


IRREVERSIBLE?

HEALTH AND SOCIAL CARE POLICY IN A POST-COALITION LANDSCAPE

Edited by **Dan Wilson Craw** and **Dr Martin Edobor**



Foreword by **JAMIE REED MP**



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FOREWORD

Jamie Reed MP

The NHS is our most valued institution; it regularly tops polls of what makes people proud to be British. On the 5th July, our NHS turned 65; it was formed when the healthcare needs of the population were significantly different to what we face today. Now, the 21st century is asking questions of our 20th century health and care system and we need to ensure that the NHS can cope with the challenges of the future. In the past, England has tried to meet one person's needs through three services: physical, through the NHS; mental through a detached system on the edge of the NHS and social through a means test and charged-for council service.

In 2013, the NHS is creaking under the pressure being exerted by David Cameron and Jeremy Hunt. A&E waiting times are up, there are thousands fewer nurses, treatments are being rationed, hospitals are full to bursting with ambulances queuing outside, patients being forced to wait on trolleys and the compulsory tendering of services to private companies. In less than 3 years, the Coalition has taken an NHS with the highest ever satisfaction levels and the lowest waiting times since records began and delivered a fragmented system thrown into chaos by an unwanted reorganisation.

Under the Coalition, the responsibility for Public Health has been transferred to local authorities, yet we have seen repeated neglect of public health issues – the dropping of standardised packaging for cigarettes and minimum unit pricing of alcohol for example. The fragmented and chaotic approach to policy making within the Coalition's Department of Health has trickled down to the front line. The shambolic roll-out of NHS 111 is a prime example of the Government's lackadaisical approach to front line care and it is the patients and hard working staff that suffer.

Everything outlined above shows that the status quo cannot be maintained. The NHS needs to be reformed to cope with the challenges of the 21st Century. This said, it is often stated by professional bodies that the Government's Health and Social Care Act actually prevented the real, clinical reforms that were needed throughout the system; only through thorough engagement with patients, clinicians and experts can we ensure that any reforms support the work that hundreds of thousands of hard-working, caring staff are doing every day.

Not only do we need to give the NHS the tools to address today's issues, we also need to put right the failures of those sat in the ministerial offices in Richmond House. This pamphlet will contribute a debate that is already taking place within the Labour Party as a whole. On the 24th January, Andy Burnham, the Shadow Secretary of State for Health, outlined his vision for Whole-Person Care: where the NHS does not focus on treating an ailment, injury or illness, it treats the whole person.

This would be the full integration of physical, social and mental care into one, unified service. When Nye Bevan established the NHS in 1948, he did so as Secretary of State for Health with the responsibility for housing. For good public health in the 21st century, we need to move towards commissioning more services focused on preventing ill-health; this would mean better links across Whitehall so that housing, planning, employment, leisure and education are all set up to ensure the wellbeing of the wider population.

These are issues that are incredibly complex and it is essential that we make the right decisions. The essays in this pamphlet show the complexity of issues throughout the system from how to measure performance in the NHS through to how to create a robust incentive system for preventing illnesses within the population.

This pamphlet seeks to ask if the policies of the coalition are irreversible. The answer is no: Labour has promised to repeal the Health & Social Care Act. It is in this spirit that we should reflect upon the words of Nye Bevan:

“The NHS will last as long as there are folk left with the faith to fight for it”

This faith endures: in the Labour Party, in the medical profession and amongst the general public.



Introduction

Dan Wilson Crow, Young Fabians Health Network Steering Group

Dr Martin Edobor, Chair of the Young Fabian Health Network 2011-12

Background

The Young Fabian Health Network was launched in January 2012, as the Coalition Government was pushing through the most controversial reforms the National Health Service has ever seen. At the same time, the pressures on the public finances have not only placed limits on the NHS's ability to respond to increasing demand for services, but have also forced us to consider what the state will be able to provide as life expectancy increases and the population above retirement age grows.

In some respects the Health and Social Care Bill was presented as a natural “evolution” of the policies pursued under the Blair and Brown Governments, but many on the left saw elements of the legislation as a threat to the very fabric of the NHS as a public service free at the point of delivery. Despite the passionate campaigning against the changes, the real issues at stake are not quite as clear-cut as whether or not the NHS should be sold off to the Tories' chums. Nevertheless, the scale of the reforms and the risk of unintended consequences in changing an organisation so big give us genuine concerns about their implications for the wellbeing of patients and the ability of professionals to do their jobs.

As a Labour-affiliated organisation, the Health Network wanted to take a look beyond the rhetoric at exactly what the Coalition's policies mean for our health and social care system, and how Labour – as the party that historically commands the most public trust with the NHS – should respond. In these six chapters, our authors look at where Labour should pick its battles and what policy post-Coalition should look like.

Overview of the chapters

Our first chapter, by Samuel Conway, looks at the shift away from targets and towards patient outcomes, suggesting a combination of measurement and aggregation of value added and stakeholder input to hold individual organisations to account.

Dan Wilson Crow considers the impact of the devolution of decision making to GPs and other clinicians and how Labour can avoid another top-down reorganisation while addressing fears of fragmentation.

Damita Abayaratne sets out principles to follow when letting private companies into the health-care system.

In our fourth essay, Kwaku Adjei calls for a combination of welfare and pension reform and integration of the care system with the NHS in order to prepare our generation for retirement.

Lauren Milden and Martin Edobor look at what steps the NHS can take to avoid costly health-care interventions by adopting preventive healthcare practices in our fifth essay.

Finally, Adebusuyi Adeyemi takes an overview of the above issues and considers the pressures facing the NHS from changing demographics and how the NHS should respond to generational dynamics in order to be sustainable in the decades ahead.

Young Fabian Health Network

The aim of the Young Fabian Health Network is to connect professionals, academics and policymakers in the health and social care sectors, providing a forum for policy-orientated debate and discussion which will feed into wider Young Fabian thinking. The network has a steering group, which members are encouraged to join. The steering group decides the overall direction of the network, in addition to organising events.

For over a century the Fabian Society has helped to drive policy formation and discussion on the left, we hope to continue that tradition. Through the chapters of this pamphlet, we aim to influence the discourse surrounding current social care policy.

To learn more about the Young Fabians, or to find out how to become a member, please visit us at www.youngfabians.org.uk.

