“If freedom is to be sustainable it is not about having choice per se, but making the right choices. And to make the right choices we need the full picture, which is partly enabled by having both male and female perspectives. Decisions then have an enhanced legitimacy and could well be more effective.”

Julia Manning, 2020health Chief Executive
What Women Want: 
A Manifesto For Health
2010

With contributions from
Dr Iona Heath CBE, Rosamund Shackleton, Baroness Julia Cumberlege CBE, Gail Beer, Barbara Arzymanow, Sarah Matthew, Miss Su-Anna Boddy, Dr Naomi Beer, Dr Nini Adetuberu, Matilda MacAttram, Kate Wortham, Baroness Jill Pitkeathley OBE, Sue Slipman, Julia Manning, Nicola Hunter, Gopa Mitra MBE and Prue Leith OBE.
What Women Want: A Manifesto For Health  2010

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When I began to tell people that 2020health was producing an all-female authored manifesto for health, about half of the responses assumed that all we would be talking about would be ‘women’s health’ issues. This reaction is a salient fact in itself, which we won’t address here. But our “What Women Want” Manifesto was actually triggered by a series of publications and events that we became aware of last year that had little or no female representation. This is not a feminist issue, but one of balance, justice and laziness! Men and women are equal but not the same; they bring different qualities into the same roles and it is not only right to hear a balance of views but an essential component of freedom. If freedom is to be sustainable it is not about having choice per se, but making the right choices. And to make the right choices we need the full picture, which is partly enabled by having both male and female perspectives. Decisions then have an enhanced legitimacy and could well be more effective. Women make up the majority of the NHS workforce and are found at every level in the wider health care industry. To host conferences with an all male line-up is inexcusable!

So to redress this imbalance, in this manifesto we have given women with expertise in health a free-reign to draw on their experiences and make recommendations for the incoming government on different aspects of health and health care. They come from all backgrounds and disciplines – all critical players either from their length or breadth of experience, or the position they hold. I am very grateful to them all for taking the time to make these contributions. This isn’t a gimmick or the start of a campaign; but we hope that this publication is a strategic reminder as we approach the general election, that half the population need to see both the justice of balanced perspectives with which they can identify and more women who are publicly valued.

Julia Manning
2020health Chief Executive
The public health agenda needs to have a greater emphasis on prevention and health promotion. About two thirds of respondents from the 2000 General Household Survey who were either current smokers or who had smoked regularly at some time in their lives, started smoking before they were 18 and well over one third started before they reached the age of 16. If positive healthy behaviour can be promoted in childhood then this is more likely to lead to healthier lifestyles in later life and will create huge savings in an already stretched NHS.

Over the past 13 years under a labour government the equality gap has widened between the richest and poorest and health inequalities still exist. Despite the amount of funding Labour has allocated to numerous initiatives to reduce inequality a child who is born into a poorer family today still has poorer life chances than a child born into a wealthier family.

It becomes even more pressing in this economic climate for government to implement innovative cost effective measures based on evidence of what works to improve the public health of children across the UK. This article attempts to highlight a few simple effective strategies that could be used based on evidence of what has worked locally.

There should be more joint appointments for Directors of Public Health across the local authority and primary care trust. This creates clear lines of accountability and shared ownership and governance of the public health agenda across the key stakeholders. Children’s trust arrangements should be strengthened and schools and GPs should be brought in as partners in commissioning services to meet the public health needs of children in a local area. This can be encouraged through joint targets for the PCT and local authority around smoking, alcohol, teenage pregnancy, sexual health, obesity and drugs instead of separate targets which can waste resources and lead to duplication of work or gaps in provision. GPs and local authorities/PCTs should also be incentivised to work with more deprived groups.

Greater emphasis should be applied to targeted campaigns to meet local needs. Instead of government dictating the way that information is conveyed from the top-down, professionals should listen to the needs and desires of their local target audience and build a marketing campaign from the bottom up. Techniques from social marketing should be applied with a focus on the “consumer” and the use of research and constant re-evaluation at each stage of the campaign.

There should be a greater emphasis on outcomes-based commissioning and funding should be awarded to innovative interventions that are based on evidence of what works. The market should be developed to encourage more providers from social enterprises and public-private partnerships.

It is important that public health interventions are not always “stand alone” short term initiatives and should be incorporated where appropriate into the core offer of wider children’s services especially schools, integrated youth services, children’s centres and universal health services such as GPs and health visiting.

There should be wider acknowledgement of the social and emotional/psychological causes of unhealthy behaviour and where possible more interventions should tackle this. Psychological and emotional support should also be provided for parents to improve their capacity to better support their children in making positive lifestyle choices. Work with parents could be carried out by health visitors, children’s centres and family support services provided through schools and GP practices.

It is important that whilst strategies for promoting public health remain local and targeted to specific groups with differing socioeconomic backgrounds, common structures and ways of working which have proved to be successful, are still be applied across the board. In order to improve the public health of

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1. Living in Britain 2000, National Statistics, 2001
2. An Anatomy of Economic Inequality in the UK, Government Equalities Office, 2010
The pharmaceutical and biotechnology industries have played a major role in improving the quality of life and longevity of people in advanced countries since World War II. Other factors have included surgical improvements, diagnostic advances, healthcare education, reduced poverty and fewer war casualties.

Most important medicines were discovered after World War II, predominantly by commercial companies. Relatively few were discovered in universities, hospitals, government agencies or charities. Between 1960 and 1990 the UK had the world’s highest pharmaceutical R&D productivity and made the greatest contribution outside the USA.

Today the UK is headquarters to two of the world’s five largest pharmaceutical companies, GlaxoSmithKline and AstraZeneca, largely as a legacy of the past. However, the UK has lost its edge in R&D, whilst France and Japan are considered to have moved upwards. Switzerland has retained its traditionally strong position. The USA has become pre-eminent. Large pharmaceutical companies, including the two UK giants, typically now do much of their R&D in the USA. The UK has become just one of a number of countries with world-class R&D. No commercially important pharmaceutical product has been discovered by any start-up European biotechnology company, whereas many have emerged from the USA.

What should the policy of the British Government be? The NHS and patients are little affected by where medicines are discovered. However, we have a responsibility to pay high enough pharmaceutical prices to support the

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**Dr Nini Adetuberu**  
**Mental Health Review Project Manager**

Dr Nini Adetuberu is a qualified medical doctor with a range of experience in the public sector across health, social care and education at a local and regional level.

She has an interest in commissioning and project management of strategic multi-agency projects within the children’s agenda. She trained at Imperial College School of Medicine, Science and Technology and also gained a health management degree.

She has experience of working in a secondary school as an inclusion worker to improve aspiration and attainment with key stage 3 and 4 pupils and is a qualified project manager.

She has managed the following projects:

- **Family Drug and Alcohol Court**, London borough Of Camden
- **Targeted Mental Health in Schools**, London Borough of Camden/NHS Camden

She is currently working as the project manager for the Mental Health Review in association with the Centre for Social Justice.

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**Barbara Arzymanow**  
**Director of True Research**

The pharmaceutical and biotechnology industries have played a major role in improving the quality of life and longevity of people in advanced countries since World War II. Other factors have included surgical improvements, diagnostic advances, healthcare education, reduced poverty and fewer war casualties.

