YOUTH HEALTH PARLIAMENT

SECURING OUR HEALTH SYSTEM FOR THE FUTURE

STRIVING TOWARDS SUSTAINING OPTIMAL HEALTH FOR ALL IN THE UNITED KINGDOM

DECEMBER 2016

YOUTH HEALTH PARLIAMENT

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1 EXECUTIVE SUMMARY

The World Health Organisation (WHO) defines a health system as 'the organisation of people, institutions, and resources that deliver health care services to meet the health needs of target populations'. At the Youth Health Parliament we believe that our current health system will increasingly struggle to meet this definition given the evolving health needs of our expanding and ageing population.

As members of the Youth Health Parliament, we call for this White Paper to mark the beginning of a new process to include the voice of young professionals in Government health policy decision making. Following one year of consultation with young healthcare professionals and other key stakeholders, we call upon the Secretary of State for Health to enact the following six recommendations. We believe these recommendations will enable our health system to support the population's needs as we look to the challenges of the future.

RECOMMENDATIONS FOR GOVERNMENT

RECOMMENDATION 1:
Reverse the imposition of the new junior doctor's contract to increase morale within the healthcare profession and demonstrate the Government's commitment to retaining doctors trained within the United Kingdom (UK) for our National Health Service (NHS).

RECOMMENDATION 2:
Maintain efficiency and productivity initiatives such as QIPP as part of the long-term strategy of the NHS. Ensure transparent reporting on the outcomes of such initiatives to continue the evolution and progression of our health system to meet population needs.

RECOMMENDATION 3:
Increase investment in healthcare to 10% of GDP, by 2020.

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RECOMMENDATION 4:
Encourage targeted health intervention by earmarking research funds to support the development and validation of risk stratification tools for medicines during the early stages of development and currently used in clinical practice.

RECOMMENDATION 5:
Set up research and development risk-sharing agreements with pharmaceutical industry and academia, to deliver new and essential medicines at an affordable price to the NHS, specifically where there is high unmet need and absence of research and development.

RECOMMENDATION 6:
Prepare the health workforce for 'community specialism' by (1) incentivising general practitioners (GPs) to develop specialist interests in paediatrics, geriatrics and mental health, and (2) increasing the provision of community nurse specialists for heart failure, chronic respiratory diseases and mental health illness.

Although we recognise that the scope of government activity to address the current status of our health system extends beyond the concerns we have raised here, we are of firm belief that informed, strategic decision-making in these areas will go a long way towards securing the health system that we want.

2 OUR FUTURE

Healthcare professionals, politicians and the public have all been calling for substantial changes to how our health services are run, financed and accounted for. Health and care services face a multitude of problems spanning from a severe lack of financial resources to understaffed organisations. Our health system is the responsibility of all health service providers and government. These groups must begin to collaborate more effectively and engage with other non-health related public service providers in order to improve care standards.

Whilst the NHS has made improvements over the past 15 years (NHS England, 2014), it has struggled to adapt to changing patient needs. Since 1960, average life expectancy has increased by around 10 years for males and 8 years for females: in 2010 the most common age at death was 85 for men and 89 for women (ONS, 2012). Although society is less susceptible to certain diseases as a result of vaccinations, sanitation and improved hygiene, living longer and at a higher standard faces our ageing population with more lifestyle driven chronic diseases, such as obesity, diabetes and chronic obstructive pulmonary disease (COPD) (CDC, 1999). Consequently, we now must prioritise investment in public health to reverse the prevalence of these growing endemics.

The national media often tracks the growing deficit and the estimated amounts needed to help repair gaps in funding for our health services. Our health system is only one of a number of political priorities, albeit one that is becoming a key worry for the public. It is evident that means of enabling current funding to stretch further is desperately needed to begin the process of rectifying existing issues. One could argue that a focused approach towards cutting costs and 'unnecessary' spending would solve a large proportion of the funding problem; others would counter that the system needs increased funding. We believe that our health system of tomorrow needs a combined approach where new funding is reserved for strategic long-term investment, whilst allowing for management of population needs by monitoring the distribution of current funds.

