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HOW TO IMPROVE THE HEALTH AND WELLBEING OF THE UK POPULATION

Introduction

This paper is written in the midst of one of the greatest threats to public health for decades, perhaps since the Spanish flu epidemic of 1918/19 and the cholera epidemics of the 19th Century. The coronavirus is sweeping through the world, and causing the premature deaths of many people, especially elderly people, and those with underlying chronic diseases.

This paper draws on a 'full report' which is available on the ResPublica website. Its key theme is that clinicians are increasingly operating in a broader health and care system that, at best, does not fully support them in delivering the quality of care that they want, and are capable of delivering, to their patients. This is because the way the NHS works is over-centralised, underfunded, poorly managed and highly fragmented.

Clinicians and carers are doing a fantastic job dealing with the Covid-19 crisis. and they will continue to do so due to their skill and dedication. It is also heart-warming to see how hundreds of thousands of volunteers have risen to the occasion. However, the heroism with which the doctors, nurses, carers and members of the public are responding to the crisis should not obscure the fact that reform of not only the NHS but also our social care system is vital. Indeed, the hard work and dedication of our clinicians should be rewarded by reforms that will allow them to do their jobs much more effectively in the future, and under considerably less stress. A saying that is commonly heard these days is 'never waste a good crisis'. This is not the time to distract from the NHS' response to the crisis, but it is the time to be explicit and honest about the defects of the system that have been apparent for many years. And it is also the time to use the lessons from the crisis – both in terms of what has not worked well, such as pandemic planning, but also the positives such as clinicians feeling much more engaged and valued – to start improving the way the system works. This is necessary not only to take the pressure off of an NHS and social care system that was embattled even before the Covid-19 crisis struck, but also because this pandemic is likely to be the first of a recurring series of such crises. These are inevitable as the global population grows, urban areas proliferate, and international travel expands. The toll will continue to be the heaviest on those most vulnerable in our society – the poor and underprivileged of all ages and, especially, the elderly who are suffering from underlying chronic diseases.

The UK has some of the poorest health and social care outcomes in the developed world

The NHS was a bold and appropriate structure when it was set up in 1948, but it no longer adequately serves the needs of the British people. The UK has some of the worst health outcomes in the developed world. An independent authority recently reported:

'The goal of a well-functioning health care system is to ensure that people lead long, healthy, and productive lives… [We measured] three outcome indicators, including mortality amenable to health care; infant mortality; and healthy life expectancy. The UK ranked 10th out of the 11 countries studied'.[1]

This is despite the NHS being 'free' and much loved, despite the UK having some of the most skilled and dedicated clinicians in the world, and despite the UK being a world leader in bio-medical science.

There are two reasons for this disappointing performance. The first is that the way the system works - the way that patients move through it - is 'stuck' in 1948 when people mostly died in their 60s and died quickly of their terminal illness. Independent, 'corner shop' General Practice (GP) surgeries and small District General Hospitals (DGHs) were perfectly fitting at that time. But they are not suitable for a population that lives, on average, 20 years longer and with chronic diseases and co-morbidities. The lack of adequate out-of-hospital (social) care was not a problem in 1948. In 2020, it is a killer.

The second reason is that the British lead less healthy lives than people in other advanced countries. The UK ranks 28th (the lowest Western European nation) in the Human Development Index (HDI). This index takes into consideration life expectancy at birth, mean years of schooling, expected years of schooling, and gross national income per capita. Lifestyle diseases such as obesity, diabetes and drug abuse are on the rise. The poorest and most deprived in our society are less healthy now than their equivalent population in the 1920s.[2]

[1] Davis, K., Stremikis, K., Squires, D., Schoen, C., The, (June, 2014) MIRROR, MIRROR ON THE WALL: How the Performance of the U.S. Health Care System Compares Internationally. Commonwealth Fund. Page 25.
[2] https://www.thetimes.co.uk/article/health-divide-between-rich-and-poor-has-widened-since-1950s-28t80tkwr, Journal of Epidemiology and Community Health

Power should be devolved to improve the health and wellbeing of local populations

As the Secretary of State for Health and Social Care, Matt Hancock rightly notes:

'We cannot continue to invest in the same service models of the past. We will not meet our mission with 'business as usual.'…This means services which target the root causes of poor health and promote the health of the whole individual, not just treating single acute illnesses.'[3]

Key to targeting the root causes of poor health is a better balance between devolution to address the particular epidemiology of an area, and national platforms that promote consistency and prevent postcode lotteries.