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What should the policy of the British Government be? The NHS and patients are little affected by where medicines are discovered. However, we have a responsibility to pay high enough pharmaceutical prices to support the
A major priority, probably through increased tax benefits and grants, should be to encourage private and institutional investors to invest in biotechnology companies. Raising money is very difficult because of the lack of historical successes in Europe even though the UK has all the required expertise.

The NHS should make more money from pharmaceutical and biotechnology companies, for example, by closer cooperation over clinical trials and by sharing facilities. Biotechnology companies would be good candidates to rent office or laboratory space in hospitals.

Medicines are approved in the UK by the Medicines and Healthcare products Regulatory Agency (MHRA). This body is highly regarded internationally and considers only medical data.

The PPRS and MHRA between them provide a long-established framework for ensuring the availability of proven medicines at fair prices. The drug for each patient has traditionally been chosen by his doctor.

However, a third organisation (NICE) was established in 1999. NICE issues independent guidance on the cost effectiveness of surgical procedures, clinical techniques and new or controversial drugs. NICE does not fix or negotiate drug prices but can strongly encourage or discourage the use of a medicine at the prevailing price. NICE cannot affect the overall cost of drugs to the NHS very significantly because this is determined by the PPRS. However, at its best NICE can help to focus the NHS on the best value-for-money products.

Unfortunately some of NICE’s pharmaceutical guidance has been controversial and the organisation has not yet earned the full respect of many eminent doctors and the pharmaceutical industry.
Recent years have seen an emphasis on admission avoidance for those suffering from acute episodes within a continuing condition and the elderly during periods when they are less able to cope.

Admission Avoidance by its name suggests that the client has presented with a clinical or care need that requires acute intervention to enable them to stay at home. These interventions are often costly in time and manpower and by their very nature reactive.

This short paper proposes that we look to the next level work more proactively to monitor health and support the ability to maintain daily life within the home by the use of technology.

Whilst technology can offer a range of supporting functions it alone is not the solution, but must support new models of care and the development of new roles within the workforce. We must recognize that human contact and compassion are essential to those in need of support. In using technology we must consider the ability of the elderly to use technology, enable individuals to maintain control of their own lives, determine where, when and how they wish to use technology, respect dignity and privacy and prevent abuse of power.
What will the future look like?

- Firstly, the complete integration of social care and health, both primary and acute will be increased using integrated electronic records and care plans. Giving health care and social care professionals the opportunity to develop and monitor the complete package of care. These can be shared with the ambulance service to enable supporting paramedics to give treatment during an acute phase of an illness enabling clients to stay at home; true admission avoidance.

- Designated professionals will be given personal responsibility to co-ordinate the review of progress, make changes, seek further advice as needed, whilst keeping all the relevant carers and the client completely up to date in a single visible record and single senior point of contact.

- Clients and those delivering personal care will take advantage of hand held devices to update records in real time, seek advice, forward Point of Care Testing (PoCT) results, and provide video or photographic images to other professionals for review.

- PoCT will increase, enabling clients, health care professionals including pharmacists to monitor progress and take co-ordinated action.

- For those clients with more advanced needs clinical monitoring within the home may be increased, e.g. monitoring pacemakers, interventions can be made either by the client or a professional; movement sensors that alert teams to periods of reduced activity or no activity, when a client may have fallen or their condition deteriorated.

- Reminders to take tablets could be electronically transmitted through television screens or computers supporting the current provision of drugs through Dosets.

- Importantly professionals will be able to increase or step down the amount of intervention required in conjunction with clients and their supporting carers.

- Technology may enable more people to go home with more confidence preventing extended stays in hospital or care homes. The longer clients are out of their own environment the less likely they are to go home.

- Links to NHS Direct could provide a single point of access for clients who feel they need additional support or who are concerned outside normal working hours.

- Alarm systems already exist for the elderly or disabled to contact support; the use of more sophisticated systems such as ‘Smart homes’ could enable a more appropriate response.

- At a very basic level home delivery systems for food and household items through the current supermarket Direct Deliveries scheme could enable those who cannot go out to eat better, especially during bad weather or when they are less able to shop. These deliveries could be free of charge for those over a certain age, who live alone or immobile.

- Elderly people are not always able to access technology and we should look to new developments in touch screen technology and voice activated technology. We should recognise that many elderly people already use some technology.

- To maintain people in their own homes will require an increased emphasis on teaching, training and recruiting professionals into this sphere. We must enhance the status and give recognition to those engaged in this work.

- Community nurses are highly skilled at co-ordinating this type of care but are often working across departmental and professional boundaries to maintain their clients at home. Senior nurses should be the lynchpin through which to maintain clients at home, with the responsibility and authority to effect care packages and obtain advice from other professional they deem appropriate. This can be e-mailing a consultant or GP through video conferencing in the home.

- The above will not prevent all admission to long term or acute facilities. A tailored programme amended as dependency increases or decreases will enable early interventions rather than crisis management to avoid an admission thereby increasing the time someone can successfully and safely stay at home.

- For those confined to their own homes or who live alone human contact is essential. We do not envisage a world where the elderly or disabled are observed on vast computer banks, but where all have equal access to modern technological advances that support them to stay in their own homes.
As a female GP with some 25 years of experience, I would like to see Primary Care development based on the following six principles:

1. **Equity of access and resource distribution** - The fundamental principle of equity of service to all should continue to drive the health service. All resource allocation in health care, including primary care, should bow to this principle. This does not sit easily with the government’s drive to make ‘48 hour Access’ the single most important feature. Also, it is difficult to achieve equity if a system of multiple registration is enforced. Less complex, less expensive and more easily satisfied patients from the population who work near a Practice may be more attractive to register than local patients with complex needs. Patients with greater health needs should attract higher remuneration, to reflect the additional time and resources required to treat them.

2. **Quality** - Choice is not necessarily central to the quality agenda and bigger is not always better, Lord Darzi! Increasing choice can increase waste, decrease quality due to diversion of resources and destabilise the system. Also, the delivery of a good quality product takes time. Currently General Practice is resourced to offer patients 10 minute appointments. This is inadequate for the more complex patients or those with a different language or set of cultural or health beliefs. Keeping people from unnecessary admissions to hospital takes time. Helping people to make significant and lasting lifestyle changes takes time and all research shows that it is the relationship between patient and therapist that is most instrumental in achieving this.

3. **Relationship-centred and in partnership with patients** - GPs should remain the primary point of access to health care. They are experts at being generalists. They are trained to spot the abnormal from the vast range of ‘normal’ presentations. They do this because...
they see patients in a holistic context. The doctor-patient relationship may go back many years. Patients do not see their doctor as a hurdle to jump in order to get another service but as a guide and interpreter of symptoms and meaning for every health related problem. Therefore primary health care professionals make excellent gate-keepers. They recognise that not everything is needed just because it is wanted. They also recognise that some things that are wanted are either potentially harmful (antibiotics for viral illnesses for example) or wasteful (unnecessary referrals to secondary care for problems which can be managed well in Primary Care). They educate and negotiate so that patients understand why they do or do not receive particular services and we work together to reach an understanding and agreement with respect to care. The ‘supermarket model’ that has been forced upon health care delivery is inadequate.

- Evidence based - When ideologies that lack a good evidence-base force change on complex organisations that are not fundamentally understood, this results in waste. Treatments in health care are based on evidence. Services should be too. Too much change has been forced on Primary care without good evidence of its effectiveness. This must end.