Enacting change requires political will and a change in mind-set amongst policy makers in healthcare. To ensure our future health system is fit for purpose, sustainable, and built upon partnerships to drive innovation, we require immediate change in investment, management and support.

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To ensure our health system of the future is sustainable we must address how it is funded. We at the Youth Health Parliament believe it is paramount that we keep the NHS free to all at the point of use. Currently, NHS providers and commissioners are running an aggregate deficit of £1.85 billion (unaudited), a threefold increase on the previous year (Dunn et al., 2016). This trend has been fuelled by austerity measures and the continuing rise in healthcare costs. We believe that in order to address these holes in healthcare finances government must effect two key imperatives. Firstly, funding in healthcare needs to increase as a proportion of Gross Domestic Product (GDP) in line with higher health-ranking OECD[1] countries. Secondly, our health system must do more with what it currently has and drive efficiencies and savings through strategic productivity objectives.

3.1 CUTTING FUNDING IN THE RIGHT PLACES

The most vital issue to be addressed is the cost base of the NHS workforce. NHS spending on staff accounts for just under half of total NHS spending and approximately 70% of a typical hospital's total costs.

Appleby et al., 2014

High staffing costs, a shortage of front-line workers and low morale all contribute to current inefficiencies. We believe the cost base of the workforce should be adjusted through strategic restructuring of middle and senior management in foundation trusts and clinical commissioning groups (CCGs), leveraging the expertise of senior management by expanding their roles to oversee multiple CCGs. This will deliver synergies by allowing opportunity for CCG alignment, sharing of best practise and delivery of a consistent standard of care across CCG regions. Additionally, it will address high staffing costs, allowing some of the savings from this managerial restructure to be invested in frontline healthcare workers. This re-investment will secure fairer remuneration for front-line staff and serve to increase morale. Improving the morale of the workforce is a key consideration in unlocking value within the health system and boosting productivity of individual healthcare professionals. According to the Kings Fund, morale within the NHS workforce is at an all-time low (West, 2015) and this has been shown to impact negatively on performance (Pearcey and Elliott, 2004). Front-line staff are the driving force of healthcare provision and we must ensure they are rewarded fairly, empowered within their roles and offered high quality education and training.

The imposition of the 'junior doctor' contract has resulted in an unprecedented breakdown of relations between the Government and frontline healthcare staff (Moberly, 2015). The combination of unrewarded overtime, inflexible annual leave and an increasingly litigated working environment has contributed to a reduction in autonomy of frontline doctors. The junior doctor contract, against a background of these issues, was an unnecessary use of Government authority and has disillusioned healthcare workers and students alike (Siddiqui et al. 2016). A UK 'brain-drain' has begun, and with a rapidly ageing population, the UK can ill afford to lose its investment in training each new doctor. In stark contrast and seemingly overlooked is the ever increasing spend on locum healthcare staff, which has an overwhelming effect on workforce spending (NAO, 2016). Some

1. Organisation for Economic Co-operation and Development

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reports indicate that healthcare professionals prefer this type of work as they find it more rewarding. It is therefore essential that trusts invest in better rewarding their staff to avoid reliance on agency workers; thus, using agency money saved to subsidise spending increases required for permanent staff.

RECOMMENDATION 1:
Reverse the imposition of the new junior doctor's contract to increase morale within the healthcare profession and demonstrate the Government's commitment to retaining doctors trained within the United Kingdom (UK) for our NHS.

3.2 DOING MORE WITH WHAT WE HAVE

To secure a sustainable, optimal health system for the future we must continue to drive efficiency and productivity savings. Without a sustained and unprecedented improvement in health service productivity coupled with a significant increase in funding, we can expect reductions in the quality of services (Appleby et al., 2010; Roberts et al., 2012).

