Putting the national, the health and service into NHS

The whole country is concerned about the developing situation with coronavirus – covid-19.

We are doing everything reasonably possible to keep the public safe.

I want to start by praising the exemplary response of my officials, Public Health England, the whole NHS and the wider health system.

Earlier the Chief Medical Officer Chris Whitty set out our plan to contain, delay, research and mitigate the virus.

That plan will be driven by the science and guided by the expert advice of Professor Whitty and others.

Tackling this virus is imperative and it's taking up the overwhelming proportion of my time.

While we grapple with the virus, I am determined that we don't take our eye off the long-term challenges that we also need to rise to, and the long-time changes that we need to make to our healthcare system to make it the best it can be.

Delivering our manifesto commitments including 50,000 more nurses and 40 new hospitals. Addressing the priorities of people, infrastructure, technology and prevention.

So today at this conference I want to ask this big, long-term question and formally set the health system a new goal.

The question is, how do we ensure that in today's world there is always public confidence in the NHS?

In a speech to the Royal College of Nursing in 1948 Nye Bevan gave a famously gloomy assessment:

He said: "we shall never have all we need".

"Expectation will always exceed capacity".

The service "must always appear to be inadequate".

Now I am generally sceptical of those who say 'this time is different' but today I want to argue exactly that.

My argument – and I appreciate this is a dangerous thing for a Health Secretary to say to the Nuffield conference – is that Bevan was wrong.

The service does not always have to 'appear to be inadequate', either for

patients or staff.

This time can be different.

And the reason is that today's technology – unlike previous technological advances – allow us to do more in healthcare at lower cost.

Now I don't think that's ever been true before in the history of the NHS.

There have been amazing advances like heart transplants and chemotherapy that have allowed us, at greater cost, to save more lives.

Those are good technologies. But the power of modern technology is that it allows us to improve outcomes and cut costs.

Radiology in the cloud is cheaper and faster than a system based on couriers and CD-ROMs for example.

And while technology on its own solves little, technology that clinicians want to use because it meets their real-world needs, designed with their input, done with them and not to them – this has game-changing potential.

And we know because we can see it right across every part of the economy and we can see it in parts of the NHS.

Get it right and by the end of the decade we can have an NHS that functions as a platform rather than a set of loosely aligned, disconnected incommunicative silos, an NHS focused on preventing sickness, not just treating it, enhancing life, not just prolonging it. Where staff do more of what they came into medicine to do – caring, treating, healing the human things that a computer could never replace – because we've removed or improved the grind of routine process.

And to make that happen, we need to change the way we think about how change happens in the NHS.

Now policymakers love the idea – and I can tell you it's tempting – that change is something to do with top-down reorganisations and big bang structural reforms.

It's why the last couple of decades are littered with failed attempts to 'transform' the NHS by structural reform from on high.

But guess what? It's not all about us policymakers!

The answer to better healthcare lies less in complex reforms cooked up by the centre. We've tested that idea to destruction.

It lies in millions of incremental improvements, carried out at every level of the service, every day by people who feel and are empowered to make things better in pursuit of a common goal.

The small tweak to a process that improves patient flow.

The trust that saves hundreds of hours of clinical time with access to real-time test results for example.

The streaming that manages record demand on our A&Es.

These are the things that transform the NHS.

It doesn’t happen on its own.

It requires strong accountability.

It requires the right data so the system can constantly learn from itself what works.

It requires the resources: including the record £33.9 billion funding increase now enshrined in law.

And it requires trust. Trust in clinicians to make those improvements. Trust in local systems to serve their population as a whole. Trust in patients to play their part in their own health.

That’s how change happens in big organisations like the NHS.

But this method of marginal improvements requires people to also have a common mission.

My case is that we must free people up to innovate, and in all the large organisations where freeing people to innovate has worked it’s because they’ve had a common goal.

Two goals for the NHS

So today, I want to set 2 goals for our healthcare system – not just the frontline NHS but the system in its broadest possible sense. The department, the central bodies, social care and the ecosystem that surrounds them.

One is a clinical goal, the other a goal of ‘user experience’.

Both are equally important. Each reinforces the other.

The ultimate clinical goal is to increase healthy life expectancy in this country.

As a nation, we have set the goal of 5 more years of healthy life expectancy by 2035.

Not just adding years to life but life to years.

But this clinical goal is not enough on its own.

Everyone in the NHS goes to work to serve patients, not just to treat them.

Indeed, the whole NHS serves our country just by existing, by giving peace of mind to everyone, even if you very rarely use it.

So the second goal I want to set is to increase public confidence in the NHS.

