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FEATURE

# What if the NHS moved most care out of hospital?

Last year the King's Fund ran an essay competition for contributions to its series"the NHS if," exploring hypothetical futures for the health service. Here, we publish the winning entry by **Sue Brown**

Sue Brown *former head of public policy, Sense, London, UK*

I'm sitting in the coffee shop of my local primary health centre. In the corner a nurse is chatting to a man over coffee. They have some forms on the table. I guess that she's helping him claim benefits, and no doubt slipping in some healthy eating advice as they talk.

On the noticeboard is a photo of the closure of another ward in the local hospital. There was quite a crowd cheering as the local MP drew a curtain over the door in celebration of another sign of the success of moving care closer to home. I'm old enough to remember it wasn't always like this; years ago, the crowd would have been waving placards in protest. I tried to tell my grandchildren this but they didn't understand. "You mean people wanted to be in hospital?" they said, incredulous.

The change all started with the election of the second coalition government. Those were difficult times. Home care agencies were closing, and the government had to step in to prevent the complete collapse of social care in three areas in just six months. It was taking four weeks to get a general practitioner appointment, and several patients died in ambulances queued up outside overcrowded emergency departments. Something had to change, and the new prime minister didn't duck the issue.

Mind you, it wasn't all plain sailing. The public took a while to get used to an honest government telling them truths they didn't want to hear. The first thing, of course, was the money. No one liked the increase in taxation, and no one believed the prime minister when she said this would be temporary. But we weren't going to be able to reduce hospital care unless we invested in the alternative, so the taxes went up and the investment began.

The Taxpayers' Alliance complained that there was oversupply in the home care market and care workers being paid with nothing to do. But people no longer had to wait for care to become available before they could leave hospital. The prime minister stood firm, and slowly the hospitals began to see their work come back under control.

## Investment in communities

The real trick, the secretary of state for health said, was to stop people needing to go into hospital in the first place. That meant investing in health and in wellbeing. Once the pressure for sustainability and transformation plans to deliver unrealistic savings was removed they started to drive innovation and change. Partnerships between primary care and local government started investing not just in community services but in communities. My local general practice now employs two community development workers, who support a network of neighbourhood connectors.

The cafe is suddenly filling up. A group has just finished on the practice allotment, and the health adviser is chasing out someone who didn't leave his muddy boots at the door. People are arriving for the local blind association re-enablement session in the community room. Briefly, there is chaos and laughter as the two groups try to get a coffee and find a place to sit. Of course, there were some surgeries like this even back in 2016, but now they are the norm. Care Quality Commission inspections focus on integration, social prescribing, and community connectedness. Failing on these is the fastest way to get a "requires improvement" rating.

The acute trusts went along with the changes for a while, but the long term plan was that the investment would allow savings in future. Once community services were established, that meant taking money out of hospitals. Doctors' strikes had huge public support, but the government held firm and the first few hospital wards closed. There was no return to the queuing ambulances outside emergency departments, and people did not die waiting for an operation. Slowly the culture changed. Hospital doctors realised that primary care was a more interesting place to work, and gradually it started to be seen as more prestigious. Most trainee doctors now aspire to work in general practice, so much so that there are too many GPs chasing too few vacancies while hospitals struggle to recruit.

As I sit here, people come to reception to book appointments with counsellors, practice nurses, and physios. Occasionally with the GP. Unless there is a good reason to book ahead you will see the GP on the same day. Two men approach the receptionist. I recognise one of them as a health peer mentor, one of the successful innovation schemes here. Practices that don't innovate are penalised financially. Practices that do are expected to rigorously assess their innovations and publish the learning from failure as well as success. The secretary of state has put a lot of emphasis on learning from failure.

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One thing that did surprise me was last week's election result. During the campaign, everyone was expecting the prime minister to promise tax cuts, now that so many of the savings have been banked. Instead, she promised to sort out the final barrier to integration of health and social care—means testing. Despite everyone's best efforts it is still necessary to classify every intervention as either free NHS care or means tested social care. As the two systems became better integrated, this is more and more difficult. The legal challenges are now the last bastion of unnecessary bureaucracy in the system. So the government went into the election with a promise to take all but the very rich out of the means tested social care system rather than to cut taxes. Astonishingly, they won—just.

Back in 2016 people thought this an impossible dream. But the changes in the system now mean the cost is more affordable, and people have got used to paying the higher tax and have seen the benefits of investing in health and social care. So the means testing social care bill will now be the top priority for parliamentary time this year.

## More than a pipe dream?

Imagining this at the very start of 2017, there seems little hope that any of it could become a reality. Across the NHS and social care there is no shortage of people working to transform the system. But I believe there are two things missing that will always hamper their efforts: money and political will. For a shift to community based services, investment in the alternative must take place before existing services are reduced. We need a government that is willing to be honest with the public and to promote the idea that paying to fund that investment is worthwhile. We also need a government willing to put in the right incentives—financial and otherwise—that will drive transformation and support innovation. Perhaps we also need a public willing to face up to the reality that the NHS they want costs money; that the NHS we need doesn't look like the one we have now. In this post-truth world that might be the hardest nut to crack.

Sue Brown joins the Arthritis and Musculoskeletal Alliance as chief executive this month.