One prime example of an initiative that puts in place guidelines to 'do more with what we have' is the Quality, Innovation, Productivity and Prevention (QIPP) initiative. The QIPP programme focuses on improving quality of care and making efficiency savings (DH, 2010b) in procurement, back office operations and management. The 'Equity and Excellence: Liberating the NHS' whitepaper (DH, 2010a) also examines efficiencies and recommendations that would remove unnecessary levels of bureaucracy, essential in reducing unnecessary spending. These programmes and initiatives are pivotal to the vision of a sustainable health system, but we must ensure they are followed through and actioned to guarantee proposed efficiency savings. QIPP targeted £20bn of savings by 2014/15 (RCN, 2012).

In order to avoid duplication of efforts and ensure past capital invested is not wasted, we must leverage progress made by QIPP-like initiatives. Achievements made under QIPP guidelines include a decreased number of patients dying in hospital, increased medicine safety, and positive changes to prescribing performance and the more efficient use of medicines (DH, 2013b). The Department of Health (DH), in close collaboration with NHS England and CCGs, must continually re-address these efficiency commitments and alter and improve them accordingly. CCGs are responsible for delivering these efficiency savings, therefore they must be consulted on a regular basis to ensure convergence towards the same goals and integrated delivery of a more efficient health system.

QIPP also offers opportunities to focus on disease prevention, an area of huge financial burden and unmet need. Major public health problems such as childhood obesity, mental illness, diabetes and smoking related disease need more public attention (NHS England, 2014). Currently, there is little incentive for individuals to take ownership of their health or that of their families due to a lack of understanding and education regarding the consequences of poor long-term health (Wagner et al. 2007). In 2015, it was reported that over two-fifths of four to five year olds and a third of eleven year olds in the UK were overweight or obese (Neave, 2014). Similarly, teenagers in England are the largest consumers of sugary drinks in Europe, with average overall sugar intake three times higher than the 5% (of energy intake) recommended by the Scientific Advisory Committee on Nutrition (SANC) (DH, 2016). Economically, this creates a huge strain on the NHS, with £5.1 billion spent in 2014/15 alone on overweight and obesity related illnesses such as diabetes (HM Government, 2016).

A collaborative emphasis on primary prevention by public health, regional and local health authorities and government will encourage grassroots community intervention. We believe health education at a young age will generate higher levels of national health literacy, driving improvements in population health and more

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effective public use of services. QIPP-based health education, supported by strong social and economic policy, will lead to improved self-care and reduced healthcare spending on lifestyle disease.

We also believe there are more savings to be made from efficiencies in back office operations and procurement practices. The National Audit Office has identified savings of £500m through better co-ordinated procurement of goods and services across the NHS (Appleby et al., 2014). It has been argued that the NHS in England could save up to £2.9 billion if all organisations adopted best practices in facilities management and procurement, and further reduced the scale of unused space (Harris, 2013). In particular, the consolidation of back office operations such as Finance, IT and Human Resources into Shared Service Centre models would deliver considerable cost savings by allowing these teams to service the health system nationally rather than duplicating efforts locally (DH, 2010c).

RECOMMENDATION 2:
Maintain efficiency and productivity initiatives such as QIPP as part of the long term strategy of the NHS. Ensure transparent reporting on the outcomes of such initiatives to continue the evolution and progression of our health system to meet population needs.

3.3 AN INCONVENIENT TRUTH: WHY HEALTH SYSTEM FUNDING MUST INCREASE

The UK health system suffers from its own success: an ageing population, increased demand and higher patient expectations all place mounting pressure on limited resources. This is not sustainable. Efficiency alone cannot substitute for the need of human and financial resource within the NHS. Our health services currently sit around the OECD median in terms of percentage of GDP expenditure. In 2014, the UK's expenditure on healthcare was 9.1% of GDP and this has been falling since reaching 9.8% in 2009 (WHO, 2015).