- Stability - Resources of time and money are constantly diverted into new – non-evidence based - initiatives instead of working to improve what exists, learning from mistakes and building on strengths. Ceaseless processes of re-tendering destabilises organisations and destroys teams. The drive to shift more service delivery to the community could threaten the ability of secondary care services to maintain specialist expertise and be more expensive. The community does not always have the facilities to support the transfer of services. The two levels of care need each other. No more change - give us a period of stability!

- Beware privatisation - Where private companies can provide evidence for value-added care then they should be considered as alternative providers. So far, there are many examples of the wasteful diversion of resources towards private care which has ‘cherry-picked’ services. For example, the tender of pan-London x-ray services was given to a private company who are unable to provide MRI results in a format that local specialists in hospital can read. When a patient is referred to the specialist the procedure then has to be repeated! A significant shift to privatisation risks huge destabilisation in a complex organisation at both primary and secondary levels. I would like to see creative and constructive responses to problems, encouraged by incentives for improvement, not destructive and wasteful so-called ‘competition’.

I am committed to the NHS as a service that is free at the point of use. I would like to see increased patient participation in the development of services, alongside an increased awareness of the responsibility to use resources effectively. I believe an emphasis on the above principles will achieve this.

Dr Naomi Beer
London Based GP

Naomi is a wife and mother of 4. She has been a GP for 20 years, working as a partner in an inner city group practice in the East End of London.

Naomi’s practice is modern, sophisticated and team-based but the links of the practice to this area go back to the 1920s when the face of General Practice was the single-handed GP. Service, quality and the vocational nature of General Practice still underpins Naomi’s work.
There are many factors which are already in place that will make surgery a more attractive career for women:

- Mentoring as a concept has become more accepted, and trainees often seek their own, informal mentor relationships. This is to be encouraged and in future, trainees should be provided with practical guidance on achieving their training goals and an appropriate ‘work-life balance’.

- Educational aids and technology have been developed that can be accessed from anywhere. In particular, they can be used on days off, or at a time of low activity.

- Having a written curriculum with clear competencies means that trainees are aware of what they must achieve from the outset of training, and can progress through these competencies at a pace suitable to their circumstances.

- Working hours are reduced by the Working Time Directive and Flexible Training options again meaning that a “work-life balance” is easier to achieve.

As the number of women in surgery continues to rise, we hope to see an increase in the number of women taking senior and public roles. I am the 7th woman to be elected to the Royal College of Surgeons Council – and the first ever mother! It will take a small number of women to lead the way like this for many more to follow our example.
It is always worthwhile as a Parliamentarian to test the system, particularly when the system is your own idea.

I think, as women, we prefer to find consensus rather than confrontation. So, as a Junior Minister taking legislation through Parliament to give nurses the status of practitioners, I was mindful that if we had a change of Government, the opposition needed to embrace the concept as well as nurses and patients.

Nurse practitioners and nurse prescribing derive from a report I chaired in the 1980’s for community nurses. I always cherished the thought that if the ideas succeeded in the community, they would spread throughout the NHS among the brightest and best of our nurses.

The Government did change and the Labour Government took up the initiative spreading it far and fast but in a responsible and measured way.

Tripping on the railway station steps landed me in St Thomas’ A & E with a broken arm. I never saw a doctor. The nurse practitioner whisked me through X-ray, plastered my arm, and sent me back to work. All one could ask for.

Making the NHS part of political knock-about can, as we have found, be unrewarding and inefficient and a gigantic waste of money. When Labour came to power they wanted change; management systems came and went before reappearing under different names. There is no harm in the slower and less spectacular consensus. It is not macho politics, but both nurse practitioners (sometimes now known under different titles, but, so what) and nurse
prescribing have brought about fundamental reform to both the delivery of health care and to nurses. Most people hardly knew it was happening until, like me, they could not do without it. The alternative for me and tens of thousands of others is to wait for a doctor who is dealing with something much more important than a broken arm.

The greatest care should be taken to think through changes and to try and achieve agreement. The farce affecting the NHS computer systems stem from failure to reach agreement and, as is said, ownership among all who will use it. Now NHS IT is a prime example of political impulsiveness, consequent shambles, and billions lost. The NHS will continue through many changes of Government. It should not be messed around for political gain. Changes are necessary because medicine and the economy are changing. We may well be training too many doctors, but using nurse potential should be gradually expanded from sure foundations. You don’t build secure families on a series of one night stands. You need a solid and lasting relationship – a considerable undertaking with over 60 million people. Much could be saved by carefully reviewing the need for many quangos, they never would be missed.

Baroness Julia Cumberlege CBE

Julia Cumberlege comes from a medical family. After a period in Local Government, she was appointed to Chair the Brighton Health Authority and subsequently the South West Thames Regional Health Authority.

In 1992 Julia was appointed a Junior Health Minister and for five years covered all health and social services matters in the House of Lords. Julia has been commissioned by two Governments to produce two national reports: Neighbourhood Nursing – a Focus for Care and Changing Childbirth.

In 2004 at the invitation of the Royal College of Physicians, Julia chaired a working party to study Medical Professionalism. The report “Doctors in Society” was published in December 2005. From 2000 until July 2006 Julia chaired St George’s, University of London, a medical school in South West London. In June 2006 Julia was awarded an honorary degree from London University. In July 2009 Julia received an honorary doctorate from Northampton University in addition to those from Brighton and Surrey Universities.

Julia is a Trustee of Leeds Castle in Kent and Chailey Heritage School in Sussex. She is a Senior Associate of the King’s Fund, and a fellow of the Royal College of Physicians and the Royal College of General Practitioners. She is Chairman of the Association of Medical Research Charities. She is involved in a number of other charities and is Patron of the National Childbirth Trust.

Julia is also a Vice President of the Royal College of Nursing and the Royal College of Midwives.
Is prevention really better than cure?

Dr Iona Heath CBE
President of the Royal College of General Practitioners

In the context of global financial crisis, it behoves politicians to scrutinise the cost-effectiveness of public expenditure extremely carefully and this should include the enormous and rising costs of accepting the seductive rhetoric that prevention is better than cure. Is this really true for healthcare?

There is little doubt about the importance of protecting health at the level of society through the provision of, for example, clean water, adequate housing, rewarding employment, streets which are safe for pedestrians and cyclists, secure but exciting outdoor play areas for children, and through minimising exposure to, for example, tobacco, excessive alcohol and environmental pollutants. However, over recent years, the focus of measures designed to prevent ill-health has shifted from the level of society to that of the individual citizen. More and more risk factors for disease have been identified and many of these can be ameliorated to at least some extent by pharmaceutical treatment.

The problem is that no universal health-care system funded by taxation can pay for the pharmaceutical treatment of all risks to health and yet this seems to be the current aspiration based on a very naïve view of the likely effectiveness of preventive healthcare. A major political achievement of Western societies, with the continuing exception of the United States, has been the provision of universal health-care systems available and accessible to all. There is now a pressing need for politicians to recognise the threat to these systems, and to the social solidarity that they embody, posed by exponential increases in pharmaceutical expenditure. There are very difficult decisions to be made, but it is necessary to balance the wish to support a vibrant and innovative pharmaceutical industry against the increasing capacity of this industry to bankrupt socially-inclusive health-care systems.