The value of measurement: Measuring performance in the NHS

Samuel Conway

In order to ensure health systems are effective it is vital to measure how they perform. No healthcare system has infinite resources, so while we ensure that patients receive high quality care, we must also ensure that interventions provide value for money. When government spending is challenged and the public demand continuous improvement in healthcare, it is more important than ever to accurately assess what works in order to maintain efficient distribution of resources and drive performance. However, performance itself has inherently different values and aims within its definition, and there are many varying ideas as to what constitutes “good” performance. It is therefore important that the values we want within our NHS are included right at the heart of our measurements of its performance.

The previous Labour government famously relied on targets, a number of absolute indicators in different areas which allowed trusts within the NHS to show how they were performing¹. Targets were in areas where the Government thought improvement was needed (for example waiting times and cancer diagnosis) and provided a useful mechanism of focusing the efforts of relatively independent NHS and Primary Care Trusts onto issues which attracted public concern.

With the massive increase in NHS spending after 2000, targets too provided an effective political tool for Labour, demonstrating that increased investment produced real results on the

ground. However, a system based on targets had inherent flaws. Targets are based on a set number (described by Andrew Lansley and others as “arbitrary”), such as a cancer pathway of 18 weeks or an A&E wait of 4 hours, which was achieved or not. When a target was hit, there was little incentive for further improvement. This was even more obvious in areas where performance was not directly measured producing neglect of services and patient outcomes; for example resources were concentrated on meeting targets for MRSA infections whilst other hospital-acquired infections were sidelined². Professionals within the NHS resented these arbitrary rules as bureaucratic and ineffective, and management were often accused of pressuring staff into cutting corners to ensure targets were met, even to the possible detriment of care³. So too was the political purpose of targets undermined when the press began reporting stories of full ambulances lined up outside A&E units to cut waiting times and patients left on trolleys in corridors⁴, creating a public perception that targets were easily manipulated and meaningless.

The coalition attempted to rectify some of these inadequacies whilst incorporating their own ideas about ‘liberating’ the NHS⁵. The NHS Outcomes Framework is the result, its intention to focus on the patient outcomes themselves rather than the processes used to achieve them⁶. This had 3 stated aims: to provide a national-level overview of health performance, provide a mechanism of accountability for the powerful local Clinical Commissioning Groups (fitting with the localism agenda) and to provide a catalyst to increase quality.

These outcome indicators are arranged into 5 groups with 60 distinct indicators overall, allowing a more sensitive and broad assessment compared to the relatively narrow targets such as those described above. The framework takes health inequalities into account when setting baseline levels of performance, which previous systems have missed, thus improving our picture of the situation. The Outcome Framework also attempts to include indicators to cover performance in those with learning difficulties and dementia; two populations long and unfairly left out of performance indicators (however, it is as yet unstated how this will actually be done). Also significant is the aim to integrate the Outcomes Framework with other government frameworks covering public health and adult social care. The longstanding gulf between these areas is already a major problem – numbers of NHS patients with complex social issues or with lifestyle-related conditions such as obesity are increasing – so the integration of frameworks is a step in the right direction⁷. However, this aim is unlikely to be realised with the greater fragmentation of services between the Department of Health and local government elsewhere in this Government’s reforms⁸.

Fundamentally, the Health and Social Care Act aims to promote competition and dramatically enhance the role of the market in healthcare, especially private provision under the ‘Any Qualified Provider’ clause of the Act. This in itself provides problems for accurate and fair assessment of performance. Private providers are not obliged to treat patients like NHS institutions are which may lead to ‘cherry-picking’ of cases where good outcomes seem more likely rather than difficult but necessary interventions.

Companies may also be apprehensive to publish results, citing corporate confidentiality as a reason especially when results are negative. In this case, there is little redress as private institu-

tions are not subject to the same Freedom of Information legislation as comparable NHS institutions, meaning there is little legal framework to make companies comply. Most worryingly, private providers may simply publish untruthful figures about their performance as Serco were caught doing recently with GP services⁹.

Yet even if these scenarios do not arise, a transition to using outcome indicators is not simple. First, the Outcomes Framework will only use the incorporation of health inequalities into indicators to set baseline measures, and will not use and update them continuously. The figures will not reflect future changes in health inequalities (a predictable consequence of austerity), which will affect their accuracy. Second, there is a question that outcomes universally are the most accurate measure of performance¹⁰. Finally, the complexity of the new system may distance the understanding of performance measures from the public at large. While the system needs to be accurate and useful to experts and government, the measures must be clear to patients and the public.

In order to drive performance and build a new NHS based on collaborative values the next Labour Government must incorporate a new system of measures which address the shortcomings of the previous methods. Measurements must ensure good utilisation of resources and accurately reflect real performance on the ground. A new system must have the trust of professionals, patients and the public. And whilst a new system must place less importance on the political objectives of showing how the government is improving performance, it must be understandable and usable by everyone who uses the NHS to understand how care is being improved.

One mechanism of ensuring accuracy is to ensure that performance represents the work of healthcare organisations themselves and is not affected by confounding factors outside the control of that organisation, i.e. the vastly different economic and social landscapes in which organisations exist. The use of a 'value-added' system, as often used in education league tables, could go some way to achieving this. One possible method of allowing a more sensitive and fair assessment of institutions is to incorporate statistics about the population the organisation serves into its final score. This will also allow sharing of strategies which are successful between different organisations which serve populations possessing difficult but similar needs - strategies that may be lost with the use of one-size-fits-all performance indicators.

Whilst this adds accuracy and fairness, use of such statistics adds more complexity to a system which by its very nature must be detailed to be useful. In order to make figures more accessible to patients, we should consider incorporating all the performance indicators into a single relative figure, such as a percentage improvement, to give an overall representation of an organisation (in the way GDP growth is used to represent the health of a nation's economy). Incorporation of a number of separate measures into a single year-on-year percentage improvement in performance, including value-added scores, makes complex statistics interpretable to people outside health or policy professions and ensures confidence in NHS standards. Such a simple figure also allows us to ensure performance is improving year on year, allowing further appraisal of trusts that perform well and special interrogation of trusts that do not. Finally, the use

of a relative figure rather than one which is absolute means there is nothing to be gained from competition with similar institutions, thereby promoting cooperation between organisations and driving improvement.

