as partners in the therapeutic relationship. Shared responsibility recognises that our active participation is essential in improving health outcomes and care delivery. It also recognises the important role of central and local government in tackling the wider determinants of health and providing leadership in improving the health of the population.

An example of shared responsibility is the work of general practices which in some areas have coached patients with type 2 diabetes to make changes in diet and other behaviours to achieve remission. Many practices use group consultations with patients who have the

same conditions and draw on the expertise of patients alongside the professional skills of clinicians. Self-management support is another way in which people are being encouraged to take an active role in their care alongside peer counselling and support.<sup>48</sup>

The NHS Assembly believes that these ideas can be taken forward with a compact with the public setting out what people can expect and what they can contribute – the reciprocity that remains vital to the NHS and its future.

On the NHS side, this involves all that is set out above. Taking services to where they are needed. Involving patients in decision making. Providing choice over treatments, where there are different options, including end-of-life care. Working hard to integrate all aspects of social and health care better, with a key aim being to make both systems easier to navigate. Tackling health inequalities. This reinforces the existing NHS Constitution, which includes the promise that all patients, regardless of ethnicity or culture, will be treated with compassion, dignity and respect.

On the public's side, there needs to be the reciprocal promise to treat staff with the respect that patients themselves expect. To use services wisely and recognise the contribution they can make to care delivery in partnership with staff. Beyond that, people need to be willing, as far as individually possible, to adapt their own engagement with the health service as it changes, both digitally and in other ways, and recognise that, in any healthcare system, there are limits to what can be offered.

ICs are well placed to engage the populations they serve on what a compact should include and how it can be tailored to the needs of different communities.

## Next steps

There is growing agreement that the shifts set out in this paper, and the conditions for change needed to deliver them, are the right ones. That growing agreement is shared at local and national level, across those who use services and those who provide them, within the NHS and amongst its partners. The task for the coming years, as the NHS fully recovers from the pandemic, is to align this consistency of purpose with concrete delivery of change.

The history of the NHS is replete with examples of plans setting out powerful visions that have not been delivered. Trusting leaders and staff across the NHS and building on lessons from the COVID-19 response offers the best prospect of avoiding this happening.

In a complex, adaptive system such as the NHS, leaders must be agile in responding to events and adapting to challenges as they arise. In doing so, they need to work collaboratively with partners, patients, staff, volunteers and unpaid carers. By embracing the ideas

expressed here, the journey of renewing the NHS for the next generation can be accelerated now.

By the end of June, all Integrated Care Boards (statutory boards that bring together all NHS providers in a local area to plan and manage health services for that area) will publish their first Joint Forward Plans. These will outline the strategic aims that they have agreed with their partners for the next five years. We expect that these will echo the key shifts we have set out here, although tailored for local services. Some of the thousands who took part in our rapid engagement work will themselves be working on delivering plans locally.

The Assembly will continue to draw on the insights gained from the many thousands of people who took part in the NHS@75 engagement, explore the key challenges and shifts outlined in this document and advise and support NHS England in taking forward the necessary changes.

# Endnotes

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