In the name of prevention being self-evidently better than cure, healthcare funding is being systematically diverted away from the sick and towards the well, both nationally and globally. The key is that there is much more money to be made by pharmaceutical companies in the production and marketing of preventive medications than in that of medication designed for the treatment of established diseases. The reasons for this were laid out very clearly in a paper published in 2005 (O’Donnell JL, Smyth D, Frampton C. Prioritizing healthcare funding. Intern Med J 2005; 35: 409–412.). When doctors use pharmaceuticals to treat patients with diseases which are defined by symptoms or signs, the outcome of treatment can be assessed at the level of the individual patient. If the symptoms or signs recede, the treatment can be continued; if not, it can be stopped. If treatments are applied to risk factors, the outcomes can only be measured at the population level and are probabilistic at the level of the individual. Thus it is impossible to know whether the medication is working for any particular individual and so, once it is started, it must be continued indefinitely or any possibility of benefit is lost. This results in the systematic medicating of an ever greater proportion of the population at enormous financial cost to the tax-payer and much of the investment will prove futile. When, for example, a patient dies of a rapidly invasive thyroid cancer, all the years of treatment for his raised blood pressure and his raised cholesterol will have been wasted and all his worry about these conditions misdirected.

Linn Getz and colleagues demonstrated that the 2003 European guidelines on cardiovascular disease prevention in clinical practice can be used to identify 76% of the total adult population of a county of Norway as being at “increased risk”. Yet the current life expectancy at birth in Norway is 78.9 years, making it one of the longest living populations in history. Something appears to be going very wrong – it is simply not possible for three quarters of a population with such longevity to be at increased risk of early death and the proposed thresholds for intervention must be wrong.

The first and enduring responsibility of medicine is the relief of suffering and reorienting the health service towards the care of those who are sick and suffering now and away from those who are now well and who might or might not become ill in the future is both a moral and an economic imperative.
By the year 2030 one third of the UK population will be over the age of 50. The ageing population means there will be fewer people in the workplace and fewer people able to provide support and care for those unable to live independently. It is predicted that the cost of care will have doubled in 20 years. Added to this there is a general decline of fitness of the population due to poor diet, inactivity and an associated increase in obesity and allied medical conditions such as heart disease and diabetes.

Physiotherapists have a key role to play in improving the health of the nation and helping the country to meet the challenges the changing environment brings. Physiotherapists work with individuals to maximise their quality of life by restoring, maintaining and improving function and independence through physical activity and therapy. Increasing activity and changing health behaviour will prevent ill health and will improve the health and wellbeing of the population. This will reduce the cost of health care and help improve the economy by keeping people in work. Physiotherapists rehabilitate individuals following illness and injury, restoring the individual’s ability to have a meaningful occupation and to participate fully in society. This reduces the burden of care on society and improves the individual’s physical and mental health and wellbeing.

As the size of the working population declines there is a need for people to work longer. This means that they need to be able to meet the physical demands of their work. The most common causes of work absence are musculoskeletal disorders and common mental health problems such as anxiety and depression. These common health conditions account for over 60% of work absence. For
Physiotherapy delivers real value in terms of outcomes for individuals and society’s health and well being and provides value for money and a high return on investment.

To realise the benefits of physiotherapy the government needs to invest in:

- A physiotherapist in every community helping everybody get fit for the future for their future.
- Fast track occupational physiotherapy to keep NHS staff at work.
- Support for business and industry and in particular SME’s to provide fast track occupational physiotherapy to their staff.
- Sufficient skilled physiotherapists in primary and secondary care to deliver effective rehabilitation for those recovering from illness and injury.

Physiotherapists play an essential role in the rehabilitation and management of long term conditions following stroke, heart attack, neurological conditions or respiratory problems in the NHS, the workplace, and the community. They deliver condition management programmes to get people back to work. The physiotherapists’ practical, positive advice and support gets people on the move and independent faster, reducing medical costs and the need for ongoing care.

The rise childhood and adult obesity is being effectively tackled by physiotherapists through weight management programmes which aim to improve diet and increase activity. Tackling obesity leads to a reduction in associated conditions such as hip and knee arthritis, heart disease, cancers and diabetes, again resulting in significant savings to the NHS in long term health care costs.

UK Physiotherapy is a dynamic forward thinking profession that supports health and well-being at all life stages, in all sectors and settings and in partnership with individuals to optimise their functional ability and quality of life. Physiotherapy can help achieve real savings in the cost of health care in the UK and can provide real benefits in the health and wellbeing of the whole population.

The profession is founded on a strong and ever evolving evidence base that delivers patient-centred, professional care that brings high levels of patient satisfaction. It is responsive to changing needs of the UK population and is developing its practice to meet new health care challenges and priorities and to address health inequalities.
When I worked as Chair of the School Food Trust, I said that I thought it the most important job I’d ever done, but I hugely under-estimated the task. I had this naive idea that all schools needed to do was to teach children about food and how to cook, stop them bringing food or drinks into school, ban vending machines, close the school gates at lunch time, make the kitchens efficient and the dining rooms pleasant places to be, provided delicious healthy meals, and get the parents to refrain from rewarding their little darlings for eating up their greens by giving them a KitKat. I thought all children in the country would have learned to like good food. I swiftly discovered it wasn’t as simple as that, but great progress has been made. There are now many schools doing all, or nearly all, these things successfully.

The fifty-year slide in school dinner take-up has stopped, and though of course it would be great to have the numbers back to 1960 levels, it is no mean achievement to have forty percent of children eating good healthy meals instead of junk.

It is often assumed that head teachers and governing bodies would see the point of a decent diet and good food education, would accept that healthy children would concentrate better, be happier, achieve more. And that they would be keen to upgrade their dining rooms and kitchens. However many teachers felt what children ate was a matter for their parents, money would be better spent on something else and that catering cost money so the less of it the better. My argument is that you would not have disgusting loos or dangerous playgrounds just because they do not cover their costs. Children should not have to spend half their break queuing, they should be able to eat in pleasant surroundings, have time to relax and not be bullied. And anyway, the better the catering

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**Nicola Hunter**

Clinical Director of RehabWorks Ltd. and Physio of the Year 2009

Nicola Hunter is the Clinical Director of RehabWorks Ltd, a leading independent provider of musculoskeletal rehabilitation services to large and middle market employers, insurers and the public sector throughout the UK. She is a leader in the field of occupational health physiotherapy and is Chairperson of the Association of Chartered Physiotherapists in Occupational Health and Ergonomics. Nicola was nominated CSP Physiotherapist of the Year in 2009.

Nicola has developed a stepped, patient centred, bio-psycho-social approach to management of musculoskeletal conditions in line with evidence based guidelines and best practice and has influenced the development of many physiotherapists through training and guided the development of her own staff and other physiotherapists over 20 years in practice.

She is focussed on evidence based practice and measurable work capability and has researched and evaluated therapeutic methods and designed programmes that enable others to deliver best practice.

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**Prue Leith OBE**

Chef, Author and Previous Chairman of the School Food Trust

When I worked as Chair of the School Food Trust, I said that I thought it the most important job I’d ever done, but I hugely under-estimated the task. I had this naive idea that all schools needed to do was to teach children about food and how to cook, stop them bringing food or drinks into school, ban vending machines, close the school gates at lunch time, make the kitchens efficient and the dining rooms pleasant places to be, provide delicious healthy meals, and get the parents to refrain from rewarding their little darlings for eating up their greens by giving them a KitKat. I thought almost every child in the country would have learned to like good food. I swiftly discovered it wasn’t as simple as that, but great progress has been made. There are now many schools doing all, or nearly all, these things successfully.

