The Outlook For Health & Social Care
Thursday 10 October 2020

#CollaborativeNW
Online guidance

- The session is being recorded and will be edited and circulated after the event
- Everybody will be muted at the start of the webinar
- You can change your participant name to show your name and surname by clicking on ‘participants’ on your toolbar, selecting yourselves and then clicking on ‘rename’
- If you have any questions, please type these in the chat box
- We may not be able to answer all questions however, we will follow up with a FAQ after the session

#CollaborativeNW
Steve Connor
Managing Director, MIAA
Social care: Before and after Covid-19

Sally Warren
Director of Policy
@so_says_sally
Social care 360: 20 trends 2018/19

ACCESS

1. More adults are asking for help...
2. ...but, overall, fewer are receiving support
3. The means test has got even meaner
4. Levels of disability have changed little
5. More people are receiving disability benefits
Key trend: More people request social care support; fewer people receive it

Percentage change since 2015/16

Source: Adult Social Care Activity and Finance Report, NHS Digital. This chart combines the number of people receiving long-term care services with the number of packages of short-term care support to maximise independence (ST-Max) provided. There may be some overlap between these figures: some people who receive long-term care may also receive ST-Max in a year and some people may receive more than one episode of ST-Max.
More working age adults request social care support...
... and more of them, but fewer older people, receive it
Social care 360: 20 trends 2018/19

EXPENDITURE

6. Spending remains below the level of 2010/11

7. Councils’ cost of buying care continues to increase
Local authority spending still nearly £0.4bn below 2010/11

Sources: NHS Digital - GDP deflators at March 2020 used from HMT. 'Total expenditure' on social care includes spending that derives from three main sources - money which councils allocate to social care from their central budget (including money they raise from the additional 'social care precept' on council tax), income from social care service users (through fees and charges) and income from the NHS.
More spent on LTC for 18-64 adults with learning disability than on physical support for older people.
Social care 360: 20 trends 2018/19

**PROVIDERS**

8. Care home beds continue to decline

**WORKFORCE AND CARERS**

9. Jobs growth has slowed
10. Pay has increased but slower than other sectors
11. Support for family carers is mixed
Growth in social care jobs slowing almost to a halt

![Year-on-year growth chart]

*Source: Skills for Care*
Pay: in 2012/13, careworkers earned more than shopworkers and cleaners…
...but in 2018/19 they earned less.

Source: Skills for Care. Low paid jobs are as defined by the Low Pay Commission report, using the Annual Survey of Hours and Earnings data from ONS.
QUALITY

12. Care quality ratings have increased slightly.

13. Satisfaction among service users remains high.


15. Use of direct payments may have peaked.

16. The fall in care home admissions has slowed.
Public satisfaction with social care lower than for the NHS

Percentage of respondents in England who are 'very' or 'quite' satisfied

Source: King’s Fund analysis of NatCen Social Research’s BSA survey data. Questions asked: All in all, how satisfied or dissatisfied would you say you are with the way in which the National Health Service runs nowadays? and ‘How satisfied or dissatisfied are you with social care provided by local authorities for people who cannot look after themselves because of illness, disability or old age?’
The percentage of service users using direct payments may have peaked.
Social care 360: 20 trends 2018/19

CONNECTIONS TO OTHER SERVICES

17. Delayed transfers have inched back up again.
18. Fewer older people receive reablement.
19. NHS CHC has shifted to short-term provision
20. Disabled Facilities Grants have increased.
Before Covid-19, delayed transfers of care had started to rise again.

Source: Delayed transfers of care, NHS England 2019/20
Social care 360: 20 trends 2018/19

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Problems before Covid-19

1. **Means testing:** it’s not like the NHS
2. **Catastrophic costs:** selling homes to pay for care
3. **Unmet need:** people going without the care and support they need
4. **Quality of care:** 15-minute care visits, neglect, institutionalisation
5. **Workforce pay and conditions:** underpaid, overworked staff
6. **Market fragility:** care home companies going out of business
7. **Disjointed care:** delayed transfers of care and lack of integration with health
8. **The postcode lottery:** unwarranted variation in access and performance
Impact of Covid-19

1 and 2. Means testing/catastrophic cost: limited impact (but still central to reform)

3. Unmet need: increased but we can’t yet judge the extent

4. Quality: huge, tragic impact (and also affected in other ways)

5. Workforce: Greater recognition but no guarantee of better pay and condition

6. Market fragility: shaken the market, especially for residential care

7. Disjointed care: rapid, enormously controversial, change in hospital discharge

8. Postcode lottery: may well have worsened but don’t have data

Underlying issues: funding, reputation, leadership
The prospects for Social Care reform
Any Questions?