The decline of expenditure as a percentage of GDP reflects the austerity measures put in place by the Government following the global financial crisis of 2008. To ensure a sustainable health system for our future, this downward trend cannot continue. We must increase expenditure in line with other OECD countries such as Japan, France, Germany and Canada, where healthcare spending stands between 10–11% of GDP (OECD, 2016). Health outcomes in these countries are some of the highest ranked in the world (Commonwealth Fund, 2016), and each faces similar challenges to the UK, for example an ageing population.

We recommend the increase of UK healthcare expenditure to 10% of GDP by 2020; based on 2015 GDP figures, this would result in an additional £19bn investment (Trading Economics, 2016). We believe this additional funding should be allocated in two ways. Firstly, it should be used to provide extra capital for health services with demonstrated patient benefit, where the current provision of high quality care is falling short. These include oncology services, care of long-term conditions and routine operations (Appleby et al., 2015). Secondly, a fund should be set up that is focused on the long term needs of the public and our future health system. This funding should be ring-fenced to ensure that the UK health system has a long-term plan to address the provision of quality care for all. The fund should be held at national level within a collaboration between NHS England and local health authorities. This will ensure that the long term needs of the public and our future health system itself are evaluated.

We recommend that the fund should be used for initiatives such as identifying and implementing best practices from other health systems around the world, and the use of innovative technology in healthcare. We must ensure that an increase in funding is actioned with long term strategic needs at the forefront.

RECOMMENDATION 3:
Government to increase investment in healthcare to 10% of GDP, by 2020.

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3.4 INCREASING THE PACE OF PROGRESS IN STRATIFIED MEDICINE

As the benefits of stratified medicine are increasingly recognised, its development is being pursued globally.

MRC, 2015

Stratified medicine can be defined as the use of genetic or other biomarker information to improve safety and health outcomes among patients through more efficiently targeted risk stratification, prevention and personalised medication, as well as treatment management approaches.

Great efforts have been made by government to encourage the development of new stratified medicine collaborations with groups such as the MRC – for example through a recent investment of £13.7 million (MRC, 2015). To date, cancer treatment is the exemplar of stratified medicine, accounting for the majority of current and known future medicine-diagnostic combinations.

However other therapeutic areas are catching up, notably cardiovascular (MRC, 2016) respiratory (Bhatt, 2016) and infectious diseases. This creates an opportunity to learn from previous experiences, ensuring future pitfalls are avoided and benefits are maximised, meaning patients will gain faster access to innovative medicines (see insert: Learning from previous success).

A new diagnostic should ideally be developed and analytically validated early in the development of a stratified medicine, rather than retrospectively after its introduction into routine practice. However, in reality, there is little incentive for manufacturers to co-develop diagnostics when a drug begins its pre-clinical or clinical phase because of (1) the different development timescales involved, and (2) the high risk that a drug may fail to meet safety and efficacy requirements, making the associated diagnostic redundant. This is compounded by regulatory and intellectual property systems not facilitating or incentivising the generation of clinical evidence for stratifying diagnostics, until recently (ABPI, 2014; AMS, 2013). Now, legislation requires robust proof of safety and clinical value to patients.

Learning from previous success

Xalkori (crizotinib), as an example of successful stratified medicine, is a drug indicated for the treatment of patients with locally advanced or metastatic non-small cell lung cancer that is anaplastic lymphoma kinase-positive, which represents approximately 5% of such patients. This patient population has a 10% response to standard chemotherapy, yet 55% respond to this targeted therapeutic. The diagnostic for this medicine was developed and analytically validated early in the development of the medicine and was then studied in parallel with the medicine for clinical validation and determination of clinical utility (AMS, 2013).

