North East Essex NHS
Primary Care Trust

Fit for the future: 21st century public services that promote health and wellbeing

Workbook

Professor Paul Stanton

Issues for contemplation and exercises for completion by members of the Futures Group and critical friends before the workshop on 1st June, 2007

'Salus populi summa lex esto.'

(Let the good of the people be the highest law.)

Cicero

Written by Professor Paul Stanton

Concept, editing, design and layout by Pip Hardy, Pilgrim Projects

Contents

Introduction

The purpose of this workbook

'If you want to build a ship do not gather men together and assign tasks. Instead teach them the longing for the wide endless sea.'

Antoine de St Exupery, 1943

This workbook is intended to help you prepare for the Futures Group workshop on 1st June, 2007. Its purpose is to prompt reflection upon, and analysis of, some of the issues that need to be kept under ongoing critical review if local services are to become and remain fit for the challenges that they have inherited – and which will confront them over the next decades. It attempts to encourage and support creative engagement with complex realities and perplexing uncertainties.

The following sections invite you to consider how the interactions between global, national and local social, economic and technological factors shape need and determine patterns of provision. They also set out the nature and scope of the public sector reform agenda and the key roles and functions of 'new' PCTs and encourage you to engage with some of these issues, and to add your own thoughts, feelings and questions, ahead of the Futures Workshop on the 1st June, 2007.

The Futures Group workshop on 1st June

The three key outcomes from the workshop will be:

- a coherent but flexible vision of the nature of local community need by the mid point of this century and, in particular, how health provision can make its contribution
- a description of the characteristics that the local NHS, working with other public services, will need to develop and sustain in order to promote health and wellbeing and cope with the on-going demands of disease management and social vulnerability/dysfunction in the face of financial constraints
- the basis of an action plan to ensure that the PCT's five year strategic plan is informed by and aligned to this consensual future focussed vision.

The Patient Voices Programme website

www.patientvoices.org.uk

The workbook includes many experiences of patients and carers (captured in the Patient Voices digital stories) to ground this speculation in concrete – and sometimes painful – current realities.

Section 1: The public sector inheritance

Most of us have grown up within the Welfare State and the NHS – they have been part of the fabric of our lives. Despite all of their imperfections, they are an essential and integral part of the fabric of English and UK society.

If you have not already done so, please go to www.patientvoices.org.uk, click on 'The Stories' tab, and watch the following stories:

David Clark's 'Wonderful experiment'

Ian Kramer's 'Introduction'

Now jot down your overall experience of and reaction to the NHS and/or our other public services.

All the stories mentioned in this workbook, and many others, can be found at the Patient Voices website: www.patientvoices.org.uk Please click on 'The Stories' tab at the top of the page and following the links in the left margin.

You will need a computer and Windows Media Player to view the stories. instructions for Apple Macintosh users are given on the website.

If you have any problems, or you would like the stories on a CD, please contact Pilgrim Projects on +44 1223 440257.

The Welfare State and the NHS were born in 1948 out of adversity. At the time they were, rightly, described by Aneurin Bevan as:

> *'the most radical reforms attempted anywhere in the world … guaranteeing to all citizens care from cradle to grave'.*

In an austere, economically-depleted society ravaged by two wars, these reforms were an expression of a determined and largely consensual conviction that a more just future could be created – one from which the five evils of idleness, squalor, want, ignorance and disease – could be banished forever. (Beveridge Report: 1942)

The Minister of Health, Aneurin Bevan, with the 'first' NHS Patient Sylvia Beckingham (age 13) at Park Hospital (now Trafford NHS Trust) July 5th 1948

The post-war welfare consensus did not hold. Within three decades of its creation, the Welfare State and the NHS had become ideological touchstones that polarised political opinion: they were reified and deified by the left, derided and castigated as symptoms of 'interfering nannyism' by the new right.

Inescapably, the NHS was caught up within the social, economic and structural upheavals that characterised UK society in the eighties and nineties. It became a key electoral battle-ground as political parties sought to extract advantage from its perceived successes and alleged failures alike. Starved of resource (according to *The Wanless Report on Social Care*, there was a staggering £230 billion under-investment from the 1970s onward), subject to proliferating structural re-organisation and media criticism, patient care and staff morale inevitably suffered.

'Fifty years later, Sylvia Beckingham was to remember

"The higher echelons of the medical world and the establishment were on the whole agin' the poor man, but it didn't stop him, so he must have been a giant,"

and to reflect that

"The NHS is fantastic - it's an incredible structure. When you really think about it, there is no one else in the world who has anything to come up to it.'"

It is tempting to hark back to a 'steady state' when the NHS was left to get on with the business of promoting health and managing illness. But it is important to recognise that the current Government's commitment to profound public service reform is the latest manifestation of a process of re-conceptualisation of the Welfare State that began more than three decades ago. The massive increase in expenditure on the NHS in the last five years was intended both to offset historical neglect and, at the same time, to pump-prime profound reform – a reform that, notwithstanding specific and striking improvements has not, thus far at least, been delivered.

'Coping with constant organisational change – at the same time as having to go on responding to the unchanging nature of human need – has left many professional staff feeling lost in familiar places.'

Shapiro & Carr, 1996

In the light of this perceived failure to deliver, the pressure for NHS and public sector reform is unlikely to diminish. Though a Gordon Brown led administration is likely to be prepared to look again at some of the levers that have been employed, the overall aim is like to remain. Indeed this aim enjoys broad cross-party support, despite inevitable disagreements about pace and means. As a result, reform needs to be understood as an on-going and inescapable process – not as an encapsulated or time-limited event. It is a process that will impact upon all NHS and other public sector organisations and all services – arguably with accelerative force and problematic implications.

'There is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things.'

Nicolo Machiavelli, 1513 The Prince

What, in your opinion, are the three top priorities for improvement and reform?

1

2

3

'There is a strong argument for driving reforms forward faster not slower .That is what we need to do.''

David Nicholson, NHS CEO 'Right On With Reform' September 2006

As you begin thinking in more practical terms about the future-focussed priorities for improvement, there are a few questions you might like to consider. You may like to remind yourself of the A, B and C framework, on page 6 of the Executive Summary as you think about these issues.

1 What needs to be done in order to prepare for the future? You may find it helpful to look at the inherited strengths and weaknesses of the new PCT.

Strengths	Weaknesses
1	1
2	2
3	3

Opportunities	Threats
1	1
2	2
3	3

2. How have these been identified? (Identify areas such as audit, clinical governance, significant events analysis and risk assessment, collaborative working with public sector and other partners.)

3. How do these reflect priorities in the wider NHS, within the Health Authority and the PCT? Not every item has to reflect all these priorities of course, but it is essential to be mindful of external priorities.

5. How will the PCT judge its success?

Section 2: The public sector reform agenda

The Cabinet Office (2007) has defined the characteristics that it requires from all public services. They should be, as the diagram below suggests:

- universal
- efficient and value for money
- equitable
- excellent and innovative
- empowering
- responsive.

Figure 1: Citizen-centred public services

There appears to be a broad political consensus in relation to these aspirations, albeit there are differences in relation to how these aspirations can be realised. However, Government believes that, notwithstanding specific improvements that have been achieved within specific and targeted areas, further profound reform is needed if the quality and responsiveness of public services is to match (or outstrip) improvements made in other sectors of the economy.

If these aspirations are to be translated into concrete realities 'on the ground', a great deal remains to be done – not least within the NHS. In the words of the Prime Minister's Personal Adviser on Health (Paul Corrigan, 2006) 'in making a patient-centred NHS a reality, we are starting from a very low base'.

'The imperative for reform is urgent and growing. People want more from their public services, to match the choice, customer service and personalisation they can get from their bank, supermarket or on-line shopping …Now is not the time to rest on our laurels; now is the time to step up the pace of reform.'

Patricia Hewitt, 2005 Health Reform in England: Update and Next Steps

Please go to www.patientvoices.co.uk and follow the link to 'Reconnecting with life: stories of life after stroke'. There you will see Andrew's story: 'Fast, appropriate responses'.

Please watch the story, and then give some thought to the questions below.

1 To what extent was Andrew the recipient of 'citizen-centred' care?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

2 What is your own view of the stated aims of achieving 'citizen-centred public services'?

3 To what extent do you agree that (in relation to the NHS or other services) 'we are starting from a very low base'?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

4 To what extent are such issues discussed by the new PCT Board?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

5 To what extent are these issues the subject of discussion and debate within the wider health and social care economy in North East Essex?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

A number of commentators, whilst accepting the case for reform, point out that successive governments need to shoulder responsibility for a number of key shortcomings in public service responsiveness to local need and in their consequent performance.

'He who pays the piper will have the tune that he desires'.

In part, this goes back to a basic (but often unrecognised and unarticulated) tension that has always been at the heart of publicly-funded provision, not least in the NHS. This tension proceeds from the separation that is enshrined between, on the one hand, the customer of care (that is, successive governments, albeit mediated through different intermediary bodies – most recently PCTs) and the consumer of care (that is, individual patients and local communities).

Although, in the broadest sense, elected governments 'represent the people', at the level of specific policies and their practical local application and implications on the ground, there is no necessary identity of interest between national government demand and local consumer preference. Often the two appear to pull in radically opposing directions (one recent example would be the 'government/customer' demand to achieve 'in year' financial balance across the NHS budget – an exercise that led to the postponement of treatments for 'consumer/patients' and/or the refusal of certain costly but clinically defensible interventions). The tension generated can easily polarise and divide what needs to be a unified NHS managerial and clinical community.

'The time has come for audacious and deep seated reform …. it's absolutely ludicrous that, for as long as most of us can remember, public sector managers have spent their lives staring up at Whitehall targets instead of looking to their customers in the street.'

Sir Sandy Bruce-Lockhart (Chair of Local Government Association), 2006

Inescapably, those who have executive and managerial roles within the NHS (and other public service organisations) are accountable for the achievement of government-defined targets and priorities. This 'customer voice' is, in every sense, a powerful one. To ignore it overtly is to place a career in immediate (and sometimes irreparable) jeopardy.

By contrast, the clinical staff group are in daily face-to-face contact with the 'consumers' of care and accord a far higher priority to responding to the immediate micro need presented by their own patients than to the achievement of a remote, macro (and, from their perspective, often arbitrary) government/customer-defined target.

All too often this competition of (legitimate but oppositional) interests can pitch management and clinicians into conflict – undermining the reciprocal trust and mutual respect between them without which no caring organisation can work efficiently or effectively.

In the worst instances, a profound breakdown of communication occurs, resulting in a retreat into oppositional stereotypes – with managers characterising clinicians as obstructive and self-interested; while clinicians regard managers as detached and uncaring.

Although these tensions cannot be fully or finally resolved (since they are, at root, structurally iatrogenic – and thus 'C' Type problems), their local manifestations can be, and are, dealt with more or less effectively. Where a Board explicitly and openly identifies and explores these dilemmas and shares them with partner organisations and their local community, they become the subject of honest and forthright discourse at all levels within the organisation and beyond – so that the 'least bad' compromise is consensually identified and can be collaboratively owned by managerial and clinical communities alike.

The system reform agenda may well surface a number of such dilemmas; if they are to be collaboratively managed, the drivers of the agenda need to be widely understood.

2.1 Principles underpinning public sector reform

The Prime Minister and the Treasury have defined four principles that should underpin system-wide public service reform. They are:

- national standards
- devolution to the frontline
- competition
- choice.

'Standards for Better Health sits at the heart of the new relationship between central Government and the NHS, under which it is the role of the Department of Health to set broad, overarching standards defining the Government's high level expectations of the health service.'

DH, 2004 *Standards for Better Health*

2.1.1 National standards

Government should establish 'broad overarching standards' that lay down the expectations that should be met by all publicly funded service providers. It is not the job of national government to seek to micro manage specific public services. In the NHS there were no explicitly defined national standards for healthcare provision until the Department of Health published *Standards For Better Health* in 2004. (Interestingly, standards for the provision of private healthcare had been established from 2002).

Since its publication, all NHS organisations have been required to comply with all of the 24 'core' standards and to pursue the 13 'developmental' standards. This requirement (like the statutory duties of quality, of care, and of patient and public involvement that they reflect) applies to *all* of the care that an NHS organisation provides, that is provided on its behalf, or that it commissions.

The implications and the complexity of this requirement, so far as PCTs are concerned, is onerous and far-reaching.

Compliance by all NHS bodies is 'independently' audited and verified by the Healthcare Commission (independent in the sense that the Commission does not report to the Department of Health, nor to Ministers, but to Parliament and the public). The first stage in this verification takes the form of an annual self-assessment carried out by each NHS organisation's Board, commented upon by its Local Authority Overview and Scrutiny Committee, the SHA and its Patient Forum.

