PRACTISING CONNECTION

—

Public Health
and
The Surgery of the Future 4.0

assura

Edited by Matthew Gwyther
with support from Becky Holloway and Roxi Cebuc
Jericho Chambers
Spring 2021

Illustrations by Elly Jahnz
hello@ellyjahnz.co.uk

www.jerichochambers.com
www.assuraplc.com

TABLE OF CONTENTS

NO 1

Introduction

Jonathan Murphy, CEO, Assura
Matthew Gwyther, Partner, Jericho Chambers

The global medical events of the last 18 months should make any confident predictors of the future put away their crystal balls, draw in their horns and take a pause for thought. Even the wisest epidemiologists didn't see the full horror of Covid-19 coming - a global pandemic the likes of which didn't exist in the lived memories of anyone on the planet.

However, think ahead we must. Especially when something as important as the nation's health is concerned. Those who do not plan nearly always come to regret it, even if things rarely turn out precisely as predicted. But the future can to an extent be moulded. It's odd that an organisation with an annual budget of £212 billion like the Department of Health and Social Care NHS spends so little time and cash on R&D and innovation - how to make its systems better.

So, here in all modesty is a small prediction. When it comes to healthcare in the UK, the current expenditure balance of 80:20 in favour of hospital over primary care is unlikely to remain the same in the future. And the direction of travel will not favour the hospital.

This is an ancient duality well understood by the Greeks. The goddess Hygeia was a health-nurturer and her father Asclepius was a hands-on healer. While Hygeia was worshipped in a preventative manner with the goal of keeping that patron healthy, Asclepius was the hierarchically superior father who was prayed to, for healing, when someone was suffering. He's muscled with a stern facial expression not a million miles away from a rugby-playing orthopedic surgeon - except for the omnipresent snake. Hygeia, his daughter is represented as sensitive, with a far away look - smooth-skinned and delicately represented. We suspect as the 21st century advances that Hygiea will get the upper hand. She is the future.

Primary care is where the action will be not simply because it is cost-effective and makes consummate sense but because out there in the community is, where the locus of sickness is and where its reverse, wellness and health, should and will be.

A visit to a family doctor in 2031 is likely to look somewhat different from the present. And the same trip in 2041 will be more altered still. Things are changing apace in healthcare. Who would have thought sixteen months ago that so many GP consultations would be conducted remotely by Zoom or Facetime? Why is this? Partly because visits to the hospital will become increasingly less necessary. And the family doctor will be the centre of health maintenance - both physical and mental. We know that technology and sensors which detect all manner of processes in our bodies - and seek to maintain the correct equilibrium in their ecosystem - are well on the way. It will be far more than blood sugar or blood pressure that will be measured at your own kitchen table.

So the GP of 2041 might be more of a health coach. A guide, an assessor, a counsellor who helps maintain her patient's well being, thus avoiding the diseases which routinely occur in the first place. This will become a person-centred model, not the provider-centric health model we know currently. What could be more provider-centric than a hospital to which you have to journey, where you sit dolefully and sometimes for hours in a waiting room for the consultant to see you, which harbours unwanted and harmful infections; factories of the sick.

It's also highly likely that the power relationship between the doctor or nurse and patient will subtly alter. Sure, a sense of the bedside manner and the magical placebo effect will remain, but empowering choice will lie in the hands of the

patient. We are likely to be far more in control of our medical destinies. Less "our life in their hands" more "your life in your hands". Prediction and prevention of disease will take over from trying to pick up the pieces once things have gone awry.

So, the 5 minute GP consultation and departure from the closed room, with a prescription in the patient's fist, will become far more unusual. It will be replaced by a continuing health dialogue, possibly even with an Artificial Intelligence device. At the present, even patients who suffer chronic disease spend less than 0.1% of the time with a medical professional - their specialist. Your own AI will be there for you 24/7 and always.

The whole system will be far less paternalistic than is now the case. This will be the "always on" system of wellbeing. Self-management of both health and well-being will become the norm. Our visits to the surgery of the future will often be out of choice rather than necessity; the proactive visit to seek advice, collaborate with others or have more complex investigations and treatments. Terrible news for the hypochondriacs of this world...

This collection of articles is a modest attempt to suggest what that future could look like, and the places we will need to deliver that high tech, patient-led, community-designed vision. We're not there yet. We have found no Panaceas. (Panacea, incidentally, was the goddess of universal remedies, sister of Hygeia and daughter of Asceplius).

And we consistently refuse to deal with the gathering crisis in social care which continues to make the end of life process more uncivilised than it ever should be in the UK.

There is a long, long way to go and many hurdles to surmount before we get to this Brave New World of Wellbeing. Integrated Care Systems are saddling up for the journey. We know that those who already suffer the poorest health and outcomes, the poor and hard to reach communities, must be the focus of the new ways, mastery of which the Worried Well with their Fitbits won't find so much of a problem. It won't be like a return to the Garden of Eden - a land without pain and suffering. Humans are far too complex for that. But we all know that prevention is better than cure. Putting primary care in the right place in the health ecosystem – literally and metaphorically – could be the apple a day to keep the doctor away.

Jonathan Murphy,
CEO, Assura
jonathan.murphy@assura.co.uk

Matthew Gwyther,
Partner, Jericho Chambers
matthew.gwyther@jerichochambers.com

Public Health Conversations

This publication has its origins in November 2020 during the second national lockdown. Jericho Chambers curated and produced a series of six roundtable conversations on behalf of Assura plc: "Public Health: In the Right Place?" The pun was intentional, suggesting an examination of where physically the processes of primary health care are carried out – in what sort of brick and mortar surgeries – and also where it sits on the continuum of medicine and wellbeing dating back many thousands of years. The online discussions were attended by a wide cross-section of individuals: architects, doctors from primary and tertiary care, experts in social care, policymakers, including an MP, Danny Kruger, who was the current Prime Minister's Political Secretary in 2019 and has a particular interest in civil society. He has just produced a report: Levelling–up our Communities: Proposals for a new Social Covenant.

The conversations were supported by Assura plc which develops, invests in and manages a portfolio of 570 primary care medical centres across the UK. "If we have one mission," said Claire Rick, Assura's Head of Public Affairs, "it is to try to create places – buildings and exterior environments – which move forward from the sense of a patient waiting for something to happen to them."

One of the panellists was Roland Sinker, Chief Executive of Cambridge University Hospitals NHS Foundation Trust (CUH) but also, since 2018, the accountable officer role for integrated care system partners in Cambridgeshire and Peterborough; who between them, the authorities serve a population of 1 million people with a health and social care spend of £1.5 billion. Roland is very much on the sharp end of health provision, from the ground up to the consultant cardiac surgeon. He has to deliver.

"We should be putting huge amounts of energy now into enabling the right people to have the right sorts of conversations. There is a tension between tight and loose when it comes to action. The idea I'm going to tell neurologist how to do his or her job is ridiculous. At the end of the day, a lot of people need joints replacing or are struggling with diabetes. That takes medicine and systems and process and uses ecosystems to sort out. How do I in my job to empower 11,000 in my hospitals and 5,000 outside not just to do their jobs but to reimagine how they can work together to keep people well? And I am optimistic.

Ultimately, it's true that these themes include exploring how to get human beings, citizens front and centre in our thinking – before they even become patients."

The emerging themes, many of which are captured in this article and integral to the shift away from "factories of the sick", include:

- Understanding the nature of the beast – why the NHS is not a monolith but a network of smaller organisations; and how to embrace it as such.
- Addressing capacity shortfalls – the lack of front-end ability to design both the systems (and the buildings) we need.
- Short- vs. long-termism – budgetary and planning. Building on Best Practice elsewhere.
- Why innovation is horizontal and local – across government, institutions and partners; explore new foundation economic models to capture this.
- Focus on localism – new, tech-enabled networks to support integration of authorities and services in a new care eco-system. Much more than a linear dependency on telemedicine.
- Commitment to "Forgotten Communities" – central to the whole programme is the urgent need to include carers; the homeless/ vulnerable; those living in poverty; minority ethnic groups; the geographically excluded; and the digitally disenfranchised. Local authorities, charities and volunteering organisations and self-organising support networks all have critical future roles to play (see localism point above).
- Public Health as a campaigning issue of "environmental justice" – building on the thought that "patient-centricity" might now be a tiring political argument. Thinking needs to go wider than and behind the individual patient and their symptoms, in search of a new societal eco-system, within a revised Social Contract.

Matthew Gwyther,
Editor

Robert Phillips
Founder, Jericho Chambers

NO 2

Foreword

Danny Kruger, Member of Parliament for Devizes

Danny Kruger's New Social Covenant Unit wants a full-scale rethink of the welfare state. In this piece, adapted from its recently published manifesto, he calls for the empowerment of local institutions, vernacular and local services run by and for local people and quality in abundance. Could this be a call to arms for Primary Care and GPs to step up and take their vital role in the surgeries of the future?

Public services – including health services - are too centralised and individualised, and 'Social solutions' are growing through the cracks in the Attlee settlement.

We need a place-based model of public services which draws on the huge resources of local communities. We also need a more 'social' public sector. Currently, for all the enormous public benefit they deliver, public services are deeply wasteful and deeply disempowering of individuals and families, of the staff who work in them and of the communities they serve. This is because they are too centralised, too siloed, too rationed, too individualised, and too reactive.

Public services are too centralised. The structures of the welfare state remain largely those created by Clement Attlee's postwar government. This was an era of professional authority when the men in bowler hats or white coats knew best, and the recipients of services were expected to be grateful for what they got. And so we have large Whitehall departments responsible for organising comprehensive, universal services, meeting all the needs of all the people.

Public services are too siloed. These departments meet at the top, via their ministers, round the Cabinet table. But on the ground, where it matters, they belong to different fiefs, accountable upwards through a dense bureaucracy and unable to collaborate or pool resources.

Public services are too rationed. The system is designed to deliver 'equity in scarcity': a fair distribution of limited resources. The result is a great bureaucracy which sucks up resources and responsibility from the front-line where resources and responsibility are most needed. In recent decades we have clad Attlee's aging structures in the gleaming veneer of private sector expertise and agility. The doctrine of 'New Public Management' sought to modernise the public sector through quasi-markets, purchaser-provider splits, unit costs and competition. Yet the basic model remains: top-down silos, 'delivering' 'services' (command and control in the language of the market) to a passive population.

Public services are too individualised. They are designed for individual recipients, 'service users' or 'customers' in the bloodless phrases of the modern public sector. Little thought is given to the wider family and community context in which the individual lives, and which is probably a far greater influence on their wellbeing than whatever tightly rationed 'service' they receive from the government.

Public services are too reactive. In the early days of the welfare state 'needs' were generally critical and acute: the cataclysms of sudden, usually short-lived ill-health or unemployment. Systems are designed to respond to things having gone wrong, rather than working to prevent them from going wrong. Resources and status concentrate on acute remedial services.

The nature of demand has changed fundamentally over the decades since Attlee. Rather than sharp swift periods of ill-health,

many people experience long-term health conditions, and often they, not doctors, have the best ideas of the treatment and care they need. Rather than short gaps of unemployment, we have generational joblessness for some, and for others, a precarious life juggling earned income, in-work benefits and welfare.

"The pandemic and lockdown showed the power of neighbourhoods to self-organise and arrange mutual support."

The supply of public services - the way we meet the needs of the population - is changing too. A range of organic 'social solutions' are growing through the cracks in the structures of the Attlee settlement. Social prescribing (sending people to a gardening club or a choir rather than giving them pills, for instance) is being adopted in the NHS. The work of charities and faith groups in welfare, criminal justice and family support is being recognised and expanded. In education, free schools set up by groups of teachers or parents are challenging the monopoly of government, and the growing home-school movement demonstrates the ability of families and communities to educate children outside the school system altogether.