One final method to ensure that there is public and professional confidence in our statistics would be to bring representative groups into the process of measuring performance itself. From the design of indicators through to the assessments of performance, incorporation of patient groups and professional organisations into the measuring process will help ensure that the measures used accurately reflect the state on the ground. This would require more than passive consultation by officials but a real inclusion of stakeholders in the panels and groups responsible for designing measures thus allowing greater utility of frontline professional opinion and appreciation of patient's priorities by bringing their unique perspectives into the heart of measurement. Whilst experts and civil servants are essential in the designing and implementation of a complex system, stakeholder involvement will ensure the measures are meaningful and retain the confidence of those most affected – a truly patient-centred assessment of performance.

The next Labour Government will inherit a healthcare situation very different to the one which it left after 13 years in office. In addition to the real-terms cuts in NHS spending and its costly reorganisation, the true social costs of this Government's austerity programme will be in full sight. Greater health inequalities and fragmented services may allow Labour to capitalise politically with its history of looking after the NHS, but it will also allow us to bring a new focus on how integrated, effective government services can challenge the complex health problems England faces, without the competitive dogma which has invaded our modern healthcare service. The New Labour solution of dramatically increasing NHS spending to overcome underinvestment and decline whilst not challenging core problems will simply not be an option. Therefore, Labour must ensure that cooperation, collaboration and sharing of best strategies are at the core of the new NHS. By using accurate and relevant measures of performance – measures that show how we are achieving our aims and priorities – we can ensure that these values are inherent within tomorrow's high capability and high value healthcare service.

[1] A short summary of targets in place and their usefulness before the 2010 General Election has been produced by The King's Fund and is available here:

<http://www.kingsfund.org.uk/projects/general-election-2010/key-election-questions/performance-targets>

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Should GPs lead the commissioning of services?

Dan Wilson Crow

The biggest change to the National Health Service under the Health and Social Care Act 2012 was the abolition of Strategic Health Authorities and Primary Care Trusts (PCTs) and their replacement with Clinical Commissioning Groups and the NHS Commissioning Board – now branded NHS England.

The idea behind this is to equip the NHS for a tighter fiscal environment by removing bureaucratic layers and to inject some competitive spirit to commissioning. These changes are intended to take out costs from the Department of Health's budget while retaining frontline caregivers and to force commissioners to seek out efficiencies where they can.¹

In this essay, I explain that there are doubts that the reforms will achieve the savings required while also maintaining the level of service the people of England currently enjoy free at the point of delivery. First, GPs are not in a position to design commissioning services while also doing their day job, so many CCGs will find they need to employ commissioning experts.

Second, the cost of the changes will be huge, particularly if the skills and expertise held by current managers is lost. Finally, the structures are at risk of undermining the provision of free healthcare to all.

Background to the reforms

Neither the central principle of the reforms – that clinicians should have a say in the design of secondary care services – nor the secondary principle – that competition can drive improvements – are new. The Conservative Government of the 1990s introduced the purchaser-provider split and GP fundholding, and the last Labour government continued the utilisation of the private sector and supported practice-based commissioning (PBC). Even the failure of PBC to take off in the late 2000s did not remove the view within Parliament that PCTs suffered due to a lack of clinical knowledge².

Indeed, Andy Burnham offered to work with the government to make clinicians responsible for commissioning if they dropped the Health and Social Care Bill, arguing that legislation was unnecessary to achieve that objective.³

Should clinicians commission?

While there is an appetite across the parties for greater involvement of doctors and nurses in designing healthcare services, the professions have been a little less enthusiastic. The British Medical Association (BMA) and Royal College of GPs both opposed the Bill, and there is evidence of poor engagement with the new clinical commissioning groups, both by practice⁴ and among salaried and locum GPs⁵. The BMA has considered a boycott of the structures⁶. Campaigners argue that GPs are far too busy already to manage commissioning structures, and cannot deliver the same level of service to patients because of the demands of the CCGs⁷. Doctors have not been trained to balance budgets, and while their expertise is vital to design efficient services that improve outcomes for patients, they will have to bring in administrative support. The government have given CCGs the freedom to develop their own structures and processes for commissioning, but after initial fears that the disbanding of PCTs would leave a skills vacuum⁸, commissioning support services have been set up in order to aid the transition and will eventually become independent. How these will develop, what use they make of the private sector and how popular they are with CCGs themselves is unclear.⁹

How much will it cost?

The reforms have been enacted while the NHS faces its biggest challenge: making £20bn of savings over five years because of rising demands from an ageing population, and a budget which, while ring-fenced, is unlikely to increase significantly in a climate of fiscal austerity. The Secretary of State, Jeremy Hunt, expects the reforms to cost £1.6 billion in total – up from an initial estimate of £1.3 billion, and he claims that they will result in £1.5 billion annual savings¹⁰. Managers will be too busy dealing with restructuring to identify savings¹¹, while the involvement of frontline staff in the new commissioning groups will divert resources from patient care¹². Furthermore, many of the people at PCTs and SHAs who are being made redundant could have been kept on and payouts would not have been made to people who would only go on to be rehired by the new structures. The savings would be easier to make without the distraction of rehiring.

Flawed structures

The Secretary of State amended the Bill belatedly and rather begrudgingly to retain responsibility for ensuring that there is universal healthcare, but the Coalition have still ensured that they avoid making tough decisions about how to fund healthcare in a time of shrinking budgets by giving this responsibility to the new commissioning structures. CCGs and NHS England are set outcomes objectives to work towards and NICE guidance and best practice to help them achieve those, but will be under-resourced and incapable of ticking every box. They will have to prioritise some aspects of care over others just to balance the books.

The Government are giving them a hand to do this by, for example, putting public health in the hands of local authorities. However, analysis in the British Medical Journal claims that this means some areas of care, such as sexual health, are not any one organisation's responsibility and could potentially be ignored by all health providers in a given area¹³.

The Act also lets each CCG determine what a free health service should provide, rather than be instructed to provide care by Whitehall. This means that they could decide to stop paying for certain types of treatments, and if the commissioning recommendations made to the board of a CCG are coming from an outsourced private, profit-making company, the decisions made could result in savings being made where people will suffer most, while money-spinning treatments are kept. Treatments not provided with public money could lead patients to pay for care with their own money, or go private completely¹³.

CCGs will not have a monopoly over the care of people within their geographical area. A resident of one area could decide to register with a GP in a neighbouring area who will prescribe them a drug that their current GP won't. While choice is a good thing, patients should not have to exercise it if there were a uniform service offered throughout the NHS. Patients who are able to travel could leave an underperforming CCG but those with less mobility or means to travel could face substandard care, and health inequalities could increase.