The UK is uniquely placed to become a vanguard of stratified – and ultimately personalised – medicine development, owing to its strong academic and industrial collaboration and research base, the wealth of health data within the NHS, and highly capable agencies for health technology assessment and pharmaceutical regulation. Progress has been bolstered by investment in infrastructure; for example, central strategic support from the Government's 2011 Life Sciences Strategy in developing and unifying relevant initiatives (ABPI, 2014; AMS, 2013). We support the increase in clinical evidence requirements for companion diagnostics. Therefore, we recommend that the pharmaceutical industry

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implements new standard operating procedures whereby it leverages diagnostic company expertise to identify biomarkers before or early on in the drug development phase. We recognise that retrospective creation of these initiatives is not timely enough and can lead to delays in access to novel medicines, since reimbursement groups now require more robust demonstration of optimal care and value to patients. Our recommendation calls for collaboration and concerted action across a broad range of stakeholders to deliver on the full promise of stratified medicine for patients.

Another area of healthcare that can benefit significantly from risk-stratified medicine is the prevention of adverse events that may lead to hospital admission. It is estimated that half of all hospital bed-days in the NHS are occupied by just 5% of the population (Lewis, 2015). Upstream intervention to reduce the risk of hospital admission of such patients would have a substantial impact on reducing pressure on services. However, there is currently no model or tool routinely used in clinical practice that offers a high predictive value to support targeted early intervention in a particular high-risk patient group. For example, it is estimated that at least one in four re-admissions of older adults is due to an adverse drug reaction (Davies et al., 2010), and if we include poor adherence to medicines, this figure is likely to be substantially higher. If patients such as this could be recognised before a harmful event occurs, then a hospital admission could be avoided. This requires engagement of multiple community providers, including community pharmacists, GPs and carers to ensure that vulnerable patients are accurately identified at an early stage for intensive clinical review and management within the primary care setting.

RECOMMENDATION 4:
Government to encourage targeted health intervention through ear-marking research funds to support the development and validation of risk stratification tools for medicines during the early stages of development and currently used in clinical practice.

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3.5 INVESTING WHERE INVESTMENT IS DUE

Pharmaceutical industry research and development (R&D) investment is typically driven by opportunity to diversify and avoid head-to-head competition. In the last 20 years, huge progress has been made in treating cancers and infectious diseases such as HIV. However, whilst investment has focused on rare diseases with high unmet need, our health services are struggling to treat more common diseases, such as antibiotic-resistant bacterial infections. Antibiotics are fast working and effective but reap weak financial returns for manufacturers, as development of an effective antibiotic is long and costly, providing little incentive for investment. We believe that it is the duty of our health system to acknowledge this absence of progress and subsequently adopt a collaborative approach with the pharmaceutical industry, academia and government to ensure the continued development of much needed medicines. We therefore recommend government assembles collaborative research and develops risk-sharing agreements to deliver new medicines at affordable prices, where there is currently a high unmet need and an absence in R&D.

Investment should be governed through consultation with a consortium comprising patient group representatives, disease area specialists (including frontline staff), the pharmaceutical industry and academic institutions. This consortium would be equally funded by government and the pharmaceutical industry, while academic groups and other participating functions would contribute as advisors. In the event of a successful finding, any commercialisation plan would involve all stakeholders, allowing the government to negotiate an affordable price and a return on investment for both government and the pharmaceutical industry. Additionally, in order to increase the probability of success and availability of innovative therapies worldwide, the government should liaise with other countries when addressing global necessities. Such initiative will make a true difference to patients and, with affordable pricing, allow for population-wide prescribing.

RECOMMENDATION 5:
Government to set up research and development risk-sharing agreements with pharmaceutical industry and academia, to deliver new and essential medicines at an affordable price to patients where there is high unmet need and absence of research and development.

4 INTEGRATED CARE CAN SUPPORT PREVENTIVE MEDICINE AND ENCOURAGE A HEALTHY POPULATION

"Chronic diseases hamper citizens from contributing to society and generate increasing and unsustainable healthcare costs which are poised to rise as the population ages."