The pandemic and lockdown showed the power of neighbourhoods to self-organise and arrange mutual support. As with the examples above, this is in a sense a return to a more old-fashioned model of community self-help. Despite the bureaucracies, nature finds a way - especially when technology helps.

We need a successor to New Public Management and this time we need to transform, not just modernise and part-privatise, the Attlee-era public sector. At the heart of the new model is the motto that delivered Brexit: take back control. We need to dismantle the great bureaucracies of the welfare state - the postwar concrete, the steel and glass of New Public Management, and make instead local institutions of local stone, albeit properly wired together by efficient digital and data systems. We need 'vernacular' local services run by and for local people. These will be just as comprehensive and universal, just as well funded and well regulated, but their organising principle will be different.

The new public service model is organised around places, not government departments, and it is accountable outwards and downwards to local partners and communities, not upwards to Whitehall. Most of all its purpose is to prevent social challenges as well treating them. The 'place' focus will allow pooling of budgets and strategies across Whitehall silos and allow the resulting savings to be reinvested in the parts of the local ecosystem that would benefit most.

As this suggests, policy should deliberately seek to reduce the demand for expensive acute public services rather than simply increasing or cutting (depending on the times and the party in government) the supply of them.

Rather than a model of 'equity in scarcity' we should aim for 'quality in abundance'. For despite the dire position of the public finances, we are not short of the resources we need. There are enough people to teach our children, care for our sick and elderly, help our addicts and homeless. They are not all in the formal public sector or formally qualified. But there are millions of people available to support the professionals.

As machines take over the manual and clerical jobs, human beings will be left with the things that humans are best at - and this includes looking after other people. The current 'equity in scarcity' model is absurdly straitened: 30 children to one teacher; 100 prisoners to one officer; ten elderly people to one care worker. These are shameful ratios. Instead, we should be flooding the system with personnel, trained and managed as necessary but qualified most of all in common sense, duty and compassion - qualified in the virtues.

Danny Kruger
Member of Parliament for Devizes Constituency
danny.kruger.mp@parliament.uk

NO 3

The view from Frome

More than a doctor's surgery, this compassionate Health Hub in Somerset is the poster child for modern ecosystem thinking

Matthew Gwyther, Partner, Jericho Chambers

Opened in 2013 on the old Cheese Show Field, the practice cost £10 million

As befits the town that won The Times newspaper award "Best Place to Live in the Southwest 2021" Frome has a pretty impressive GP surgery. It's a large, airy and light building faced with pale Bath stone up near what used to be The Cheese Showground. However, to call The Frome Practice a GP surgery is way to underestimate what it represents. It's more than a doctor's surgery. It's a thoroughly modern Health Hub. And it's the future.

To call The Frome Practice a GP surgery is way to underestimate what it represents. It's more than a doctor's surgery. It's a thoroughly modern Health Hub. And it's the future.

For a start, when moving at non-COVID full pelt it has more than 150 staff and 30,000 patients on its list. It has a cafe, extensive outside space that can be used for exercise or even meetings. A surgical centre does minor operations including a variety of ENT procedures. You can even pop in for a vasectomy. Group Consultations are offered for those suffering from back pain, diabetes and arthritis - you get more time with the specialist and can exchange ideas about better coping with your condition. It even boasts a Green Health Connector - a 2-year project funded by the National Lottery and their dedicated Climate Action Fund to explore how the Practice can create a climate and health "win-win" by working together as a community.

Frome is different for other reasons. They like doing things differently in the Somerset town which is far less showy than its ritzy neighbour to the North, Bath. Back in 2011, the town council - which had a modest budget of around £1m - was won over from established political parties by a new group of self-styled independents who then began running things, with a focus on participation, sustainability and community wellbeing. The same basic idea has now spread to about 15 other areas across the UK: its name, coined by Frome's inspirational councillor called Peter Macfadyen, is "flatpack democracy." The council and the medical Practice are very close.

This approach proved ideal when the pandemic struck. The agile, open way in which the town council now works came into its own. The town centre venue previously used for gigs and indoor markets was turned into a food depot. Banners suddenly appeared everywhere, suggesting residents all check in on five of their neighbours. Things "connected up." Bikes criss-crossed the hilly town dropping off food and prescriptions. This work, which also includes help for local businesses, has carried on; the town council is now thinking hard about how to sustain it beyond the pandemic.

The Practice became a centre for vaccination and they set off at a pace. This connecting up for the good of the community's health is a collective dream realised but the individual who first dared to dream of something a bit different is Dr Helen Kingston, 56, the senior GP partner. The practice has 5 partners, 12 salaried partners and five registrars or trainee GPs.

At Cambridge where Dr Kingston studied, she decided general practice as the route for her. "I like people and being with them rather than

science." The thought of gowning-up for yet another hernia list didn't appeal. She realised that general practice would allow her to have three children with her husband, a potter. The last of them was born in 1999. She works 8 am - 7 pm, five days a week and often into the evenings. Her on-call duty is one in five. She still has the benefit of the Community Hospital next door and does the ward round there when it's her turn. You don't get into the building to speak to her without a tonsil-swabbing COVID test.

Dr Helen Kingston, Senior GP Partner

The last year has been odd, she acknowledges. And exhausting. For GPs consulting with their patients remotely has become the norm. Dr Kingston sees that for straightforward issues this is fine. The young, after all, communicate mainly by smart phone anyway. "However, some young people will give you a far fuller story, talk about what's really going on in their lives, if you see them face to face," she says. "It's the pauses, the look in the eyes that often give clues. Just words can be very transactional. When there are issues with mental health to consider you really do need to eyeball people."

She also knows from long experience that complexity is at the heart of a lot of medicine. Things need careful unbundling. "Lots of life isn't black and white especially as you grow older. If you're 94 with diabetes, dementia and your only relative in Sheffield...there's a limit to what certainty technology and guidelines can offer." These are the sort of situations where the talent, experience and honesty of a good GP are of huge value.

Dr Kingston was always interested in health beyond the one-to-one doctor patient consultation. In 2013, Kingston applied for and was granted £110,000 of "innovation" funding from her local Clinical Commissioning Group (CCG). She used it to hire someone to help manage patients who were being discharged from the hospital and into her care. But she also hired Jenny Hartnoll to map out community resources in Mendip region, which has a population of 115,000. There were many out there: choirs, stroke support groups, exercise classes for people with health challenges, even men's sheds, places - in the UK and worldwide where men gather to chew the fat, complete tasks together and do that thing that men often find tricky - bond. Hartnoll built a website cataloging all of them. Kingston knows that fully a fifth of those who consult their GP do so for what are primarily social problems. Some estimates think this may even be as many as half. People who struggle with life alongside their health are less able to cope with ill health, or they find themselves 'medicalising' this struggle in order to get help. In 2015, Kingston secured more funding (£309,000), including a chunk from the independent Frome town council, and the CCG. They hired almost half a dozen health connectors and two district leads, professionals trained to help patients who might have three of four conditions and need help managing them.

As Kingston and Hartnoll built out the community connectors and health connectors, Kingston tried to weave the primary care model together to make it easier for different parts of the medical system to work together: district nurses, social care, GPs, mental health workers and hospital staff, health connectors. It was known as the Compassionate Frome project. And the word is well chosen. Sympathy and compassion mean fellow feeling - and those who are afflicted with a problem will more fully understand what individuals are going through. A problem shared can, indeed, prove a problem halved.

Then in 2018 came some research that raised Kingston and Hartnoll's project from novel to national news: Emergency hospital admissions in Frome fell by 14% over three years. In Somerset county overall, where Frome is located, they rose 28.5%. George Monbiot, in The Guardian, wrote a piece under the headline - "The town that's found a potent cure for illness – community."

The gist of the project is that communities can build better ways to support individual needs.

In part, that's due to the reality that the modern medical industrial complex, and that includes what has been created in the UK since 1948, can't solve every problem, and countries can't afford trying. But it's also, as another article suggested "an acknowledgement that modern society is conspiring against us a bit, leaving it to communities to try and build resilience and unlock what makes humans thrive."

As emergency admissions fell, so did cost. From 2013-2014, the cost of unplanned admissions in Frome was £5.8 million; in 2016-2017 it was £4.6 million, a 20.8% reduction. Downing Street took notice and awarded Kingston a "Points of Light" award for public service and Camilla, the Duchess of Cornwall, paid a visit.

"Our practice size of thirty thousand is a good number," says Kingston "It's big enough to measure changes. But not unmanageable. You feel like you can own it. It's tangible. I never felt we could fix everything all at once. But I know from experience locality and a sense of place matters. People will do something for the good of their community. Lockdown has really shown the value of networks - how people can support each other."

"I know from experience locality and a sense of place matters. People will do something for the good of their community."

Helen has become the receiver of many visitors from all over who want to observe and learn from her programme. They often ask Kingston what the governance framework of the system is. Where are the rules? How can we replicate this? She hints that it's about more than hard and fast rules. "There were lots and lots of rules and guidance about what the evidence says you should do," she has said, "but what happens is that is evidence for the disease, and not for the person."

The newest - but not youngest - GP at Frome is Dan Cook. He has arrived after a Damascene vision which occurred in Camp Tombstone, Helmand, Afghanistan in 2006. He was working in the army as a nurse when he realised he had to become a doctor. He filled out his UCAS form and then lost it. Undeterred, he wound up on a special course at St George's in London for late developers after grinding his way through 6 A/S levels. It has been a long haul. (Cook's original GCSEs were "rubbish") He did resits, was diagnosed with dyslexia. "I had no choice," he recalls. "I had to make it work."

What Cook has, as a man in his mid-30s, is experience of life and people. He's seen a fair bit already and such mileage on the clock is invaluable for a family doctor. And, he says, what makes his practice special is being surrounded by so many support staff to whom he can refer. He's already looking for his special interest area where he can innovate, try something new and that is palliative care.

Dan Cook, GP / fresh into the saddle

"Young people especially are really aware of wellbeing. Loads are teetotal, giving up on meat. Those work hard/play hard philosophies are starting to look old school." And the long-term effects of COVID? "We're already seeing a big rise in poor mental health right across the age range. Some have coped with lockdown and isolation, but many haven't. I've seen anxiety and depression that actually makes people vomit. Many who have been lying low are now presenting with a multitude of complex problems. The classic is when someone comes in and opens with a 'I didn't want to bother you... but' and then it all spills out". Never mind he's got £80,000 worth of student debt and isn't getting much sleep with a 3-month-old baby in the house. He's on his way in his new career.

So, what of Frome's patients? Shannon Trickett is in Year 13 at Frome College doing what she can during numerous lockdowns and school closures to keep it together and study for her A levels. 2020 was pretty bumpy but, all being well, she will win a place to study Criminology in Winchester.

"It's been ups and downs" she admits, speaking from her bedroom on WhatsApp, her Japanese anime posters on the wall behind her. "Spending time away from people was OK but sometimes it was all awful. I felt like I was losing my mind. I live outside Frome so seeing my friends has been impossible." She's conscious that her generation isn't always easy to deal with in general practice. "Younger people don't find it easier to talk to their GP especially about their mental health." She was part of a Young Person's Participation group helping younger students at her school talk about problems. She had some unpleasant experiences with social media - "people will do anything to fit in and be liked online but so often it ends up destroying your self-confidence" - so she deleted lots of stuff and now only occasionally posts on Instagram. She's finding her way in the world. "Despite everything I'm optimistic about my future. I want very much to go to university - to get away."