In some areas GPs will face dilemmas where they have to choose between saving money and giving a patient the most appropriate care. Many CCGs will inherit large deficits from outgoing PCTs and may face insolvency if the system of incentives fails to ensure that doing the best thing for patients results in adequate funding. An underperforming CCG could fail financially and end up being taken over by a private sector organisation – as we have already seen with Hinchingsbrooke Hospital. With a more ruthless appreciation of the bottom line, a profit-driven manager may be more willing to ration services.

Given the long-term budgetary constraints facing the NHS, if we follow this possibility to its natural conclusion, the NHS could end up mostly run by private companies, with limited ability for the government of the day to improve the service or address any resulting inequities. These fears are widespread among health professionals¹⁴.

Conclusion – Labour’s approach

In principle, clinicians’ involvement in decisions about how to design packages of care is welcome and will help improve the health service while allocating scarce resources more effectively. However, there are flaws in the system that the Coalition has created which will need to be mitigated.

The Labour health team recognises that after the next election CCGs will already be established but has committed to repealing the Act. It will have to work with the structures that there are in order to avoid another resource-devouring set of reforms. Time will tell which aspects of clinical commissioning will backfire, but Labour should pay close attention to gaps in:

- **Geography:** The Health Secretary in 2015 should ensure that there are measures in place to prevent whole geographical areas being served by hamstrung and underperforming CCGs. Partnering CCGs in areas with different levels of performance could be a way to spread best practice.
- **Health areas:** Clear responsibilities for certain types of care will need to be set out to avoid neglect of areas such as sexual health and drug addiction. There will be a significant role for Health and Wellbeing Boards in areas where there is a public health element.
- **Patients:** The most vulnerable and disadvantaged in society risk being left behind by the choice agenda and must continue to have access to healthcare that they currently enjoy. Labour’s policy commission on integrating health and social care is an opportunity to develop a system of identifying these people.

In the meantime, Labour can observe the implementation of the NHS reforms, knowing that there is little that can be done except highlight injustices when they occur, avoid foreseeable problems, and identify issues that can be dealt with soon before they become embedded in the new landscape.

[1] House of Commons, Hansard, 12 July 2010, Columns 661-3

[2] House of Commons Health Committee, Fourth Report of Session 2009–10, Vol 1, page 3 <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/268i.pdf>

[3] House of Commons, Hansard, 22 Feb 2012, Column 893

[4] H. Mooney, *CCGs fail to engage ‘apathetic’ GPs*, Pulse, 14 Sep 2012, <http://www.pulsetoday.co.uk/ccgs-fail-to-engage-apathetic-gps/14596357.article#.UJZjhW8xrPY>

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- [10] House of Commons, Hansard, 18 Oct 2012, Column 36WS
- [11] Health Select Committee, Public Expenditure, 24 January 2012, p5
- [12] S. Sidaway, *How will commissioning affect my income?*, Pulse, 10 Sep 2012, <http://www.aisma.org.uk/wp-content/uploads/2011/06/How-will-commissioning-affect-my-income.pdf>
- [13] Pollock et al, BMJ, Mar 2012, <http://www.bmj.com/content/344/bmj.e1729>
- [14] Examples of this argument can be found on the following pages:
<http://bengoldacre.posterous.com/what-will-happen-with-the-nhs-bill-in-5-tweet>
<http://web.bma.org.uk/nrezine.nsf/wd/RTHS-8UJE2V?OpenDocument&C=26+May+2012>
<http://www.dcsience.net/?p=5058>

Can Any Qualified Provider provide efficient and integrated health services?

Dr Damita Abayaratne

The Department of Health has stated that the Any Qualified Provider (AQP) model of health service provision in effect means “that when patients are referred (usually by their GP) for a particular service they should be able to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations”.

Andrew Lansley has stated that he sees “social enterprise and employee led models from within and outside the NHS, alongside charities and voluntary groups as the key players” in the AQP model. In addition to these players, private, for-profit organisations are also able to provide services.

Two broad objectives underpin the legitimisation of a shift to the AQP model: the theoretical empowerment of patients through choice, and the assumption that competition will drive innovation and service improvement due to the pressure placed upon providers to attract patients and gain favour with commissioners.

When looked at from afar, the intentions of the AQP model are difficult to refute. However when single elements are examined in greater detail, we see incongruence between the intentions and probable outcomes. These elements are examined in this paper.

The market and competition

The AQP model provides two platforms upon which providers may compete to maximise their share of the market¹.

The first platform represents “competition in the market”. The intention for this platform is that multiple providers compete for the ability to provide care to a patient; a patient who, at the point of referral, has the option to choose the provider with which they wish to have their treatment. As well as providing a mechanism to empower patients through choice, another potential advantage of this platform is that it removes the need for potential providers to enter into an expensive and inherently risky competitive tendering process, thus freeing providers to use this money for service improvement.

While Andrew Lansley has cited social enterprises and voluntary groups as key providers in this model, there is concern that in the long term these providers will be unable to compete against more resource-rich private for-profit corporations.

These concerns are based upon the likelihood that larger corporations will be able to cross-subsidise potentially loss-making provision against more profitable income streams. This is especially pertinent upon initial entry to the market, as it may take time to build market share and reap the benefits inherent in economies of scale².

This long-term likelihood presents a problem given that the AQP model has been justified upon its ability to provide patient choice. The concern is that this model in effect does not deliver choice, just the opportunity to privatise public money - money which should be reinvested within the healthcare service rather than pockets of shareholders².

The second platform, “competition for the market”, occurs when potential providers compete to be the sole provider of a service within a geographical region. Patient choice is arguably maintained by the ability to choose where one wishes to be treated. However, for the most part this will probably represent the illusion of choice, as patients are likely to prefer a service that is close to where they live³. Again, the concern is that this platform mainly provides the opportunity to channel public funds into private hands without empowering patients.

In addition, the AQP model is inherently metro-centric; those living in large cities – particularly London – may find that they have many providers to choose from, but it is less likely that there will be multiple providers in rural and small town locations⁴. Choice, if available at all, would be restricted to those with the ability to travel. Likewise, decisions must be made in the best interests of those unable to make choices for themselves – the most vulnerable, and often those in greatest need of health services.

Furthermore, choice is ideally based upon reliable and timely information about services. The framework by which this information will be gathered, analysed and released has not been fully developed, but providers themselves are likely to play a role in this process as gatherers of raw

data. The potential for data to damage a provider's image presents a conflict of interest which may hinder transparency; a real concern given the ability to withhold data due to commercial confidentiality clauses⁵.