The fifty-year slide in school dinner take-up has stopped, and though of course it would be great to have the numbers back to 1960 levels, it is no mean achievement to have forty percent of children eating good healthy meals instead of junk.

It is often assumed that head teachers and governing bodies would see the point of a decent diet and good food education, would accept that healthy children would concentrate better, be happier, achieve more. And that they would be keen to upgrade their dining rooms and kitchens. However many teachers felt what children ate was a matter for their parents, money would be better spent on something else and that catering cost money so the less of it the better. My argument is that you would not have disgusting loos or dangerous playgrounds just because they do not cover their costs. Children should not have to spend half their break queuing, they should be able to eat in pleasant surroundings, have time to relax and not be bullied. And anyway, the better the catering
My message to Government is simple: do not drop your guard. Keep food a priority.

Prue Leith OBE
Chef, Author and Previous Chairman of the School Food Trust

Prue Leith’s career has included her own restaurants, catering and cookery school businesses, Board memberships of companies such as Halifax, Safeway, Whitbread, Woolworths, and Orient Express Hotels, a deep involvement with education – she chaired the first of the companies charged with turning round failing state schools and was Chair of the School Food Trust, responsible for the improvement of school food and food education.

She has published 12 cookbooks and five novels. Her latest, ‘A Serving of Scandal’ was published in March.
Mental Health – The Diversity Approach

Matilda MacAttram
Director of Black Mental Health UK

The aspiration for better an improvement of mental health service provision and patient outcomes will only be achieved in practice if the Government articulates in a clear statement of what it expects public services to be able to offer. Priority must be given to evidence based approaches that have a proven track record.

The multicultural nature of British society means that any strategy that aims to promote mental health and well being needs a diversity approach. The fiscal as well as human costs make it imperative to prioritise services and interventions that are cost effective and evidence based and to discontinue and withdraw from ineffective ones.

- Community based services - To achieve positive outcomes for individuals, families and communities a transfer of public sector spending into earlier intervention and prevention is needed urgently. To delay investment until acute mental illness presents is a costly approach in both human and financial terms.

- Partnership working and investment - commissioning of mental health services must be based on the needs of local populations, it is essential that this is reflected in the final commissioning of contracts.

- Single sexed wards - this is one of the few ways to ensure a basic level of safety for vulnerable patients in locked settings. There is a need for all mental health trusts provide women only units that include separate washing, toilet, day and dining room facilities in order to avoid compromising the safety and dignity of patients.

- Advocacy – The right to an Independent Mental Health Advocate (IMHA) must be made available to those with mental health needs before they are subject to detention under the Mental Health Act. There is also a need for IMHA to be made available to all inpatients. Any future strategy for mental health should focus on the need for culturally appropriate advocacy and strategies for sustainable investment in this area.

- Overcrowding - oversubscribed and often volatile environments of some psychiatric setting has been reported to make patients more unwell. The environment of a ward has a significant impact on a patient’s health, wellbeing and recovery. A commitment is needed to ensure that every patient admitted to hospital under the Mental Health Act will be guaranteed their own bed to sleep in while they are in the care of a health provider.

- Age appropriate settings – all health providers must be obliged to ensure patients aged under 18 who are admitted to hospital for mental disorder are placed in age appropriate settings. Under no circumstances should a child be detained on an acute adult ward.

- Child and Adolescent Mental Health Services should also develop services to maintain young people in the community as much as possible.

- Places of safety – Mental Health Trusts and community mental health providers should be resourced to be able to provide places of safety for people detained under the Act in order to end the practice of detaining people with mental health problems in police cells for up to 72 hours.

- Unexplained inpatient deaths – explanations around sudden deaths in psychiatric hospitals often remain unclear. More detailed statistics need to be kept so that it can be known how many patients in mental health institutions die when being restrained or within a short time thereafter, this needs to be kept with details of their ethnic grouping.

- Conditions on wards – commitment to ensure overcrowding and unsanitary conditions of acute inpatient settings are addressed. The squalid conditions of inpatient locked wards must become a thing of the past.

- Race equality – commitment to see reduction in the disproportionate numbers of people from ethnic minorities detained under the Mental Health Act is needed. The practice of psychiatry and the provision of mental health services should be free of racial discrimination. There needs to be a commitment from government to address the inequalities and injustices in the mental health system so that services and the practices are just and fair to all sections of our society irrespective of race, gender and cultural background.
As healthcare communication specialists, we are passionate about the provision of clear, accurate and educational health information that we believe is essential for achieving positive patient outcomes.

Health, in general, is a big issue; according to David Cameron, the NHS is “the number one priority” for the Conservatives and Labour has pledged that no budget cuts will ever be made under a Labour government. Helping people to take more responsibility and accountability for their own health is central to government policy, and information is a critical component in making it happen. The Central Office of Information (COI) already spends around £500 million annually (£540 million in 2008/9) on public health campaigns, but what else should be done?

To address this complex issue, we must first abandon two prevailing beliefs. Firstly, that ‘one size fits all’. Self-care and patient empowerment have long been hailed as the ultimate destination and encouragingly, patients are increasingly exercising their right to choose, but others are still operating within the paternalistic ‘doctor knows best’ model. However, the self-management and paternalistic models should be seen not as conflicting but rather different points on the same spectrum. ‘Doctor knows best’ is out of step with patients who are motivated to navigate the wealth of online information, but a total shift to self-management risks leaving less motivated and vulnerable patients behind.

Secondly, we must dispatch the notion of a ‘one-way street’ where the provision of information is assumed to lead to the desired behavioural change. In practice, several complex interactions must occur as to hear is not to listen; to...
Knowledge empowers patients. It should not be underestimated as a practical means of improving the healthcare of the nation, nor should the right of patients to access accurate, reliable—and ultimately safe—information be overlooked. In line with complementary initiatives, the provision of patient information should remain top of mind for any government’s health policy.

Attitudes are shifting and although behaviour and policy may not be following quickly enough, we are by no means starting from scratch. Pioneering public health initiatives already exist at a local level, but where is the overview and what is the informed consensus on the future vision of patient information? Who are the experts and trailblazers and how can their accumulated knowledge and expertise be harnessed and intelligently applied at a national level? Where else might the necessary expertise lie? For example, sophisticated understanding and a wealth of experience already exists within the business world with deep understanding of personalised communication and motivational techniques. One hopefully obvious idea could be to form a steering group or review body bringing ‘expert’ individuals together from this diverse range of backgrounds to help distil and mobilise these learnings for the direct benefit of patients and even beyond to the public in general. Their agenda would focus on those areas of most pressing need including:

- **Genuine consultation with the public**
- **Upskilling healthcare professionals in advanced communications**
- **Bolstering existing self-management and patient support resources**
- **Some form of a nationally recognised validation scheme for patient information**

Such a project is justifiable—patient information has the potential to significantly reduce NHS expenditure. Education and information alone might still not inspire behavioural change in hard-to-convince populations, but it undoubtedly creates an environment more conducive to making it happen.

Sarah Matthew
Joint Chief Executive of Virgo Health

Joint Chief Executive of Virgo HEALTH, Sarah Matthew has over twenty years’ experience in marketing and communications within the pharmaceutical and healthcare sectors.