The Great Isolation of the last year has been testing, especially for the young like Shannon. A famous paper published in the Public Library of Science in 2010 reviewed 148 studies, involving 300,000 people, and discovered that those with strong social relationships had a 50% lower chance of death across the average study period (7.5 years) than those with weak connections. "The magnitude of this effect," the paper reported, "is comparable with quitting smoking." Only Connect, as EM Forster, a non-smoker, said.

Matthew Gwyther,
Partner, Jericho Chambers
matthew.gwyther@jerichochambers.com

KEY TAKEAWAYS

- The Surgery of the Future should be the centre of a new health ecosystem – creating the right space for the primary care model to weave together, making it easier for different parts of the medical system to integrate including district nurses, social care, GPs, physiotherapists, mental health workers and hospital staff, occupational therapists, health connectors and local voluntary organisations and projects supporting better health
- Locality and a sense of place matters. Lockdown has shown the value of networks - how people can support each other. Now is the time to enhance the momentum of communities
- A community and health connectors-based model can reduce costs and hospital admissions

Frome Medical Practice
SUPPORTING YOUR HEALTH

NO 4

Full system health: illuminating the way forward

Connected tech will provide many of the answers in tomorrow's new look surgery

Matthew Gwyther, Partner, Jericho Chambers
Daniel Katz

When it comes to predicting the future of primary healthcare, futurologists tend to fall frequently into a trap of blind faith and optimism about the prospects of technology and forget about the people.

An exception was a report written in 2018 by Andy Wilkins and Richard Gold which was commissioned by the Royal Free Charity in Hampstead, London. Wilkins and Gold penned an illuminating and sensible vision about the potential trajectory of healthcare, the 'megatrends' underpinning them, and the potential for a far more personalised and sensitive primary healthcare system. It's a piece of work of interest to all GPs.

The underlying thesis of the report is that the NHS as constituted in 1948, was designed for a fundamentally different approach to healthcare, in line with a very different society. The traditional symptom-led clinical care was geared towards acutely ill patients, while today, chronic conditions are more common. In combination with the way in which healthcare is better understood as heavily linked to lifestyle and environmental issues, there's a need for a greater focus on wellbeing and lifelong care. As discussed in Matthew Gwyther's chapter about the Peckham Experiment, there has been precedent for this school of thinking, but Wilkins and Gold have examined how this can be realised through the use of emerging 21st century technology.

The key rubric of the report is the identification of 'megatrends' – that of long-term shifts in society that shift the purpose and capacity of healthcare provision. Health technology is an emerging field - from AI assistants to digital sensors. Other industries, from social media to banking, already utilise technology to provide more personalised services which may create expectations for similar development in healthcare.

On a personal level, people can be provided with the capacity to understand their health, between or instead of consultations with medical professionals. Technologies such as genome sequencing can also provide early warning of genetic diseases, while AI can analyse data efficiently and provide psychological 'nudges' to encourage healthier lifestyles.

The central through line of the whole report is that healthcare encompasses far more than visits to clinicians and that technology should be used to facilitate a shift to preventative care. According to the report, even patients with chronic disease spend less than 0.1% of their time with a medical professional, and virtual assistance can be used to create a holistic 'health ecosystem.' Such a system would use 'always on' health technology in combination with an integrated health system, across the whole NHS and care system. Building upon the values of wellbeing, early detection, management of conditions, and assisted independent living, the digital healthcare ecosystem would have the aim of providing lifelong care that improves the quality of life as well as reducing the need for medical interventions.

At the same time, the collection of data, on a population scale, can also be utilised to provide health benefits. Analysing links between environmental or genetic factors and health can be used to identify at-risk groups or further medical research. In order to realise this broad vision, it is key to centre prevention and population health, over the treatment of individual symptoms, and ensure that there is an integrated healthcare model that can provide holistic support.

People must be encouraged to take control of their health, through technology and AI digital coaches, while a consensus must be built for the appropriate sharing of data and use of sensors to collect intimate data. Data protection and security must also be key to realising this vision, as well as new clinical organisational structures to decentralise healthcare, into community care with the support of AI health technology.

Crucially the report provides hypothetical 'case studies' to demonstrate how a technologically adept and community-focused healthcare system could function. For example, a 26-year-old with an 'NHS dot' device, and a family history of high cholesterol could be provided with their weekly report of sleep, stress, energy, and exercising levels. This could then link to suggested local exercise activities and diet recommendations. It is vital that the advice is provided in a natural way, rather than dictated paternalistically, as the technology is designed to empower patients to take active choices. Alternatively, a 68-year-old with a chronic condition such as COPD could be provided with live pollution data and specialised exercises; at the same time, the sensor collects

data on Oxygen levels and can automatically prescribe emergency medication when it detects an issue - preventing hospitalisation.

The data collected can also be used in consultations at community 'polycentres' where medical professionals can provide general lifestyle advice, as well as targeted healthcare interventions. The goal is to prevent illness before it occurs, promote wellbeing, and integrate health into everyday activities. A stern critic might point out some shortfalls in this vision. In this Brave New World, take up among Fitbit fanatics can be assumed. They are frequently The Worried Well. However, those less engaged and committed, those who doubt, might be left by the wayside. How are those who might still wish to be passively carried from the cradle to the grave by the NHS to be persuaded to engage with their own long-term wellbeing?

What tech would do in an ideal world is challenge the individual in real time and regularly when they are engaging in activities that are to the detriment of their health - alcohol and cigarettes, for example - and make them accept that a visit to the GP in the hope that they can sort it out when they've developed a chronic disease will not suffice. Because it doesn't. That's why a transfer of power is important.

There remains an undeniable link between poverty and poor health. If you're not well off, you are far more likely to get to breathe more lousy air in cities. You are also more likely to resist having a COVID-19 vaccination.

Big and small Tech has its sights on healthcare, and it won't go away. If one thinks about what Facebook/Google know about us already, they know what more data they might scrape together if they had loads of tiny probes all over us and what the data derived from those probes would be worth.

Matthew Gwyther
Partner, Jericho Chambers
matthew.gwyther@jerichochambers.com

Daniel Katz
daniel.katz@jerichochambers.com

Healthcare and the levelling up agenda

The government is committed to a 'levelling-up' agenda in which more resources are focused on deprived Midlands and Northern areas, with the economy being rebalanced away from London and the South East. There is a concerted aim to improve the prospects of post-industrial towns; poor health is one aspect of the malaise found within these communities.

The COVID crisis has exposed the pre-existing divisions in prosperity between north and south, with a Manchester Evening News investigation highlighting devastating death tolls and caseloads in towns such as Oldham and Blackburn. This is intrinsically interlinked with factors such as overcrowding and precarious economic prospects, as well as a high BAME population that has been disproportionately affected by the pandemic. The landmark 2010 Marmot Review, and its ten-year reappraisal demonstrated the deep levels of health inequality, especially in Northern England, with deprived groups living shorter lives in poorer health.

A 2017 Financial Times article also highlighted the multitude of health crises in the seaside town of Blackpool. It mirthfully noted the use of the term "Shit Life Syndrome" as a cause for poor health; temporary and/or badly paid jobs, easy access to vices such as alcohol & gambling, and high personal debt all contribute to an epidemic of poor physical and mental health. It is evident that purely clinical healthcare (e.g. GPs) is only part of the solution, with community action and a general re-evaluation of the town's economic model also key to improving its prospects. A real commitment to the levelling-up agenda necessitates a holistic approach to towns such as Blackpool, with an understanding of how to significantly improve residents' quality of life and thus overall health.

NO 5

We've been here before: The Peckham Experiment

Peckham is more than the home to Del Boy and Rodney. Its trail-blazing historic community health hub offered a glimpse into the potential for the Surgery of the Future

Matthew Gwyther, Partner, Jericho Chambers

History offers many lessons. It's extraordinary how in so many walks of life to look forward one would do well to take a considered look back. (The Hippocratic oath, after all, dates back to the 5th century BC) Health, and specifically primary healthcare, is no exception and for those who study it seriously, a remarkable experiment which took place in a sparkling Peckham building of glass and light in the 1930s can teach us all much about how to design primary care that works in the 21st century.

The Peckham Experiment was conducted by a pair of radical doctors, the husband and wife team of George Scott Williamson and Innes Pearse, when they established the Pioneer Health Centre. It was not a surgery, treating the sick, but rather a place dedicated to spreading - and studying - health.

Their aim was to study health as a medical condition in a manner comparable to studies of the natural history of disease - in the same way as working out how viruses cause illness. Scott Williamson was a pathologist and therefore good at deduction from clues. Peckham was in a number of ways the harbinger of today's healthy living centres and the Department of Health's "Choosing Activity" initiative. It had some of the ingredients of what is today known as "social prescribing."

Social prescription is hard to measure and evaluate. However, what research is starting to show is that demands on primary care fall when a patient's overriding issues are addressed and that medical prescribing also falls. Social prescribing is not a "treatment" like CBT, it is finding a social solution for the challenges that people face in life so they are less reliant on health professionals. Peckham could show a pathway to the GP practice of the 21st century.

The founders believed that health had much in common with disease - that it was contagious. The trick was to create an environment, a joint enterprise, in which people would infect each other with wellbeing. The result was a beautiful club, boasting a large swimming pool, a gym, boxing rings, a dance hall, a library, a creche with "room for perambulators" and a cafeteria serving "compost grown" - organic in today's language - food, produced at the centre's own farm a few miles away in Bromley. Local families could join for 6d a week, so ensuring they felt like members rather than recipients of charity. And they joined in their hundreds. At its peak 1,000 Peckham families were members.

When Pam Elven, who attended Peckham as a child 70 years earlier, was interviewed by the BBC she remembered her "eyes lighting up" when she first saw the place. How many kids feel that about their first trip to a GP surgery in the 21st century? She watched others in the gym and felt compelled to join in. There was no compulsion or even much active direction: people could just get on with what they liked the look of. Pam recalled the food too - home-baked bread that was brown and "a bit coarse" - and the lessons she was taught about "what food was good for you", lessons she passed on to her children and grandchildren.

Much of the data on the "Peckham experiment" was lost in the war, but all the signs pointed to great success. Experts noticed that babies born to Peckham mothers - those who had eaten the centre's organic fruit and vegetables - had a "bloom, sparkle and bounce" lacking before.

And yet the Pioneer Health Centre closed in 1950, weeks before Pam was due to hold her wedding reception there. "It felt like news of a death," she said. "We were like one massive family." The reason for the closure was the arrival of the NHS. There was no room for an independent outfit, focusing on wellness rather than disease, in the new, centralised National Health Service. The Peckham building has gone the way of many unwanted municipal structures and is today a block of luxury apartments. A two-bedder could currently be yours for £540,000.

For all the organisational changes that the NHS has undergone in recent decades - choice and marketisation, strict adherence to KPIs - most miss a vital point. They focus on disease and hospitals rather than on improving the environment in which people live. Williamson and Pearse understood 70 years ago that prevention was better than cure and that fitness, diet and social interaction were the key. It was a different sort of mindset.

Sure the tone of the book which the doctors wrote and was published in 1943 is slightly old-fashioned. Its tone is odd, rather paternalistic, haughty even. Notes on an interview with an unnamed couple describe the wife as "fat, flabby, constipated, dressed in slovenly clothes,

suspicious, diffident and negative." Their elder daughter was "undernourished, anaemic (lack of night sleep and worms) bit her nails, was a wriggler bed-wetter, lisped. Was furtive…" Ouch.