The resultant 'declaration' is then triangulated by the Commission against all of its (sometimes questionable) data sources and verified, where there is surface discrepancy, by a 'reality check'. The results of this process, together with a separate evaluation of the organisation's 'use of resources' (judged via the Audit Commission's Annual Local Evaluation or ALE), forms the basis of an annual comparative organisational performance rating published by the Commission each October which attracts significant media and SHA interest.

'Our approach to this assessment is based upon the central principle that it is the responsibility of trust boards to satisfy themselves that they are meeting the core standards and, where this is not happening, to take appropriate steps to correct the situation.'

Healthcare Commission, 2005

Are there any issues in relation to *Standards for Better Health* (or national standards generally) about which you are unclear?

What specific challenges have the PCT inherited in relation to local compliance with national standards?

Although this system has only been in place for two years, such is the pace of change that it is likely that a new mechanism of unified system regulation (based upon the principle of 'licensed' health and social care providers) will be introduced across health and social care by 2010. As a result, both the Healthcare Commission (the largest health regulator in the world) and the Social Care Inspectorate will be superseded by a new regulatory body.

2.1.2 Devolution to the frontline

It is significant that Standards for Better Health were published as an annex to National Standards, Local Action – a document that reflected the emphasis upon what is termed 'new localism'. Belatedly, some may feel, Government has come to accept that micro-management from the centre is an obstacle, rather than a prompt, to efficiency.

At the level of rhetoric at least, Government is now committed, in the next stage of reform, to the principle not just of 'new localism' but of 'double devolution'. In other words, central government devolves greater responsibility for public services, and greater autonomy in establishing priorities back to local organisations.

It is then the task of local public service organisations to devolve authority back to their local communities and to their own front line staff – giving both a louder 'voice' in the establishment of local priorities. Within the NHS, both the creation of Foundation Trusts (which are independent of direct DH or SHA control) and the establishment of Practice Based Commissioning (designed to ensure front line clinical engagement with the commissioning of services) are expressions of this principle.

To what extent, on the following scale, do you believe that, up to now, there has been substantial devolution of authority and autonomy from the centre to local public sector organisations?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

'The government has owned my business until I don't know who the bloody hell owns it. I am suspected, inspected, informed, required and commanded so that I do not know who the hell I am and where I am, or why I am here at all ….. The only reason I am clinging to life at all is to see what the Bloody Hell is going to happen next.''

[London Small Trader's Letter to the Chancellor April 1944]

'Each nationally defined target had an important validity, but taken together they left those actually delivering the service overcome with a bewildering array of targets. In this way a national system of accountability, seeking to provide the public with a clear understanding of improvement, has created something far from clear or accountable.'

John Reid, 2003 *Localising the NHS*

2.1.3 Competition

The recognition of the need to devolve more authority and earned autonomy to local public sector bodies has reinforced the government's determination to push through profound reforms in the way that these bodies understand and conduct their business. Government (not without justification) believes that many monopoly public services had become complacent and self-protective – when compared with their private sector counterparts.

'There will be more freedom for all NHS organisations as emphasis shifts from Whitehall-led to patient-led improvements.'

Paul Corrigan, Personal Adviser to the Prime Minister, 2006

'The interests of the providers of services came to take precedence over the interests of the users of services. The NHS's monopoly over the provision of services compounded these problems … [and] meant that the system lacked both alternative sources of capacity, and the inbuilt challenge and spur to innovation and efficiency that a plurality of providers can bring.'

Patricia Hewitt, 2005 'Labour's values and the modern NHS', keynote speech to the Fabian Society

As a corrective to this 'complacency', alongside national standards and devolution, the key lever that has been introduced to increase capacity and drive up 'responsiveness, efficiency and innovation' is market competition. This principle, allied to an NHS pricing regime that has introduced a system of 'payment by results' (more accurately, payment by activity) faces NHS providers with a new set of challenges if they are to survive, and indeed to thrive, in a competitive market place. Their continued existence is no longer a given and, within a number of health economies, a significant number will need either to merge, retrench into niche markets, or disappear.

'Many hospitals are ill-equipped to survive in the competitive healthcare market being set up by the government. Auditors are now concerned about the financial standing of a third of all NHS bodies ….if trusts cannot raise their financial game, they will not be able to cope with reforms, including patient choice and payment by results.'

National Audit Office/Audit Commission, 2005

In a move that parallels the actions of the then Conservative Government in relation to social and other local authority services in the 1990s, the NHS Priority and Planning Framework 2004-2008 decreed that the NHS would outsource in the region of 15% of publicly-funded healthcare to the private sector by 2008, to bring new providers into the market place and to drive up competitive pressures.

'If there are barriers that prevent collaboration, we will remove them. If there are rules that prevent private and third sector bodies bidding against the public sector, we will change them.'

Tony Blair, June 2006

Independent sector diagnostic and treatment centres have been in the vanguard of this development. The overall percentage of independently-provided, publicly-funded care seems set to rise, as it has done with local authority services, as market pluralism becomes established as a central plank of public provision and as 'best value led' contestability is extended from acute and sub-acute provision to all community services and to general practice itself.

Lord Warner, former Minister of Health, argued that 'choice of practice is almost more important than choice of hospital' and that no element of publicly-funded care should escape the discipline of 'transparent and accountable contestability'.

Recent months have seen significant acquisitions and mergers in the private sector of healthcare as large corporate players seek to position themselves to take advantage of what is, by any measure, a huge market place.

The intention is to use competition to compel public care providers to match or improve the flexibility and responsiveness promised by new market entrants. In East London, Care UK (a company specialising in the delivery of community and primary care), has established a 7,000-patient GP practice and 100-patient-per-day walk-in centre. The deal includes extended GP opening hours, evening and Saturday morning surgeries, and the walk-in centre will be open seven days a week.

To what extent may some key local hospitals or other service providers be 'ill prepared' for the impact of market competition?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

To what extent do you think that the concept of 'best value' currently underpins the commissioning of acute and other health services in North Essex?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

To what extent do you think that the concept of 'best value' and contestability currently underpins the commissioning of local General Practitioner services?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

To what extent do you think that the concept of 'best value' and contestability currently underpins the commissioning of local authority services in the area?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

'Over the coming months, the Department will work with further PCTs with the fewest GPs for their populations as well as other relatively under-doctored or Spearhead PCTs, to invite new providers to deliver extra local services. The programme aims to attract a broad range of providers, from existing entrepreneurial GPs to social enterprises and corporate independent providers. Advertisements will appear in both the national and local media from the end of March to help ensure that a full range of potential providers are aware of the programme, including local GPs. New services are expected to open to patients by the end of 2007.'

DH, February 2007 Press release

2.1.4 Choice

All of the above reforms are intended to increase the extent of individual service user and patient choice – initially in relation to elective interventions – but ultimately in relation to all treatment provision.

'Currently all patients requiring any routine surgery can choose from four local hospitals, 34 foundation trusts and 15 independent sector providers. The aim is that from April 2008, patients will be able to choose from any hospital that meets NHS standards and costs but…. this 'free' choice is being delivered earlier than expected for some kinds of surgery.'
Patricia Hewitt 2007

Some politicians and commentators have gone further and advocated the extension of the principle of 'direct payments' from social into healthcare.

Very real concern has been expressed that, at least in the short term, an unintended by-product of choice will be a further escalation in health inequalities – and a further extension of professional power. A survey in London on choice pilots (MORI, 2006) found that whilst younger, more affluent, more IT-literate and more mobile (A1 and B1) groups were prepared to exercise and take advantage of 'choice', in most other groups, dependence upon professional 'expertise' was reinforced:75% of people, when offered a choice of providers asked 'which would you recommend, doctor?'.

'The idea would be to give patients [with long term conditions] a choice between receiving a package of care from the NHS, as they do now, or instead having their own budget - an NHS credit - which they could control directly.'
Alan Milburn, Former Secretary of State for Health October, October 2006

In an attempt to ensure that individual choice does not further disadvantage those without ready IT access, and to help people develop the confidence to make their own informed judgement, a number of pilot schemes have been launched to provide what are, in effect, publicly-funded 'advisory services'.

> *'Patient choice is about people being in control. Patients needing a hospital appointment should have the right to pick and choose their time, date and place. To make this happen, we need to invest in facilities to help patients take control. Using public libraries and the Internet is an ideal way to support patients, families and carers with information.*
>
> *From now, patients or any member of the public in ten areas across the country will be able to go to their local library and have trained librarians support them as they choose and book hospital appointments on-line, offering new convenience and flexibility.'*
>
> Patricia Hewitt, 2007

In the future, because of the technical complexity of some of the options that will face individual patients, it is possible that the role of 'Independent Health Advisors' or 'Health Brokers' will have a parallel role to that exercised by 'Independent Financial Advisers' in relation to investment and borrowing. The impact of such developments on patterns of patient flow within specific local health economies is difficult to predict.

There is a significant potential tension between this notion of 'free choice' exercised by the individual and the 'strategic planning' role envisaged for Local Strategic Partnerships and PCTs. There would be little point in elegant local services being developed in relation to theoretical community need if individuals choose treatment options or centres away from this local provision. On the basis of current consumer preference for 'care close to home', this seems an unlikely possibility. There will, in the future, be a real need to factor in to strategic planning processes 'market research-led' local intelligence about individual treatment preferences and choices.

Partly to offset this risk, the principle of choice is not only intended to operate at the level of the individual service user; it is also designed to:

- support 'devolution to the front line'
- give a more powerful 'voice' and extend 'choice' to local communities.

This will give local people a say in the determination of models, patterns and locations of care as well as priorities for more forward-focussed investment.

To what extent do you believe that the local health (and social care) economy is equipped overall to deal with the impact of these policies?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

'Brokerage Services in Sheffield and Cheshire will use trained local brokers to support people with learning disabilities and their parents or carers. The advisors will visit people in their homes and work with them to devise the best possible support for individuals within their budgets allocated by the government.

The service is being provided by HFT, previously known as The Home Farm Trust, a national charity for adults with a learning disability. The aim is to create new ways to plan and organise the support that people want … negotiating and mediating with other agencies and in some cases supporting people to recruit and manage their own staff.'

DH Press Release, February 2007

'The principle of choice must extend far beyond hospitals. … it means involving residents in the development of local services and the regeneration of their own neighbourhoods – all helping to create a virtuous circle of healthier people in safer communities supported by responsive public services.'

Patricia Hewitt, 2005 'Labour's values and the modern NHS', Keynote speech to the Fabian Society

2.2 From illness management to the promotion of health and wellbeing

Together with the post-Wanless recognition of the economic and social costs of ill health, the reform agenda has shifted the emphasis, within the Department of Health and the NHS, from a pre-occupation with the safe management of episodes of acute disease, through a recognition of the need to manage long term conditions more effectively, to the prevention of illness and a whole system approach to building healthier communities.

'As the drive for responsive, convenient and personalised services takes root across the whole of the NHS and for all patients …the NHS will concentrate on transforming itself from a sickness service to a health service.'

DH, 2004 *NHS Improvement Plan*

Our Health, Our Care, Our Say (DH, 2006) established a number of key priorities that focused upon better prevention services and earlier intervention, better management of co-morbidities, more choice and a louder voice for patients and local communities and the need to tackle inequalities and improve equitable access to community services. Inescapably this demanded 'greater integration across the health and social care frontier'.

Similarly, the White Paper *Choosing Health* set out short, medium and long term priorities not only for the NHS but for local health and social care economies, focussing on:

- whole-system management of long term conditions
- pro-active steps to maximise disease prevention
- the promotion of individual and community health and wellbeing.

'For too long health has been seen simply in terms of hospitals and bed numbers. NHS stands for the National Health Service not the National Sickness Service and we want it to live up to its name. We need to radically change the culture of how we shape and deliver care – shifting focus from curing the sick to the proactive prevention of ill health, as well as tackling health inequalities.'

Patricia Hewitt, 2007

Whilst the logic of this approach is unquestionably sound (and long overdue) it is difficult to see how such a re-profiling will not demand a parallel re-focussing of expenditure – thus adding to pressures on 'in-year' disease management, in order to fund investment in medium- and long-term prevention or quality-of-life improvements.

To what extent has it been possible, thus far, to shift the balance, locally, from 'a sickness service to a health service'?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

What do you believe are the three major challenges that must be overcome in order for such a shift to occur?

1

2

3

2.3 'Whole system' collaboration

Whilst the NHS (and PCTs in particular) have a vital contribution to make to the achievement of each of these priorities, it is clear that it cannot and must not act in isolation. Every Local Authority function has a crucial impact on the short term well-being and long term health of local communities – from education to leisure services, from policing to transport. Not only needs definition, but commissioning and contracting decisions and the patterns and characteristics of care that result need to reflect this whole system approach.

'As an outsider …. I would have thought that hospitals, community agencies, and primary care trusts – having, in effect the same owner and employer (the public) and drawing on the same common pool of taxation – would work together seamlessly to assure flow, efficiency, integrated experiences and common aims [and] would lead unerringly to sound development of community-wide systems for the care of chronically ill people. To my surprise …….'