Underlying all these issues is the question of whether the assumptions underpinning the neo-liberal market model are valid when the aim of the healthcare system is to serve the common good⁶.

The role of the Labour Party

Labour came into power in 1997 at a time when neoliberal philosophy was the dominant influence on policy.

As well as inheriting a health system that already had liberal market structures embedded within it, New Labour developed the role of these structures within the system, introducing Independent Sector Treatment Centres (ISTCs), Private Finance Initiatives (PFI) for hospitals and ultimately laying the foundations for the AQP model via the "preferred provider" model. However, the current financial crisis has called neoliberal thinking into question. Now more than ever we need to ask whether the healthcare service reform package, drawn up in the 1980s, is able to serve the common good.

The Labour Party can make two broad responses with respect to the current health service reform package. The first option is to mitigate the potentially negative elements of the AQP model. I suggest five broad policy options for the Labour Party to consider:

1. That the "competition in the market" platform is preferred to the "competition for the market" platform – as, out of the two options, "competition in the market" is the only one that has the potential to allow patient choice.
2. If the "competition in the market" platform is not feasible, perhaps due to complex patient needs, then the state should always be the "preferred provider".
3. Within the "competition in the market" platform, the state must always maintain its role as financier, regulator and provider; the role of provider is arguably the most powerful way of driving service improvement within the whole of the market, so the state should retain a role here rather than leave it to independent providers to do everything.
4. The party should help create and protect the space within which civil society groups (such as Citizens UK) can scrutinise commissioners, regulators and providers and freely challenge aspects of poor practice. Healthwatch groups should do this but there is concern that these groups have been "gagged" from actively challenging CCGs and local authorities⁷. Community organisers could conduct local surveys assessing denials of human rights, raise such cases at public hearings, and campaign on issues of concern to the local community that are not being addressed. The Scottish Community Development Centre provides an example of such a model⁸.
5. A clear boundary should be drawn between politicians, commissioners and regulators on the one hand and state providers on the other, in order to minimise bias when setting

policy. Donations should not be given when there is the potential for conflicts of interest and there should be a time period within which individuals who have worked for providers are not able to work in the political, commissioning or regulatory arena and vice versa.

However Labour policy must not be limited to mitigation. It is essential that Labour uses the political platform to drive forward the explicit questioning of neoliberal structures, while fostering the progressive realisation of alternatives on both the local and global stage.

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Caring for our generation in old age

Kwaku Adjei

We owe it not just to today's generation of retirees but also to tomorrow's, to fix the existing social care system. When in government, Labour had several notable policy achievements. These included: introducing personal budgets and direct payments so that vulnerable adults could exercise choice and control over the care they received; facilitating greater co-operation between health and social care services through care trusts; and where possible putting integration on a statutory footing. The previous government tasked the Law Commission to review existing social care legislation. The commission would put forward new ideas with the aim of making the legal framework that informs care practice less complex, e.g. reducing the existing number of statutes by simplifying them; offer new rights to service users; and place new duties on local authorities¹.

As a care professional, the commission's input was a welcome intervention after decades of care law. Labour also understood that carers and families required help too if everyone in the care system were to have the optimum experience. This logic found expression in the Department for Health White Paper 'Our Health, Our Care, Our Say'² and the Darzi review³. Labour made money available to local councils to fund carers' breaks, and as part of the New Deal for Carers, the party committed itself to wider provision of information and advice for carers⁴.

Despite the aforementioned accomplishments, practitioners and families argue that a sustainable solution to how long term care should be paid for has to be found⁵. As Labour's thirteen years in power and various green and white papers and commissions including Sutherland (1999) and Wanless (2002) set up to investigate it attest, care funding has become the intracta-

ble policy issue of our time⁶. This problem has been compounded by reductions in public expenditure and austerity measures. This chapter will look at the current coalition government's care policy for England, what the Labour's response to this policy has been so far, and what policy proposals Labour could offer the electorate.

Background and Labour's response

Back in the summer of 2010 the Coalition published its white paper on NHS reform 'Equity & excellence: Liberating the NHS'. Of the proposals cited in the document, included was a promise to legislate for a new financial settlement on adult social care in the current Parliament. The remit of the Dilnot Commission which convened that summer was to make recommendations to ministers on how a properly funded care system could be achieved⁷. The commission published its report Fairer Care Funding in July 2011. When the Coalition finally published its eagerly anticipated response to Dilnot, 'Caring for our Future, Progress Report on Funding Reform'⁸ it lacked credibility without firm commitments on investment.

The Treasury was accused of being the roadblock to reform when George Osborne was reluctant to entertain any ideas that jeopardised his deficit and debt reduction plans⁹. Dilnot asserts that an extra £1.7 billion in spending would be required to introduce his proposals which include a cap on lifetime care costs and raising the threshold for means tested savings from £23,250 to £100,000. The Coalition now appears to have accepted a cap model and raising the means test threshold. Both elements were embraced by ministers during the Winter of 2013¹⁰. While the inclusion of numbers in the government's plans is a start there is still little mention of the problem surrounding an individual's eligibility for care services. There remain wild variations across England in terms of care provision made available to adults. Eligibility criteria differ from one local authority to another.

Labour knows that the public can ill-afford to wait for an answer to the social care funding question. Potentially Labour could compromise and agree a 'halfway house' with the Coalition until the budget deficit has been eliminated. Root and branch changes to the care system could be postponed in favour of quick fixes, for instance, transferring some NHS expenditure to local councils in order to widen access to statutory care. At present most councils only offer care services to those with 'critical' or 'substantial' needs given limitations in resources. This means those with either 'moderate' or 'low' care needs must go without support¹¹.

Furthermore, where the NHS has under-spent some of its budget this money could be spent on plugging gaps in social care expenditure as members of the shadow cabinet have suggested in the past¹². A good example can be found in the commissioning of community based services, e.g. handyperson, which can reduce costs to the taxpayer by preventing emergency hospital admissions and keeping people at home. O'Leary et al found that 32% of older people were at risk of falling and being admitted to hospital when they had no home improvements. On the other hand of those older people that did receive handyperson assistance only 10% of older people were at risk¹³.