However looking at the NHS in 2021 the couple would perhaps feel that an enormous ecosystem of complexity has been created but one which - by its own admission - only delivers between 50-60% of care to the highest standards are Level 1, that probably wastes one third of its time and resources and actually has adverse effects with up to one in ten patients.

But Peckham is also a parable of a wider kind. The post-1945 rush to build a universal and highly centralised plus prescriptive welfare state put paid to many small, creative and ingenious hives of ingenuity. After the war the new welfare state was obsessed with a centralised power that saw much get lost. Britain had been host to a whole ecosystem of mutual societies, cooperatives, Sunday schools and workers' associations. Many functioned in an interdependent way. Most went the way of Peckham, crushed under the giant wheel of the Whitehall state.

One response to this is to set about rolling back the state, so that we might once again reveal Burke's "little platoons" of social activism, denied encouragement so long. It is important to note that Burke should choose such quasi-military terminology for his description of the community. However, just like a 'platoon', the community is both well-structured and mutually dependent in 'battle', which in social thought we might simply call 'life'.

When the inquiry into the COVID pandemic is carried out it will be interesting to see how the efficacy of those at ground level who knew the lie of the land and took responsibility into their own hands without waiting for central diktat helped fight the disease. He may have fallen from favour in the eyes of many but David Cameron's self-described "big idea" of social responsibility argues as much, shrinking the state and letting "society" take the strain. He could - though he won't - look for some succour for this approach from Britain's own anarchistic or left-libertarian tradition, which remains largely forgotten.

But that would be to go too far in the other direction. The post-1945 shift towards the state has its strong critics but there were sound reasons for it. Reliance on charities and well-meaning individuals could never be a complete answer to the problems of health, education or poverty. Too many people fall through the gaps. The family doctor in the NHS is quite rightly the first line of defence, the port of call for those suffering and requiring help with the vicissitudes of life. The Peckham experiment was of huge value if you lived in Peckham, but not much use if you lived down the road in New Cross or in Newcastle. And it made your receipt of those essentials - a schooling or medical treatment - not only random but contingent on the kindness of strangers. The state ensured citizens got those services as of right.

That case for the state still holds true in the 21st century. So, perhaps the key aspect of the Peckham experiment is not which sector produced it - voluntary rather than public - but its scale. It was small and beautiful. It was bought into by being performed by its members and not "done to." It was a micro collectivism. That collectivism is being edged towards by the existence of patient representatives in good GP surgeries. Few will have the money or space for a swimming pool, but the ethos is clear.

Peckham only hints at answers. Any normal business would spend a proper sum on R&D if it wished to survive, especially in these times of The Great Acceleration and rapid change. But where does the NHS do its R&D? What might it achieve, for example, if it joined up with those responsible for social care - always the Aunt Sally to the NHS - to see what might be done to solve our many problems.

Drs Pearse and Scott Williamson did draw an extensive list of important conclusions:

- Health is a process that has to be cultivated if it is to thrive.
- If people are given information about themselves and their families they will attempt to make decisions that are in the best interests of their families.
- People thrive when they are given the freedom to make choices about their activities and will choose those that help in their development.
- When people are given resources in a community to enable them to grow, they will be active in their community for the benefit of that community.

A book by Philip Conford published last year examined Peckham's history and sought to explain its demise. He suggests that while financial and administrative problems never helped, various vested interests (including those of pharmaceutical companies and the medical profession) put paid to Peckham. He also highlights the even more ancient (than 1930) tension between the principles of Hygeia (the goddess of healthy living) and Aesculapius (the god of healing and surgery). "Our culture values those who try to put things right more than those who try to ensure they do not go wrong in the first place." Those sitting at their drawing boards to design the surgery of the future would do well to remember this.

Taking a dip in SE15

Matthew Gwyther
Partner, Jericho Chambers
matthew.gwyther@jerichochambers.com

KEY TAKEAWAYS

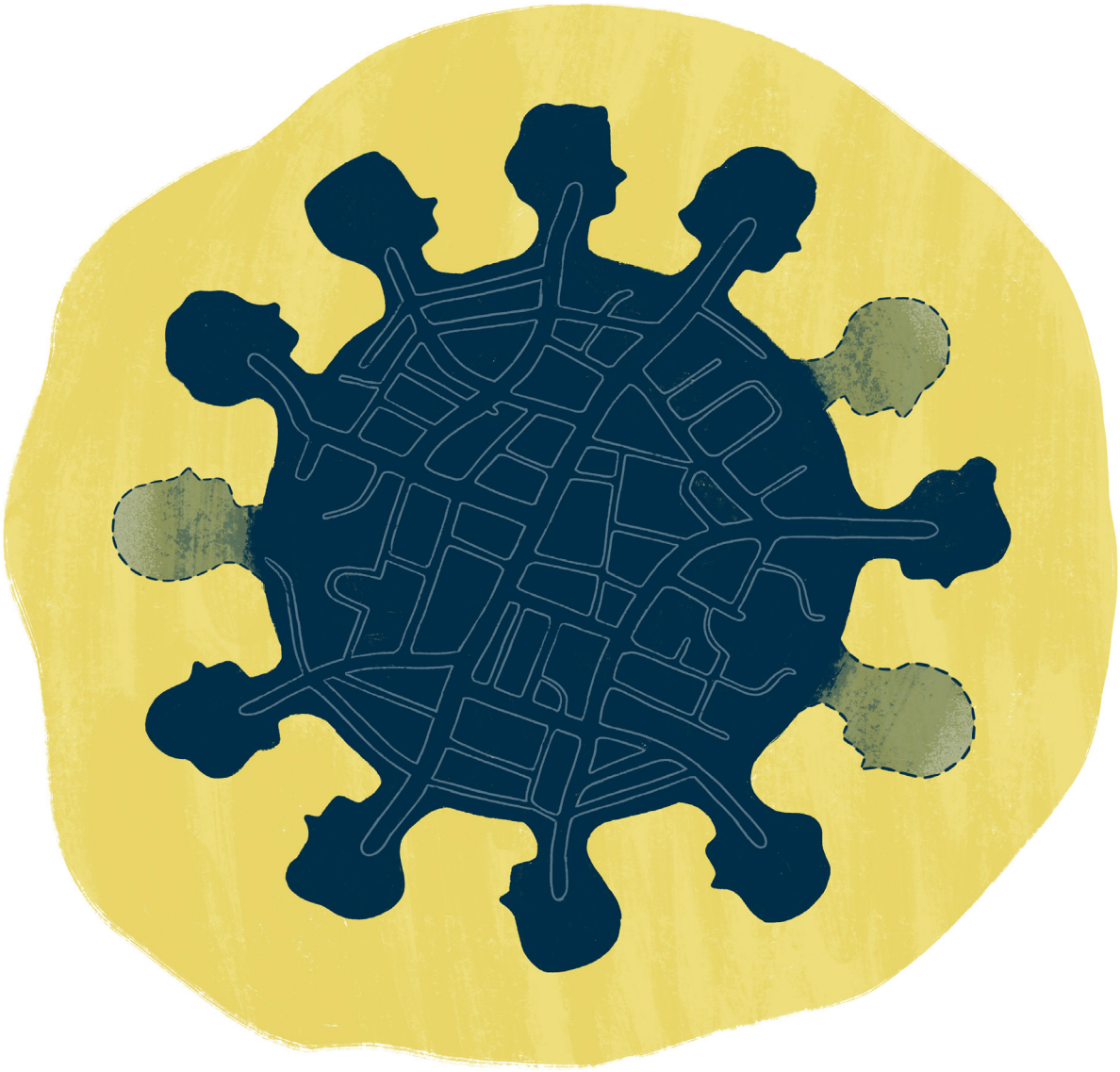
- The Surgery of the Future should harness the essence of creative local hives of ingenuity – where local members are part of a micro collectivism rather than "done to"
- Effective change will need to factor in knowledge about the system's complexity rather than perpetuate the current improvement paradigm, which applies linear thinking in blunt ways
- Yet we should recognise how truly hard this is in the messy, real world of complex care

NO 6

Forgotten Communities

COVID has shown that the time is ripe for a collaborative commitment for Social and Primary Care

David Grayson, former Chair, Carers UK



'Collaborative commitments' were defined by the former Prime Minister Gordon Brown's Prime Minister's Council on Social Action as "agreements made voluntarily between individuals and organisations from business, public sector and civil society, to achieve positive social impacts which would not be possible for one sector acting alone, to obtain."

The idea is that different partners pledge to do more, conditional on others delivering other, additional benefits. GAVI – (originally the Global Alliance for Vaccines and Immunization) – would be a powerful, international example of Collaborative Commitments in action.

Could the time be ripe for a Collaborative Commitment for Social Care? Certainly, politicians outside government, from across the political spectrum seem to be agreed that action is urgently needed. The present Prime Minister promised a plan in his first speech in office; a pledge repeated in the Conservative manifesto for the December 2019 election. Think-tanks of different hues are touting different funding solutions.

Successive Westminster Governments have failed to grasp the nettle of how to fund social care. The Blair Government appointed the Sutherland Commission in 1997. Since then, there have been 12 White Papers, Green Papers and other consultations about social care in England, but very little progress. The Coalition Government established the Dilnot Commission. The Dilnot commission recommended a partnership model with a much more generous means test and a lifetime 'cap' of between £25,000 and £50,000 on social care costs.

It's clear that after the COVID-19 crisis, social care cannot continue to be delivered in its current form. Radical change is needed to address unmet need, ensuring that both older people and disabled adults of working age get the care they need. Social care is massively under-funded. The charity Age UK estimated that the number of older people in England with some level of unmet need stood at 1.5 million in 2019.

There is no substitute for the long-promised, cross-party agreement on long-term funding of Social Care. The sector needs more money. A lot more money. Now. No argument.

Only Government can deliver this in co-operation with the other political parties and industry stakeholders. Better long-term funding should, however, be linked to other elements of a radical change agenda: hence the idea of Collaborative Commitment. Care-work is not currently seen as an attractive career option. Yet caring for the elderly, infirm and vulnerable in our society should be one of the most prestigious, honoured and appreciated professions. Care-workers require significant technical skills, compassion, empathy and high Emotional Intelligence to do their jobs well.

Care providers – public, private and not-for-profit – need to be able to commit to pay at least Living Wage (rather than just minimum wage) and to honour the Living Hours pledge of the Living Wage Foundation.

"It's clear that after the COVID-19 crisis, social care cannot continue to be delivered in its current form."

This in turn, should be linked to union and staff commitments to upskill. We need to capitalise on current investigations into the Care Worker of the Future and how vocational training can be provided effectively, combining on-the-job training and blended-learning, supported by further and higher education. Here the active engagement of Skills for Care will be crucial.

We also need to expand the talent pool coming into social care. Teaching, policing, even the prison service are now benefitting from graduate recruitment via prestigious programmes modelled on Teach First. Might there be lessons here for care-work too? Much of the current debate focuses on how to fund and how to organise from the government side. Consideration is needed just as much about how social care is staffed and also how it is provided: namely the market of providers of residential and domiciliary care.

There is a strong argument that increased public and service user funding should stimulate more of a mixed economy of care. Local authority commissioners, for example, might give more emphasis to the enhanced Social Value Act and more weight to the wider sectoral benefits of having a multiplicity of care-providers with

a variety of ownership models (PE and other privately-owned chains; but also individual for-profit care businesses, social enterprises, local, self-organising co-operatives modelled on the widely acclaimed Dutch Buurtzorg model and charities).