Devolution from Whitehall and Westminster is essential not only so that there can be greater local responsiveness but also to tackle health inequalities. People often, and rightly, consider access to high-quality healthcare as essential to good health. But individual life circumstances, such as where you were born, where you went to school, where you work - essentially where and how you live - play a greater part in determining health outcomes than healthcare itself. For instance, the Audit Commission has found that four more years of school (in total, up to age 25) on average correlate to a 16 percent reduction in mortality rates. These extra years are also associated with a reduced risk of heart disease, obesity, and diabetes.[4] Around 80% of the factors that cause ill health are not influenceable by the NHS.[5] As the Health and Social Care Secretary, Matt Hancock, has said:

"Our focus must shift from treating single acute illnesses to promoting the health of the whole individual. And from prevention across the population as a whole to targeted, predictive prevention."[6]

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[3] Department of Health and Social Care, 2018. 'Prevention is Better than Cure: Our vision to help you live well for longer'. P. 2, [online]. Available at: < assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf> Accessed 3 March 2020. p 2.

[4] Institute of Health Equity (IEH), 2014. 'Local action of health inequalities: Reducing the number of young people not in employment, education of training (NEET)'. *Public Health England*, [online]. Available at: <assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/356062/Review3_NEETs_health_inequalities.pdf> Accessed: 16 December 2019.

[5] McManners, J., 2018. 'Population Health Management: an opportunity to break the cycles of poor health'. *NHS England*, [online]. Available at: <www.england.nhs.uk/blog/population-health-management-an-opportunity-to-break-the-cycles-of-poor-health/> Accessed: 16 December 2019.

[6] Speech to the International Association of National Public Health Institutes, 5th November 2018.

This focus on population health, and devolution to respond to the particularities of the local population, has been made even more critical as a result of the coronavirus pandemic. The economic fallout of the pandemic will be severe and prolonged:

"The shock to the global economy from Covid-19 has been faster and more severe than the 2008 global financial crisis and even the Great Depression."[7]

And the economic fallout will bear down most savagely on the poorest and most vulnerable in our society. As Professor Chris Witty, the Chief Medical Officer in England and one of the leaders of the UK's response to the coronavirus has observed:

"Of course, anything that has an impact on the socioeconomic status, particularly of people who are more deprived, will have a long-term health impact."[8]

In order to better protect the poorest in our society, local health and care economies need to be empowered to deliver local answers to local needs. At the same time, as we will discuss below, robust and expert national platforms need to be put in place so that regions benefit from best practice which results from the economies of scale and scope that can only be enjoyed at a country-wide level.

Some devolution from Westminster and Whitehall has started in some areas, such as Greater Manchester, but the process needs to be enhanced, turbo-charged, and extended across the country. These powers need to extend beyond health and social care to include all of the drivers of a person's lifetime health and wellbeing: education, employment, housing and community activity.

It will take time, but firm plans need to be enacted with measured, but sustained, energy within the next couple of years. This is not a takeover of the NHS by local authorities, nor vice versa. Rather it is an uplifting vision that, over time, re-engineers the full range of services around the needs of patients and citizens.

In addition, there are reforms and initiatives that can improve health outcomes right now.