Commissioner Vytenis Andriukaitis,
letter to the EU Health Ministers, 7 April 2015

4.1 OUR AGEING POPULATION AND COMMUNITY HEALTHCARE

The impact of chronic conditions on our health services cannot be ignored. Recent findings by the Kings Fund show that people with long-term conditions, such as type 2 diabetes, cardiovascular disease, hypertension and COPD, account for about 50% of all GP appointments, 64% of all outpatient appointments and over 70% of all inpatient bed days, which equates to roughly 70% of total health and social care expenditure (Thorlby et al., 2016). Long-term conditions often present with co-morbidities, which in turn increase demand on our health services and resources (see insert: Holistic management). Addressing these chronic health conditions, especially in the elderly, also means addressing the severe lack of funding available for these services (Guardian, 2016).

The King's Fund report 'Making the Case for Public Health Interventions' (2014), argues that we must invest in effective public health in order to reduce the burden on our health services (Kings Fund, 2014). Yet despite an initial increase in public health spending under the coalition government, public health services now face an average 3.9% reduction in funding annually until 2020/21, further to a previous £200 million in year reduction in 2015/16 (Kings Fund, 2014). An analysis on local authorities planned spending for 2016/17 showed cuts in services across the board, with only obesity related children's services and adult alcohol misuse services escaping with their financing untouched (Thorlby et al., 2016).

The 2013 Better Care Fund was created to drive the transformation of local services (DH, 2014), with £3.4 billion of the £5.3 billion fund being allocated directly to CCGs. We believe this fund should be used to invest in the management of chronic conditions, in part through investment in training and provision of district nurses, to reduce the strain on cash-strapped local services. In 2013, the Royal College of Nursing (RCN) highlighted how district nurses help reduce long-term costs whilst providing appropriate and patient-centred community care (David et al., 2013). Subsequently in 2014, the Department of Health outlined a new vision for district nursing to help build sustainable communities of care, allowing for greater patient independence and relieving strain on existing clinical services (DH, 2013a). However, the RCN has since voiced concern for a severe lack of support for community care despite government intention to shift care from the acute sector to the community sector (RCN, 2014). Moreover, in 2016, the Kings Fund indicated that six consecutive years' worth of local authority funding cuts have resulted in 26% fewer people having access to adequate care and services (Thorlby et al., 2016). The past ten years of government statistics show a 44% decline in the number of qualified district nurses working within the community, and equally those in work spend less time with their patients (HSCIC, 2014). District nurses offer the opportunity to provide acute, complex and end of life care at home, three areas that we know drive the population into GP surgeries and hospitals (David et al., 2013).

4 INTEGRATED CARE CAN SUPPORT PREVENTIVE MEDICINE AND ENCOURAGE A HEALTHY POPULATION

Holistic management: the future of chronic care

A key limitation in the management of acute exacerbations in chronic obstructive pulmonary disease (COPD) is the lack of a standardised operating procedure for these patients (Boeck et al., 2016). There are many questions around which therapies should be used, for whom, and for how long; however, most patients with acute exacerbation of COPD suffer from co-morbidities, which often worsen during the acute exacerbation course. It has been suggested that to effectively manage COPD exacerbation and pneumonia, a holistic management approach in specialist units should be implemented as the standard management approach (Boeck et al., 2016). The counterargument to this approach is predominantly driven by the payers. The up-front investment for holistic management versus standard care for these patients (usually consisting of a short course of antibiotics and systemic steroids) is considerably higher, and with potential long-term gains, such as avoided re-exacerbations and hospitalisations, not recognised within the accounting year. Thus it is fair to say that for the moment, cost-effective treatment of NHS patients with long-term conditions remains an aspiration for UK health system.