A further component of a putative Collaborative Commitment on Social Care, should be to tackle the so-called "Care Deserts" - parts of the country where older people can't access residential or home care, regardless of whether they can pay for it or not. Entrepreneurial programmes like the Tribe Platform, developed by Artificial Intelligence entrepreneur Richard Howell and his Bronze Labs, demonstrate how AI can positively disrupt and bring much needed innovation and "make markets" between local providers and customers of care services.

Most people want to "age in place" and be cared for in their own home – which is why improving the quality and ease of access to domiciliary care is so important. Indeed, polling by Hanbury Strategy for IPPR and Policy Exchange (respectively leading progressive and centre-right think tanks, which have come together to seek a long-term solution to Social Care), in the early stages of the pandemic, suggest – unsurprisingly – that care homes are now a less attractive option. Hanbury found both families and the over-65s themselves far less interested now in a care home option. Hence, the importance of radially improving both the quality and availability of home care. In his recent report for DEMOS, the Tory MP Danny Kruger suggested that family members might be paid to provide care services. This is the case, for example, in Sweden. This is not, however, the right choice for all and improving information for older people and their families about their care options is also critical. Hence the value of new services like Legal & General's Care Concierge.

A new think-piece also from L&G: Caring for Britain (December 2020) highlights a range of other exciting innovations already happening in the care sector. Several of these are technology-based and there is no doubt that a range of technological solutions could positively disrupt the sector.

Finally, the bulk of caring is – and likely will remain – informal and unpaid i.e. provided by family and friends. Most of us want to care for our loved ones: partner/ sibling/ disabled son or daughter etc. if we can, but such caregiving should be because we want to – not because we feel we have to or because there is no alternative. Caring should be based on love – not because of a sense of obligation. So, here I have reservations about Danny Kruger's Demos paper where he argues families must take more responsibility. Apart from the morality of forcing individuals to care for others, it begs several questions. What happens to the increasing numbers ageing without children? To those whose families live far away/abroad or who are estranged?

"Most people want to "age in place" and be cared for in their own home – which is why improving the quality and ease of access to domiciliary care is so important."

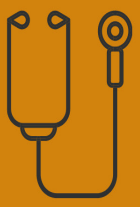
A comprehensive approach to care reform, must respect, value and support the role of unpaid carers. This includes better access to Advice & Information; peer-to-peer emotional support and encouragement; fair financial support for carers who give up work to care for a loved one (substantially higher Carer's Allowance or alternative); legal protection for working carers including right to request flexible working, working from home etc; and better help for ex-carers to re-enter the labour market. The COVID-19 pandemic and lockdowns have pushed many carers to breaking point – and sadly, a few beyond.

If #BuildBackBetter #LevellingUp and #JustTransition are to be more than empty slogans, there needs to be a comprehensive settlement of social care. How much better if it can produce a Collaborative Commitment to improve care radically and to put those cared for, at the heart of reforms.

David Grayson
Former Chair, Carers UK
david@davidgrayson.net

KEY TAKEAWAYS

- The Surgery of the Future should work to bring Primary and Social care closer together – enabling a wider range of care options including examples such as “care concierge”; “age in place”; better access to advice & information; peer-to-peer emotional support and encouragement
- The Surgery of the Future can be at the centre of a new (principles) framework within which patient-centric care will need to operate – putting carers and care at the heart of the reform



Forgotten communities

The COVID crisis has exposed deep divides in our societies and highlighted the strengths and weaknesses of our health and social services. From the administrative processes to the physical infrastructure of health centres, health services too often fail marginalised groups. The 'Forgotten Communities' roundtable highlighted the groups that are most likely to be poorly served by existing health structures.

The Sewell Report on Racial inequalities highlighted poorer health outcomes for some ethnic minority groups, and the way in which it interacts with deprivation and general poverty. In particular, the report highlighted how women from minority backgrounds are significantly more likely to die in childbirth, and a need for greater research in this area. At the same time it emphasized the diversity within BAME groups; there are a great many different communities with different health and social needs.

Mind Cymru and *Diverse Cymru* charities have also expressed concern that people from Ethnic Minority backgrounds in Wales face high - disproportionate - barriers to receiving mental health services. Language barriers can be a factor preventing people getting help, as can lack of culturally sensitive practitioners. Other inequalities, such as that of employment and housing, can also inhibit people from minority backgrounds from accessing services.

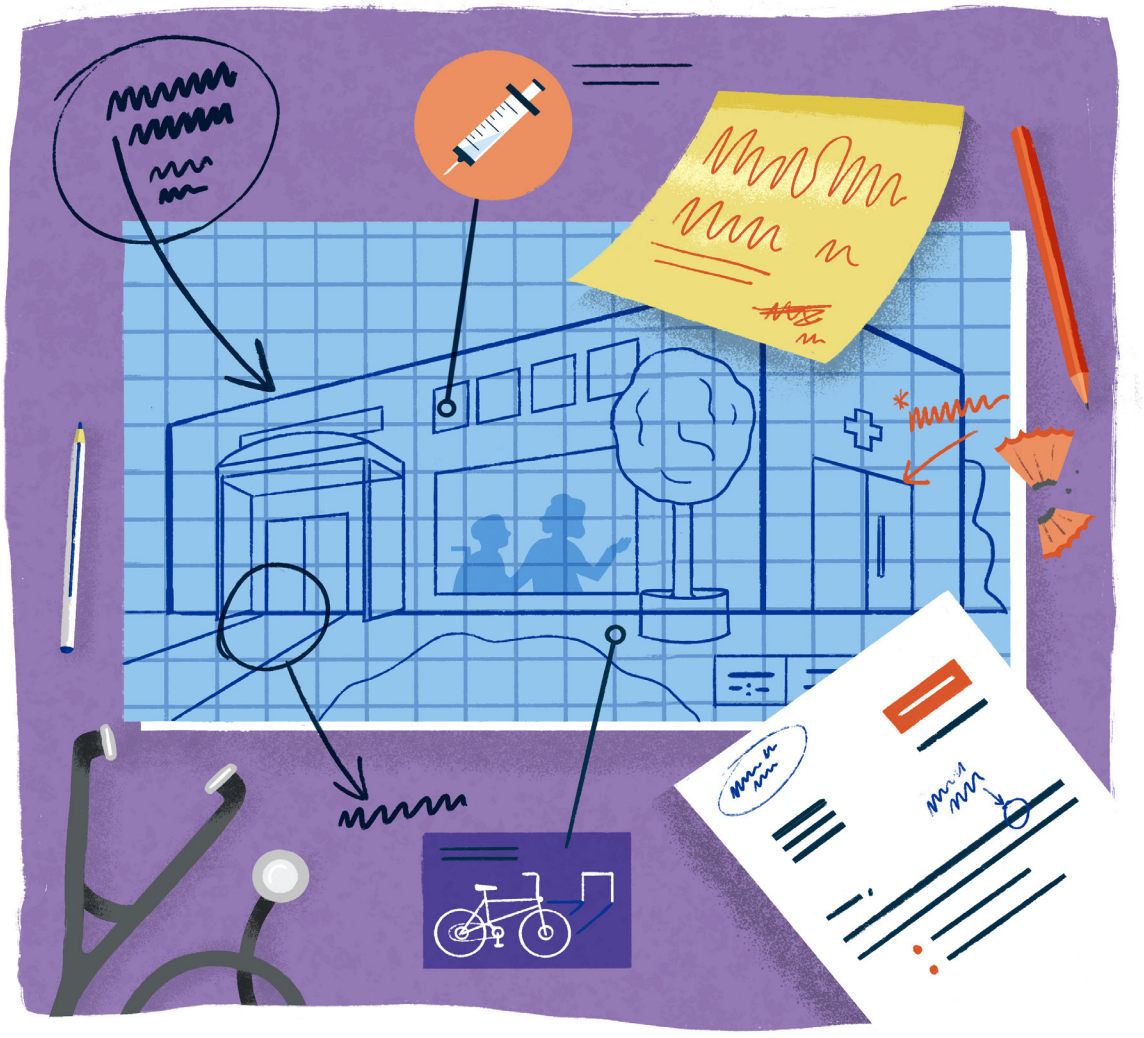
The very structure of health centres can also be alienating and difficult to navigate for those with dementia or physical disabilities; It's vital to involve the community in designing or retrofitting health services. ONS research has revealed that people with disabilities are more likely to be victims of the 'digital divide'; having lower access rates to the internet. Any technological or internet-based adaptations to healthcare must also keep these challenges in mind.

NO 7

An architect's blueprint for the NHS

Why design is central to achieving spaces that can fit form to function no matter how demand shifts while feeling truly embedded in the local neighbourhood

Ab Rogers, Designer



"We have been working in the healthcare sector for the last eight years and remain continuously assured by the power that design can have in spaces built around the treatment of physical and mental health.

Through our work with the cancer charity Maggie's we have seen what design can achieve when allowed to flourish. Connecting the outdoors with the interiors, harnessing the healing properties of fresh air and natural light, privileging warm and tactile materials, and employing emotionally engaging colours are all strategies conducive to nurturing the soul and aiding recovery. Now more than ever, we are determined to take our expertise and our learning into the public health sector and GP Surgeries."

- Ab Rogers

"Progress is perhaps the biggest challenge the hospital, in its current form, faces."

The biggest challenge we encounter as designers working with the NHS is the misconception that design is a luxury rather than a necessity, a cosmetic fix that only serves to improve appearances. We want to communicate how much design can instead support patients and carers and ultimately benefit the NHS. We believe that design has a fundamental role to play in improving quality of life when life is at its most vulnerable and that designing environments that are truly fit for purpose is the most valuable use of our skills. Careless design intensifies difficult experiences – fighting disease, supporting a loved one in pain, receiving bad news – all these struggles are amplified when surrounded by a neglected or confusing space, and the impact of a hostile environment on mental health and patient recovery times – particularly in intensive care – is well documented. The culture of care is incredibly strong throughout the NHS, but this culture needs to be embodied by its physical spaces too, supporting doctors and nurses as a 'third carer' and protecting all users from the perils of sick building syndrome.

The design problems we encounter in our hospital projects – lack of natural light, inadequate storage space, cluttered corridors, low ceilings, poor lighting and acoustics, and confusing signage, along with problems inherited from years of short-term fixes – only serve to convince us further that the healthcare sector is where design can make the most positive change. We are not alone, the doctors and nurses we have had the privilege to work within our projects for Charing Cross, St Thomas' and St Mary's Hospitals never failed to impress us with their vision, understanding and commitment to improving the lives of their patients and staff through environmental change.

Most frequently we are brought in by a small department with a small budget who desperately wants to make a change, we then struggle against the restrictions of bureaucracy, procurement and rigid funding structures that come with working as part of a large hospital for a larger NHS Trust that is but a minor part of the wider machinery of the NHS. Our experience to date has convinced us that there are two ways we could improve this process.

One is to find a way to garner support from the top and have policymakers put their faith in designers to enact real, long-lasting change, empowering us to cut through the red tape wrapped around everything, from door handles to ceiling heights, and restructuring the release of funds to allow implementation of the kind of holistic improvements – circulation and flow, orientation of patient rooms, acoustic protection and sound design – that will save money in the long term and prevent the constant need for quick fixes.

The second is to catalyse change from within, encouraging the NHS to assume a sector leadership role in championing the value of design and innovation, setting high-level agendas that identify problems across the sector rather than operating case by case, in a fragmented way. This could even mean imagining a new professional figure who understands the inner workings of hospitals and is also experienced in design in its most expanded sense, as a tool to improve the human experience. This specialist figure or department would be able to listen to and coordinate all relevant parties, and above all be empowered to make things happen.