[7] https://www.theguardian.com/business/2020/mar/25/coronavirus-pandemic-has-delivered-the-fastest-deepest-economic-shock-in-history
[8] https://www.thetimes.co.uk/article/effect-on-the-poor-will-decide-when-lockdown-is-lifted-nhvclmqmv

Immediate actions that can improve health outcomes for the UK population

Devolution from the overly centralised English State will take time. However, there are five additional key innovations that can be implemented much more quickly, and that will help support the NHS in the short term.

Firstly, immediate progress can be made in integrating health and social care to prevent so many people, especially vulnerable frail elderly people, from falling dangerously between the ragged cracks of the two systems. This can be achieved quickly by moving the Adult and Child Social Care departments of Local Authorities into new, integrated health and care systems. It is important that social care is recognised, and managed, as a key part of the total health and care system. The Covid-19 crisis might help in making this a reality:

"Social care is not well understood by many, but it has always been a key part of the overall world of care and health. Now more than ever, it has a vital part to play in supporting whole communities in the fight against Covid-19 and keeping many different groups of vulnerable people safe."[9]

Integration of health and social care will save money by reducing the number of expensive and debilitating hospital stays that many vulnerable people currently endure. But more money is needed in the system.

The second imperative, then, is to combine health and social care funding into a ring-fenced pot of money serviced by a hypothecated tax. This tax should be made more progressive so that rich people pay more, with means testing being spread more fairly across health and social care. Abuse of the NHS, such as drunken assaults on staff or missed appointments, should be charged. More private investment can be attracted to supplement the taxpayers' investment by creating an NHS venture capital fund that commercialises clinical and scientific innovations that are currently squandered.

Thirdly, the current jumble and confusion of jurisdictions means that it is often difficult to find out who is 'in charge'. These need to be cleaned up so that empowered managers and clinicians have the authority to deliver better services and be held accountable for doing so.

There are too few clinician managers in the NHS, and too few well-trained managers generally. NHS operations are intricate and difficult to manage, yet at best there is no systematic management training, and, at worst, managers are decried and belittled as

[9] https://www.theguardian.com/society/2020/mar/20/care-workers-coronavirus-frontline

'overhead' and 'bureaucracy'. Managers, preferably with a clinical background, need to be schooled in advanced operational techniques, and the NHS should develop Medical MBAs in partnership with the best universities in the country. Part 2 of the full report describes some of the complexity of operational management in the NHS, drawing on examples from King's College Hospital in south east London, and explains how NHS operations generally can be better managed.

Finally, this greater support to frontline managers and clinicians requires that the National Bodies amend their remits, complementing devolution with national functions, such as management training (culminating in the Medical MBA), that spread best practice throughout the country. The main quality regulator, the Care Quality Commission (CQC) needs to reverse its policy of increasingly criminalising unintended clinical error. Instead it should support clinicians in learning from mistakes in the context of a 'just culture' that encourages clinicians to use inadvertent error as a means of improving patient safety. Technology development should be one of the national programmes that leverages pan-UK economies of scale, defining API[10] protocols, negotiating framework agreements with suppliers, sponsoring innovation, and so on. The aim is to create world-class national platforms which ensure that devolved localism does not result in isolated silos, but rather puts scale and consistency at the service of local delivery.

Corporate NHS[11] has too often been confused as to whether it is a regulator or a platform for national support of clinicians and managers at the coalface. It needs to become resolutely the latter.

The five imperatives (in addition to greater devolution) will have an immediate impact on patient outcomes. In the full report, the impact of this current dysfunction is illustrated using a case study about the UK's poor performance in cancer survival rates compared to most other European countries.

Improved operational management in the four key clinical domains

Operational management in the NHS is not good, and both efficiency in terms of higher costs and effectiveness in terms of patient outcomes are, as a consequence, compromised. Part 2 of the full report describes the operational measures, using real life clinical examples, that can improve performance in the near term. There are four major domains in the health and care system, and all of them are under increasing pressure and strain. Rapid progress on the

[10] API stands for Application Programming Interface. An API is a software intermediary that allows two applications to talk to each other.
[11] Corporate NHS comprises largely NHS England and NHS Improvement which are now merged.

impediments to change, especially more competent management with appropriately defined spans of control, will support improved operational performance in these four domains: community-based care; primary care; A&E and the Emergency Pathway; and in-hospital specialities.