For Sally Warren
LEARNING TO LIVE WITH COVID:
KEY ISSUES FOR THE NEXT YEAR

MIAA ANNUAL HEALTH CHECK

September 10 2020
Agenda

Where were we before COVID-19?

Lessons from COVID-19

Four key short term issues

Three key longer term issues
Agenda

Where were we before COVID-19?

Lessons from COVID-19

Four key short term issues

Three key longer term issues
Where were we before COVID-19?

• Deepest and longest financial squeeze in NHS history
• Demand consistently outstripping capacity across board
• Despite treating more patients than ever before, worst performance statistics in a decade
• Significant and pervasive workforce shortages
• Social care in ever worsening crisis
• NHS Long Term Plan with clear vision...but lots of priorities and insufficient funding to deliver
• System working...but on an uneven and unclear path
• Frontline staff doing best in a difficult context
• An increasingly unsustainable position?
## Agenda

<table>
<thead>
<tr>
<th>Section</th>
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<tbody>
<tr>
<td>Where were we before COVID-19?</td>
</tr>
<tr>
<td>Lessons from COVID-19</td>
</tr>
<tr>
<td>Four key short term issues</td>
</tr>
<tr>
<td>Three key longer term issues</td>
</tr>
</tbody>
</table>
Ten lessons from COVID-19?

- NHS ability to mobilise at pace when needed
- Importance of place & system based working
- Providers working together in collaboratives
- Stability & empowerment from guaranteed funding
- Success of empowering local leaders
- Flexibilities found, especially in workforce
- Speed of movement to innovate and problem solve
- The role, or not, of commissioners, systems & places
- Pandemic preparedness
- Vulnerability of social care, especially care homes
Agenda

Where were we before COVID-19?

Lessons from COVID-19

Four key short term issues

Three key longer term issues
Dealing with COVID-19: more demand wherever you look!

The underlying reality
• Increased social contact = increased transmission rates

The healthcare needs
• Retain acute hospital surge capacity
• COVID-19 rehab capacity including long covid
• Rapidly growing mental health demand, higher acuity
• Increased community services & GP demand
• Infection control
• Mass vaccination programme
• Effective test and trace at scale

Three hopeful pointers?
• Increased infection rates but stable hospital admissions and deaths
• Easier to control spread from national lockdown
• Public awareness of what’s needed/attitude to risk (but differential)
Recovering Activity Volumes

The problem
• Recovering activity & tackling care backlog: precision needed on size & cause
• Constraints: infection control requirements reducing capacity (c15-30%); tired workforce; patient confidence

The solution
• Frontline effort, focus and innovation: diagnostics; collaborative working; clinical prioritisation
• Public campaign aimed at reassuring patients
• Acceptance of reality of constraints

Progress
• Phase 3 targets
• Speed of recovery
• Perception lags reality
• Patient impact
Preparing for winter

The risk

• Potential quadruple demand pressure:
  • ‘Normal winter pressures’
  • COVID-19 second spike
  • Winter flu
  • Care backlog
• Similarity of COVID-19 and winter flu symptoms
• Workforce pressures
• Lost capacity due to COVID-19
• Underlying long term demand / capacity mismatch on Urgent and Emergency Care (UEC) pathway

The ‘solution’

• Redesigned “111 first” UEC pathway
• Hospital ED expansion capital funding
• Start introducing new UEC pathway standards
• Fit for purpose test and trace at scale
Effective test and trace at scale

• Key to virus control but not a silver bullet by itself

• A difficult start for NHS Test and Trace

• Lots of work needed to be fit for winter purpose:
  • Quadruple testing capacity
  • Build testing capacity where geographically needed
  • Shift to greater local control
  • Improve success rate of end to end contact tracing process
  • Better in-reach into harder to reach local communities
  • Improve local outbreak control
  • Improve test turnaround times
  • Deploy new and innovative tests
  • Ensure consistent quality of necessary data flows
  • Build at scale asymptomatic testing, especially in health & care settings
  • Ensure overall public confidence
  • Answer questions / reassure on efficacy of PCR testing
Agenda

Where were we before COVID-19?