Sarah created Virgo HEALTH, a specialist healthcare communications consultancy, along with her business partner, Angie Wiles, in July 2003. In the last 7 years, Virgo HEALTH has been awarded amongst others, the Communiciqué Consultancy of the Year 2006 and 2009. Sarah and Angie were also the joint recipients of the Communiciqué Award for Outstanding Healthcare Communications 2007.

Prior to Virgo HEALTH, Sarah was Managing Director of SUGAR Consulting and Managing Director of Shire Health London, having spent the previous 11 years within the pharmaceutical industry in a variety of sales and marketing roles. Finally, in addition to being a founding member, Sarah is the current Chair of the Healthcare Communications Association.
We need a revolution to defeat the new ‘demand giants’

Julia Manning
Chief Executive 2020health.org

The future health of our nation depends on next future Secretary of State for Health creating a revolution in demand. For years we’ve talked of “evolution not revolution” in the NHS, with a focus on process change, which, both being top down and without aligning incentives, rarely achieved the desired outcomes. This spotlight on process rather than priorities or outcomes has meant difficult decisions have been deferred, commissioning confusion has reigned, practice variation has persisted and productivity has declined. Waste which would be unthinkable in a private business has abounded in the public sector - inexcusable given that it’s our tax money. Talk of demand has often simply been about the unavoidable challenge of an ageing population or cost of technology.

I’m not the naive sort who thinks that was once a Golden Age of the NHS, or one who promises a utopian dream, but I am the practical type who surveys the scene and knows we have not been tackling seriously the malleable drivers of demand, despite all the talk of ‘demand management’ in the NHS. Like Beveridge’s vision of the five giant social challenges in the 1940s, there are now ‘demand giants’, related both to each other and to the bigger picture of our lives, and to beat them requires a revolution in our thinking. This time around they are neglect, risk, drift, commoditisation and conflict.

Neglect is partly due to ignorance, but also the loss in cachet of caring. Possibly the most adjustable determinant of health is how you are nurtured in the first few years of life, although it matters how we treat the frail elderly person at life’s end too. This is the first revolution in which we have to invest – raising the status of caring - because physical, mental and emotional health all rely on us valuing the role of the primary carer. Ignorance of nutrition and first aid are creating a crisis; we are in the extraordinary position of seeing a resurgence of vitamin deficient conditions in both the old and the young. And we must not allow the drive for care at home, which suits many, to mean that the elderly have no choice but to be left alone 23 hours a day, neglected behind their front door.

Risk is a threat in several guises. On an individual level, taking risks with our health has reached epidemic proportions. One significant reason for this is risk displacement i.e. where people take greater risks because there is some real or perceived sort of safety net. Examples include driving faster because you’re wearing a safety belt, having more sexual partners because condoms reduce (note, they don’t eliminate) the incidence of disease or knowing A&E is there to mop you up on a Saturday night. The result is of course that assets are diverted to preventable episodes of care, rather than ensuring that unavoidable needs are resourced in the best way possible. On top of this we put resources at risk through waste – about £800m worth of prescribed medicines are thrown away each year – as we’ve become cavalier about the actual costs of the care we receive. Another aspect of risk is the rise in over-the-counter genetic tests that tell us, and often without a credible basis for doing so, that we have a ‘raised risk’ of certain diseases. This will further fuel the third demand giant – drift.

Drift is about the ever increasing range or normal human variation that is classified as a disease or ‘risk factor’ for disease. Prevention is de rigueur but classifying variations as conditions creates a demand that diverts resources from the genuine need, and screening for some diseases can be counterproductive. Genetics must not be allowed to turn us all from being ‘the public’ into being ‘the patients’.

Commoditisation is the partner of drift. We are becoming objects to be perfected rather than subjects to be accepted. There are genuinely exciting biotechnological developments which could hold solutions to debilitating diseases of old age, long term conditions, compliance and safety but the line between medical therapy and ‘enhancement’ cannot afford to be crossed by the NHS. Real designer babies may be a myth, but the mindset is taking hold – our worth is in what we can buy or sell – yet healing must remain the priority of NHS care.

Finally conflict. The BMAs and Unions of this world seem to refuse to accept that anyone who isn’t an employee of the NHS can possibly want, let alone deliver, the best in healthcare, and they regularly stir up a public-private conflict.
that denies the reality of how important the private sector is in meeting health demands. We need a grown up attitude from these ‘unionistas’; monopolies maintain mediocrity; the future is in more partnerships.

The solutions to all these unsustainable demands are in ownership, stewardship and partnership between the four players in healthcare – the government (or other payer), individuals, professionals and industry. Industry should be providing more health services, individuals should be using services more wisely, professionals need to be enabling self-care and the government should be ensuring the highest standards of practice are disseminated and implemented.

The NHS must remain a national treasure, free at the point of delivery, a safety net for rich and poor alike. But to ensure that is does, we must revolutionise the unacceptable demands.

Julia Manning
Chief Executive 2020health.org

Julia studied Visual Science at City University, graduating in 1990, and became a member of the College of Optometrists in 1991. She was a founder member of the British Association of Behavioural Optometrists and her work has included being a visiting lecturer at City University, a visiting clinician at the Royal Free Hospital, London, working with several London PCTs and being a Director of the Institute of Optometry. She took postgraduate studies in diabetes and established her own optometry practice working with physically and mentally disabled patients which was sold to Healthcall Ltd. in 2009.

Julia is a founder and Chief Executive of the think tank ‘2020health.org’ which launched at the end of 2006. She stood for parliament in 2005 and has written on many health and technology policy issues as well as the history of her profession in ‘60 years of the NHS’ [St. James’s House, 2008]. She has a special interest in framing the policy questions surrounding emerging technologies.
Self Care – Lost and Found

Ms Gopa Mitra MBE
Director of Health Policy & Public Affairs at PAGB

‘Self care is the frontline of healthcare’, a universal truth acknowledged in health policies and by politicians and healthcare workers alike. It is an axiom that needs to be stated. In the 62 years of the NHS we have lost the ability to self-care – individual and collective confidence has been replaced by the doctor’s principal attribute to cure.

We are now a society in which the common disturbances to normal good health, such as coughs and colds, take up on average an hour a day of every GP’s time, costing the NHS £2bn and accounting for 20% of GP workload. The 57m consultations for minor ailments are testament to an NHS addressing demand rather than need, the founding principle of the service. More significantly, evidence has emerged that demonstrates that this demand-led behaviour for minor ailments and GP prescribing has not changed over the past two decades.

Even though people do self care initially, too often they abandon this approach and seek a GP consultation earlier than they need to. Furthermore, whilst GPs acknowledge that they are seeing minor ailments patients earlier than they need to (and often unnecessarily) 99% of these consultations end with a prescription. This cycle of behaviour only goes to reinforce people’s health seeking practices. The way people deal with their common and minor ailments, as well as the GP’s response to this, establishes a mindset that is hard to change at a time when the NHS is communicating messages about prevention and self management of long term conditions.

To ensure a sustainable NHS that can support us all in later life, there must now be an ethical imperative to address the way NHS is used. Never has consensus been greater that our current demand culture, especially around minor ailments, needs to be addressed. There is no longer a choice; the NHS must manage demand for its services. This does not mean denying treatment to the sick, but making sure that people receive the services they actually need, rather than simply the services they demand. Self care needs to be re-introduced into common behaviour as a normal practice – a habit – thereby setting up a virtuous cycle of behaviour in which medical intervention is sought at the point of need.