Labour's principal approach has always been to argue for a more expansive overhaul of existing social care financing. Inevitably this would involve tax rises, a sensitive topic in the run up to an election. However Labour's response to Government policy is not simply characterised by calls for extra spend on care. Shadow ministers often talk of 'service change'. This acknowledges that a revamp of service delivery, for example bringing services into people's homes is absolutely imperative too. The cost of a hip operation on the NHS far exceeds the cost of a handy person installing a grab rail in one's home. Without such a change, additional social care expenditure would be akin to throwing good money after bad.

Transferring some welfare expenditure to the social care pot

There are a number of policy options Labour could put forward in the future. One potential solution is to divert more money from the welfare budget towards social care. Universal welfare entitlements such as travel concessions for pensioners and the winter fuel allowance could be reduced for older people in higher income brackets. This is known as "progressive universalism".

One potential concern would be the resources, for example administrative staff, required in order to determine which individuals reductions should be applied to. Such a policy proposal should not cost more to run than it takes in revenue. Alternatively the onus could be placed on higher earning individuals to return their entitlements. However there must be formal mechanisms to facilitate this which build on initiatives such as the "Surviving Winter Appeal" in 2011¹⁴.

Labour should be mindful that any attempt to secure extra investment for social care in this way does not ultimately serve to unravel our welfare institutions and undermine solidarity. For universality to be meaningful, the size of the award - in this case the winter fuel allowance - cannot become too unequal. For instance, if the reduced value of the entitlement a middle income pensioner receives is too small, the entitlement shall lose its importance.

The pensioner in this scenario may begin to feel that he or she has been treated unfairly. This is one consideration Labour should make when contemplating reductions or even withdrawals of some universal benefits. It also merits further investigation for Labour to consider the implications of this policy for those pensioners marginally above low income status.

Limiting tax relief on pension contributions

It is correct that the state encourages and rewards individuals for saving for their retirement. Tax relief helps individuals grow their retirement funds. Individuals that save stand a good chance of living independently and enjoying the benefits of growing old. However it is neither fair nor sustainable to offer the greatest incentive to save to those who need that incentive the least, i.e. the wealthiest. Those in higher income groups disproportionately benefit from

tax concessions on their pension contributions. The last Labour Government attempted to solve this problem by implementing limits on annual and lifetime allowances¹⁵. This essentially meant imposing restrictions on tax relief for saving deposits so that those concessions did not exceed a certain value during the course of a year. Lifetime allowances worked in a similar way but the restrictions applied to a much longer timescale. Labour should contemplate retaining this policy in its next manifesto.

Development of Integrated Care

The next Labour government should extend its care trust policy to other parts of the country. Care Trusts describe organisations where health and social care services are joined up to the extent that everything from the commissioning to the planning and delivery of services is undertaken by a single body. The widely acclaimed Torbay model exemplifies how the NHS can be improved by a closer social care relationship¹⁶. As a result of the trust's interventions the daily average number of occupied hospital beds in the area fell from 750 in 1998/99 to 502 in 2009/10.

Furthermore in the first year of the trust's existence it saved £250,000 in management costs¹⁷. The savings accrued enabled the trust to invest in its frontline services. The Torbay experience can offer policymakers and commissioners an insight into the value afforded by a better health and social care interface.

The next Labour government shall need to create incentives for health and social care partners to undertake more collaborative work. However the party could go further by extending joint working arrangements to include other statutory services such as housing, leisure services and adult education. Adequate housing, exercise and learning opportunities are conducive to good health and wellbeing and can prevent illness. That is why policies for active ageing which draw on resources from other areas can ultimately drive down the costs of social care provision. Labour's decision during the Spring of 2013 to set up an independent commission which shall consider methods of aligning health and social care services is encouraging.

Conclusion

Social care reform is set to concentrate the minds of all politicians for many years to come. What is clear is that the state must significantly invest in adult social care now and in the future. Whichever mixture of policies the political class chooses to pursue each must be economically credible and be simple to administer. Labour can rise to this challenge by:

- Allocating resources for pensioners through the care system rather than welfare payments
- Limiting tax relief on savings for retirement
- Developing incentives to promote collaboration between health and care organisations
- Extending joint working arrangements with other public services to promote wellbeing

Ultimately what should motivate our approach in the Labour Party is making this country a wonderful place to grow old and grow old in the most dignified manner possible.

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Preventive medicine: When prevention is the cure

Lauren Milden and Dr Martin Edobor

The paradigm under which the NHS has operated for 60 years is shifting away from simply being a service to help people get better from episodes of ill health to one that reduces the need for people to receive care in the first place. Today, as we struggle with an ageing population and a difficult economic climate, we must focus on preventive care in order to provide effective and affordable healthcare to all. This can be achieved in part by bringing mental and social care under the healthcare umbrella¹.

We define preventive care as predicting harms and then acting to prevent them before they occur. This generally allows primary care (i.e. GPs, pharmacists and community nurses) to take pressure off the secondary care system (i.e. hospitals).

The benefits of preventive care are twofold – firstly, it helps people live longer and healthier lives. For example, cardiovascular disease is estimated to affect over 3 million people in the UK, and causes around 198,000 deaths in England and Wales every year². A preventive measure often used by GPs to address cardiovascular disease is to monitor cholesterol levels in at-risk patients. If a patient's cholesterol levels are high, doctors can then prescribe statins (cholesterol-reducing medication) and advise the patient to exercise and to make dietary changes. This approach has been proven to reduce the risk of cardiovascular disease in at-risk patients³.

The second benefit of preventive care is that it saves money. Indeed, the most costly illnesses are chronic but could be managed within the community, rather than in a hospital ward⁴. According to Dean Royles, Director of NHS Employers, “The critical challenge facing the NHS

is to help patients manage chronic and long term conditions and tackle exponentially rising demand. This means we need to focus on providing more care in the community, rather than simply expanding hospitals⁵. This helps to illustrate why preventive medicine could pay for itself through the savings it provides to the NHS. An evaluation report by the Personal Social Services Research Unit (PSSRU) revealed that for every £1 spent on preventive services to support older people, hospitals saved £1.20 in spending on emergency beds⁶.

The policies of the past and of the future

The past decade witnessed a shift from a focus on secondary care to a focus on primary care. Under the previous Labour administration, there was an increase in investment in the NHS. An independent audit of Labour's health policy during its early years in government showed that overall investment increased, waiting lists and access to care improved and many targets were met while overall performance within the NHS improved⁷. Labour's investment in the NHS promoted preventive medicine, amongst other areas. For example, public health schemes were rolled out across the country to encourage exercise and smoking cessation.