Lessons from COVID-19

Four key short term issues

Three key longer term issues
Money: Pressure Wherever You Look

- NHS budget three parts: ringfenced NHS England budget; rest of DHSC budget (including NHS education and training and public health); capital

- May Government 3.4% real terms annual increases in ringfenced NHS England budget to 2023/24: barely keeps up with growing demand

- Extra demands for Comprehensive Spending Review (CSR):
  - *Capital Budget*
    - Manifesto commitment on hospital building
    - Long Term Plan transformation requirements (e.g. digital and diagnostic hubs)
    - Maintenance backlog
  - *Non ringfenced budgets*
    - Manifesto commitments on extra nurses and more GPs
    - New covid requirements e.g. Test and Trace
  - *Core NHS England budget*
    - Ongoing covid demand and recovering care backlogs
    - Pay pressure
    - Long Term Plan delivery needs

All before the cost of funding social care reform...and a very difficult public expenditure outlook
Reprioritisation

NHS Long Term Plan Priorities

Manifesto Commitments

New COVID-19 created priorities

- Prevention
- Health inequalities
- Moving to systems
- Recovering elective waiting lists
- Improving A&E
- 40 new hospitals
- 40,000 new nurses
- Improving mental health
- Expanding community services
- Extra GP appointments
- Permanent Test & Trace
- Social care reform
- Mass vaccination
- Ongoing Covid demand
- Better cancer, cardiac etc. outcomes
- People Plan priorities
- Whole population health
- Keep Covid gains e.g. flexibility
- Pandemic preparedness

Prioritisation process to weigh a large number of different priorities
Match priorities to three year CSR revenue and four year capital envelope
Announce new, refreshed, priorities for rest of Parliament as part of CSR
Legislation, System by Default, and NHS structure

• Bill in Spring 2021? Two main themes on a Xmas tree bill?
  • Arms length body structure/responsibilities and relationship with Government
  • How to move to consistent effective system working – roles and responsibilities of systems, providers and commissioners

• NHS England / Improvement developing next iteration of system by default policy, due September / October

• Big questions to answer:
  • What are systems? Voluntary forums, tightly defined strategic planners or a new tier?
  • What formal responsibilities do they have?
  • What statutory powers do they have / need to discharge responsibilities?
  • How do these relate to existing responsibilities of providers & CCGs?
  • How does STP/ICS governance work?
  • How should commissioning work?
  • How do different footprints – neighbourhood, place, system, region, nation – work?
  • What sits at what level – do we want four replicated sets of functions at trust, system, regional and national level?
## Sample range of outcomes

<table>
<thead>
<tr>
<th>Voluntary system level forum</th>
<th>Strategic planner with defined functions</th>
<th>Full new statutory tier</th>
</tr>
</thead>
</table>
| • One of a number of health and care geographic footprints  
• No statutory underpinning  
• System function centred on providing a voluntary strategic planning forum for health and care organisations in a system footprint  
• System does not have enforcement power over trusts and CCGs  
• Essentially preserves existing accountabilities, would only require minor changes  
• Acceptance and embracing of local variation | • Agreed footprint for certain defined functions  
• Limited statutory underpinning to support defined functions  
• Functions might include strategy, planning, whole population health, health inequalities and specific functions such as capital allocation. Could extend to replacing CCG as commissioner and money channel  
• System only has enforcement power over trusts/CCGs in defined areas  
• Would require careful alignment with existing trust and CCG responsibilities  
• Balancing local variation with minimum standards for all systems | • Dominant footprint  
• Extensive statutory underpinning  
• Functions akin to an old Strategic Health Authority including full responsibility for money, performance management etc.  
• System has wide ranging enforcement power over CCGs and trusts  
• Would require extensive redrawing of existing provider/CCG statutory responsibilities and transfer of power from trusts/CCGs and from regions to system level  
• Likely to end in a quest for uniformity |
Summary

- NHS not in a sustainable position as we entered COVID-19

- COVID-19 shows extraordinary underlying NHS capacity and capability thanks to our frontline staff....

- ...But it’s also brought a wide range of complex, new, extra demands

- We now need to do five things:
  - Have national debate about long term level of funding for health and care
  - Honestly, openly, and ruthlessly prioritise against available financial envelope
  - Answer the questions on structure and how we get to system working
  - Reform social care
  - Stabilise NHS in its new post covid-19 pattern

- Our workforce remains the single most important success factor, so we also need to get to a sustainable position on workload, job satisfaction, working pattern, numbers, culture, flexibility, consistently good leadership and pay
THANK YOU

Chris.hopson@nhsproviders.org
Any Questions?