Our dream client in the healthcare sector has the ability to make decisions and take responsibility for the outcomes, writing ambitious briefs and looking into the future. In the commercial sector this kind of power inherently belong to

the client, but within the NHS we find this is often not the case: our clients are supportive and invested, but also restrained by access to funds and lack of critical support from hospital estate departments. No matter how strong and visionary the brief or how informed the client team are, if there is no open dialogue and cohesion within the wider hospital departments it is difficult to make progress.

Progress is perhaps the biggest challenge the hospital, in its current form, faces. It has been said that the minute a hospital finishes being built it is already out of date. There is some truth in the idea that while they are contained within rigid, immovable structures, hospitals will always struggle to keep pace with the changing needs of their staff and patients, and with an ever-evolving technology.

"We imagine a health facility of the future that responds to the evolving needs of its patients, doctors and nurses, a collection of spaces that are flexible, able to move, respond, expand and contract, changing shape to fit form to function no matter how demand shifts"

We imagine a hospital of the future that responds to the evolving needs of its patients, doctors and nurses, a collection of spaces that are flexible, able to move, respond, expand and contract, changing shape to fit form to function no matter how demand shifts, and it is our belief that design plays a critical part in realising such a vision.

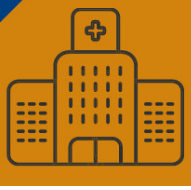
ARD would leap at the chance to take the above thinking and learning and use it to challenge the primary care centre, applying it to unlocking its complex practical and operational requirements. As the widest-reaching portal into the healthcare system, it would make a fascinating site for design, an opportunity to create a connected, inclusive community hub, a welcoming and humanist anchor that nurtures the sick, comforts the elderly, stimulates children and supports staff.

Increasingly primary care centres will function as the centre of a network of connected satellites – pharmacies, tele-health, vaccination clinics – services that are not just for the sick but that support all of us in our daily lives, and design is central to achieving a family of spaces that can enable this multi-layered operation while feeling truly embedded in their local neighbourhood.

Ab Rogers
Designer
ab@abrogers.com

KEY TAKEAWAYS

- The Surgery of the Future will function as a collection of spaces that are flexible, able to respond to the evolving needs of its patients, doctors and nurses
- The Surgery of the Future can function as the centre of a network of connected satellites – pharmacies, tele-health, vaccination clinics – services that are not just for the sick but that support all of us in our daily lives
- Design is central to improving our experiences as patients, and to unlocking the complex practical and operational requirements needed to create an inclusive community hub - a welcoming and humanist anchor that nurtures the sick, comforts the elderly, stimulates children and supports staff.

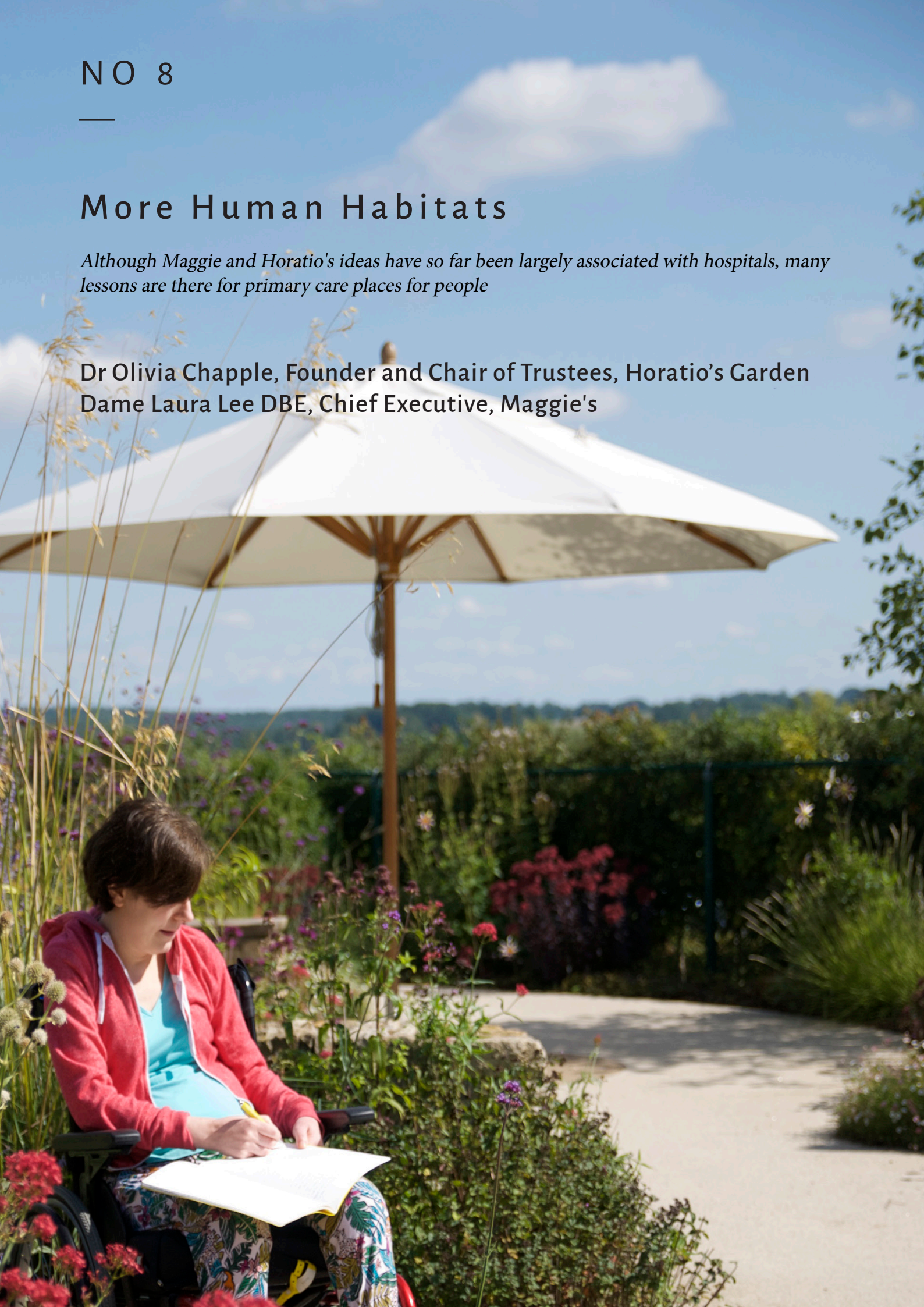


NO 8

More Human Habitats

Although Maggie and Horatio's ideas have so far been largely associated with hospitals, many lessons are there for primary care places for people

Dr Olivia Chapple, Founder and Chair of Trustees, Horatio's Garden
Dame Laura Lee DBE, Chief Executive, Maggie's



A sense of peace and inspiration in Horatio's garden

Olivia Chapple

Horatio's Garden is a national charity improving the lives of people affected by spinal injury through creating and nurturing beautiful gardens in NHS spinal injury centres. We grow thriving communities to support patients and their loved ones who are facing long stays in NHS hospitals. Our mission is to bring a Horatio's Garden to all the UK's spinal injury centres and trail blaze the benefits of gardens in healthcare.

The beautiful accessible gardens, all with integral garden rooms, are designed by leading garden designers and architects specifically to]improve people's physical and psychological health as they adjust to, or care for someone with, life-changing injuries. Each Horatio's Garden is tended by a team of volunteers, who are led by a trained Head Gardener, employed by the charity. The design emphasis is to create a sanctuary which is the antithesis of the clinical hospital environment, a safe and subtly accessible space, so people are not reminded of their new disability and can enjoy the garden independently.

"Gardens are not just a pretty addition – they should be a vital part of healthcare design."

Once the gardens have been built, therapeutic activities are organised by the charity to complement the clinical care provided by the spinal centres' NHS teams. Garden therapy, arts and crafts, artists in residence, mindfulness, yoga and live music, are some of the many sessions organised, in collaboration with the therapists. Seasonal social events are also arranged for patients and their families which help with the adaptation of the whole family to the traumatic injury. The garden sanctuaries also offer NHS staff a respite from the pressures of working on the wards.

I founded the charity in 2011 and it's named after my eldest son Horatio, who wanted to be a doctor and volunteered at the spinal injury centre in Salisbury where my husband, David is a consultant spinal surgeon. It was Horatio's idea to create a garden for patients and he conducted research which shaped the charity's aims. Horatio's life was cut short at 17 when on an expedition to Svalbard, his camp was attacked by a polar bear. Through the grief and terrible sadness we experienced, setting up and growing the charity has given us hope and a positive way improve lives, on Horatio's behalf.

Our work is evidence-based. The King's Fund Report in 2016 into Gardens and Health cited Horatio's Garden as an example and concluded that there is overwhelming evidence for the benefits to health to have gardens in all institutions. The charity's patient annual audit data shows the projects' profound impact on wellbeing, mood, sleep, physical rehabilitation and this year, coping with the impact of covid for patients, their families and the NHS staff.

Annually, 2500 people in the UK experience spinal cord injury and there are 50,000 people living with the effect of this life-changing injury in the country. The UK has 11 regional spinal injury centres, so patients are often far from home and family while they spend months in NHS hospitals learning to live with paralysis and planning their changed futures. Adjusting in the confines of a hospital ward while sharing your room with several other strangers, with artificial lighting and little respite from the sounds and smells of the medical environment just adds to the challenges.

There are now five Horatio's Garden projects established in Salisbury, Glasgow, Stoke Mandeville, Oswestry and London, one being built in Cardiff and the next in development in Belfast. Further projects will be in Sheffield, Wakefield, Middlesbrough and Southport. The charity does not receive statutory funding and relies totally on donations from kind individuals, charitable foundations and businesses for support.

Having seen first-hand the impact of bringing back gardens into the heart of our hospitals, I believe passionately that gardens should become the norm in all healthcare settings. Gardens are not just a pretty addition – they should be a vital part of healthcare design. Natural sanctuaries add phenomenal value to any care setting both

in their multifactorial physical impact, mental health benefits and as social spaces. Covid has magnified this – being outside is safer with reduced infection transmission and it makes no sense to eliminate it from our built healthcare settings.

Garden Room, August 2020

My sincere hope is that the positive legacy of the pandemic will bring about change within the NHS and skew the emphasis in design to bring nature close to people in times of stress and illness. There is a vast untapped potential to improve the environments where we care for our most vulnerable members of our society. Let's hope that we can seize the opportunity.

Dr Olivia Chapple
Founder and Chair of Trustees, Horatio's Garden
olivia@horatiosgarden.org.uk

The modernisation of the NHS ready for a post-COVID future

Dame Laura Lee

For 25 years I've been at the helm of Maggie's as we've designed, built and run world class cancer centres. We have worked with some of the world's best architects to design our buildings because we know that light, colour and a connection to nature really matter in how people deal with a cancer diagnosis.

Each Maggie's is architecturally unique, yet they are all built around the same founding principle; that architecture and design have a positive effect on health and mind. Our centres are built right alongside the hospital and are staffed by professionals with a healthcare background, but every centre is thoughtfully designed to be calming and welcoming; a place apart from the clinical environment of the hospital.

At Maggie's I have been experienced first hand, countless times the positive effect our spaces have on people with cancer. As Bami one of our centre visitors to Swansea puts it:

"It makes me feel special, I feel privileged to be in a place like this. There is so much attention to detail and beauty that is dedicated to making me feel better."