Under the current Coalition government, preventive medicine has taken a back seat. The main aims of the Coalition's NHS reforms were to give patients increased choice and control, focus on measurable outcomes and to create savings through increased efficiency.

The massive scale of structural change in the NHS, coupled with the pressure placed on primary care trusts to implement efficiency savings, has led to many programmes promoting prevention being jeopardised. For example, since 2009, Birmingham's Be Active Scheme had provided free swimming, gym use and exercise classes at a cost of about £4.5m a year. The scheme helped users exercise regularly, which is known to reduce certain cardiovascular risk factors and ultimately reduce the risk of heart attacks and strokes. Under the Coalition, health commissioners were pressured to close the scheme, which then had over 300,000 registered users. While this programme ultimately found a way to function for less money, many similarly beneficial schemes across the country weren't so lucky⁶.

Although the Coalition is doing some things right, such as planning on making the winter flu vaccine free for all children – which would prevent an estimated 11,000 hospitalisations and 2000 deaths – the overall lack of focus on preventive care is problematic⁴. The drive for efficiency savings is leading to the closure of community-based programmes, for example Heatherwood and Wexham Park Hospitals Trust in Berkshire has closed its birth centre due to financial pressure and staff issues⁸. It is estimated that cuts to councils resulted in £900m less for social care in 2011⁹. This will have a huge impact on healthcare outcomes. One study reviewing the cost effectiveness of preventive social care showed that low-level intervention such as smoking cessation as well as high level intervention, for example community-based fitness classes, can play an important role in reducing the number of hospitalisations¹⁰. Failing to properly invest in preventive healthcare may ultimately cost more.

Having endorsed Sir David Nicholson's call to encourage a shift in culture towards innovation,

the government is currently pushing innovation from the top down; in 2012 the NHS highlighted 108 effective innovations, “many of which” now feature as part of the Commissioning for Quality and innovation incentives for 2014-15¹¹. Currently missing is a mechanism to reinforce a culture of innovation at the local level.

So what will Labour have to do?

Firstly, Labour will need to invest more now to save in the future. In the next 30 years, the main pressure on NHS finances will come from our ageing population. The NHS can save money by keeping this demographic healthy and out of hospital. They can achieve this through government partnership with third sector providers that can reduce the number of hospital admissions. For example, Care and Repair is a charity which seeks to place older patients in residential care or hospital homes quicker, tackling the problem of bed blocking¹². Hospital beds are expensive – the average cost of an excess bed is £260 a day⁵. Through this form of investment, a Labour Government can move to reduce cost through bridging the gap between health and social care.

Secondly, combining mental, physical and social health services under the umbrella of the NHS could allow the preventive approach to function most efficiently. Shadow Health Secretary Andy Burnham has noted, in regards to his proposal for providing free social care at home for those with terminal illnesses, “this could be the first step towards a whole person approach to care - a vision for the integration of our physical, mental and social care system”¹³. By treating the whole person rather than just the disease, Burnham’s vision of an integrated health and social care system can help to prevent patients from inefficiently being managed by the different healthcare bodies.

For example, take an elderly patient who lives in a care home and suffers from moderate depression and high cholesterol. Let us imagine that their depression negatively impacts the likelihood of them exercising, attending medical appointments and taking their medication. Under the current system, the communication between the care home and the GP may not be sufficient, so that the GP may not be aware of the patient’s decline in health until the patient ends up accessing emergency care. Ideally, in a system where mental, physical and social care are integrated, there would be continuous communication between a mental health specialist who would be treating the depression, a community nurse who would be monitoring exercise and medicine, and the care home staff who could continually provide updates to the relevant parties. As Burnham argued in a speech delivered at the King’s Fund, “The trouble is no-one has the incentive to invest in prevention. Councils face different pressures and priorities than the NHS, with significant cuts in funding and an overriding incentive to keep council tax low.”¹⁴ Burnham has consequently proposed a combined health and social care service which would have the mandate, and the financial incentive, to invest in whole person care.

Finally, Labour will need to ensure that preventive healthcare works on the ground. For example, training must give medical professionals the tools to effectively implement policy. A 2010 paper by The King’s Fund entitled “A pro-active approach. Health Promotion and Ill-health prevention”, noted that GPs don’t feel equipped to provide health promotion tools to their pa-

tients effectively.² This obviously needs to change, starting with training health professionals as part of the cost of preventive medicine. To encourage bottom-up innovation, GPs and CCGs should also have access to a budget for preventive medicine, which they would be required to use to try and prevent future health needs. Unlike current measures, local decision makers would be free to test new ideas, the performance of which can then be measured over a controlled period in costs to care services, the NHS and wider local spending. Successful initiatives can then be trialled more widely and, if proven, embedded elsewhere in the NHS.

Ultimately, by focusing on identifying risks, investing in individuals before they become ill, and before they need to access costly secondary care services, we help individuals avoid illness and help our resources go further. The biggest challenge facing the new government in 2015 will be continuing to provide for an ageing population in an austere economic climate; central to a successful response will be prevention-focused reform of health and social care.

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Sandwiched? Competitive care options for the NHS

Adebusuyi Adeyemi
Chair of the Young Fabians Health Network

For the current generation of adults, over the past decade, it has become apparent that more of them can expect not only to raise their kids, but care for their elderly parents too. As the nation's population grows older – the number of people over 80 is expected to double in the next 20 years¹ – expected levels of care between generations will change radically. The authors of this pamphlet and their peers are likely to be squeezed further and stuck – one could call them the “Sandwiched” generation!

Theoretical underpinnings of a competitive NHS

To examine what this means for the state and public services, we can take several different sociological perspectives.

The functionalist argument would contend elderly people voluntarily withdraw from society by retiring and reducing their participation in activities. Different brands of such theories suggest that as they withdraw their participation, they are simultaneously relieved of responsibilities. Some see this withdrawal as functional as it provides a transition from one generation to the next². The elderly move aside so that the young can step in. As the older generation's contribution to society declines, they are regarded less. According to such a functionalist argument, the diminished usefulness of the elderly justifies their depressed earning power.

Other theories suggest workers in middle age keep young people and the elderly away from the labour market to improve their own prospects. Once removed from competition, the elderly

have very little power and like other societal minorities are denied access to the resources they need to change their situation.