For Chris Hopson
2020 Health check beyond the COVID-19 crisis

Anita Charlesworth
Director of Research and REAL Centre
(Research and Economic Analysis for the Long term)

September 2020
### The overall impact on mortality across the pandemic period

<table>
<thead>
<tr>
<th>Country</th>
<th>Excess deaths</th>
<th>Excess deaths/usual deaths</th>
<th>Excess deaths/million population</th>
<th>Start week</th>
<th>End week</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>26,285</td>
<td>20%</td>
<td>377</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Germany</td>
<td>7,300</td>
<td>4%</td>
<td>88</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Italy</td>
<td>44,866</td>
<td>35%</td>
<td>743</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Spain</td>
<td>48,399</td>
<td>56%</td>
<td>1,023</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Sweden</td>
<td>5,080</td>
<td>28%</td>
<td>497</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>UK</td>
<td>64,451</td>
<td>52%</td>
<td>965</td>
<td>13</td>
<td>23</td>
</tr>
</tbody>
</table>

**Note:** The number of excess deaths is that over the 11-week period selected for each country. This may differ from the total number of excess deaths a country has recorded, if there are excess deaths outside the 11-week period.
Health footprint of COVID-19 pandemic

1st Wave
Immediate mortality and morbidity of COVID-19

2nd Wave
Impact of resource restriction on urgent non-COVID conditions

3rd Wave
Impact of interrupted care on chronic conditions

1st Wave Tail
Post-ICU recovery

4th Wave
- Psychic trauma
- Mental illness
- Economic injury
- Burnout

Source: Victor Tseng
The WHO health system framework

Source: Strengthening health systems to improve health outcomes – WHO’S framework for action https://www.who.int/healthsystems/strategy/everybodys_business.pdf?ua=1
Increases in life expectancy at birth stalling in England

Source: Human Mortality Database; calculations by Murphy, Luy and Torrisi

Notes: Data for Australia, Ireland, Italy and Norway are to 2014, for Switzerland and Finland to 2015.
The amount of life spent in good health decreased for men and women in England

<table>
<thead>
<tr>
<th></th>
<th>Healthy life expectancy (HLE)</th>
<th>Years in poor health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-11</td>
<td>63.0</td>
<td>15.8</td>
</tr>
<tr>
<td>2012-14</td>
<td>63.4</td>
<td>16.1</td>
</tr>
<tr>
<td>2015-17</td>
<td>63.4</td>
<td>16.2</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-11</td>
<td>64.0</td>
<td>18.7</td>
</tr>
<tr>
<td>2012-14</td>
<td>63.9</td>
<td>19.3</td>
</tr>
<tr>
<td>2015-17</td>
<td>63.8</td>
<td>19.4</td>
</tr>
</tbody>
</table>
Boys born in the most deprived areas can expect 18.6 fewer years of good health than those born in the least deprived areas.

Male life expectancy and healthy life expectancy at birth by decile of deprivation, England: 2016–18

Source: ONS Health State Life Expectancies by decile of deprivation, England: 2016–18
### How does the UK compare with the G7 & EU14

