Niall Dickson’s Confed18 keynote address
14 June 2018, Manchester

Well, a very good morning.

Fifteen minutes’ walk from this hall is the Manchester Arena. And it is just over a year ago, as Ariana Grande finished her encore, that a suicide bomber set off a blast that killed 23 mainly young people and 139 were wounded – some with terrible injuries.

The response – and again reflecting the comments Stephen made about Grenfell from NHS staff – is not only tireless, selfless and committed, it was effective; the result of very careful planning, good and trusting relationships.

As one medic put it, “staff from almost every imaginable background, race and religion came together and put their all into caring for those wounded.” And it is right, at times of adversity and national trauma, in Manchester, as in Grenfell exactly a year ago, when the spotlight is shining on this service, we see something special.

And even today, after 70 amazing years, it is a more diverse service than ever, and I would argue one with even greater potential.

And that is why later this afternoon, it is right that we celebrate together what’s been achieved by this extraordinary and powerful institution, which has captured the hearts of the British people. And I hope we will renew our vows as well to strengthen and protect it in the years ahead.

In my remarks this morning, I want to suggest we are at a moment when key decisions need to be made about what we are willing to invest in our health and care system. I will argue that we need to make a compact with the British people about what they will receive in return for a longer-term settlement. And that if we are to deliver our side of that bargain, we will need to act locally and nationally to create a framework that will facilitate radical transformation and build the workforce that will be required.

I think this conference has underlined this shared realisation that we have reached a seminal moment. It won’t be the first time that this service has found itself at such a crossroads.

In 1948, in the early 70s and the early 90s, the service faced existential challenges, as it did at the start of the new millennium. In some ways, the challenges today are greater, and the economic and political terrain is more uncertain. But as a society, I hope we have at least begun to recognise that we are at one of those critical junctions.

When it comes to investment, at the Confederation, we’ve been calling in public and working behind the scenes for three things.
One: A significant commitment. The minimum we now believe is necessary based on the Institute for Fiscal Studies (IFS) and Health Foundation study is 4 per cent real-terms growth for both health and social care every year for the next 15 years.

I am not saying, incidentally, that the politicians will be able to make that promise for 15 years, but we do want a longer-term commitment.

Two: A bringing together of health and social care funding. We simply cannot allow social care to disintegrate any further.

And three: A longer-term settlement to provide stability, the stability that we need to plan and transform. And we are clear the system needs a reset.

There is already a substantial gap, and it is a growing one, between what we can deliver and what is needed. Just to return to the constitutional standards on elective care, we would need an additional 600,000 admissions just to clear the backlog. That's why the IFS/Health Foundation report recommends further additional funding in the early years, to take us back over a period of time to the key standards we were achieving a few years ago.

Now, too often it has taken tragedy to trigger change – if you think of Hillsborough, Dunblane, Grenfell and in health, Bristol, Mid-Staffs, Morecambe Bay. But for us, there is now a window of opportunity before tragedy strikes to act before the service cracks under the strain, and frankly, is unable to provide safe care.

The good news is that I think we’ve begun to see a switch in government thinking. And I think we should give the Secretary of State in particular credit for fighting hard to convince a sceptical Treasury, as well as colleagues on the front and back benches, that a different approach is needed.

Indeed, in each of the areas where we have been pressing, we have seen some signs of movement. But as yet, I have to say it is not clear, not sure if it will be clear by the end of the afternoon either, what is required to make these changes.

The experience of the first decade of this century, however, shows clearly that investment can deliver results. That it needs to be focused and targeted. And we need a shared understanding of what can be done and over what period.

In short, in England at least, we need a new plan for health and care, developed, created, and agreed with the service and the wider public. Our immediate concern is that a quickly devised centrally imposed plan will fail to address the enormity of the challenge or the need to secure widespread support. We had some reassurances on this yesterday from Simon [Stevens], but the promised engagement really does need to be real.

We need a new compact or agreement between the government, NHS and public. And for the avoidance of doubt, we’re talking about months not years for this engagement process. But I believe the service is willing to have its feet held to the fire in exchange for adequate resources and a coherent plan.
But any new strings attached to this money should be the result of a conversation; it must be realistic, and rooted in the realities of a 21st century service and the demands that that brings.

I am conscious that much of what I am now saying applies to England rather than to other parts of the UK. The challenges are unsurprisingly remarkably similar, but in Northern Ireland, they already have Health and wellbeing 2026: Delivering together, and in Wales they have Revolution from within: Transforming health and care in Wales.