Dr Donald Berwick, CEO and founder of the US Institute for Health Improvement

Please go to www.patientvoices.org.uk , click on 'The Stories' tab at the top of the page, and listen to Monica Clarke's 'Nobody told me'.

How far does her story exemplify the ideals expressed by Dr Berwick?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

What are the implications of her story for the PCT?

A damaging consequence of the failure, in the past, to commission for 'whole system care' has been the fragmented and disjointed nature of the provision that has, far too often, been the lot of the most vulnerable.

'The management of points of transition and the assurance of continuity of care' is a characteristic weakness within all complex and inter-dependent systems of care delivery. Further, 'weaknesses in any system of care will express themselves most forcefully, from the perspective of service users, at intra-organisational interfaces; organisational boundaries; and sectoral frontiers in an escalating hierarchy of dislocation and risk'.

Paul Stanton, 2007

Comparative studies carried out by Picker Europe identified this as a characteristic weakness in NHS provision. 45% of UK patients identified that 'serious problems' resulted from 'discontinuities in information flows and failures to coordinate treatment and care regimes' even before the additional transitional complexity generated by a plurality of public and private care providers was factored in to the patient experience.

'The services modalities available to many people with long term conditions are characterised by: their high dependency on acute care, their singularly clinical focus, their reactive character, their fragmented and sporadic nature, their lack of emphasis on personal experience and the residual character of community services and secondary prevention.'

Wilson et al, 2005

Please go to www.patientvoices.org.uk and click on 'The Stories' tab at the top of the page. Navigate to 'Carers' Resource, Harrogate, Craven and Airedale', and listen to Alyson Hill's 'Learning to care is part of the job'.

How might this story change:

a) in the light of 'additional transitional complexity' generated by a plurality of private care providers?

b) in a system where points of transition were managed well and continuity of care was assured?

What could the PCT do to contribute to a different, better, story?

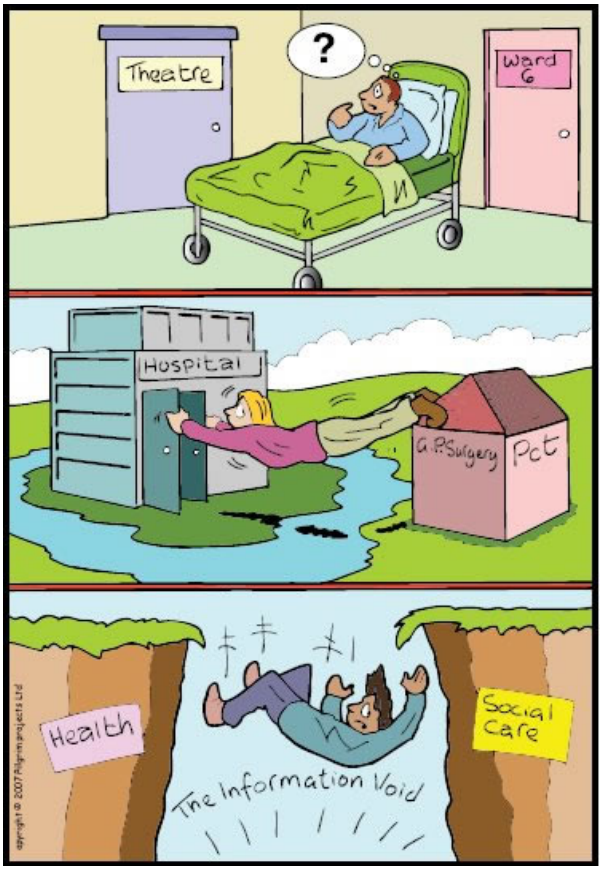


Figure 2: Lost In Transition

'By giving GPs more flexibility in how they use NHS money and investing more in community based programmes, local services will be able to offer people a seamless service of care – whether in a hospital, in their home or in the community.'

Patricia Hewitt, 2007

In the future, such discontinuities can only be minimised if PCTs and Practice Based Commissioners are sensitive to these issues and explicitly contract for the management of 'hand-over and transition' and if they actively monitor the quality – not just of the episode of care, but of the overall 'care journey' – thus ensuring service user-focussed collaboration and co-operation between all local providers of health and social care.

Clearly local collaboration and partnership within and between the health and social care community is vital, since neither is an encapsulated system. This is true not only in the management of illness, but becomes even more vital as the emphasis shifts from illness management to the promotion of health and wellbeing.

Factors that promote, or inhibit, health and wellbeing go far beyond the responsibilities or competence of the NHS. As Wanless emphasised, it is impossible to separate the physical and emotional wellbeing of a community from its economic health and wellbeing. Thus, not only PCTs and local government, but also local employers, trades union and business representative bodies need to inform and shape the thinking of broadly based Local Strategic Partnerships.

Only where all such broadly-based partnerships generate and sustain effective collaborative working will they be able to develop a consensual approach to the definition of need; pool their resources to ensure the best return on investment; and work collaboratively to implement and evaluate reform led improvement. A new system of performance management from the centre needs to underpin such actions. Current crude and simplistic models of intra-organisational cost (rather than value) based accounting have often compelled local health and social care organisations to put their own 'self-interest' ahead of the public good. Collaborative working will only become a system property when Government, the DH, NHS and public service regulators consistently implement a more subtle regime of financial performance management and overall performance monitoring – so that 'righteous' organisations are rewarded for their altruistic 'corporate citizenship' – rather than (as at present) being punished.

'By encouraging local government and the NHS to work more closely together and with their communities, we can transform the way we deliver healthcare - tackling health inequalities, preventing serious illness, giving people greater choices as well as treating the sick. I want to see greater flexibility in the use of resources to target investment where it will have biggest impact to improve health and prevent premature death.'

Patricia Hewitt, 2007

A key and critical challenge is to ensure that local people and local communities themselves are full and active parties in these collaborative partnerships and in this collective endeavour to improve health and social care provision.

'76% of people in Britain have never been asked about what they want from local NHS services. This is despite the fact that the public and health professionals almost unanimously (90% and 93% respectively) agree that local people ought to have a say in how health services are run.'

Developing Patient Partnerships, 2006 *'NHS users: the silent majority'*

How well established locally is the principle of whole-system collaboration?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

Identify three concrete ways in which such collaboration could be encouraged.

1

2

3

Section 3: The role and function of 'new' PCTS

The immediate challenges that confront 'new' PCTs – especially ones like the North East Essex PCT that have been recently formed from the merger of historically discrete organisational parts – are complex, multi-dimensional and inter-connected.

> *'The after-shocks of organisational merger can reverberate through an NHS (or any other organisation for years). In the commercial and industrial sectors, 75% of mergers fail to achieve the objectives set for them. Unless the trauma that such 'organisational collisions' inevitably generate are explicitly recognised and sensitively addressed by the merged body, they cause damage that becomes a key predictor of future organisational failure.'*
>
> CGST, 2005

Having created a sense of identity and common purpose across their professionally-variegated and widely-dispersed staff communities – itself a time-intensive and challenging task – a 'new' PCT, such as North East Essex, is required to take a new 'needs-led' and 'partnership-informed' approach to the governance of all of their functions. This demands the adoption of a new mind set and a new approach, which demands, in turn, a new set of governance and leadership competences.

'Counterfeits of the past, under new names, can easily be mistaken for the future. We must be wary of this trap.'

Victor Hugo *Les Miserables*

It has been argued (Stanton, 2005) that such new organisations (with responsibilities that stretch well beyond the provision of primary care services) might have been helped to make a cleaner break with the past had the term PCT been replaced by Health Investment Trusts (HITs). Such a body works with the local community and partners to:

- agree a consensual approach to current and emergent need
- promote equity
- invest in and develop a sustainable and flexible 'supply network' of providers.

This would enable the HIT not only to respond to immediate, medium- and long-term illness demand but also to improve the overall health status and wellbeing of all elements of the local communities that it serves.

This better captures the essence of the core functions and future role of the new PCTs' – it is more comprehensible to those inside and outside an organisation if it does what it says on the tin.

Despite their 'old description', it is through their commissioning and contracting functions that 'new' PCTs exercise their key performance management role in their health economies. This is accomplished through the development and management of, and partnership with, a sustainable 'supply chain' of reliable providers – both existing NHS organisations and 'new' private or third sector market entrants.

Notwithstanding the resource constraints within which they operate in relation to their management costs, this demands an increase in a PCT's own commissioning capacity and capability – not least since they are also charged with enhancing the capacity and capability of Practice Based Commissioners (PBC) whilst ensuring that no unintended conflicts of interest arise between practice provider and commissioning function. It also requires a fundamental re-orientation and re-prioritisation of the factors that have, historically, driven commissioning.

Commissioning Drivers

'Old' PCT	'New' PCT
Historical precedent	Long term analysis of health opportunity and illness burden
Cost	Investment
Volume	Value & sustainability

Stanton CGST 2006

Figure 3: Commissioning drivers for PCTs

Co-incidentally, with meeting the new challenges of commissioning and system performance management, the PCT must work with and through its General Practitioners and all other independent contractor groups in relation to the quality and safety of general practice, dentistry, pharmacy and optometry service provision.

'Effective commissioning is a pre-requisite for making [improvement] real….PCTs will support Practice Based Commissioning and take on the responsibility for performance management through contracts with all providers, including those in the independent sector.'

DH, 2005 *Commissioning A Patient Led NHS*

In a recent issue of the Health Service Journal, (November, 2006) Sophia Christie, the CEO of the 'new' Birmingham East and North PCT, has pointed out that, with an annual commissioning budget in excess of £500 million, the PCT has a smaller commissioning Directorate (to define need, contract for service and monitor quality and contract compliance) than one of the local acute Trusts has in its Payment By Results coding team.

'Commissioning is vital to the improvement of the quality of services. Good commissioning – hearing the views of people, involving partners and focused on outcomes – is essential to our reforms of health and social care. We still have a mindset where commissioners look to the safe, familiar tools.'

Ivan Lewis, Minister for Social Care 2007

Additionally it must maintain the safety and effectiveness of its own provided services until such time as it either oversee the managed and safe transition of these services to an arms length body (independent sector or other), or develops a compelling case that it is in the public interest that these services remain 'in-house'.

Finally, it must combine all of these discrete but interconnected activities so that it shifts the 'locus of care' closer to people's homes' and gradually moves the overall service balance from disease management to the promotion of health and wellbeing without, in the process, creating unintended dislocation and disruption within the local health economy that would threaten the safety or viability of essential services.

This requires an increase in governance capability and a shift in governance emphasis compared with previous PCTs in England, where the hierarchy of Board attention was on (in rapidly descending priority) provided services; independently contracted services and (a poor third) commissioning (CGST 2005).

For 'new' PCTs, anything other than a 'balanced scorecard of governance attention will expose them and the communities that they serve to significant risk.

It is easier to capture the core functions of a PCT diagrammatically than to translate them into complex, real-world reality.

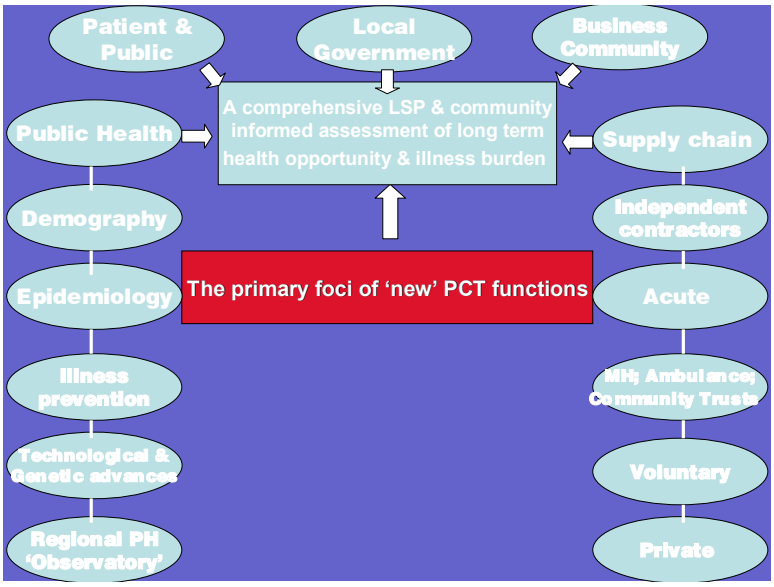


Figure 4a: The primary foci of 'new' PCT functions (1)