It is this challenge around resource competition that our national treasure – the NHS – is supposed to nullify and may, in the future, increasingly fail to do. The aims of the Blair and Brown governments' NHS reforms included trimming hospital waiting times and improving the quality of care. At the time, critics contended that socioeconomic equity in health care was being undermined by the choice and competition elements of the reforms; that a more competitive NHS manager would be less motivated to treat socioeconomically disadvantaged patients who “cost more”, as they are relatively unhealthy³. At that time, rebuttals took the shape of arguments saying reform was a condition of more spending, which combined with increased patient choice of hospital, would enhance equity for poorer patients.

The reform agenda continues under the Coalition but with a reversal of the fiscal circumstances, which precludes further increases in spending. If Labour's aim in 2015 is victory on the battleground of health and the NHS, the party's Health and Social Care policy could do well to truly utilise Andy Burnham's vision and the original values of equity for minority (i.e. older generation) patients. After all, these people are critical for Labour's electoral success.

NHS and its elderly

Almost everyone has a personal story about the NHS. Many of these are uplifting stories which celebrate the hard-work, compassion and diligence of the country's healthcare professionals. Unfortunately, these stories are increasingly becoming overshadowed by the sort of tales exposed by the report into the Mid-Staffs scandal. These tales are of over-worked, discouraged and negligent staff, and portray an NHS that appears to shuffling from a national source of pride to one of shame.

Earlier in this pamphlet, Damita Abayaratne clearly outlined the potentially negative elements of the Any Qualified Provider model, and questioned the assumptions underpinning the validity of the neo-liberal market model in healthcare delivery. With electoral “sex-appeal” in mind, let us draw further on this question, considering the elderly (not just with voter turnout in mind!) in our scope.

By accepting that health care is difficult to obtain or the system unfairly represents them, it is possible that more elderly people will continue resorting to alternate means – including getting treated at home, rather than entrusting themselves to the care of hospitals. The Labour health team understands this well but what does the evidence have to say about this shift and how best can Labour respond to such dynamics? Unfortunately, economic studies of the cost-effectiveness of home-based therapies for older people make it unclear whether such interventions are of benefit to older people⁴. Studies indicate some likelihood that home-based, nurse-led health promotion may offer cost savings to the NHS and associated sectors, such as social services. However, this evidence is rather lean compared to studies that suggest, at best, a negligible incremental benefit in terms of preference-based health-related quality-of-life measures⁵.

With this currently limited evidence base, what perhaps needs to follow is an understanding of how to manage this perception amongst the electorate, whilst having a competitive NHS we can be proud of.

Avoiding the jam – a competitive NHS

Currently, the NHS is not competitive. Poor providers do not go out of business, nor are the best providers significantly rewarded. The Coalition Government's agenda to make the NHS more competitive strikes the right tone, but its approach will introduce a tangled set of complex epistemic and ethical challenges. Amongst the elderly at least, Labour can win hearts and minds over by promising to disentangle this mess we are likely to encounter in 2015. The central contention is that affording patients greater influence over the processes of healthcare delivery requires the NHS to accommodate and respond to their agendas and values, as well as those of medical professionals and stakeholders. Its likely agendas and values will not be shared amongst the various stakeholders, so for Labour, the successful creation of a system of patient-led services depends on strong implementation. In practice, this means:

- Recognising the role of health professionals and patients as active citizens creating services, rather than passive consumers in a world where “choice” is bandied about but is impossible to deliver.
- Maintaining the state's role as financier, regulator and provider of health services
- Promoting competition in areas of care where it offers the greatest potential benefits
- Given the rather limited evidence base Monitor will have to base decisions upon, its increasing role in tackling anti-competitive behaviour should be addressed to ensure it adequately drives competition

For all its commitment to competition-based principles, the Coalition will cause those who need them most (i.e. the elderly) to suffer. If we know hospitals are “very bad places” to care for the elderly⁶, and empathise with theories that social dynamics of power seemed stacked against them, then perhaps we must devolve decisions about care to places best-suited to make them? In any event, narratives must be sought that resonate loudly with the electorate and move the agenda towards preventive healthcare agenda as described by Lauren and Martin.

The problem with the NHS is not the lack of competition, but the wrong kind of competition. Competition either happens at the wrong tiers or does not consider some levels of health and social care at all. The zero-sum competition critics believe the NHS is edging towards does not create value for patients, but erodes quality, fosters inefficiency and creates excess capacity.

Such dysfunctional competition results from misaligned incentives and a series of strategic, organisational and regulatory choices by stakeholders in the system that fall short. The best way to transform health care, without reversing the irreversible is to realign competition with value for patients.

At the most basic level, competition in health care must take place where value is actually created. Asking acute hospitals to lead the provision of care in the community will not create

value. Furthermore, value should be determined in addressing the patient's particular medical condition over a full cycle of care, from monitoring and prevention, to treatment and ongoing disease management. This is what makes Andy Burnham's speech most encouraging, but there's more needed to truly hit the bulls-eye.

Redefining competition around value for the patient, elderly or not, and putting competition at the right places are what the authors of this pamphlet have broadly argued for. Though the Health and Social Care Act threatens the very fabric of the NHS as a public service free at the point of delivery, adopting preventive healthcare practices and following good principles when letting private companies into the healthcare system as outlined in this pamphlet may be the first step towards arming the NHS fit for the fight of 21st century healthcare.

[1] Office of National Statistics, *National Population Projections, 2010-Based Projections*, 23 Nov 2011, <http://www.ons.gov.uk/ons/rel/npp/national-population-projections/2010-based-projections/index.html>

[2] E. Cumming, W. Henry. *Growing Old*. New York: Basic 1961.

[3] R Cookson R et al. *Effects of the Blair/Brown NHS reforms on socioeconomic equity in health care*. *Journal of Health Services Research and Policy*, 2012, 17, 55-63.

[4] P Tappenden et al. *The clinical effectiveness and cost-effectiveness of home-based, nurse-led health promotion for older people: A systematic review*. *Health Technology Assessment*, 2012, 16(20), 1-71.

[5] S Gustafsson, A Edberg, B Johansson & S Dahlin-Ivanoff. *Multi-component health promotion and disease prevention for community-dwelling frail elderly persons: A systematic review*. *European Journal of Ageing*, 2009, 6(4), 315-329

[6] O. Wight, *Sir David Nicholson: 'Hospitals are bad places for old, frail people'*, Independent, 20 Jan 2013, <http://www.independent.co.uk/news/people/profiles/sir-david-nicholson-hospitals-are-bad-places-for-old-frail-people-8459242.html>

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