These are clear blueprints with some degree of political and service consensus about the way forward. And let me just in passing pay tribute to the Northern Ireland and Welsh Confederations, both of whom are part of the NHS Confederation group who have played such a vital role in convening different parts of their system and in providing a distinctive voice for the service.

So what might be the issues such a plan for England would need to address?

It has to begin with an admission: even with additional investment, the system is unsustainable without fundamental reform. We heard that unequivocally yesterday from Ian Dalton, and the IFS/ Health Foundation report estimated that in ten years’ time if we go on as we are, we will need 50 per cent more acute beds, and obviously that is not credible.

And so in a sense the underlying question is simple: how do we create a sustainable system which effectively manages growing demand? The success of the next ten to 15 years will depend on our ability to tackle this, and it is against that question we should perhaps judge each element.

First, there is the vexed issue of the relationship between what is national and what is local. Now the latest moves to reform the regulatory architecture articulated by Simon and Ian are really welcome. The prospect of a genuinely coordinated approach between NHS Improvement and NHS England, and a much greater emphasis on support and improvement, and a commitment to breakdown traditional boundaries between different parts of the system.

The intention is good, but as one of you pointed out to me last night, we’ve seen good intentions before, and this in part is about cultural and behavioural change. And it will need to go further. The centre should be about agreeing strategic direction, setting objectives, creating or helping to create the right environment, and freeing good leaders to deliver great care.

Secondly, and related to this, I think we’re all agreed that the current payments and incentives system is simply not fit for purpose. One set of complicated rules arrive to replace another, with more and more organisations ending up in deficit, having tried to manage impossible targets. What’s needed is a set of performance management arrangements and financial incentives which support system working and encourage investment in new models of care.

Now to be fair, greenshoots are appearing and we saw plenty of examples of that in Simon’s film yesterday. But many have been delivered in spite, not because of, the current arrangements. And we need to roll out what works faster and more systematically than we have managed hitherto.
Third, we need legislative change. Much of what is being attempted now amounts to work rounds and local fixes and all the more commendable for that. But as a taxpayer or a patient or a service user of a nationally funded service, I want to understand who is responsible for what and how I can hold them to account. Clarity and simplicity are needed, with organisational forms that support rather than hinder integrated delivery.

Fourth, we must finally deal with the challenge of mental health and social care. We have made some progress on mental health, and it is to the credit of leaders with and beyond the NHS that we have a commitment to, and some progress on, moves towards parity of esteem.

It will be critical in any NHS implementation plan that clear milestones are set, and that both in terms of funding and outcomes, the current momentum around mental health reform is maintained.

And social care, I have to say, we seem to be at ground zero. Again, both the health secretary and the Prime Minister appear committed – he now even has social care in his job title. But we spent more than 20 years lamenting this problem, and we spent more than 20 years failing to act.

The promised green paper has been delayed at least three times. We can't go on like this. The levels of unmet need are nothing short of a disgrace. And they result in unnecessary health costs and unnecessary suffering. At the Confederation, we set out ten areas where action is needed and our members have consistently argued that unless we tackle this, the health service itself will continue to struggle.

Like mental health, our ambition for social care should be parity of esteem.

Fifth, we have failed to invest at the speed or with the urgency required in new models of care in the community. It is really shocking that over the past eight years, spending on primary care in England has actually fallen in real terms. Indeed, from the mid-90s, the number of hospital doctors has increased by 72 per cent, whereas in the same period, the number of GPs fell by 5 per cent.

Now this is not about attacking the acute sector, but unless we invest in and reform the services that surround our hospitals, the whole system will fail. That means getting to grips with the division between social, primary and community care, bringing teams and budgets together, using data to segment the population and target interventions, and making sure that care and support is offered at the right place, at the right time.

Already we can see what's possible with primary care home and similar models which create an integrated workforce, close partnerships, and shared budgets with a joint commitment to health outcomes and for a defined population. But again, the pace of change needs to accelerate.

Incidentally, with NHS Providers we have set up a new network to provide a stronger, louder voice for community services. We believe that voice will be vital to help secure investment and drive reform that is needed in that sector.
Sixth, we need to have an open and honest conversation about the future of commissioning in England. Our view, informed by NHS Clinical Commissioners, who are another part of the Confederation, is that we need to see the development of a form of strategic commissioning. That continuing involvement and leadership from the clinical community is vital. And that commissioning needs to come together with local government and be on a larger scale.