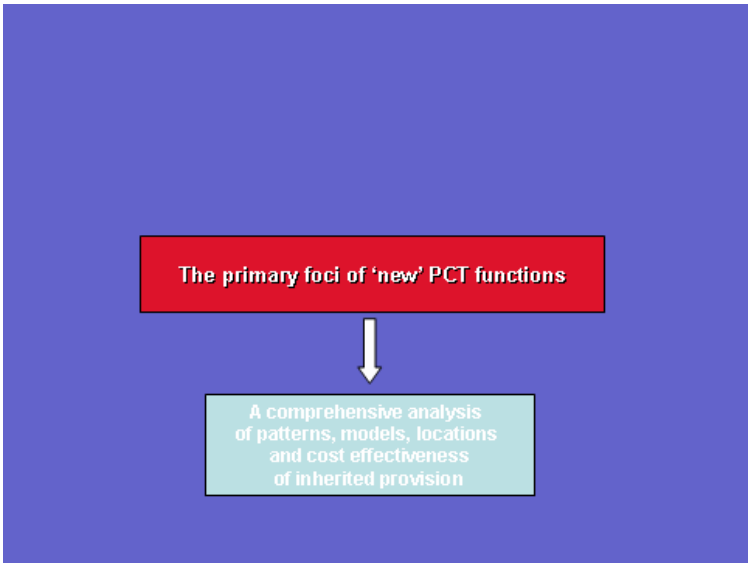


Figure 4b: The primary foci of 'new' PCT functions (2)

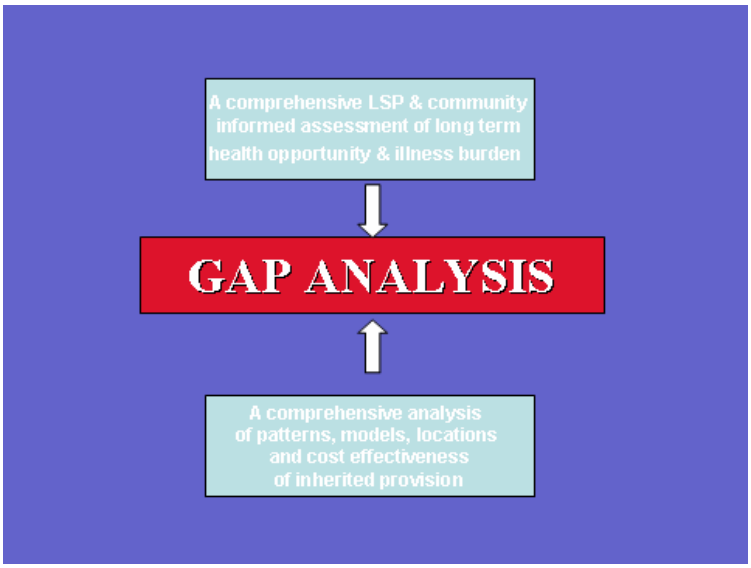


Figure 4c: Gap analysis (1)

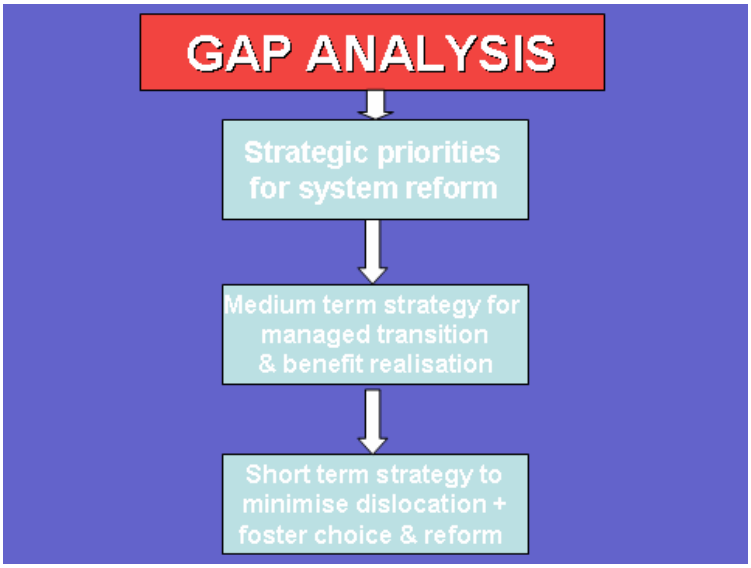


Figure 4d: Gap analysis (2)

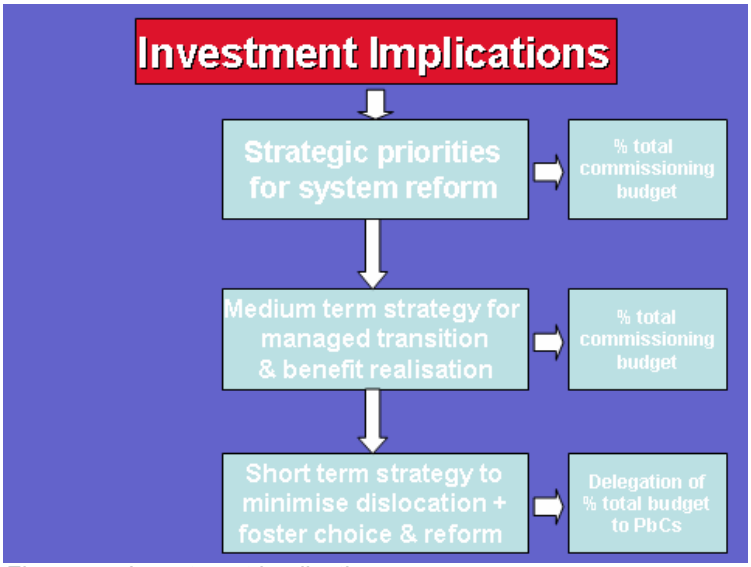


Figure 4e: Investment implications

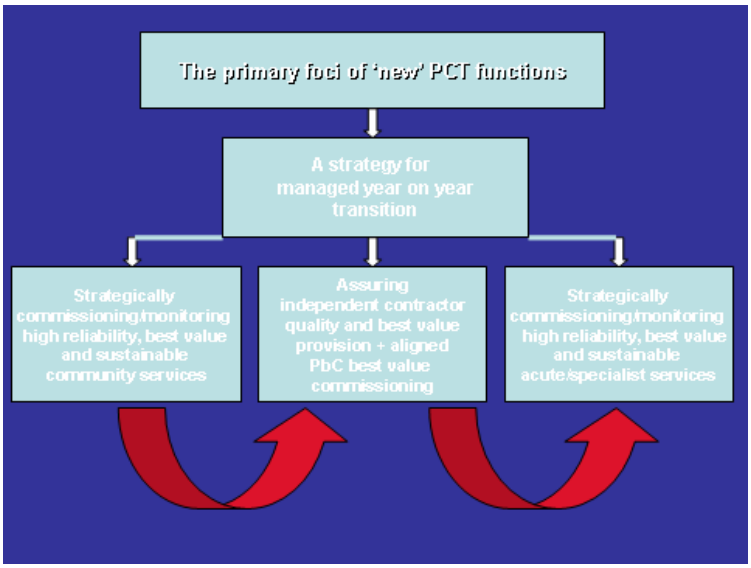


Figure 4f: The primary foci of 'new' PCT functions (3)

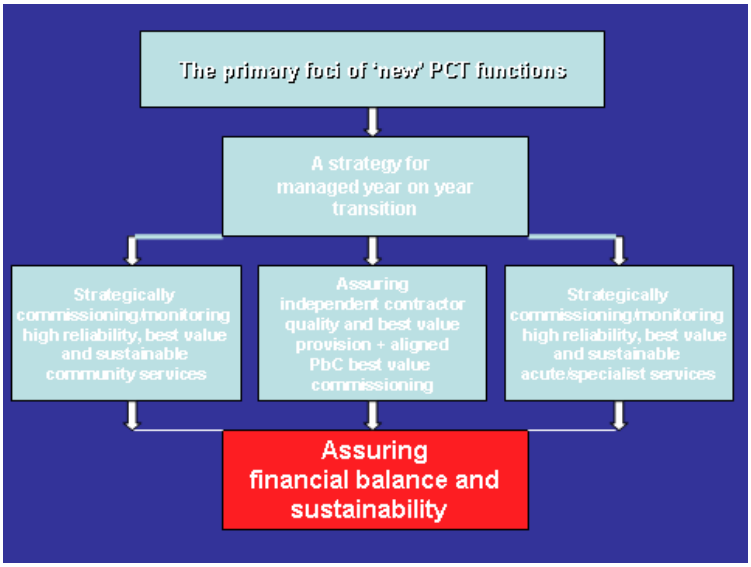


Figure 4g: The primary foci of 'new' PCT functions (4)

'The PCT must make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.'

Primary Care Trusts model standing orders, reservation and delegation of powers and standing financial instructions

DH, August 2006 (p. 84)

Difficult as it is for any PCT or health and social care community to address the immediate challenges generated by this stage of the system reform agenda, this is only one dimension for the challenge that confronts them. The other major challenge is to stay attentive to the future and to build, as a system property of local public services, the flexible, adaptive capacity that will be necessary in order to stay abreast of constant and accelerative change.

Given the scale and scope off its functions, what do you believe are the three greatest challenges that immediately confront the new PCT?

1

2

3

3.1 Organisational authority and accountability

The Cabinet Office has explicitly defined the inter-connected pressures upon the system that it intends to employ to drive future system reform.

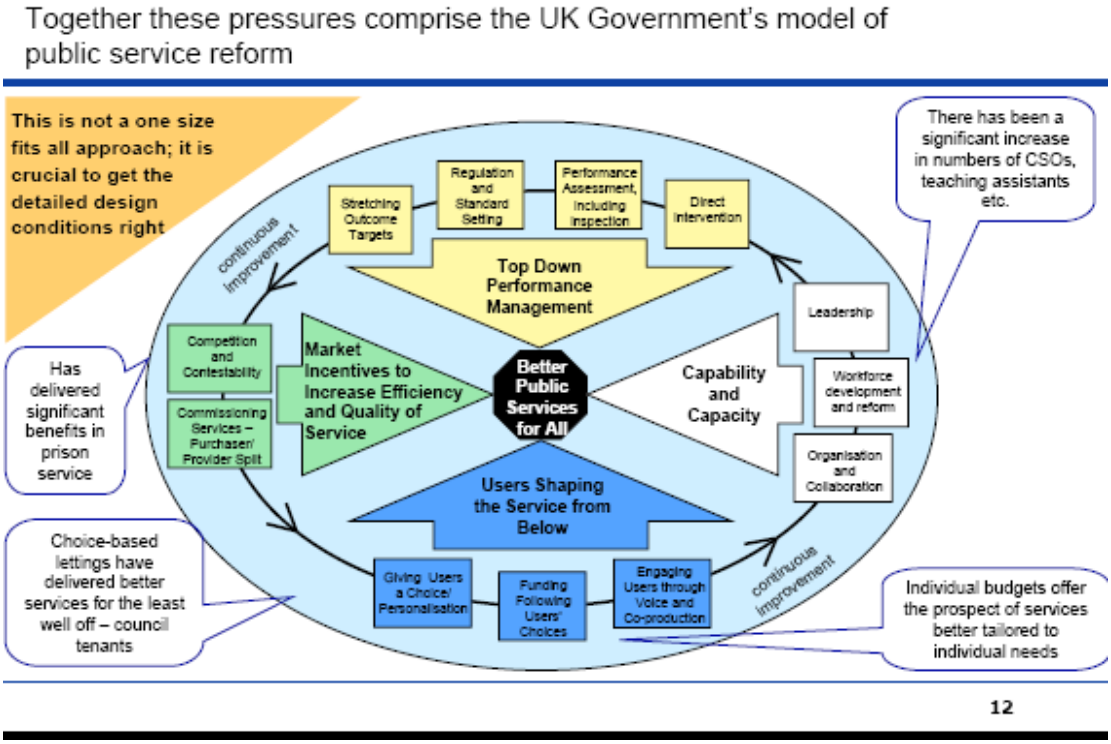


Figure 5: Model of public service reform

There is a clear expectation that this agenda will be at the forefront of the minds of those who lead and work within the public sector. However, in practice, by no means all of these pressures 'pull' in the same direction. There are unintended contradictions within –and unintentionally perverse incentives that proceed from – the interaction of some of these pressures, both at the level of individual organisations and of the local public service system as an interdependent whole.

In addition, both the NHS and other public services have been bombarded by centrally imposed targets and regionally imposed performance management data that have tended to prioritise short-term urgency at the expense of long-term importance.

Local clinicians (those in the acute sector every bit as much as their colleagues in primary care) have often felt detached from – if not actively hostile to – the system reform agenda.

'The role of NHS boards is blurred and their accountabilities are not clear. … It's not clearly delineated. The real action is along the line-management/executive axis, and boards are somewhat peripheral…It's a product of the systems structure … Boards are under-exploited here.'

Dr Michael Walsh, formerly CEO of South East London SHA and CEO of Bayside Health, Melbourne.

Figure 6: Noticing

Notwithstanding the rhetoric of 'new localism' and of corporate Board accountability, the system within many health economies seems to default to decision making and prioritisation down the 'executive line' that runs from Ministers and the DH to the NHS CEO, through SHA CEOs to the Chief Executives of PCTs and (non-Foundation) acute and specialist NHS Trusts. The result is that some NHS Boards and Chairs have felt marginalised by the system.