We know how a beautiful, considered and well-designed space can make the people in them feel valued and safe – and that includes our staff. How great architecture, landscaping and considered artwork allows people to express how they're feeling in a way a hospital space isn't designed to do.

This was bought home to me when our first centre opened in Edinburgh and I moved from the NHS to run it. I'd been looking after a patient in the hospital as her cancer nurse, but when she first came through the doors at Maggie's she was completely different, so much more at ease, comfortable and able to express her true concerns and anxieties. All because she was in a space that felt like a home, not a hospital. It was incredibly powerful and it's this effect that we've carried through all of our centres today. Buildings which create a sense of place, encourage human support but also offer privacy and comfort when it's most needed.

In our centres there are no reception desks and no clocks; instead, we have comfy sofas and plenty of time. We don't have signs up on our walls, our staff don't wear uniforms and we pay attention to the important little details that make people feel at home and valued. Plants, plumped cushions, fresh fruit, furniture you can move around because you are in control, you are not being doneto. A kitchen at the heart of the centre, just like a home, where you're encouraged to make your own cup of tea, a small but important gesture. You are going through the worst time of your life and you deserve the very best.

Maggie's Kitchen Table

When we started Maggie's, the environment was thought to be a far secondary concern after medical care. But that attitude has slowly changed as the importance of psychological support has been recognised and how building design enables that to happen. After a year where the strain and importance placed on hospitals have never been so high, it's of huge significance that the government has announced it will be investing into new acute hospital infrastructure. The Wolfson Economics Prize, of which I sit on the judging panel, has announced this year's focus will be on radically improving the planning and design of hospitals in the future.

If we're going to be investing in our hospitals in a post-COVID world, we need to make sure the investment has a wider health and societal outcome. We have a remarkable opportunity now to rethink what a hospital's primary purpose is, to think about the role hospitals can play in supporting its community. A chance to build upon what we've learnt at Maggie's and to further explore what a hospital building can offer above and beyond its physical form.

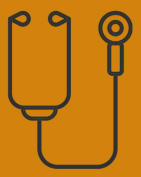
I'd like to use this opportunity to reshape a hospital's role, not just as a place to come to when you're ill but as a positive space where people can turn to and come together. A chance to create buildings, not from a purely practical standpoint, but to take a human and design-led approach, with the intangibles built in from the very start. A chance to create a space that inspires and lifts a community by being architecturally special as a reflection of how a hospital values its community and a community values its hospital.

Let's use this post-COVID period as a chance for investment and change. A chance to really think about how we want to help people navigate through the healthcare system and come out all the better for it. An opportunity to get creative, innovative and make a real change in how hospitals are designed, built and used for generations to come.

Dame Laura Lee DBE
Chief Executive, Maggie's
laura.lee@maggiescentres.org

KEY TAKEAWAYS

- There is a vast untapped potential to improve the environments where we care for our most vulnerable members of our society – and to learn from them in the design of all health spaces
- Great architecture, landscaping and design are not just pretty additions – they should be a vital part of the healthcare ecosystem because of their huge impact on wellbeing, mood, sleep, physical rehabilitation
- Spaces which create a sense of place and a feeling of home encourage human support but also offer privacy and comfort when it's most needed



NO 9

Answers from Almelo

Buurtzorg's self-managed, non-hierarchical nursing teams show the possibilities of serving rather than controlling primary care

Brendan Martin, Managing Director
Buurtzorg Britain & Ireland

A collision between the need for local decision-making and the government's default tendency to centralise has run through England's Covid response, often with disastrous results. So it is no surprise to find it expressed so explicitly in the White Paper Matt Hancock published in February to make place-based Integrated Care Systems (ICSs) compulsory. Some places have already created ICSs, with promising results in terms of improved collaboration between the local agencies they link, which are mainly NHS bodies and local authorities. But instead of continuing to encourage these collaborative experiments and giving them time to inspire others to follow suit, Hancock plans not only to require them but also to take powers to command them.

What if, instead of asking how much local decision-making is possible, we asked how much centralisation is necessary? Instead of fixating on organisational integration, why not start with what a person needs and integrate around them?

The success of Buurtzorg Nederland, launched with one neighbourhood team 15 years ago and now employing 15,000 health and care professionals in hundreds of self-managed non-hierarchical teams, shows how this can work. Buurtzorg's practice is based on core beliefs about the human condition, that people want meaningful lives and both individual autonomy and warm social interaction. This defines its purpose.

The day-to-day work of Buurtzorg teams involves supporting people to self-manage their care as much as possible, drawing on and working to strengthen the support of family and community To operate consistently in that way requires that the professionals themselves self-manage, individually and collectively, guided by their craft and ethics to co-create solutions with the people they support and do what is needed when it is needed. That doesn't mean there is no central authority or support: as well as operating within an agreed framework of ground rules, Buurtzorg teams are supported by regional coaches and a lean and responsive back office. But the default is local and personal, and the organisation's purpose is to serve the primary process not to control it.

Buurtzorg's response to the pandemic illustrates how this approach works well. When Covid hit, the back office responded to intelligence from the first teams affected by setting up a task force to gather and disseminate guidance, and by bulk buying personal protective equipment (PPE).

The results of trusting and supporting the intrinsic motivation of professionals, and valuing both their codified and tacit knowledge, speak for themselves with Buurtzorg's success, and not only in great care outcomes and job satisfaction.

"The day-to-day work of Buurtzorg teams involves supporting people to self-manage their care as much as possible, drawing on and working to strengthen the support of family and community."

Buurtzorg has saved millions by halving the average number of hours of professional input per client and keeping overheads low, which is important given that Westminster's centralising impulse is due in part to resource rationing.

The funny thing is that I know Matt Hancock gets a lot of this. He has told me he 'loves' Buurtzorg. His advisor Camilla Cavendish tells a beautiful story in her book Extra Time about shadowing a Buurtzorg nurse, and in her Financial Times column wrote that the model 'should be adopted everywhere'.

But the key word there is 'adopted'. Buurtzorg's founders created just one team. The rest have been created by nurses flocking to the company or by an equally organic approach to self-division of teams as they grow to scale. The possibilities of working from a "Health Hub" alongside GPs who understand the great value of cooperative, collaborative and mutually supportive relationship are huge. The time is right for innovation within our health and social care system - trusting those on the front line, with all their tacit knowledge, to try some R&D. See what might work better.

The problem is that political and bureaucratic mindsets tend to force what needs to be nurtured, to 'scale up' what needs to be supported to grow itself. This shows up not only in the government's treatment of local organisations but also in how many of the latter distrust their own communities and professionals.

As Jos de Blok has said: "We started working with different countries and discovered that the problems are the same: the message every time is to start again from the patient perspective and simplify the systems."

"The message every time is to start again from the patient perspective and simplify the systems."

Brendan Martin
Managing Director, Buurtzorg Britain & Ireland
brendan@buurtzorg.org.uk

KEY TAKEAWAYS

- Design of the primary care and community health environment should co-create solutions with the people they support – a health ecosystem operating within an agreed framework
- New approaches should avoid the political and bureaucratic mindset that tends to force what needs to be nurtured, to 'scale up' – new ecosystems need to be supported to grow themselves
- Question how much centralisation is actually necessary

Localism

The last year has demonstrated the strengths of our local communities, with neighbours banding together to help the vulnerable in their community, and a groundswell of goodwill and eagerness to contribute to societal wellbeing. The weekly clapping for NHS and other key workers, physically brought neighbours together – in a socially distanced way – demonstrating the way in which we are not atomised individuals but part of a greater whole.

The challenge is how to imbue that spirit into local healthcare provision and create 'joined-up' social services provision that centre patients' needs and experiences. This includes the use of 'social prescribing' and noting the interlinking of non-clinical factors (e.g. housing) with medical needs; this involves increasing the integration of Voluntary Community and Social Enterprises [VCSEs] into healthcare provision.

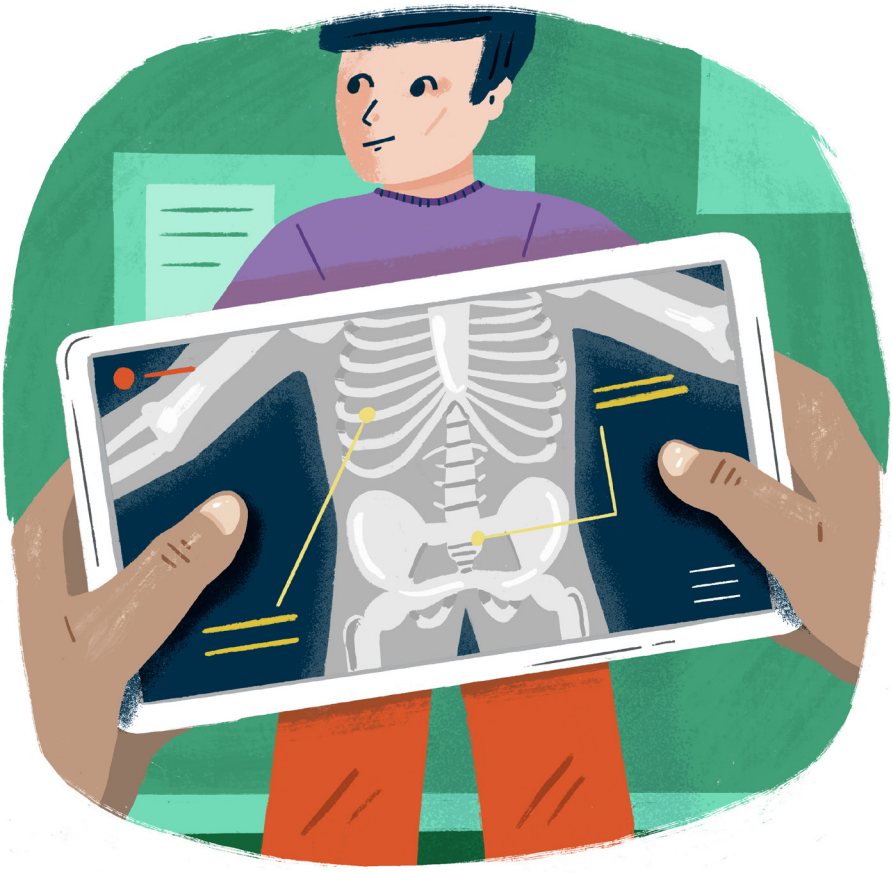
A vital part of this is building relationships with individuals who are in need of social services - such as healthcare - in an environment of trust. Organisations such as the Halifax Opportunity Trust work to promote holistic community health from cradle to grave. Childcare, employment and learning are all part and parcel of a localism health agenda. It's vital to move away from top-down healthcare dispensing mechanisms – too often driven by targets- to a more 'Buurtzog' stye community care model that prioritises overall wellbeing. Drawing upon historical parallels such as the 'Peckham Experiment' localism in healthcare provides the opportunity to further preventative healthcare, as well as increasing NHS efficiency through increased general prosperity.

NO 10

Power to the networks: the peer-to-peer future of health and care

Nyby's peer-to-peer network platform transforms how primary health care connections can be made without relying on inefficient centralised service models

Andy Russell, Social Impact Investor and Consultant



There has never been a better time to think about how we care for one another. COVID-19 has accelerated shifts in how we work, shop, learn and communicate, but the heart of long-term changes will be connected to health and care. Lockdowns protected our physical health, it is health and care workers we have relied on and literally applauded, and problems that were festering in our care systems long before the pandemic have now been brought to the surface. Specifically, three challenges we must urgently address are: the effects of our aging populations; how we support people with chronic conditions; and the epidemic of loneliness that has been growing over recent decades.