#### Health expenditure

<table>
<thead>
<tr>
<th>Rank</th>
<th>Health spending as % of GDP - total, 2018</th>
<th>USA</th>
<th>GER</th>
<th>FRA</th>
<th>JAP</th>
<th>SWE</th>
<th>CAN</th>
<th>BEL</th>
<th>AUT</th>
<th>DEN</th>
<th>UK</th>
<th>NET</th>
<th>POR</th>
<th>FIN</th>
<th>ESP</th>
<th>ITA</th>
<th>GRE</th>
<th>IRE</th>
</tr>
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<tbody>
<tr>
<td>16.9%</td>
<td>11.5%</td>
<td>11.3%</td>
<td>11.0%</td>
<td>10.9%</td>
<td>10.8%</td>
<td>10.3%</td>
<td>10.3%</td>
<td>10.1%</td>
<td>10.0%</td>
<td>10.0%</td>
<td>9.4%</td>
<td>9.0%</td>
<td>9.0%</td>
<td>8.7%</td>
<td>8.7%</td>
<td>7.7%</td>
<td>6.9%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health spending as % of GDP - government spending/compulsory contribution, 2018</th>
<th>USA</th>
<th>GER</th>
<th>FRA</th>
<th>SWE</th>
<th>JAP</th>
<th>DEN</th>
<th>NET</th>
<th>BEL</th>
<th>UK</th>
<th>AUT</th>
<th>CAN</th>
<th>FIN</th>
<th>ITA</th>
<th>ESP</th>
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<tbody>
<tr>
<td>14.3%</td>
<td>9.7%</td>
<td>9.4%</td>
<td>9.3%</td>
<td>9.2%</td>
<td>8.5%</td>
<td>8.2%</td>
<td>7.8%</td>
<td>7.5%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.6%</td>
<td>7.8%</td>
<td>7.8%</td>
<td>7.7%</td>
<td>7.6%</td>
<td>7.5%</td>
<td>7.4%</td>
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<table>
<thead>
<tr>
<th>Health spending per capita PPP, $USD, 2018</th>
<th>USA</th>
<th>GER</th>
<th>AUT</th>
<th>SWE</th>
<th>DEN</th>
<th>CAN</th>
<th>FRA</th>
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<th>IRE</th>
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<th>USA</th>
<th>JAP</th>
<th>GRE</th>
<th>POR</th>
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<tbody>
<tr>
<td>$10,637.14</td>
<td>$6,223.79</td>
<td>$5,631.59</td>
<td>$4,633.73</td>
<td>$4,714.41</td>
<td>$4,919.25</td>
<td>$5,103.20</td>
<td>$4,911.85</td>
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<td>$4,331.48</td>
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<td>$2,652.90</td>
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<thead>
<tr>
<th>Practicing physicians per 1,000 population, 2018</th>
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<th>GER</th>
<th>SWE</th>
<th>DEN</th>
<th>ESP</th>
<th>ITA</th>
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<tr>
<td>5.24</td>
<td>4.31</td>
<td>4.27</td>
<td>4.19</td>
<td>4.02</td>
<td>3.98</td>
<td>3.67</td>
<td>3.28</td>
<td>3.21</td>
<td>3.17</td>
<td>3.13</td>
<td>3.14</td>
<td>2.84</td>
<td>2.72</td>
<td>2.61</td>
<td>2.49</td>
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<table>
<thead>
<tr>
<th>Practicing nurses per 1,000 population, 2018</th>
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<th>GER</th>
<th>JAP</th>
<th>BEL</th>
<th>NET</th>
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<th>USA</th>
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<tr>
<td>14.26</td>
<td>13.22</td>
<td>11.76</td>
<td>11.22</td>
<td>11.13</td>
<td>10.88</td>
<td>10.10</td>
<td>9.95</td>
<td>7.78</td>
<td>6.87</td>
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<table>
<thead>
<tr>
<th>CT scanners per million population, various years (UK is 2014 and public sector only)</th>
<th>JAP</th>
<th>USA</th>
<th>DEN</th>
<th>GRE</th>
<th>GER</th>
<th>ITA</th>
<th>AUT</th>
<th>BEL</th>
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<th>UK</th>
<th>POR</th>
<th>SWE</th>
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<tbody>
<tr>
<td>111.49</td>
<td>44.94</td>
<td>40.65</td>
<td>40.62</td>
<td>35.13</td>
<td>35.12</td>
<td>28.84</td>
<td>23.89</td>
<td>21.41</td>
<td>19.12</td>
<td>18.24</td>
<td>16.56</td>
<td>15.35</td>
<td>14.22</td>
<td>9.46</td>
<td>NA</td>
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</table>

| MRI scanners per million population, various years (UK is 2014 and public sector only) | JAP | USA | GER | GRE | FIN | ITA | AUT | ESP | FRA | NET | BEL | CAN | UK | DEN | POR | SWE |
|-----------------------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 55.21 | 40.44 | 34.71 | 29.35 | 28.82 | 28.73 | 23.53 | 17.22 | 16.03 | 15.43 | 13.06 | 11.61 | 10.35 | 7.23 | NA | NA | NA |

<table>
<thead>
<tr>
<th>Total hospital beds per 1,000 population</th>
<th>JAP</th>
<th>GER</th>
<th>AUT</th>
<th>FRA</th>
<th>BEL</th>
<th>GRE</th>
<th>FIN</th>
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<th>IRE</th>
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<th>CAN</th>
<th>UK</th>
<th>DEN</th>
<th>SWE</th>
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<tbody>
<tr>
<td>13.09</td>
<td>8.37</td>
<td>5.07</td>
<td>5.03</td>
<td>4.58</td>
<td>3.85</td>
<td>3.67</td>
<td>3.41</td>
<td>3.37</td>
<td>3.07</td>
<td>2.97</td>
<td>2.87</td>
<td>2.65</td>
<td>2.49</td>
<td>2.14</td>
<td>2.07</td>
<td>1.91</td>
<td>1.84</td>
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How does the UK compare with the G7 & EU14