Figure 5: A PCT Chair discusses Board authority with the CEO of a local SHA

This phenomenon is not unique to the NHS or the public sector. Nor is it inevitable. The Clinical Governance Support Team programme for almost 180 NHS and PCT Boards uncovered a number of examples where the Board, as a corporate entity, added significant value – often providing what one CEO described as 'air cover' that enabled her to withstand undue pressure and interference from the centre.

In other cases the relationship between the SHA and the PCT Board was a collaborative and harmonious one. Where both of these conditions were satisfied, organisations had a track record of achievement in relation to centrally defined targets as well as of innovation and success in tackling local priority issues alongside their NHS, local government and other partners.

In the case of PCTs, other key variables related to the Professional Executive Committee included:

- the competence of the PEC Chair
- the capability and capacity of the PEC
- the clarity of its remit
- the strength of the collaborative partnership forged by the triumvirate of PCT Chair, CEO and PEC Chair.

To what extent does the PCT Board have the authority to act on the priorities that it has agreed with local partners?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

'When it came to the crunch, the Accountable Officer status of the CEO was believed, by a significant number of NHST and PCT Board Chairs, to trump corporate Board accountability.'

Jay Bevington, 2006

'Such organisations (SHAs and NHSTs/PCTs) were characterised by their clarity about the nature of "governance", by engaged and "fit for purpose" Non-Executives and by an authoritative (but non-authoritarian) Chair who worked with a highly competent CEO and Executive Team in an atmosphere of 'informed and reciprocal trust.'

Paul Stanton and Jay Bevington, 2005

Section 4: Challenges posed by the rate and nature of 21st century change

In the 1970s, Alvin Toffler suggested that 20th century men and women needed to adapt, within their own brief lifetimes, to changes equivalent to those that that had taken place over one thousand generations for their evolutionary forebears. More recent theorists paint an even more dramatic picture in relation to the 21st century.

Kurzweil and other commentators estimate that the rate of technological change doubles every decade; thus the 21st century as a whole will experience almost one thousand times more technological change than did the 20th century.

It is not without cause, therefore, that a Japanese business proverb asserts 'the future is our greatest challenge – we ignore it at our peril'. The greater the pace of change in the external environment, the more important it becomes that any organisation is outward-looking, and that those who govern and lead it are 'future focussed' and sensitive to macro and micro change.

Within the NHS (and other public services), so turbulent is the internal environment and so insistent and urgent are the demands from the system itself for data and reaction to short term priorities, that a thinly-stretched Executive Team (and the Board itself) can spend so much of their energy and time fire-fighting and managing immediate pressures that opportunities to engage with the future are severely constrained.

It is for this reason that a group such as the 'futures group' – that has the opportunity to stand back for a brief period and reflect, and some of whose members have a more detached perspective – can add significant value and make a distinctive contribution to the evolution of the PCT itself and of its local health and social care economy.

The purpose is not to attempt to 'second guess' the future – a notoriously fruitless exercise – rather to sensitise the PCT and its partners to some of the key issues and factors that may need to be kept under on-going review if the flexible adaptive capacity of local public services are to keep abreast of ever changing need.

'What we're experiencing is not simply the acceleration of the pace of change, but the acceleration of acceleration itself. In other words, change growing at an exponential rate.'

Kurzweil, 2006

'In the highly competitive and constantly evolving new technologies sector, the Board of DEL (one of the more successful corporate entities) strives to ensure that its Board spends 70% of its energies in looking to the future – 30% to scrutinising the past and the 'here and now'. Similarly, it differentiates its senior executives from its senior managers by reference to a similar equation: an executive spends 70% of energy dealing with the future, 30% with the here and now; whilst for a senior manager the equation is reversed –70% of energy being committed to the here and now and 30% to future need.'

'Liars tell lies to other people. Visionaries lie to themselves.'

Nietzsche

Factors that conspire to generate emergent need

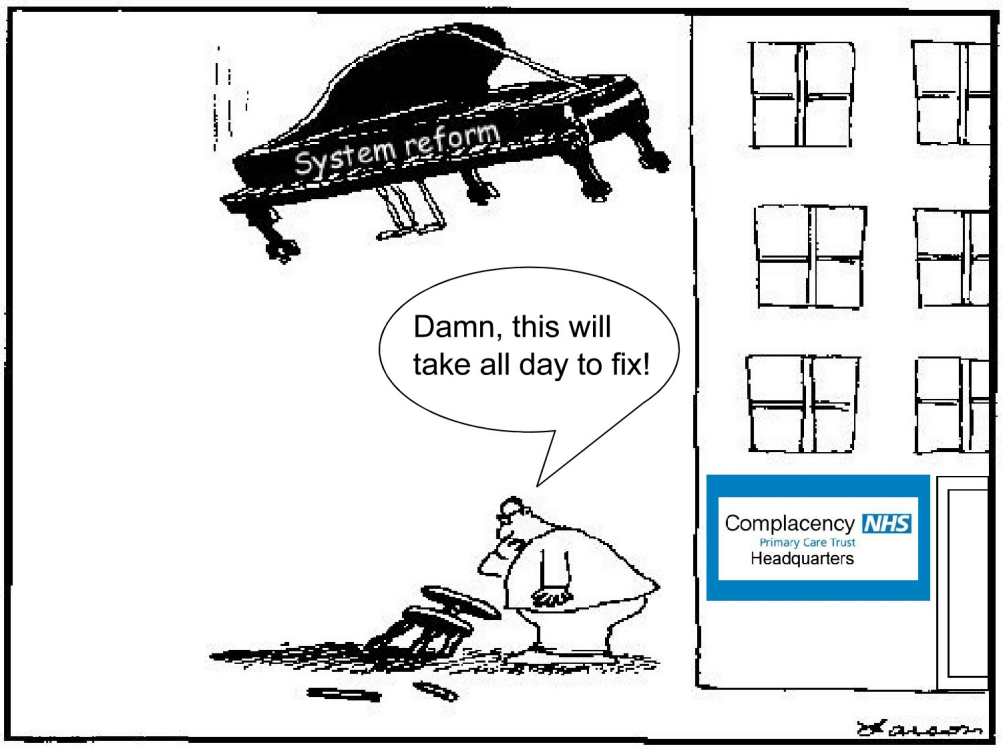


Figure 6: System reform

The 2007 Cabinet Office Policy Review of Public Services that identified the requisite characteristics of 21st century public services (page 9) also recognised that 'fitness for purpose' could not be achieved through a once-and-for-all 'catch up' by local public sector organisations. They recognised that organisations would need to develop 'flexible adaptive capacity' if they were not only to achieve but sustain 'needs-led fitness for purpose' in a rapidly evolving social and economic global, national and local context.

They identified a number of external drivers that will shape and alter the demands made upon the public services as the 21st Century unfolds – some of these issues will be touched upon in the rest of this section, beginning with the diagram on the next page.

It is difficult and misleading to over-generalise about the characteristics of North East Essex – as if it were one uniform community that will, as the century unfolds, generate a common level of need or a similar pattern of demand from NHS and public service providers as these co-incident factors interact to shape evolutionary change.

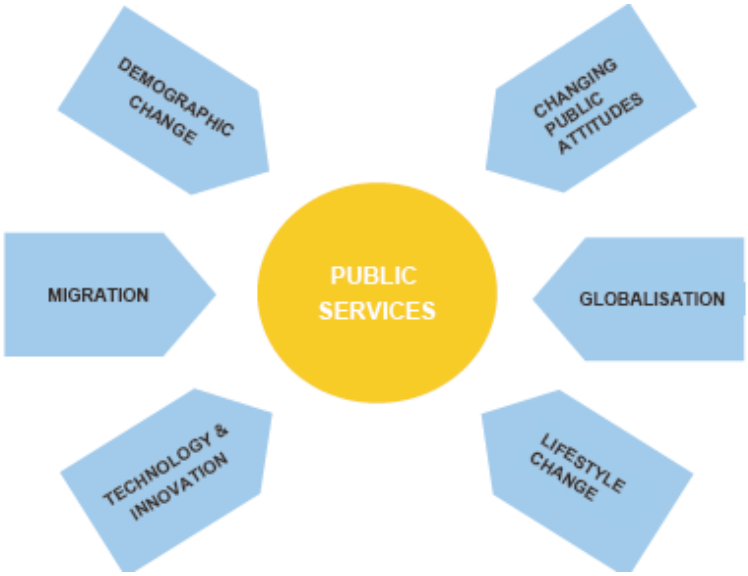


Figure 9: External factors driving public services

North East Essex is composed of a 'community of communities' with widely varying characteristics and variegated needs. Pockets of deep and persistent deprivation co-exist with strident and optimistically expanding areas. It is likely that, unless addressed, levels of relative deprivation may significantly rise.

As some parts of the local economy grow, and others contract, and as road systems and patterns of public transport evolve, the balance of its population may shift fundamentally.

At the same time, climatic changes caused by global warming could, by the mid-century, have a profound impact not only upon agriculture but upon coastal and low-lying communities.

Which of the factors identified by the Cabinet Office do you think are likely to have the most profound impact on the demands made upon the public services?

What other factors that they have not identified do you think need to be kept under active review?

What, overall, do you believe are the three most important factors that will drive change in local communities in the first half of the 21st century?

1

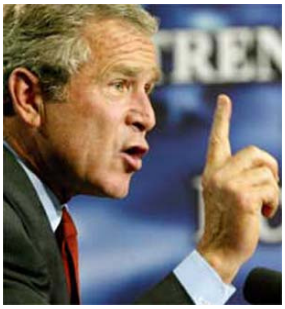
2

3

4.1 Globalisation

Within a 'global economy', no community is completely insulated from the indirect impact of profound geo-political change or trauma, or of disease.

Inevitably, the same is true in the sphere of global economic activity. If the post war 20th century decades were increasingly characterised by the economic and political dominance of the western democracies – a process which culminated in 'victory' in the Cold War – the new world order that has since emerged is not the stable capitalist utopia dreamed of by the neo-Christian right.



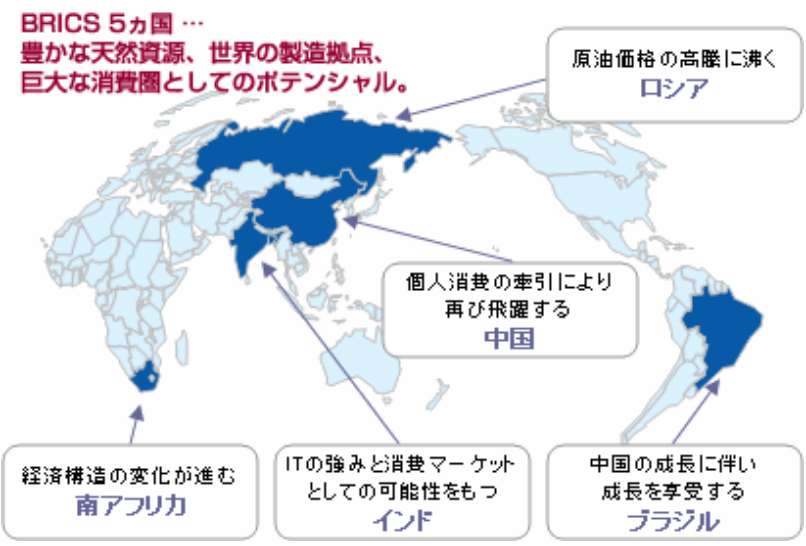
It is not merely the deep-seated (and potentially prolonged) ideological conflict with fundamentalist Islam, the 'Scold Wars' in Afghanistan and Iraq, and the after shocks of 9/11 and the London bombings that will shape the emergent 21st century world order.

Figure 10: Shaping the new world order

As the century progresses, it seems inevitable that the political, economic and military dominance of the USA and the other G6 economies will increasingly be challenged by the rise of the economies of Brazil, Russia, India and (not least) China (what are known as the BRICS 4 or 5 economies – since eastern, though not western, definitions tend to include South Africa). Their combined GDP is predicted to outstrip that of the USA within three decades – and to overtake that of the combined G6 by the time of the Centenary of the NHS in the UK).

'In today's globalised world, we can no longer consider the health of the UK in isolation. Globalisation can bring benefits for human health, leading to increased trade, travel and communications, and greater human interaction – but it is true that infectious diseases do not respect borders…. To address challenges to global health and ensure that the UK harnesses the opportunities of globalisation, we need to develop a UK government-wide strategy to work effectively with our international and domestic partners.'

Professor Sir Liam Donaldson, Chief Medical Officer, 2007



'If things go right, in less than 40 years, the BRICs economies together could be larger than the G6 in US dollar terms. By 2025 they could account for over half the size of the G6. Of the current G6, only the US and Japan may be among the six largest economies in US dollar terms in 2050.'

Figure 11: BRICS 5 engines of growth

This will herald both new opportunities and unprecedented challenges for the economies of the European Union in general and for local businesses in North East Essex in particular.