Community-based Care

Community-based Care, mostly comprising care homes and care at home (domiciliary care), is in dire straits, with over 21,000 beds closing and many bankruptcies in the past few years. This is occurring at a time of increasing need due to the ageing population. More community-based beds are required, especially those that provide higher acuity, intermediate care. The private providers who operate in this sector need to become fully integrated into the NHS for the services that receive public money. Managers in hospitals responsible for discharging patients in a timely and safe way need to have control of out-of-hospital capacity and budgets. The CQC needs to extend its regulatory remit to cover the financial structure of private companies in the care home and home care sectors. Elaborate financial engineering by private equity firms has too often damaged the stability of this sector and needs to be controlled. More, and better trained, carers are required in the sector. In the full report a case study from the Netherlands describes the success that Buurtzorg has had in creating a more appropriate level of care in that country. As noted earlier, it is hoped that the UK generally, and the NHS specifically, will recognise, as a result of the coronavirus crisis, the crucial role played by social care in the health and wellbeing of the country. It was significant, and encouraging, that the Queen offered her thanks not only to the NHS, but also to care workers in her speeches during the crisis[12]. Such acknowledgement would have been unlikely even a couple of years ago.

Primary Care

Nine-minute appointments, currently the average consultation time, in an increasingly stretched Primary Care system are not good for patients and are highly frustrating for GPs. The service needs to move from being a reactive and acute one, to one in which GPs become responsible for coordinating the care of the most vulnerable in society: the frail elderly; patients with chronic diseases such as cancer and COPD;[13] and those with mental health conditions.

The transformation required in primary care is explained, in the full report, using the case of Bromley in south east London which has made encouraging progress in reshaping services

[12] https://www.plymouthherald.co.uk/news/uk-world-news/queens-coronavirus-speech-full-majesty-4022540
[13] Chronic Obstructive Pulmonary Disease.

around patient pathways. Bromley drew on the experience of primary care in Boston Massachusetts where a high-risk-care-management programme has been in place for the past decade. It is described in a case study in the full report.

Furthermore, GP practices need to be consolidated into polyclinics with 24/7/365 urgent care centres and advanced services and equipment, especially diagnostic capabilities, supported by digital technology. More satisfying, less stressed working practices will smooth the way to moving GPs away from being independent businesses to becoming fully employed members of a more coherently managed system. The need for GPs to be fully employed within the NHS, and managed as part of a cogent system, has been highlighted in the coronavirus crisis. GPs have played their valiant part in the crisis. But it has proved difficult for regional healthcare leaders to enlist GPs, who are effectively independent contractors, in a coordinated system-wide response to the crisis.

Information technology (IT) is key to making vital clinical information available throughout the patient journey. Many other countries, such as Singapore and Israel, are excellent examples to follow, and their application of IT in primary care is included as a case study in the full report. One silver lining to the coronavirus cloud would be to consolidate the behavioural changes that the crisis has prompted in the use of digital technology. One supplier of digital technology has noted how quickly in the Covid-19 crisis patients are moving from telephoning their GP clinic to accessing it online, and how many are also now prepared to have their consultation on the phone or online.

"One of the first changes we noticed was in how patients choose to contact their practice. In January 2020 about 32 to 35 per cent of all incoming requests arrived by telephone. This proportion started to drop early in March and is now around 23 per cent with the slack taken up online. We noticed an even bigger change in how patients wanted their practice to respond and in how GPs were choosing to respond to requests. In January around 31 per cent of patients requested a face to face appointment and roughly the same number got one.

But that preference started dropping mid-March and in the week starting 23 March it had fallen to only around 4 per cent….