Confidence that the NHS will always be there for us. That the NHS will look after us and care for us with dignity and respect. That it will treat me as a person with a history and a future, not just a series of unconnected clinical episodes.

Now public confidence is not the same thing as public support – important as that is – or even public satisfaction with the quality of an individual treatment.

How you're treated at reception, whether staff have pride and the hospital is tidy, whether someone explains to you what's happening and keeps you properly updated.

These things might not matter from a strictly clinical point of view, but they should matter to an organisation paid for entirely by the public and which exists to serve the public.

I want to draw a parallel to what's happening on coronavirus right now. This approach is working.

It is an explicit goal not just to tackle the disease but to maintain public confidence.

We should take this same attitude to health services in normal times too.

In the second quarter of 2019 the NHS received 50,000 written complaints on various subjects. What was the one subject that accounted for the largest proportion of complaints?

Communication.

So I'm setting the NHS the challenge that it should be as good at process and admin as it is at medicine, that if you've got a chronic condition you shouldn't have to carry a ring-binder of notes from one appointment to the next because your provider can't access your full medical record.

That we shouldn't be asking you to make a stressful journey into hospital when you could get the same result at home using modern digital tools.

That when you're notified of an appointment it should never arrive after the appointment was meant to take place. That is one of the most frustrating things and it happens right now.

The National Health Service must be just that.

The National. The Health. And the Service.

Not just a hospital system but a service for the nation's health.

So I want to take each of these in turn, because they are all important.

National

Let me take these 3 in turn: national first.

Loving the NHS is a part of our national identity.

We love it because it's always been there for us, unconditionally, through some of the best moments in life and through some of the worst.

This is what maintains the public support for the NHS.

As the Prime Minister puts it, it's like the whole country figuratively gathering round your bedside when you fall sick, doing everything it can to make you well again.

But that shared ideal is one of the few things about the NHS that is truly national.

Because the NHS is not some centralised command-and-control state like Bismarckian Germany.

And I can assure you as Health Secretary I know that.

It's more like the Holy Roman Empire: a story of fragmentation, duplication and high levels of regional variation.

There is no single national NHS back office for example.

Local providers have their own teams and systems for every conceivable non-clinical activity, from booking appointments to registering patients to organising staff rotas to ordering medical supplies – with massive duplication of effort.

Nor is there a national data architecture.

I first discovered this through personal experience – like many people do.

My sister had a very serious accident just before I became Health Secretary and a near-fatal brain injury.

She received amazing, life-saving care at Southmead hospital in Bristol. She underwent 6 months of rehabilitation. And when she went back to her GP to get approval to reapply for her driving licence, despite having known her all her life, her GP had no idea – no record – no details at all.

That is not a unique experience, it's an everyday occurrence.

And when I say national there's another aspect to national we need to look at – let's look at national health outcomes.

We have a chequerboard of local variations.

Take healthy life expectancy. I think this is a very serious problem.

A person born in Wokingham can expect 72 years of healthy life. In Nottingham it’s 54 years.

In Blackpool, 1 in 4 women smoke during pregnancy. In Westminster, it’s 1 in 50.

So this is the first part of our project.

In the 2020s we must make it our mission to put the ‘national’ back into the National Health Service.

At the patient-facing end of the service that means levelling up access to healthcare.

Ending postcode inequality so for instance your chance of seeing a GP doesn’t depend on where you live.

Not just delivering the 50 million more GP appointments that we committed to in the manifesto but making sure they’re focused on where they’re needed most.

Being a national service means having consistent standards that all patients can expect.

You want local variation where there’s variation in local conditions.

It will be a central task of the new Integrated Care Systems in every part of the country to take into account local conditions when improving the health of their populations.

But we need less unwarranted variation in both commissioning and delivery of services.

Why should 3 cycles of IVF be allowed in some parts of the country while some parts offer none?

A local part of the NHS deciding it’s OK not to offer IVF, with no accountability – it’s absurd and it’s unacceptable in a national service.

It also means having a platform approach to the way we deliver some of things like the back office.

Building once at the centre where it makes sense to do so, so suppliers and commissioning bodies don’t have to recreate the plumbing each time.

Look at NHS Login, our national ID assurance platform.

It supports a growing ecosystem of new digital services, from GP appointment bookings to remote consultations to digital maternity services – all of which require you to prove who you are.

We’re also looking at a consistent way to identify staff across the system.

But the most impactful and clinically useful platform we can create is a

national data architecture for the NHS.

It’s a massive opportunity: for patient experience, clinical excellence and the next generation of research.

Fixing this is not, repeat not, about building a single, giant centrally owned patient database in the basement of NHS England.

Instead it’s about creating an architecture so systems can talk to each other and so data can be safely accessed where it’s needed.