> *'A world where change is faster, more far-reaching and global than ever sets big challenges for all Governments and all organisations. Britain – with a stable economy, fine universities, a well-educated population and improving public services – is better placed than most countries to succeed in the modern world. But continued success depends upon identifying long-term trends and new challenges and examining how existing policies need to be changed to continue to meet the country's priorities'.*
>
> Cabinet Office, 2006 *Building on progress: Public Services*

As the turbulence and profound instability in Eastern Europe and the Balkans that proceeded from the collapse of the Soviet Union has subsided, and as the slow-down in the German economy that was caused (in part) by re-unification has worked through, the European Union has been able to embark upon a profound expansion that opens up new markets to the business communities in North and East Essex – at the same time as it exposes them to new competitive challenges.

Since the health and well-being of any community is intimately related to its economic well-being, the way that local businesses respond to these challenges will be one key determinant of the patterns of need that will exist as the mid-point of the century approaches.

Over the last decades, the main engine of growth within the economy of the Eastern Region of England as a whole has been diverse, small to medium sized enterprises – rather than any one predominant employer or industrial or commercial sector. Whilst this spreads risk, it may also make it more difficult to predict vulnerability or fully exploit new opportunities for the business communities of North and East Essex. However, the area has significant potential advantages if the symbiotic relationship between local universities and the business community can be strengthened and exploited to their mutual advantage – and, as a consequence, to the advantage of the community as a whole.

'In Luton, the demands upon the local health and social services escalated dramatically in the wake of the collapse of the Vauxhall plant – demand not only from displaced Vauxhall workers themselves but from the many 'secondary economic casualties' of this collapse.'

Where might the PCT and other public services look for expert advice and support in predicting how the local economy is likely to perform over the next decades?

Can you foresee any potential engines of growth within the local economy?

Can you foresee any specific vulnerabilities?

How attentive is the local public sector and business community to what the Cabinet Office calls 'long -term trends and new challenges'?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

4.2 Migration

At the present time, the 300,000 + population served by North East Essex PCT includes a relatively small number of people from minority ethnic communities – with those from Asian and mixed backgrounds currently predominant.

However, economic migrants from the newly-accessed member states of the EU are already making a significant impact on skill shortages and seasonal labour market demand in the UK. Some may be vulnerable to exploitation and in need of protection by public services. Many are likely to be 'short-term' residents, who come and go as the labour market – or the needs of families in their country of origin change. Others may be purely transitory – using entry points within North East Essex before moving on to other parts of the UK. Some, with the passage of time – as has happened throughout this country's economic history – may choose to settle – perhaps in clusters (at least in the first generation) with people from their own culture and/or country of origin.

The expectations that these new entrants (whether short- or long-term) have of public services, and the demands that they make upon these services(though not necessarily any greater in volume than the indigenous population) are likely to extend the boundary of what is understood by 'person-centred services' – if these services are to become culturally as well as individually sensitive (in ways that, hitherto, our public services have not always been in responding to the specific needs of particular ethnic communities).

'A patient went without food at a major Suffolk hospital because "he could not speak English very well", it has been claimed.'

East Anglian Daily Times, 14 May, 2007

Are there currently concentrations of specific migrant communities within some parts of North East Essex?

Are there specific parts of North East Essex that seem likely to attract economic or other migrants?

What are the implications for the PCT?

4.3 Demographic change

The population served by North East Essex PCT, set at 300,000 + in the 2005 census, is projected to rise by a further 50,000 by 2025 (though with significantly stronger growth in Tendring, than in Colchester). It is not yet clear whether this growth trend will be sustained, accelerate or go into reverse from 2025 until the mid-point of the century.

It is, however, clear that the overwhelming majority of the demand that most of us place upon the public services occur in the first and the last five years of our lives. As the Wanless Social Care Review (March 2006) made clear, simply keeping pace with population changes caused by increasing numbers of older people will require total spending (public and private) on social care for that group to increase from the 2002 level of £10.1 billion (1.1% of GDP) to £24.0 billion (1.5%of GDP) by 2026. Achieving more ambitious goals for social care would mean increasing GDP by 2.0% by 2026.

The age profile of the UK and of the local community in North Essex will change dramatically over the next decades. The post-war 'Baby Boomers', the first children of the Welfare State born, for the most part, within its hospitals, will increasingly need to have recourse to its services as they approach the other end of their lives. Currently there are 17.5 million people living with chronic conditions in the UK. According to recent estimates published by the Department of Health, by 2030 the incidence of chronic disease in the over 65s will more than double.

The timing and patterns of demand (as with so much else) are likely to reflect economic inequity – with older people in disadvantaged communities placing the earliest and most profound demands upon the system as complex deprivation-influenced co-morbidities conspire with age to escalate need.

While the onset of demands from the middle classes may be deferred by lifestyle-supported improvements in their physical health, once they do occur, these demands are likely to be prolonged, since advances in physical disease management currently outstrip the medical profession/pharmaceutical industry's capacity to sustain independent intellectual functioning. This fact has led some commentators (gloomily) to pre-characterise the 2120s and 2130s as the 'dementing decades'.

'To achieve sustainable and responsive provision, health and social care will be more closely linked, enabling doctors to prescribe social care to meet health needs. The aim is personalisation of services – working with users to design services that are specific to them. This might mean offering funding to a neighbour who provides meals for an elderly person'

D. Furness, 2007. Health Project Social Market Foundation

The demand that this will generate will not only fall upon public services but (if the present distribution of the 'burden' of care is sustained) upon a statistically smaller cohort of unpaid carers – who care out of love, duty or necessity – but who, up to now, have been poorly supported – not least by the NHS. Building support structures and networks for carers may be as important as gearing up direct health and social care services themselves to cope with the impact of this surge in demand.

At the other end of the demand spectrum, new population centres that spring up as transport infrastructures support more widely dispersed dormitory towns to feed the insatiable employment demands of the capital (and of sub-regional employment centres) are likely to see concentrations of young families come into areas where children have been thinly distributed in the last decades.

Are there likely to be particular concentrations of need so far as demand for elderly care services are concerned?

Is there a firm local voluntary foundation upon which to build new carer support networks?

Are there areas that are particularly likely to attract an influx of young families and children?

On which three services would you expect demographic change to have a particularly challenging impact?

1

2

3

What are the implications for the PCT?

4.4 Rising public expectations

'A mature culture will settle on sharing power and responsibility, on a subtle negotiation . . . between professional and patient as to what each wants and what each can deliver. This is the culture we should work towards – helping each other as we go'.

Ian Kennedy, 2003. 'Patients are experts in their own field' *BMJ*

Historically, public services have been defined by the preferences of those who have provided them. During his (characteristically brief) sojourn as Secretary of State for Health, John Reed used to point out frequently (and rightly) that rising public expectations of and demands upon public services should be celebrated, not decried. The fact that he – as well as others of his generation and younger people – were unwilling to accept passively and gratefully the brusque and minimalist provision of publicly-funded care that his parents would have accepted with genuine gratitude was, he argued, concrete evidence of social progress.

This is likely to be an accelerative trend. If, in the past, deference has characterised the way in which many people have responded to professionals (if not to organisational providers of care), children of the 21st century are likely to adopt a more assertive and challenging posture where services fail to meet their expectations.

The current trend of strident consumerism is fuelled by competition-driven commercial claims to attend to individual demand satisfaction and extend automated industrial production processes that make 'mass customisation' a practicable reality.

This tailoring of corporate 'brands' to 'individual pick and mix preference' – whether for a pink Porsche with lilac leather seats; a daily newspaper devoid of the 'boring' sections; or a weekly shopping delivery automatically generated to reflect and extend previous preference – is likely to fuel an expectation that publicly-funded services will be responsive to articulated lifestyle-based preference – even if they lack the sophisticated capability to predict it.

It is not just younger consumers of publicly-funded care whose expectations are likely to rise.

Those 'Baby Boomers' who do make it through to residential care (whether in full possession of their full faculties or not) are socio-culturally unlikely to be as compliant and uncomplaining in the face of organisationally defined life choices as were their predecessors.

The living 'life in death' that is an unrelieved diet of daytime television may provoke open revolt. At the very least, wall-to-wall Dylan, Rolling Stones or (for the terminally nostalgic) Carole King are – alongside a demand for access to drugs that do not currently figure prominently in the NHS pharmacopoeia – likely to form the basis of minimum consensual demands.

Warning!

When I am an old woman,
I shall wear purple - -
With a red hat which doesn't go,
and doesn't suit me.
And I shall spend my pension
on brandy and summer gloves and satin sandals,
And say we've no money for butter.
I shall sit down on the pavement when I'm tired
and gobble up samples in shops
and press alarm bells
and run with my stick along public railings,
and make up for the sobriety of my youth.
I shall go out in my slippers in the rain
and pick flowers in other people's gardens
and learn to spit!
You can wear terrible shirts and grow more fat
and eat three pounds of sausages at a go,
or only bread and pickles for a week,
and hoard pens and pencils
and beer-mats and things in boxes.
But now we must have clothes that keep us dry,
and pay our rent
and not swear in the street,
and set a good example for the children.
We must have friends to dinner
and read the papers.
But maybe I ought to practice a little now?
So people who know me
are not too shocked and surprised
when suddenly I am old,
And start to wear purple!

Jenny Joseph

On which particular services would you expect rising public expectations to have a particularly challenging impact?

1

2

3

What are the implications for the PCT?

4.5 The impact of new technologies – eHealth

If Kurzweil is even partially right in his contention that 'the 21st century as a whole will experience almost one thousand times more technological change than did the 20th century' then nowhere will the scale and rate of change be greater, in the decades leading up to the centenary of the Welfare State, than in the development, implications and application of new technologies.

For all of the other profound changes that have occurred and will continue to occur politically, socially, economically and demographically, comparisons between the world of 1948 and that of 2148 would demonstrate no greater contrast then in this specific area. Consider the nature of the presents opened by children at Christmas 1948 compared with those likely to be received by their great-grand children in 2148.

The development of new medications and new technology-assisted surgical techniques are likely to open new possibilities in the management of chronic and acute illnesses. These same developments will strain cash-limited health budgets and pose new ethical dilemmas in relation to treatment priorities.

Although currently in their infancy, bio-genetic methods of disease prevention and symptom control are likely to have an

'Ultimately, technology deals with extension of human capability. It does not address the question of the meaning and purpose of human society. Thus, in my view, the great need in the coming two decades is not so much for more mind-blowing technology, as it is to explore the depths of the human personality; to discover what deeper meaning can be given to human existence as we enter a radically changed environment of technological possibility.'

Van Wishard (2006) 'Global changes reshaping the corporate environment' A Presentation for the Public Affairs Council, Washington, D.C.

accelerating impact (albeit in ways that are currently hard to predict) on patterns of morbidity as the century progresses – making it more challenging to plan long-term capital- and workforce- investment.

The broad interface between technology and healthcare is generally referred to as eHealth. The notion subsumes, but should go beyond, the application of computer-assisted information management systems and new technology-assisted forms of health and social care delivery and self and community care focussed support.

The great challenge for the health and social care communities is to harness the power and the potential of new technologies in ways that transform the nature of public care as profoundly as they have transformed other areas of all of our lives.

Before considering some of the challenges in relation to eHealth, it is worth considering how technological advances have impacted on each of our personal lives. Although such impact is not always positive, some new technologies can add enormous value to the quality of our lives.

1 Reflecting on the last decade, can you identify a way in which technological advance has had a damaging impact upon:

a) the quality of your personal life and/or that of your family?

b) the quality of your work life?

2 Again, reflecting on the last decade, can you identify a specific technological innovation that has *improved*:

a) the quality of your own life and/or that of your family?

b) the quality of your working life?

3 Reflecting on the two positive impacts, are there any common themes that unite the technologies concerned?

Common themes ……..

'Convivial tools are those which give each person who uses them the greatest opportunity to enrich the environment with the fruits of his or her vision.'

Ivan Illich, 1973 *Tools for Conviviality*

In our personal response to all innovation, each one of us falls somewhere on a spectrum that stretches from 'early adopters' – that is, those who eagerly experiment with and embrace innovation – to 'resistors', that is, those who cling to habitual and familiar patterns and are suspicious or hesitant in their approach to innovation. Despite generational factors (an innovation to an older person may form a given and intuitively understood part of the world picture of a young child), distribution is on a classic Bell shaped curve: a minority clusters towards one or other end of this continuum, while the majority of us come to terms gradually with the need to overcome 'the tyranny of habit'.

However, the track record of public sector organisations in relation to the early adoption of innovations does not seem to be similarly distributed. Not least in relation to new technological innovation, public sector bodies tend to exhibit resistor characteristics: they are slow to adapt, adopt and implement new technologies.