These challenges are too often overlooked in discussions about the future of health and care, where it is more common to hear about advances in robotics, AI and which diseases are close to being cured. Too much focus on new tech and treatments betrays a version of 'the faster horse' paradigm. As the (probably fictitious) quote from Henry Ford goes: "If I had asked people what they wanted, they would have said faster horses." This mindset, which views progress primarily as a better version of what we already have, misses the fact that innovations transform rather than just improve what has gone before. The car is not only a faster form of transport than the horse, it brings huge changes to our environment, the need for millions of miles of new roads, new designs for cities, a new perspective on distance etc. Likewise, innovations in health and care also mean social and cultural changes.

"Health and social care cannot and should not be exempt from gaining the benefits of peer-to-peer networks"

The tendency towards faster horse thinking is likely caused by the lag between the potential of a new technology and the new social structures that evolve in its wake. One recent instance is the advent of peer-to-peer networks. These networks have already started to transform how we relate to each other and our resources where we previously relied on centralised service models. AirBnB, Uber and Kahoot! are just a few examples of companies that have changed how we relate to travel, transport and education respectively.

Health and social care cannot and should not be exempt from gaining the benefits of peer-to-peer networks, which can help us meet challenges brought by aging populations, chronic conditions and loneliness.

Yes, there are additional demands on safeguarding and privacy that any innovators in health and care must face, but there are people already stepping up to the challenge. In Norway, an organisation called Nyby is connecting thousands of nurses, carers, government administrators, charity staff and volunteers through their version of a peer-to-peer network; in this case, a resource collaboration platform that frees up time for healthcare professionals and gets more support to the most vulnerable and lonely by increasing inclusion and connecting people.

Peer-to-peer networks can be difficult to visualise. After all, ordering an Uber driver does not feel that different from ordering a taxi through a minicab company. I need a taxi, I make a request, a taxi arrives and drops me off at my destination. But a minicab company relies on a central authority to collect and manage requests. Health and care has its equivalents in centralised systems of managers and administrators, which, as Nyby is showing, is inefficient compared to a peer-to-peer approach.

Nyby was inspired by the experiences of one of its founders, Fredrik Gulowsen, whose brother required significant care before passing away in 2013. In researching how new networks could improve care systems for families like his own, Fredrik met people like Jan, a resident of a care home in Norway. Jan had recently lost much of his mobility and needed to use a wheelchair. As the two spoke about what care Jan needed, the conversation turned to what support Jan could provide to his community if given the opportunity.

It had been a long time since Jan had been asked this question, but Fredrik found out that he spoke several languages, he was tech savvy, and he used to volunteer to help children with their homework. The conversation reminded Jan just how much he had to offer and inspired the team at Nyby to build a platform that helps everyone view themselves in terms of the possibilities they have and not just the barriers they face. The platform is now being used by

fifty local government areas across Norway and has recently spread to Sweden, Denmark and Germany. Now you can find Jan, along with his carers and thousands like them, both requesting and offering support directly through the decentralised Nyby network.

"A future where we see everyone for their possibilities first and their barriers second is one where empowered peer-to-peer networks transform what it means to be healthy and cared for."

Using Nyby, nurses and carers are getting support from each other and volunteers, so they have time to do more of the things that enrich patients' lives. A future where we see everyone for their possibilities first and their barriers second is one where empowered peer-to-peer networks transform what it means to be healthy and cared for. The robots and AI can wait a little longer; there is so much more we as people can achieve together first.

Andy Russell
Social Impact Angel Investor and Consultant
andy@nyby.com

KEY TAKEAWAYS

- Advancements in tech. and treatments don't have to focus on a version of 'the faster horse' paradigm. Innovations in networking and new social structures transform rather than just improve what has gone before
- A future where we see everyone for their possibilities first and their barriers second is one where empowered peer-to-peer networks transform what it means to be healthy and cared for

NO 11

Afterword
Try, try and try again

Margaret Heffernan, Enterpreneur, CEO and Author

David Ring is an orthopaedic surgeon who gave up his Chair at Harvard Medical School and his job at Massachusetts General Hospital to move to Texas. Why would a highly successful physician do such a thing? Frustration with the persistent and well-recognized ills of American healthcare: too expensive, inaccessible to too many people and poor outcomes. But also the opportunity to join like-minded physicians and educators who wanted to prove they could build a better system from scratch.

On arrival in Austin, he found thousands of patients on his waiting list—and no hospital yet! He had no choice but to offer video consultations. He already hated how transactional patient meetings felt and worried that technology would make everything worse, but Ring is a doctor who's comfortable with experiments. And what he found surprised him.

"Most consultations give the doctor all the power; my time, my place, my office, my fifteen minutes—then you're out." But Ring discovered that, on video consults, power was reversed; he met patients online in their homes, at their convenience where they could include friends or family members as they chose." Moreover, there was an inevitable gap between consultation and face-to-face meetings, when the patients decide on, and receive, treatment. That combination – disrupting the power equation, together with time to reflect and decide – made a huge difference. Thinking time generated better decisions which the patients owned and which produced better results.

There are so many experiments going on at Dell, it can be hard to see how the day jobs get done. But the day job is all about experimentation, each consultation an experiment in doing one thing better. Much of the focus is on inter-personal medicine: the recognition that how doctor and patient relate to one another has a measurable impact on outcomes. It's why the hospital has no waiting rooms –they make patients feel anxious and dehumanized – and its why medical staff do dozens of experiments in communication to understand what kind of language yields the best information.

The overarching hypothesis is that if you change the power relationship in medicine by putting the patient in charge, you get better, more affordable and more sustainable outcomes. Already they can demonstrate that Dell produces better care, at a lower price, with a better experience. Patients and doctors succeed together, or not at all.

While everyone at Dell came with a passion for improvement, they also started with humility. The recognition that much of what they'd been brought up with was wrong, and the belief that there had to be something better, means that Dell is one great big experiment, where everything is susceptible to experimentation and improvement. In just the way that, Buurtzorg was founded on an experiment that yielded unanticipated breakthroughs, the future of healthcare now depends on open minds willing to challenge and test deeply entrenched orthodoxies. Even the power structure.

In a future that is uncertain and unpredictable, experiments are vital. In healthcare, even more so. There are simply too many problems where thinking alone won't reveal an answer. You have to try things. Learn. Repeat. That requires a very open mind. And it also requires everyone. If we know anything about innovation it is this: it demands diverse minds that can speak up and make suggestions without fear of scorn or retribution. As the rise of open innovation platforms demonstrates, hard problems are frequently solved by those working outside their domain expertise. In reframing the question, they see alternative solutions. Creativity is no respecter for hierarchy.

Silos kill people. We have seen this in the NHS where the division of patients into hospitals vs care homes created a deadly toll. But people save people; in at least one hospital, doctors and nurses at the end of a long shift and eager to get home, instead of loaded their cars with PPE and drove them to care homes where there was none. As the doctors, nurses, technicians and designers at Dell Medical keep learning, human interaction is the heart and soul of innovation and improvement.

Experiments that draw in a broad range of skills and life experience is one place to start. Teaching everyone – from the janitor to the CEO – to be world-class listeners is another. So much of healthcare depends on being able to pick up the information that leaks from the most casual encounters. In the UK, if anyone were listening they would know that the vast majority of people want to die at home. That it is frequently so hard to do so, that funding fights and ideological

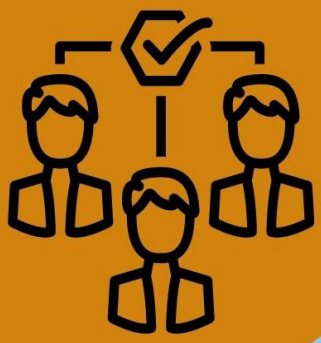
differences put the NHS and hospices so often at loggerheads, is yet another area where collaboration, not competition, will serve patients, their families and their communities, far better. Born in the UK, it often seems that the hospice movement is widely admired everywhere else more than its homeland. There's another silo waiting to be busted.

We used to see the body as a machine which, given enough repairs, could go on indefinitely; some still think that way. But the case studies in this report tell a different story: that it is health we must focus on, not illness. In Wales, the Commissioner for Future Generations found that just 10 percent of life expectancy depends on health care services. By contrast, 29 percent depends on housing conditions (clean air, houses, green space), 18 to 19 percent on social capital and 30 percent on jobs and welfare. If that isn't an argument for cross-disciplinary collaboration, I don't know what is.

This does not mean that expertise doesn't matter; it has never been more important. But for us to achieve the improvements that lie within our grasp will require that we all get off of our high horses and accept that we need many disciplines, many perspectives and experiences, a deeply enhanced capacity to listen and the kind of leadership which can bring these together to tackle the most fundamental of human goals: making life better for one another. We have the knowledge. We have the resources. It's time to use them and to experiment.

Jonathan Murphy's vision of a health care system that truly focuses on wellness rather than sickness is one that the world is coming to share.

Margaret Heffernan
Entrepreneur, CEO and Author
margaret@mheffernan.com



About Jericho and Assura

Jericho is an advisory firm helping clients address complex public policy issues. Since 2013, we've championed a very different, collaborative approach to public engagement that breaks beyond conventional echo chambers and hierarchies in search of better outcomes for all. We work at the heart of the 'holy trinity' of trust, purpose and engagement - convening those with lived experience alongside experts, influencers and political and business leaders. It's sometimes uncomfortable but the model works.

Current programmes include: the Global Responsible Tax Project, curated in partnership with KPMG; Public Health: In The Right Place?, on behalf of Assura plc; Young People: Our Future Voice Now, supported by Barclays LifeSkills; Energy and the Net Zero Carbon Future, convened with the backing of Sizewell C; the post-Brexit, post-COVID Recovery, for Stifel Europe; Central London Optimism, a Capco initiative; and the Healthy Work Project. Jericho is committed to a better society and the common good.

www.jerichochambers.com

From our national base in Warrington, Assura is a primary care premises specialist supporting local health teams across the country. Our 590+ GP surgery, primary care, diagnostic and treatment centre buildings serve millions of patients, are the workplaces of NHS staff and help make space for other community services too.

www.assuraplc.com

www.jerichochambers.com/publichealth

robert.phillips@jerichochambers.com

matthew.gwyther@jerichochambers.com

Thank you to contributors

Dr Olivia Chapple, Founder and Chair of Trustees, Horatio's Garden

David Grayson, Former Chair, Carers UK

Matthew Gwyther, Partner, Jericho Chambers

Margaret Heffernan, Entrepreneur, CEO and Author

Daniel Katz, Team Assistant, Jericho Chambers

Danny Kruger, Member of Parliament for Devizes

Dame Laura Lee, Chief Executive, Maggie's

Brendan Martin, Managing Director, Buurtzorg Britain & Ireland

Jonathan Murphy, CEO, Assura

Robert Phillips, Founder, Jericho Chambers

Ab Rogers, Designer

Andy Russell, Social Impact Investor and Consultant

Andy Wilkins, Founder, Future of Health

Join the conversation

Jericho Chambers, together with Assura, is hugely grateful to the individuals and organisations who contributed articles to this publication - as well as those who participated in the autumn 2020 roundtable programme. This report is part of an important conversation about the Surgery of the Future and possible new eco-systems for primary healthcare.

Have you seen a design idea of which the surgery of the future should take note?
If your team wants to be working in a surgery of the future, would you like to be a pilot project with this community?
Please email info@assura.co.uk to share your ideas.

Jericho programmes invite contributions from across the spectrum: professionals and business leaders, designers, experts and those with lived experience. All views are welcome.
Please email hello@jerichochambers.com to join the conversation.