….This is a huge and unprecedented change in behaviour in a short time. It has helped GPs to offer an even faster service, median completion times speeding up over 40 per cent, with an increase in patient satisfaction. We suggest it demonstrates the value of a total triage

approach to handling patient requests in primary care, as now advocated by NHSE for all practices."[14]

The need now is to consolidate these changes and ensure that people do not revert to the old ways.

A&E and the Emergency Pathway

Across the UK, A&E and Emergency Pathways are embattled as patients flood into hospitals. More beds in the community-based care sector, and better, proactive chronic disease management and polyclinics in primary care will help. But much of the problem lies with under-resourced, inadequate and outdated facilities designed for patient flows long since exceeded. Efficiency can be improved significantly with: better triage at the 'front door', involving greater use of Ambulatory Emergency Care; better clinician management within the A&E department; a 'whole hospital' perspective that more fittingly coordinates in-hospital specialities with the A&E department and moves patients as quickly as possible through, and then out of, the hospital. Examples from King's College Hospital are available in the full report.

Even with better in-hospital management and more out-of-hospital care, it is likely that the ageing population and the rise in acuity of lifestyle diseases will mean that more clinicians are required in the A&E department. However good are out-of-hospital urgent care centres and polyclinics, the increase in the population of the frail elderly – nearly all of them with complicated and interconnected comorbidities – will require more and better acute beds in hospitals. The UK has fewer acute beds than any other advanced European country. In addition, more ICU beds are required. The Covid-19 crisis has highlighted the chronic shortage of such beds in the UK: the UK has 6.6 per 100,0000 compared to Germany which has 29.2.[15] However, more acute beds in hospitals should go hand in glove with increasing bed capacity in the community which is a much safer solution for lower-acuity patients. Data from the A&E department at King's Denmark Hill, and a case study from the Netherlands, are used in the full report to illustrate both the challenges and the solutions to the problem of overwhelmed Emergency Departments.

[14] https://www.hsj.co.uk/technology-and-innovation/pandemic-leads-to-huge-change-in-patient-and-gp-behaviour/7027276.article
[15] https://www.aljazeera.com/indepth/opinion/welfare-cuts-left-uk-undefended-coronavirus-200312193147678.html

In-hospital specialities

In-hospital specialities – there are 23 at King's College Hospital – are where specialists in, for instance ophthalmology or kidney disease, work. Clinicians are hugely skilled and care deeply about their patients, but they feel too often that the system is failing them, and that unhelpful decisions are made 'from on high', without their expert input. They lament the increasingly chaotic environment in which they work. Service managers in hospitals are highly pressured and move on quickly, often leaving the NHS due to high levels of stress. The turnaround at King's coincided with an unusually helpful central initiative called Getting It Right First Time, driven by the distinguished orthopaedic surgeon, Professor Tim Briggs. This initiative was applied to the 'trauma and orthopaedics' (T&O) specialty at King's and served as an exemplar to demonstrate that positive change is possible if clinicians are supported in re-taking control of their clinical environment. A more detailed description is available in the full report.

Organising health and social care around manageable geographies

Jumbled authorities and responsibilities need to be cleaned up so that it is clear who is 'in charge' and accountable for performance. This builds from primary care networks covering about 50,000 people, to integrated health and social care units covering territories of about 350,000 people (as in Bromley). Depending on the particularities of specific geographies, these territories build to form Health and Care Systems of 2-5 million people. This size allows for the efficient organisation of specialised tertiary services, such as advanced haematology and neurosurgery services in the case of King's, as well as support services such as pathology and pharmacy. These reforms need to be implemented by clinicians and managers on-the-ground, and not imposed by the too-frequent top-down reorganisations. There is a danger that the current round of NHS reorganisations, and the proliferation of acronyms such as PCNs, ICPs, ICSs and STPs[16], will add to the confusion and muddle rather than launch much needed reform around patient welfare.