We need the whole country to be covered by local shared care records. We need those shared care records to be able to speak to each other with common standards, we need clinicians to have the trust and confidence to use them.

And I can announce that we’ve just published our new draft digital health technology standard.

Designed to make it easier to commission great new digital health services, it requires developers to follow our standards on interoperability if they want us to buy their stuff.

There’s much more to come.

And today we’re kicking off engagement on our Tech Plan for health and care, setting out how technology will support delivery of the NHS Long Term Plan.

This includes establishing what good looks like for all forms of tech-enabled care, clarifying who pays for what, and what we need to do to drive these improvements.

I would urge you to all get involved, everybody, whether you’re interested in technology or not, because developing this plan should not be left to us at the centre – it’s too important for that.

There will never be a big bang moment when we flip a switch and the problem is solved.

Like all genuine improvement this is an incremental, iterative process.

Done right, this approach must be entirely embedded in evidence. It’s about what works. And the evidence is abundant, it’s strong and it’s growing. Bringing technology in the NHS into the twenty-first century works. Modern use of data works.

Ignoring that evidence is as much of an error as blind faith in technology.

So I’m determined to drive this agenda because if we get the technology and the data right, we can do incredibly powerful things in health.

Which brings me to the second letter in NHS – H for health.

Health

According to the best evidence we have, only around a quarter of what leads to longer, healthier lives is the result of what happens in hospitals.

The remainder is down to genetics, the environment and the lifestyle choices that we make.

As a healthcare system, we actually have strong track record on improving both the broader determinants of health – the inputs – and health outcomes.

So smoking rates in Britain have halved in the last 35 years and we now have one of the lowest rates in Europe.

We lead the world in managing long-term conditions like diabetes, with fewer than one in a thousand patients being admitted to hospital in a given year.

Deaths from cardiovascular disease have halved since 1990, cancer survival is at an all-time high, male suicide is at a 31-year low.

We also have some of the finest public health officials in the world and I'm very grateful for the work they've done on our response to covid-19.

But we can and must go further.

For most of its 70 years, the NHS has been focused on curing a patient of a single illness, putting ever more funding into big acute hospitals.

This has had an impressive impact on lifespan over the past 70 years.

Yet as it enters its eighth decade, as we've seen those increases in lifespan start to slow, it's clear the NHS needs to focus more on health-span: the number of years a person can expect to live healthily and independently.

Prediction and prevention are mission-critical for delivering on those 5 extra healthy years of life.

This is partly about getting smarter in the way we use NHS resources.

Things like dedicated alcohol care teams in hospitals with the highest rates of alcohol-related admission, or quit-smoking help targeted at CVD patients.

Modernising the IT systems on which our national screening programmes are delivered, so they're easy to use and no one gets left behind.

Putting more resources into primary care and community care, and asking our army of pharmacists to do far more to keep people healthy.

Or rolling out non-drug therapies through social prescribing, right across the country.

But this approach is also about recognising that not all the answers are in the NHS.

That we need cross-government action on air pollution, properly insulated homes and urban design that supports cycling and walking.

People have been talking about the need for more prevention since the 1950s. So again you're entitled to ask: why is this time different?

Firstly because we have more and better information than ever before.

A lot of it is distributed outside the system, on Fitbits and smartphones and other internet-linked devices.

We're also creating increasing amounts of genomic data, including our project to sequence 5 million genomes.

Having all that data matters because there are still big gaps in our knowledge about what works and for whom.

Take drug responsiveness.

A few years ago, Professors Eric Topol and Nicholas Schork put together a study showing the responsiveness – the intended clinical response – of the top 10 drugs by gross sales in the US.

It shows that overall, 75 percent of patients receiving these drugs do not have the desired or expected benefit.

This ranges from only 1 in 5 patients with schizophrenia deriving a benefit from the market leading schizophrenia drug, to only 1 in 16 patients with multiple sclerosis.

This is known as the 'number needed to treat', which means the number of patients you need to treat to prevent one additional bad outcome.

Until we can safely use all the data that we hold about individual patients, that number will remain stubbornly high.

Cancer is another example.

Major trials funded by the NIHR show that many people given surgery or radiotherapy for prostate cancer will do no better than those without treatment.

But we don't know which people in advance.

If we can marshal all the data about a patient, then we can treat each patient as an individual, finding the treatment that's right for them.

Bringing the 'number needed to treat' closer to one, saving the NHS and patients the cost and pain of unnecessary treatments.

So that's the first big change we can harness.

The other big difference is that we now have the computing power and the artificial intelligence to do the marshalling.

Already, AI can perform as well as human radiologists at detecting certain cancers.