This is not merely a reflection of a risk-averse approach to the cost of new technologies. Anyone who worked in Local Government or the NHS from the 1970s onwards will have witnessed the delivery of costly computer systems that gathered dust or, more recently, seen state-of-the-art video conferencing facilities installed in rooms that have quickly reverted back to their prior status as 'meeting rooms' – albeit now cluttered with somewhat forlorn audio visual kit.

'The NHS has been slow to adopt existing technologies, such as personal computers and mobile 'phones, which have the potential to benefit patients and healthcare professionals. The poor track record of successfully introducing large-scale public sector information technology (IT) systems has generated resistance and scepticism about whether new complex systems will ever work and if they are good use of public money.'

Royal Society, 2006. *Digital healthcare: the impact of information and communication technologies on health and healthcare*

'Information and communication technologies (ICTs) have the potential to transform radically the delivery of healthcare and to address future health challenges. Whether they actually do so will depend on the design and implementation processes

The Royal Society has undertaken a broadly-based and well structured review of some aspects of eHealth – 'Digital healthcare: the impact of information and communication technologies on health and healthcare' Royal Society 2006 – though as the title indicates, it tends to focus upon ICT as opposed to wider technological innovation. Nevertheless, it recognises some of the real obstacles to releasing the potential for improvement as well as some of the profound benefits that could result, were this potential to be realised.

sufficiently accounting for the users' needs, and the provision of adequate support and training after their introduction.'

Royal Society, 2006

There is no doubt that insufficient attention has been paid to those factors that facilitate or impede implementation. Purchasing decisions have, for the most part, been undertaken by technophiles whose pre-occupation has been with the power of the technology – as opposed to the likelihood of that power being understood and utilised in the pressured world of health and social care practice.

The problems that have beset the NHS National Programme for Information Technology (NPFIT) have been well rehearsed – and its shortcomings graphically exposed by the Public Accounts Committee, the National Audit Office and a host of commentators both within and without the NHS. Neither the long-trailed Electronic Patient Record nor the 'Choose and Book' programme have – as yet – delivered many of improvements and efficiency gains that are long overdue in a system, some of whose mechanisms of (mis)communication are archaic.

'The single most important factor in realising the potential of IMCT is the people who use it. Users, who understand the complexities of the care process, must also understand the systems, and must be involved in their design, development and implementation. IMCT must become an integral part of all basic nursing [and by extension all other professional] education and CPD – not an add-on or optional extra.'

Clark, J. (2007) Chair, RCN Information in Nursing Forum

According to the House of Commons Public Accounts Committee's report on NPfIT:

- *the piloting and deployment of the shared electronic patient clinical record is already running two years behind schedule and no firm implementation date exists;*
- *the suppliers to the Programme are clearly struggling to deliver – one of the largest, Accenture, has now withdrawn – and the Department is unlikely to complete the Programme anywhere near its original schedule;*
- *the Department has much still to do to win hearts and minds in the NHS, especially among clinicians, and needs to show that it can deliver on its*

'The role of technology is to facilitate this self-care by deploying systems and devices that users find genuinely useful in their endeavours, providing them with the psychological security to remain independent for as long as possible.'

BT Vital Life, 2006

> *promises, supply solutions that are fit for purpose, learn from its mistakes, and respond constructively to feedback from users in the NHS;*
>
> - *there is still much uncertainty about the costs of the Programme for the local NHS and the value of the benefits it should achieve.*
>
> Public Accounts Committee, 2007. *Department of Health: 29th Report on the National Programme for Information Technology in the NHS.* April 2007

Whilst the 'Connecting for Health' programme is an attempt to address a previous failure to engage professional groups as full and active partners in the development and roll out of new IMCT systems, it has been argued (Stanton, 2007) that it's focus is more upon 'Connecting the NHS' than it is on connecting the health and social care systems – let alone all of those other interdependent services that need to collaborate in the promotion of health and wellbeing.

'A number of NHS Alliance GPs report younger patients arriving for appointments armed with a wealth of up-to-date (if not always scientifically robust) information about their own condition - and treatment options - that they have plundered from the Internet. Given the scope of their generalist clinical responsibilities and the exponential proliferation of new research and pharmacological advances within often very specific disease areas, many acknowledge that, once their initial defensiveness had been overcome, it has become an unexpected adjunct to their professional updating and development.'

An unintended negative consequence of the NPfIT difficulties has been that its allegedly 'looming imminence' has acted as a break upon local initiatives and the take-up of immediately available IMCT developments which are not dependent upon it (albeit many of them could, subsequently, interface with it).

One such example is the BT Vital Life programme (BT 2006), that can deliver significant efficiency gains and quality of life improvements for older people by linking existing technologies and some innovative service elements of provision in a 'linked solution package' (please see Figure 12 on the next page).

Notwithstanding the benefits that it could deliver, take-up has been poor – in part because the benefits accrue to a healthcare system – rather than to any one organisation that might need to commit to investment in the development of the local system.

It may well be that it will take bottom-up, service user pressure to lever change into a resistant system – as people who are themselves accustomed to making use of new technologies become impatient with a system that seems not to have entered the 21st Century.

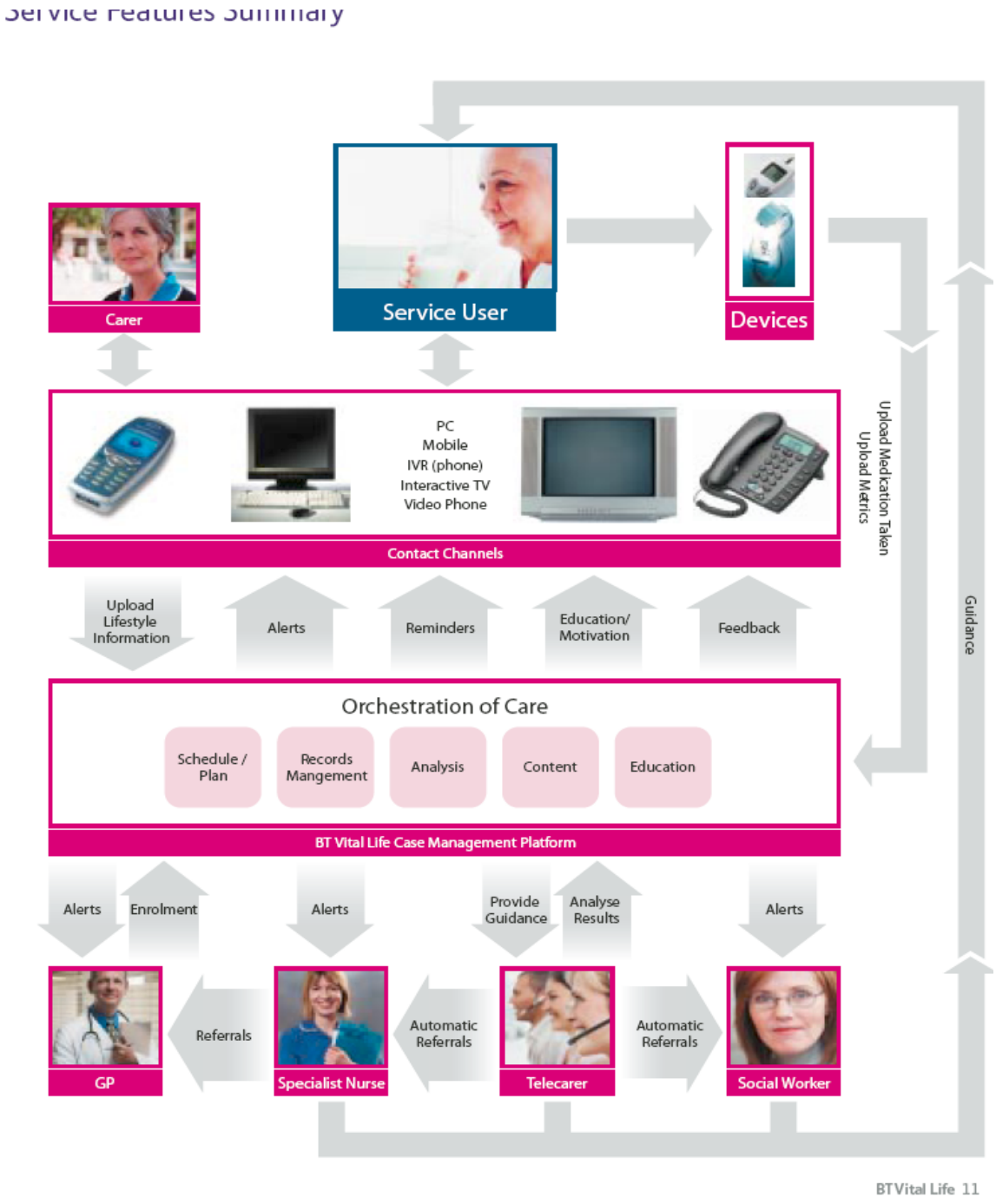


Figure 12: BT Vital Life – summary of service features

Alongside pressure from service users, undaunted by NPfIT's persisting problems – or perhaps spurred on by them – the Government has just launched the new centrally funded and highly ambitious NHS 'Choices' programme that will go live this summer and makes a range of new technologies available to support its broader Patient Choices policy imperative.

The programme will employ state-of-the art interactive and multi-media technology and claims to overcome the digital divide by making information available in a range of formats in order to 'extend choice to the most disadvantaged groups in society'. Whether individual practitioners or NHS organisations are themselves geared up to deal with the potential demand for evidenced-based care that the success of such a programme could generate is open to question.

> *The NHS Choices programme includes the following features:*
>
> *Searchable comprehensive directories e.g. on hospitals, GPs and care homes;*
>
> *Comparative data on hospital waiting times, cleanliness and readmission rates;*
>
> *Access to a vast library of approved medical literature, previously only available to clinicians, to enable a deeper understanding of conditions & treatment options;*
>
> *Easy to understand multi-media guides on the 40 most common procedures e.g. hip replacement;*
>
> *Detailed guides to living with 20 long-term conditions such as diabetes will help patients manage their condition. Expert opinions from professionals and patients will provide advice and support;*
>
> *Individual and family health risk assessments based on age, sex and location;*
>
> *Information that will help the well to stay fit and assist those who are unwell to manage their condition;*
>
> *'Magazine' content that will reflect the interests and needs of different groups such as teenagers, families and those over 70; and*
>
> *Patients will be able to directly comment and feedback on their hospital*
>
> *Audio programmes will be available for streaming to local radio stations, televisual content will be supplied for burning onto DVDs, and health professionals will be able to provide lifestyle information about healthier living with pamphlets that can be printed off at public libraries or in the GP surgery.*

Another, more profound criticism that could be made of a number of these approaches is that, notwithstanding their strengths, they share three characteristic weaknesses.

- They have, for the most part, been designed *for*, rather than *by and with*, service users.
- They tend to be sectorally specific rather than whole system in their origin and design features.
- They derive from 'within the box' as opposed to visionary and transformative thinking.

Please go to the Patient Voices website – www.patientvoices.org.uk. Click on 'The Stories' tab and navigate to 'Stories from Connecting for Health'

There you can look at/listen to the story called 'Leanna', which illustrates from a service user's perspective how existing technologies might have been used to improve both the quality and the safety of care for a vulnerable child.

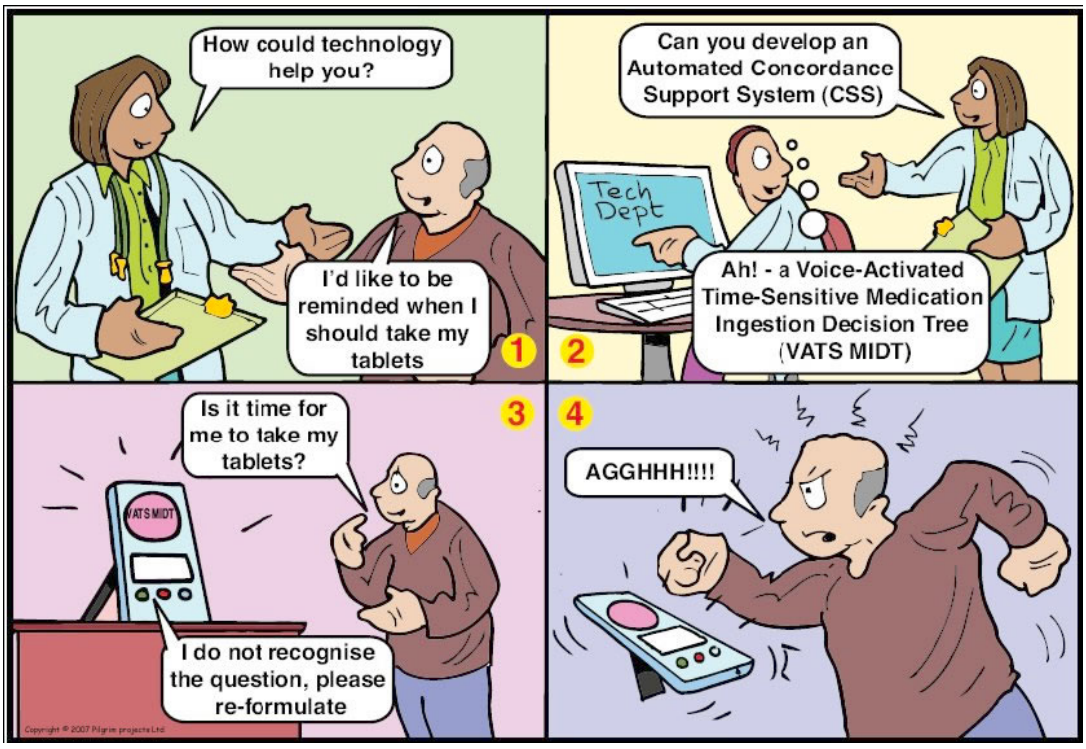


Figure 13: Can technology help?