Effecting behavioural change of this magnitude is not an easy target but it is an aim we cannot afford to ignore – if we do, then continuing demand behaviour will push the pressure on NHS resources to breaking point. Instilling self reliance and self confidence in people at an early stage - ideally beginning with education at school – is vital if we are to sustain a functioning NHS. Increasing self care in the whole population is an investment in the future. Taking responsibility for maintaining health, preventing ill health and dealing with minor ailments should be sensible behaviour for individuals. Allowing people to understand their minor ailments and to look after them through self care would result in a very significant reduction in NHS costs releasing vitally needed time and resource.

A 21st century national health service needs not only to be sustainable but also be available to deal with consultations in primary care for the complex needs of people with long term conditions and co-morbidities. We must now introduce a movement, at the individual, national and local authority levels which:

- **Empowers the individual to be confident in their self care choices.**
- **Enables healthcare professionals, especially the GP, to offer support in empowering people to use the NHS at the point of need.**
- **Educates children through the national curriculum to understand their bodies and what effects normal good health, causes ill health and how to address this in self care and how to use the NHS effectively when this is necessary.**

3. Minor ailments and GP workload; December 2007; IMS Health
4. Ibid
7. Minor ailments and GP workload; December 2007; IMS Health

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Because of the huge advances in Health Care in recent years, and because many individuals are more conscious than ever before of keeping healthy, most of us can expect to live a much longer life than any previous generation. My grandmother was only 39 when I was born yet all my memories of her are of an elderly woman, with false teeth, a hearing aid and rather unsteady on her legs. I have just turned 70 and present a rather different image to my own grandchildren. That is good news for me and for society in general. Older people who are still in work, keep healthy and are able to contribute by providing care for others are an asset to society, not a drain—a fact often overlooked when demographic time bombs are being discussed. Nor should any politician forget that the next General Election will be the first in which the ‘grey vote’ will account for the majority of votes cast.

However we cannot ignore the concerns about health which become more acute with an ageing population. Cancer is largely a disease of old age and the way it is diagnosed and treated becomes more concern as the population ages. Cancer survival rates have improved in the under 75s but worsened in the over 75s, perhaps because patients present late with symptoms or are denied curative surgery. Dementia too becomes more prevalent and the NHS already struggles to cope while the treatment of mental health problems in older people such as depression is often woefully inadequate. So treating older people with dignity and with proper regard for their human rights must be at the top of any NHS reform agenda.

Above all the future of elderly care must tackle the issue of social care—how it is to be provided and how it is to be funded? Those of us in the know are...
perfectly aware that while health care is free at the point of use, social care has always been means tested but many older people need a mix of health and social care and are astonished to find that they have to make financial contributions. The Green Paper, on Adult Social Care, published in July 2009 was an admirable attempt to set out, at long last, a set of options for social care provision in the future and when it was published there appeared to be a laudable amount of cross party support for tackling the issue. Since then we have had the controversy around the Personal Care at Home Bill, which while important, should not be allowed to cloud the wider issue of the long term future for social care and the importance of the expected White Paper. There appeared to be some hope of cross party agreement about next steps but a further falling out seems to have scuppered this prospect, at least for the time being. Perhaps it is inevitable that as a General Election approaches politicians will use this most sensitive of topics to gain political advantage. But since everyone is aware that the current system is unsustainable, it would be refreshing if the politicians could do what the professionals, the carers and the local authorities who will be responsible for delivery are begging them to do- put forward sensible proposals for a reasoned debate about just how we are to tackle this issue in the future- not the distant future, but starting next year. Is it too much to hope that they will do so?

Baroness Jill Pitkeathley OBE

Baroness Jill Pitkeathley trained originally as a social worker and led the carers movement for twelve years, creating Carers National Association (now Carers UK) and turning what had been a private, hidden trouble, the needs of Great Britain’s six million carers, into a public issue. She remains a Vice President of Carers UK.

She was Chair of the New Opportunities Fund, responsible for allocating £2 billion of lottery money for six years and Chair of Cafcass (Children and Family Court Advisory and Support Service) for five years, from 2003 to 2008.

She is currently Chair of the Advisory Body for the Office of the Third Sector and of the Council for Healthcare Regulatory Excellence (CHRE). She was raised to the peerage as Baroness Pitkeathley in 1997, and is a very active working peer as well as Deputy Speaker of the House of Lords.
What Government needs to implement to improve the performance of the Health Visiting profession

Rosamund Shackleton
London based Health Visitor

Fundamentally health visiting needs to be recognised as a valuable profession in its own right. This is vital if the health needs of young children and infants’ needs are to be addressed in a preventive way. This situation deteriorated after the advent of the Nursing and Midwifery Order of 2001 when the Nursing and Midwifery Council (NMC) replaced the Central Council for Nursing, Midwifery and Health Visiting (UKCC). The profession was removed from statute, and this was followed by the closure of the health visiting Register in 2004.

Government support for a return to statute would help with both the clear regulation of conduct and with standards, and help to support the “brand” of health visiting that is still clearly understood by clients. Health visitor numbers plummeted after removal from statute as this move was interpreted as a lack of support for the service. It allowed workforce questions to be clouded in non-specific answers about wider nursing numbers and skill-mixed teams. It has also made the provision of clear clinical career pathways for health visitors difficult, as the profession has had less control over its standards for professional education. Support from the government in funding and encouraging such a career structure, would help to support recruitment, a vital element with major staff shortages in some areas, such as London.

There should be room, as for example in social work, for the appointment of senior clinical practitioners and practice or team managers, whose first priority is providing an excellent frontline service. The training budget for new health visitors and for training their trainers (community practice teachers) is vital as the age of the profession is top-heavy with over 20% of the workforce aged 55 years or more.

The government needs to take on board consumer surveys (e.g. via Netmums and the Family & Parenting Institute) that have show high levels of satisfaction with health visiting, and a wish for more input, especially in the form of home visiting. Good quality contact with families can only happen where health visitors are not faced with huge caseloads, and when their success is not literally “counted” in terms of number seen, tasks completed etc. A long home visit to a mother struggling with for example breastfeeding, or a toddler’s behaviour, or postnatal depression may in itself take well over an hour, not counting the follow-up needed including writing good professional records, liaising with others (for example, their GP or the Social Worker or nursery). There is a physical limit to how many good quality encounters like this can be achieved in a day, no matter how skilled the health visitor, but the future value in prevention, and present value to that particular family, are self-evident.

What are the needs Health Visitors can meet? Health visitors have the unique position of being a universally-offered service that home visits all new families, then tailors their input according to assessment of need and is available freely to all parents with an under 5. This means that health visitors can be at the very forefront of prevention, health education and safeguarding whilst not creating any stigma as all families have received health visiting.

Subjects that health visitors can make significant contributions on (though not exclusively) are encouraging health infant feeding, giving vital health information (e.g. about vaccination), supporting early child development and bonding, detection and support of families with mental health issues including postnatal depression, detecting early health and development problems, supporting good parenting and child behaviour, health education to all family members (and anyone else in the household!), recognition of complex and vulnerable families, giving high levels of support and input both below the threshold for child protection referrals and when formal child protection networks are in place. Health visitors also have skills in helping community development and instigating bottom-up initiatives that meet local health needs from involving fathers to health eating groups to asylum and refugee support.
This year NHS foundation trusts will be six years old. But for such a young sector it has grown fast, established itself speedily and made significant progress. Among the best public healthcare providers, they have embraced their important role in health and in the public sector.