Commissioning has, I am sure it's shared in this audience, has had its critics indeed since the purchaser provider split was created in 1990. But we also believe it will be a mistake to return to a closed system of allocations without significant local accountability for provision. And we need a new national settlement with local government, that shapes how local services are commissioned.

It would, in our view, be a mistake if we allowed the emergence of large NHS monopolies and the exclusion of social enterprises and other community interest operations, exclusion of local government, third sector providers, and the independent sector. All of whom can add a different dimension, foster innovation and sometimes, yes, put some grit into the oyster.

Indeed, drawing on independent sector capacity back in the 2000s was a big part of helping to cut long waiting lists, and we need to think through how the non-statutory provider sector can be given a clear role in integrated care systems, a point that was made clearly this week by the Commons’ Health and Social Care Committee.

And last, but not least – certainly not least – we need national and local strategies to deal with the workforce crisis. We’ll have more of that in a moment, with Ian Cumming. Lack of qualified clinical staff is likely to be the biggest impediment to us making effective use of additional funds. As the draft workforce strategy makes clear, we need to act quickly. The recent investment in pay was vital in making us more competitive in a tough labour market which will only become tougher as we leave the EU.

The Confederation, through NHS Employers, is proud of the deal that we agreed with the unions and I want to say a big thanks to the team for achieving that. Securing extra staff will take time, but we also believe there are immediate steps to be taken. The government must act urgently to reform the present migration system. Preferably by tomorrow morning, if that's at all possible!

1,800 rejected work permits for much-needed doctors was totally unnecessary: it sends the wrong signal and adds strain and cost to teams operating under enormous pressure. The inflexibility of the current apprenticeship levy prevents the NHS funding much-needed additional entry routes into nursing and indeed other roles. And a reinstatement of the professional development training funds which were drastically reduced three years ago have had a really bad effect on morale.

They are all signs of how the system values our people. The IFS/Health Foundation report estimated over the next 15 years the English NHS is likely to require 64,000 extra hospital doctors, and 171,000 extra nurses. Not to mention the additional community staff I mentioned earlier.
We need a well thought through plan of how we are going to train, recruit and retain them, and to develop new roles to meet the changing needs of the patient population.

In addition to all this though, there is much that we can do ourselves as a sector to meet the coming challenges, and it is right that government, politicians and the public expect us not simply to appear as an apparition holding a begging bowl.

So, what more will we need to do as a sector?

Well, first, just staying on this workforce, the plug in workforce is as important as the tap, and in spite of great progress in many organisations, there remain unjustified variations in retention rates. Overall, the NHS across England is a good employer, with the 2017 Staff Survey showing a relatively high level of staff engagement.

But the figures also show that more needs to be done on staff satisfaction, on flexible working, sickness rates, bullying behaviour, discrimination and the use of agencies; again big progress in almost all those areas, but an awful lot more to do.

And I wonder whether we are also sensitive enough to the mood of the professions who deliver the care. The Bawa-Garba case has rocked the medical profession and dented confidence among doctors and other professionals. In all efforts to reform and adapt the NHS, we need to engage and empower clinical staff in shaping future services, giving them the tools of data, and quality improvement to drive change. For without their active support, the reforms will certainly founder.

NHS Employers, incidentally, has a retention checklist which covers issues such as using data to know your staff, flexible working, flexible retirement options, talent management, and development, if you are interested in following that up.

Some of you, of course, face more difficult challenges than others. From rurality, to huge problem in terms of recruitment, to recruiting into less popular specialities. But this has to be a key component of our workforce strategy, retention, and it has to be led from the board.

There is also more we can do on race and equality. We celebrated at the beginning of this conference the achievements of the Windrush generation, but we need to do more to create opportunities for all our staff, and within the Confederation group, we'll work with NHS England and with members on taking forward the workforce race equality standard, and more generally making the case that developing all our staff is not just the right thing to do, it is what actually makes really good business sense.

Secondly, as a sector, I am sure we're going to be expected to wage war on unwarranted variation. We'll never achieve uniformity of course, but with the expansion of data and the better understanding of outcomes, there are now opportunities to do things better and to do better things.
There are various programmes for combating clinical variation, and as the recent Carter report recommended, extending programmes such as GIRFT, the Getting It Right First Time programme, to community-based services is another obvious thing to do.