It is arguable that only if and when these weaknesses are addressed – whether by local or national actions – will the full potential of new technologies as drivers, as well as enablers, of system change be unleashed.

Is there anything that can be done locally to engage service users in the development and implementation of new technologies in healthcare?

Are there ways in which the local health, social care and wider Local Strategic Partnership can develop collaborative technology focussed strategies?

Can the expertise within local universities and the business community be harnessed to add creative value to an approach to technological development that is focussed on health and wellbeing?

Even without futuristic innovation it is clear that more effective uses could be made of existing technological potential. The isolation experienced by older people and the profoundly physically disabled could be significantly lessened by participation in 'virtual online communities' – and other facets of the personality could be explored through Avatars who/that inhabit virtual worlds.

Some effective uses of new technology already exist in some parts of the country, including:

- 'Smart' houses for older people that prompt medication concordance and monitor wellbeing
- body sensors that provide on going transmissible monitoring of the health status of people with complex co-morbidities
- 'electronic tagging' of confused people to reduce the risk they present to themselves while living in the community already exist in different parts of the country.

In Japan, robotic assistants already undertake lifting and moving tasks for infirm patients while 'robot nurse assistants' that undertake routine cleaning and information giving tasks are scheduled to make their first appearance in a number of UK hospitals by 2010.

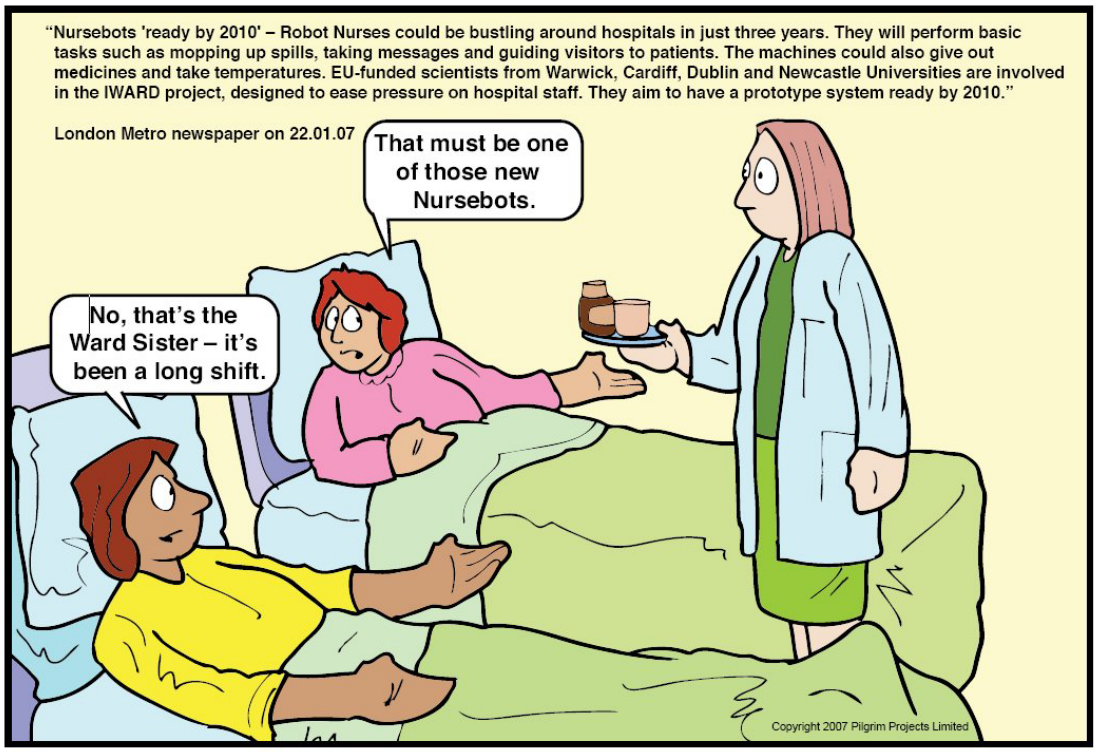


Figure 14: Nursebots

The fact that many routine elements of care will, in the future, be delivered without face-to-face human intervention makes it all the more essential that the quality of the face-to-face transactions that do occur between the next generation of professional staff and service users should encapsulate the humanity, compassion and respect upon the welfare state itself is based.

In which three areas do you think new technologies can make the most profound contribution to improvements in the relevance and quality of local public services?

1

2

3

Section 5: Conclusion

Possibly, all that can be said with certainty about the nature of public services in 2148 is that, if they have survived, they will be profoundly different to those with which we have become familiar – possibly in relation to their funding, as well as in relation to the nature, pattern and location of the services themselves and the professional staff who work within them.

'We are not producing people with the skills to lead organisations and we need to do something about that.'

David Nicholson, CEO, NHS 'Right On With Reform' September 2006

Because of this uncertainty, and the exponential rate of change in so many of the factors that impact upon the health and wellbeing of individuals and of communities – some of which arise directly out of the current government's system reform agenda – only one certain imperative exists both for public sector organisations and for the professional, managerial and executive staff who comprise them (as well as for those who govern them).

If they are to thrive they will need to develop and sustain maximum Flexible Adaptive Capability Tactically and Strategically (the 'new' FACTS of 21st century working life). Only in this way can they remain relevant, efficient and effective servants of the public good.

The dominant organisational form of healthcare delivery across the western capitalist (and former communist world) has been the 'bureaucratic hierarchy'. Bureaucratic hierarchies, as Eliot Jacques pointed out, 'are a power instrument of the first order – for those who control the bureaucratic apparatus'. They are powerful, promote a culture of obedience and are self-perpetuating. By their nature, however, they tend to be inflexible, procedurally bound, retrospective, suspicious of innovation, risk averse and insensitive.

The 'caring bureaucracy' is, at best, a perplexing conundrum – not least because such systems are resistant to learning. Although, optimistically, the Department of Health response to the deep systemic failure revealed by Sir Ian Kennedy's investigation at Bristol Royal Infirmary was entitled An Organisation with a Memory, many commentators have pointed out that every one of the recommendations made by Kennedy had been made by previous public inquiries into significant failures – and that the majority of them were not and have still to be routinely implemented. Alternative and more apposite descriptions of the system's capacity to retain information have, therefore, been proposed.

Figure 15: Forgetting to remember

If any organisation is to survive in a rapidly changing and competitive environment, it is essential that it is attentive to and learns from its evolving context – and adapts itself to respond rapidly to altered market conditions and novel customer/consumer demand.

The fact that North East Essex PCT is a new organisation offers an opportunity to develop a lean and flexible organisational form – one that is organic rather than bureaucratic, and 'leaderful' rather than hierarchical. In other words, tactical decision making authority is devolved, within specified strategic parameters, to local groups, teams and individuals.

'Bureaucracies are inspired by the policy manuals, forms and structural diagrams that litter their offices. They have thesaurus crammed with a thousand ways to say "no".

Transformational organisations are inspired by works of art and poetry. They say "Yes" – or "Yes, if".

Where would you rather work?'

Bertrand Jouslin De Noray, 2005

Unlike many established acute health and other care providers, it is not tied to historical organisational orthodoxies and can, not least because of the small central services infra-structure that it has inherited, more easily pursue the holy grail of 'zero gravity' that has been identified by the Harvard Business School and others for '21st Century Fit' organisations.

Zero gravity refers to an organisation that has minimised the drag presented by fixed physical assets, that out-sources all functions that are not integrally its 'core' business – and that recognises that its greatest assets are the creativity and genius of its staff, the quality and strength of its collaborative alliances and the esteem in which it is held by all of those who come into contact with it.

Just as a new form of organisational form and culture is demanded by the FACTS of 21st Century working life, so a new form of professionalism, shorn of narrow and outdated tribalism, role rigidity and reflexive paternalism needs to be evolved by the education and training to which all new professionals are exposed – not least by those in health, social care and other public facing professions.

Exemplary work to translate this into reality is already underway in the Medical Schools at Leeds and Sheffield and in a number of national and regional nursing and AHP faculties.

Such a profound re-conceptualisation of professional identity goes significantly beyond the managerialist and structuralist professional changes imposed by Agenda for Change and Modernising Medical Careers. It presupposes a willingness to welcome rather than resist more transparent accountability to service users, to their organisations and, by extension, to society at large.

It requires that technical and clinical expertise is matched in face to face transactions by authenticity, compassion and attention to the whole person in all of their physical, emotional, psychological and spiritual complexity– rather than just to the symptom, disease process or presenting problem.

Such attention is a prerequisite to what Bob Sang, Peter Degeling and others have identified as the need to move from professionally driven to 'co-produced care' – not least in primary care – during this century.

'It is clear that a very different model of professionalism needs to be developed in policing.'

P. Neyroud, CEO National Policing Improvement Agency *The challenge of 21st Century Policing*

'Professional resistance to transparent accountability and performance regimes runs counter to the publics demand to know and choose rather than just to trust what the professionals tell them.'

Hill, R. *The Matter of How: Change and Reform in 21st Century Public Services*

'Patients and carers reported feeling excluded from aspects of patients' care. The most frequent complaint was that clinicians were often insensitive …. It was felt that they tended to dispense treatment rather than care.'

National Audit Office (2007) 'Improving quality and safety - progress in implementing clinical governance in primary care: Lessons for the new Primary Care Trusts.

'All too often, the work of primary care is limited to haphazard monitoring and, with the onset of a crisis, acting as a referral point into hospital-based medical expertise. On a broader front, service providers in both acute and primary care are either ignorant of or ignore the potential and functional centrality of their 'patients' potential contributions to managing and determining both short- and long-term outcome.'

Gravel et al, 2006

In the future, in order to secure improvements in both the safety, quality and cost-effectiveness of provision, professionals, patients and their own carers will need to work in open, collaborative partnerships to define individual need, plan, deliver and evaluate care in a constant, iterative cycle of reflection and refinement.

'A mature culture will settle on sharing power and responsibility, on a subtle negotiation . . . between professional and patient as to what each wants and what each can deliver. This is the culture we should work towards – helping each other as we go'.

Ian Kennedy, 2003. 'Patients are experts in their own field' *BMJ*

Please go to www.patientvoices.org.uk , click on 'The Stories' tab, and follow the link to Ian Kramer's story: 'Measured Innovation'.

Briefly note your responses to the story.

New professionals need to go on learning from, for and through their own practice and to recognise that this will itself enable them to thrive in an employment market where linear progression and scaling of predefined progression ladders will be replaced by the ability to adapt to and adopt novel professional identities – both within public sector, third sector and private sector provider organisations.

'We should help [professionals] through the barriers that prevent them seeing their patients as interactive partners. The place to start is at the beginning of professional education, but this process never ends'

Ian Kennedy, 2003. 'Patients are experts in their own field' *BMJ*

Organisations that attract and retain the highest calibre staff have an obvious competitive advantage and are likely to embody and reflect the same values, aspirations and characteristics of wonder, enquiry and measured innovation that Donald Schon defined as the key ingredient of expert helping:

'The unique situation is understood through the attempt to change it, and changed through the attempt to understand it.'

It is this understanding that should characterise the approach of the North East Essex PCT, its partners and their staff groups as they grapple with the old and new needs that arise in the decades that lie between them and 2048. Notwithstanding the scale of these challenges, they can take comfort from the resilience, optimism and strength displayed by so many of those that they seek to help.

If you have not already done so, please go to www.patientvoices.org.uk, click on 'The Stories' tab and follow the link to 'Reconnecting with Life: stories of life after stroke. There you can watch/listen to Rhizia Choudhury's story 'A brighter world waiting' before considering the following question.

How confident are you that the local NHS and other public services will have survived and thrived by 2148?

Not at all *Fully*

0 1 2 3 4 5 6 7 8 9

In looking to the future, all of us need to continue to act purposefully and hopefully in the present, inspired and sustained by the recognition voiced by the young Anne Frank in the darkest days of the war in Europe that was so powerful a stimulus to the creation of the Welfare State:

'How wonderful it is that nobody need wait a single moment before starting to improve the world.'

Anne Frank (1945) *The Diary of a Young Girl*

Paul Stanton

May 2007