In April 2004 ten foundation trusts were authorised. There are now 126 in the acute and mental health sectors in health with more authorisations planned each month. Every foundation trust is on a transformational journey, and the innovation and dynamism required to be a successful foundation trust are driving the movement forward. They are creating a new sector within the public economy, based on mutual principles.

What makes them stand out is their governance and accountability structures, and the marriage of entrepreneurialism with a public sector ethos. Foundation trusts must meet the same targets and standards as all NHS organisations, yet they are free from central government control. They are run by corporate boards, which are accountable to patients, public and the community who join the FT and elect governors. They are also accountable to their independent regulator, Monitor.

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Rosamund Shackleton
London based Health Visitor

Rosamund Shackleton has spent over 15 years working as a Health Visitor in London. After training in central London around the Kings Cross and Holborn area, she worked in south-west London around Tooting and Wandsworth, then after a 20 month interlude as a research HV working on a study about stillbirths, she moved working to location south-east London, where she has combined working part-time with the demands of having three children aged 4, 7 and 11.

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Sue Slipman
Director of the Foundation Trust Network

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The FT model is young, but we can see that it is working and succeeding:

- **Quality** - in the 2009 Annual Healthcheck results, 35 out of 38 trusts scoring excellent for both quality of services and use of resources are foundation trusts.

- **This year foundation trusts are forecasting a surplus of £353 million.** This will enable them to plan for the long term, and to be better placed to weather the financial storm and to reinvest in service innovations.

- **There are over 1.5 million members and over 3,800 governors in foundation trusts up and down the country.** They are involving patients, public and staff in creating and improving services, both in the foundation trust and in the local health community, demonstrating that local accountability is alive and well.

Given these successes, and against a backdrop of an NHS recession that will challenge every part of the service, it is more critical than ever before that commitment to foundation trusts does not falter.

To secure the future of foundation trusts we need to:

1. **Ensure that the sector remains autonomous and independent, and maintains its operating freedoms and its accountability to the local community, through members and governors.**

2. **Remove the private patient income cap.** This applies only to foundation trusts and hinders innovation and partnership working, which can bring much needed additional resource into the NHS to sustain and develop new services for NHS patients.

3. **Achieve critical mass amongst public healthcare providers.** The number of foundation trusts is growing, but the whole system will benefit from more organisations achieving foundation trust status. This will move the NHS further and faster on public sector reform.

Foundation trusts are an important part of the solution not only to the challenges facing the health service, but also to the challenges facing the public sector.

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**Sue Slipman**  
**Director of the Foundation Trust Network**

Sue Slipman has been the Director of the Foundation Trust Network since October 2004. She was previously Chair of the Financial Ombudsman Service, an executive director with Camelot group responsible for social responsibility and external affairs, Chief Executive of the Gas Consumers Council, the London TEC Council and the National council for One Parent Families.

She has also held a number of public appointments including as a member of the government’s Better Regulation Task Force, Chair of the Corporate Responsibility Group, Chair of the Department for Trade and Industry’s Working Group on corporate social responsibility and Chair of the National Consumer Council’s Policy commission on Public Services and was also Chair of the Financial Services authorities Schools Working Group on Financial Capability.
As with partnership working, good quality, timely information and communication are key elements of effective healthcare.

Information is a key ingredient for decision making and to guide actions taken when diagnosing and treating ill health. It makes no sense that clinicians, patients and their carers are expected to make decisions and take action without access to up to date patient information (as well as best evidence on healthcare options).

How many times is the patient (or their carer) asked to supply information based on what they can remember of current and previous treatment, reactions etc? I could not remember everything that had been said and done to me during day case surgery, when asked by an out of hours GP I called out at 2 a.m. the next morning as I was haemorrhaging. I am a poor historian when it comes to past medications, vaccinations etc.

One solution is for the patient to hold their own records. Another more robust solution is to use information technology to store and share information electronically, as envisaged with the NHS Connecting for Health Shared Care Record (SCR). There are risks with electronically stored data; but the risks of not having essential information available at the time of seeing the patient can carry far greater risks.

Shared information needs to be good quality. For this to be achieved it needs to be derived from the main patient record. There are too many clinicians (including nurses and therapists) using paper records as they have no access to suitable IT systems (software and hardware). If these clinicians are required to enter summary information onto an electronic patient record, it will be at another time. This leads to inaccuracies and time delays entering data, as well as the time lost entering the same data twice. Until all clinicians have the IT systems to use when seeing patients, there will be inadequate sharing of information and no true partnership working.

There has been considerable investment in IT linked to an ambitious programme to link up, use and improve information within the NHS. Some

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**Kate Wortham**

Partnership working is essential if the NHS is to provide seamless, holistic, patient-centred services and, at the same time, make best use of resources for taxpayers. Information and communication are one of the key elements that make or break partnership working.

Failure to achieve coordinated care will at best lead to suboptimal care and/or use of resources. At worst it can lead to delay in treatment resulting in avoidable death. There are many partnerships involved in healthcare including:

- **Patient-doctor**
- **Across health professions**
- **Between GP and hospital doctor**
- **Across NHS organisations**
- **NHS and other organisations including local government (social care, education, housing, leisure, police etc), as well as private and voluntary/third sector**

There are outstanding examples of partnership working achieving truly innovative services. These range from the large scale project to develop and deliver services across a number of NHS and other organisations (e.g. central Manchester’s radical re-design of rehabilitation services, moving from solely hospital in-patient service to a range of services in community settings and patient’s own home); to an NHS service working in partnership with its patients (e.g. Leeds Hot Foot Phone: service for people with diabetes providing patients with a mobile phone number for rapid access to an urgent foot care appointment). 8

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8. For details of examples see - NHS Alliance, Clinical leadership for commissioning in the NHS: Exploring how allied health and other health professionals lead change through and beyond commissioning for a patient-led NHS (2007)
individuals will opt out as they do not want their information stored in this way and are willing to take the risk of vital information not being available when needed. But this should not prevent the majority from benefiting from their information being available when and where needed to assist in the delivery of effective healthcare. Government must take the lead in driving this forward.

Kate Wortham
Kate Wortham works with the NHS as an independent consultant in areas of change and development. Her background is as a clinician (orthoptist) and senior manager in the NHS; she tutored on evidence based health care at Oxford University; and coordinated an Allied Health and other Health Professionals Network for the NHS Alliance. Kate holds public office as a tribunal member for Primary Health Lists with the First Tier Tribunal Health, Education and Social Care Chamber.

About 2020health

Our Vision
2020health is a health and technology think tank with a vision of more people enjoying good health.

Our Mission
- We want to improve health through effective commissioning, competition and technology.
- We seek a level playing field between the public and private sector as the work to improve health outcomes.
- We search for ways in which the workforce can take more responsibility in local healthcare.
- We examine the consequences of healthcare decisions on society, lifestyle and culture.

Our Method
We are ‘professional’ led, ensuring all we do has the constant input of people working for and in the public services. Our unique emphasis is on giving people who work delivering healthcare, the ‘grass-roots’, the opportunity to use their experience and expertise to direct our work.

Our partnership
2020health’s work is made possible through partnership and sponsorship.

Please do contact Julia@2020health.org if you would like to know more about getting involved in our work.