The same relentless attention needs to go on service configuration and administrative support. The variation on estates, costs per area, covered varies from £105 to £900 and it's a similar story on back office and procurement. And perhaps the greatest price will be creating user pathways that are centred round the patient and user, again providing the right care at the right time.

And thirdly, I think we do have to try to escape from the silo working which has blighted us for the last 70 years. There has always been, I think, a tendency in our sector to believe that wherever we are sitting is the centre of the health and care universe.

It has fostered a mentality which sometimes fails to show how interdependent each part of the system is upon the other. Now this is really changing now, I think it's one of the most exciting things, but we still have to over come misunderstandings and fissures between primary and secondary care, between primary and community, between health and social, between mental and physical, between statutory and non-statutory delivered services.

None of those divisions incidentally make the slightest sense to anyone who actually uses our services. And this is where the moves towards integrated care systems can make such a difference in changing perceptions and breaking down barriers.

Within the Confederation group, we bring together the different parts of the NHS family, and our ambition is to do everything we can to support this coming together of different parts of the system.

In the autumn, we'll be launching our regional support service, which will work with members, STPs and integrated care systems across England. We hope this small team will support joint working and provide a closer link between the Confederation nationally and our members, and enabling us to represent your views effectively, spread good practice and help drive local agendas.

They will seek to work across the patch with the NHS, providers and commissioners, local government and the independent sector, as well as voluntary sector.

Fourthly, we will need to embrace innovation and change more comprehensively and at a faster pace. We are not short of projects and ideas that break new ground – we actually have been less good at spreading them. I hope you have found some over the past couple of the days that you can take back with you to your organisations and systems.

I want to pay tribute here to another part of the Confederation family, the academic health science networks licence has just been renewed for another five years. As Ian Dodge of NHS England said at the time, “this is the national network that can help us to destroy the ‘not invented here’ syndrome.”
Related to this, is it not time for us to think more about our relationship with all of our suppliers? Erik Nordkamp yesterday cited the life sciences strategy which calls for a much more engaged and forward looking relationship between industry and the NHS, and makes the critical point that many of the opportunities ahead are uniquely available to the NHS and could not be realised in many insurance-based healthcare systems.

The strategy points to the clear advantages for more interaction between industry in the NHS in the evaluation of products. How the UK and patients and clinicians would benefit from innovative product use in clinical trials, and as Erik said: “This is not just about academic centres of excellence or even just about hospitals.”

Now, I'm enormously proud of one aspect of the talk I have just given you – I have managed to get through all of this without mentioning the word Brexit!

Now, that it is a phenomenon that hangs over so much of our national life and it is contributing to so much uncertainty. As I hope you know, we set up the Brexit Health Alliance last year, bringing together the NHS, health professionals, pharma and devices industry, research institutions, patient groups, to campaign for the best possible deal for UK patients.

We have had traction with and support from ministers and officials in the UK Government, and indeed with negotiators in UK, negotiators in Brussels. And I hope and believe that we have kept health on the agenda throughout, even though it is not an EU competence, which is one of the fears.

The Confederation's European Office has also succeeded in mobilising European organisations to put pressure on the Commission and raise awareness of the risks, not just of British patients, but to European ones as well, if we get a poor deal. Yesterday, we launched our latest campaign on public health. This must surely be one area where we recognise that maximum collaboration is in all of our interests: diseases do not recognise borders.

We are working hard to represent your interests and views, and not just on Brexit. After the long campaign to highlight social care, there was some more money, and the health secretary, as I mentioned earlier, has social care added to his job title. After creating a coalition of organisations, we wrote to the Prime Minister about the need for a long-term funding settlement, and she now has promised a multi-year funding plan. With the seminal report on funding, we have helped to trigger a national debate.

But none of this would have been possible without the insights and support of you our members. The Confed group is a single charity, but within it is a wide coalition – it reaches in to every healthcare organisation in England, Wales, and Northern Ireland through NHS Employers, the Welsh and Northern Ireland Confederations, NHS Clinical Commissioners, the new Community Network I mentioned, and Mental Health Network, as well as individual direct members of the group.

We believe there has never been such an important time for the diverse organisations that make up health and care to come together locally and nationally, to find common ground and to
help shape a different future. And we believe that we can play a part in that, and that our new regional team, our networks and national offices can convene, provide support and act as a conduit between local reality and national policy.

And if you are not a member, you are paying too much to be at this conference first of all, so please join us. Thank you very much.

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