The government must reinvigorate the 2014 plans for community care, investing in training and embedding district nurses into local care services in order to manage patients with complex needs. Enabling high quality generalist care with community expertise in key areas of paediatrics, geriatrics and mental health must be a strategic priority for Government. The firm separation of community generalist care and expert secondary and tertiary care is not conducive to providing integrated, seamless healthcare for those with complex health problems (Edwards, 2014; RCGP, 2013). The current set-up encourages patients with complex health problems to circulate in and out of hospital, because the expertise and confidence to deal with multiple long-term conditions associated with ageing, complexities of childhood disease, and more serious mental health illness, is currently missing. Despite young children, the elderly and those with mental health problems making up the vast majority of consultations in general practice, it is concerning that training in these specialties is not mandatory within every GP training programme. Harnessing the broad and holistic skills of general practitioners, whilst supporting the additional development of clinical expertise in these three key areas within GP clusters, would serve to reduce pressures on secondary and tertiary care, better ensure continuity of care for the most vulnerable patients, and offer new opportunities to GPs that wish to specialise further.

RECOMMENDATION 6:
Government to prepare the health workforce for 'community specialism' by (1) incentivising GPs to develop specialist interests in paediatrics, geriatrics and mental health, and (2) increase the provision of community nurse specialists per 1000 patient population for heart failure, chronic diseases and mental health illness.

5 A SUSTAINABLE FUTURE FOR OUR HEALTH SYSTEM

The NHS, a universal, free at the point of care, high-quality health service provider, has been a prized possession of UK citizens for almost 70 years. Indeed, it is the public service that is valued most (Kirklin, 2013). Yet the general consensus among experts is that if we stick with the current structure of funding and administration, our health system as we know it is not financially sustainable. The cost of healthcare is rising significantly faster, proportionally, to national income and thus also as a share of government budgets. As discussed, the basic causes of healthcare inflation are well-known: new innovative procedures and technologies that permit us to live longer, in turn leading to our ageing population. Although we recognise that the scope of government activity to address the current status of our health system extends beyond the concerns we have raised here, we are of firm belief that informed, strategic decision-making in these areas will go a long way towards securing the health system that we want.

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THE TYPE OF HEALTHCARE SYSTEM WE WANT
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WHAT KIND OF HEALTHCARE SYSTEM DO YOU WANT?

The following insights come from research conducted by the Youth Health Parliament, a group of highly motivated and passionate future leaders determined to shape the future of the NHS.

YOUTH HEALTH PARLIAMENT

We call for the **MANDATORY INCLUSION** of Regional Youth Forums in Health Policy decision making, working directly with the Health Secretary and wider Government, ensuring the consideration and inclusion of concerns and priorities of today's youth.

WE RECOMMEND GOVERNMENT PREPARE THE HEALTH WORKFORCE FOR 'COMMUNITY SPECIALISM' BY

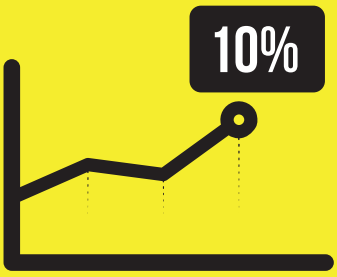
1. INCENTIVISING GPs

to develop specialist interests in paediatrics, geriatrics and mental health.

2. INCREASE THE PROVISION OF COMMUNITY NURSE SPECIALISTS

for heart failure, chronic respiratory disease and mental health illness.

WE CALL ON GOVERNMENT TO INCREASE INVESTMENT IN HEALTHCARE



OF GDP, BY 2020

EFFICIENCY, PRODUCTIVITY AND TRANSPARENCY

Initiatives such as QIPP should be part of the long term strategy of the NHS and continued to be actioned regardless of terms of Government.

Moreover, transparent reporting on the outcomes of implementing such initiatives is essential to continue the evolution and progression of our health system to meet population needs.

ENCOURAGE TARGETED HEALTH INTERVENTION

through ear-marking research funds for the development of risk stratification tools.

SET UP RESEARCH AND DEVELOPMENT RISK-SHARING AGREEMENTS

between Government the pharmaceutical industry and academia, to deliver new and essential medicines at an affordable price to the NHS where there is high unmet need.

REVERSE THE IMPOSITION OF THE NEW JUNIOR DOCTORS' CONTRACTS

to increase morale within the healthcare profession and demonstrate the Government's commitment to retaining doctors trained within the UK for our NHS.