<table>
<thead>
<tr>
<th>Rank - Best Performing to Worst Performing</th>
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<tr>
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<tr>
<td>Health status</td>
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<td>Access to health care</td>
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<td>Median wait for hip replacement, days, 2017</td>
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<tr>
<td>Asthma hospital admission in adults, age-standardised rate per 100,000, 2017</td>
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<tr>
<td>30 day mortality following AMI, age-standardised rates per 1000, 2017</td>
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<tr>
<td>Quality and outcomes</td>
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</tbody>
</table>

Source: OECD Health Statistics 2019
Age adjusted health spending

Source: DHSC accounts; ONS population estimates
The UK spends significantly less on capital in health care than comparable countries as a share of GDP.


Source: Health Foundation analysis of OECD data for countries for which data for all years were available. Countries included: Austria, Canada, Denmark, Finland, France, Greece, Italy, Norway, Sweden, United Kingdom, United States.
NHS workforce shortages in England are set to double within five years.


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The outlook for health and care beyond the immediate COVID-19 crisis.

Source: Health Foundation analysis of workforce and vacancy data from NHS Digital and Health Education England. • Note: These projections are for Hospital and Community Health Services (HCHS) staff working in NHS organisations and do not include staff working in primary care, including GPs and practice nurses. These projections do not account for any COVID-19 impacts.
NHS England funding growth
Planned and assumed allocation of NHS England funding growth 2018/19 to 2023/24

July 2020

The outlook for health and care beyond the immediate COVID-19 crisis

Source: Investing in the Long Term Plan: Job Done, The Health Foundation
Age adjusted health spending

Source: DHSC accounts; ONS population estimates
Additional funding to stabilise the current social care system and improve access to care in 2023/24

Meet the expected growth in demand from an ageing population – the scenario where the additional funding provided keeps up with increases in demand from an ageing population. This would cost around £2.1bn.

Increase pay – in addition to meeting future demand, providing additional funding to increase the pay of the adult social care workforce. This should improve retention and recruitment, as such helping to address the vacancy rate which has risen from around 5.5% to 7.8% over the last 6 years, equivalent to 122,000 vacant posts at any one time. This would cost around £3.9bn.

Recover peak spending levels – returning spending (relative to demand) to the peak levels seen in 2010/11. This would cost around £10.0bn.

Recover peak spending levels and increase pay – in addition to returning to peak spending levels, providing additional funding to increase pay. This would cost around £12.2bn.

July 2020

The outlook for health and care beyond the immediate COVID-19 crisis
After the first wave

**Service delivery:**
- A health service not just a Covid-19 service – elective care, cancer, mental health, other emergency care services.
- Tackling inequalities in health
- Putting social care on an equal footing with the NHS

**Workforce:**
- More staff – large scale postgraduate programme for nursing, apprenticeships, more investment in CPD, tackling discrimination and having a workforce that reflects all sections of society and is inclusive.
- Social care – a fundamentally better deal for staff and improved regulation, need a workforce plan that looks at options such as a sector wages council, a professional register, reform of apprenticeships to allow a major expansion in numbers and CQC focus on workforce practices in regulation of providers.
After the first wave

• **Information:**
  • Data in social care
  • Data and technology needs to support service innovations – digital first in primary care and out-patients, enhanced role for the ambulance service and paramedics.

• **Vaccines and medicines:**
  • Reliable procurement and equitable access.

• **Financing**
  • Funding to build health capacity and resilience, investment focused on public health, workforce and capital.
  • A major injection of public money for social care and reform of the funding system to implement Dilnot recommendations as in 2014 Care Act.
  • Investment in the social determinants of health.

• **Leadership and governance:**
  • Balance between national and local decision making (NHS and local government)
  • Regional tier?
  • Making a reality of system thinking at the centre e.g. cross government action on obesity.
World Health Organization

‘A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is, therefore, more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation.’
Thank you
Any Questions?

For Anita Charlesworth

#CollaborativeNW
Key Themes
Evaluation

Please click on the link below to fill in a quick survey regarding today’s session:

https://www.surveyhero.com/s/3b64477
Thank You