AI developed at MIT recently found a new antibiotic for tackling drug resistant microbes.

This is why we've set up a £250 million AI Lab in the NHS to identify and scale the most promising technologies and crucially, to get the regulation right.

By the end of the decade we need doctors to have all the relevant data about the patient in front of them, not just the patient's full health record but genomic data, any self-generated data they want to volunteer, and data on similar cases.

We need them to have the AI and other decision-support tools to process that data, and we need them to have the right training to understand it all.

It can be done. It is being done in the most advanced parts of the NHS. We need to turn the NHS from a national hospital service to a health service. Making sure that we're focused on the health of the patient.

Service

And that brings me to the third part of the NHS: 'S' is for service.

I've drawn a deliberate distinction between health and service.

Between clinical outcomes and public confidence.

To help explain what I mean, I want to tell a story.

I mentioned the problem of different care settings not being able to access vital patient records.

At Barts in East London, they've solved that problem for chronic kidney patients.

It works like this.

The renal unit at Barts have a data-sharing agreement with 160 local GP practices, allowing consultants to remotely view full GP records with patient consent.

It means they can see a patient's creatinine levels over time – a crucial indicator of kidney health – as well the medical history, co-morbidities, past hospitalisations and so on.

Following review of the notes, the consultant records her advice on Barts's system and the practice gets a notification.

The small minority of patients who need further investigation then get triaged into traditional face-to-face clinics.

The vast majority of patients don’t ever have to go to hospital. And they get reviewed much faster.

Before the virtual kidney clinic started, the average time from referral to first outpatient appointment was 64 days.

Now the time between referral and assessment is less than a week.

It’s too early to say if it’s improved clinical outcomes.

But that is not the point of the exercise. The point is to improve the service.

Because if you’re in a nursing home with chronic kidney disease, then getting into central London to go to Barts can be a real ordeal.

The virtual clinic improves patient access to the NHS, while removing the whole rigmarole of arranging transport, travelling in, worrying about tube delays, tracking down missing referral letters and sitting around in waiting rooms when you’re not very well.

Not only did patients enthusiastically consent to their records being shared but like all the best service improvements, they were amazed that it wasn’t already happening.

There are loads of other areas where we can make the service better.

As I said, the medical advances in the NHS are amazing but the process advances are far too slow.

Royal Mail should not be the default mode of communication between patients and providers.

Patients should have access to their own medical records. We know it improves the quality of the data and where they spot a mistake, it can be lifesaving.

University Hospital Southampton give their prostate patients real-time digital access to their PSA results as soon as they come out of the lab, unmediated by a physician.

It’s incredibly popular, even among older men with less digital experience. And the reason is that people want to manage their own care.

And wherever possible, healthcare should come to you before you have to go to healthcare.

This is not as radical as it sounds.

And I know there are some people who scoff at this agenda. But let me give you one example that we now take as read.

Thirty years ago you had to go to a doctor to get a pregnancy test. Now you take the test yourself before you go to the doctor. Of course you do!

It’s not just about the technology.

Our capital building programme is about ensuring the best possible service for patients, as well as clinical outcomes.

Because patients don’t only care about the clinical treatment.

They care that the hospital looks smart. That it’s clean. That staff are friendly and well-motivated. That the food is good, and that they were told clearly what is going on.

These are the things that matter to patients, and they need to matter to every single person who works in the service. For the NHS is a service or it is nothing. And we are at the service of our nation.

At Great Ormond Street they now note a child’s favourite food or football team to help busy staff make a connection with the child. A simple change that can make an incredibly stressful experience just a little bit easier.

So there you are.

The NHS. Our National. Health. Service.

To entrench and underline the central importance of that sense of service – that’s why I’m setting today the explicit goal of raising public confidence in the NHS.

This is a hugely ambitious and exciting agenda. Everyone here has a part to play.

It’s first and foremost about people: about how we get the most out of the people who make up the NHS – how we motivate, incentivise, support and train our people. I’m proud to see the staff survey results moving in the right direction.

It’s brilliant news that we’ve increased the number of nurses in the NHS by over 8,000 in the last year alone.

And with the People Plan we will set out yet more how we can support every single person in the NHS to reach their potential.

It’s about infrastructure, fixing the roofs and getting the modern buildings we need to deliver modern services closer to home.

It’s about prevention of ill health to reduce pressures on the system.

And yes it’s about technology, because there are historic problems that we can now fix by bringing the technology of the NHS into the twenty-first century.

We all know that demand and expectations are rising. We can’t afford to stand still.

To reshape our health service we must harness the resources that the modern

world can offer.

And deliver a National. Health. Service. Of which we can be proud.