The 'accountability' reforms outlined here are required not only to provide better patient care, but also to protect bio-medical science in the UK. The early promise of Academic Health Science Centres – which bind world-class science universities, such as Imperial College and Cambridge University, with clinical practice – is fading as pressure builds on the NHS. Reform is required so that the UK can defend and extend its global excellence in, especially, the New Medicine and genetic science. In so doing, the country can become a pioneer in the

[16] Primary Care Network, Integrated Care Provider, Integrated Care System, Sustainability and Transformation Partnerships

increasingly important fields of Personalised and Precision Medicine, as described further in the full report.

Conclusion

The UK is blessed with highly committed and exceptionally well-trained, skilled clinicians and carers. Bio-medical science in our universities is world-class. Yet these scientists and clinicians struggle against a system that is often outdated, underinvested, poorly managed and often threadbare.

The issues discussed in this essay, and the urgent need to address them – made even more urgent as a result of the Covid-19 crisis - provide a 'call to arms' to restore the NHS to a position where it is, once again, the 'envy of the world'.

About the Authors

Two of the authors have extensive experience managing the front lines of health and social care. One of the authors recently worked in one of the most troubled hospital groups in the UK, King's College Hospital (King's), and this paper draws on his experiences there both to illustrate the problems the health and care system faces and to propose solutions to those difficulties. The third author has been a pioneer in advocating devolved place-based governance that finds local and institutional solutions to inequality and the wider determinants of health.

Ian Smith was Chair of King's, one of the largest National Health Service (NHS) Trusts in the country. He is a non-executive Director at the Ministry of Defence, an Operating Partner at the private equity group, Trilantic, and he advises, and is on the board of, three health and care start-ups.

Mr Smith was previously Chair of the Four Seasons Health Care Group, the UK's leading independent health and social care provider, with over 20,000 patients and residents across the country. He was also previously CEO of General Healthcare Group, which owned and operated nearly 70 hospitals (comprising a mixture of acute surgical facilities and psychiatric care) in the UK. During his time at General Healthcare he had a role in shaping the healthcare reforms introduced by the Tony Blair government. He published a book called *Building a World-Class National Health Service* in 2007.

During his career, Ian Smith has been a CEO of Royal Dutch/Shell Group businesses in the Middle East; CEO of Reed Elsevier, an information company; CEO of Taylor Woodrow, the house-building and construction company; CEO Europe for Exel, the logistics and transportation group; and CEO of Monitor Company Europe, a strategy consulting firm. At Monitor Company, he worked on concepts in competitive strategy, national competitiveness, and organisational behaviour with Harvard Business School Professors Michael Porter and Chris Argyris.

He has an MA from Oxford and an MBA from Harvard. He is currently an Adjunct Professor at the Imperial College Business School.

He served on the Parliamentary Review (the Hooper Review) of the Royal Mail that reported in December 2008, and in March 2010 he completed a Parliamentary Review (the Smith Review) on Civil Service relocation and regional strategy, which received full Cabinet approval from Gordon Brown's government. He worked with the Quartet on the Israeli/Palestinian peace process for three years, from 2010 to 2013. His contribution to this paper is solely in a personal capacity.

Professor Stephen K Smith (Dsc, FRCOG, FMedSci) is the Chair of East Kent NHS Hospital Trust. He is also involved in a number of early stage healthcare 'tech' enterprises. Previously, he was the Dean, Faculty of Medicine, Dentistry, and Health Sciences at the University of Melbourne and Chair Melbourne Health Academic Centre.

Prior to taking up the position of Dean, Professor Smith was Vice President (Research) at the Nanyang Technological University (NTU) in Singapore and was the Founding Dean of the Lee Kong Chian School of Medicine, a joint school between NTU and Imperial College, London from August 2010 to July 2012.

Professor Smith was the Principal of the Faculty of Medicine at Imperial College London from 2004 and has served as Chief Executive of Imperial College Healthcare NHS Trust since its inception, the largest such trust in the United Kingdom, with an annual turnover of £1 billion.

A gynaecologist by training, Professor Smith is active in research and has published over 230 papers on reproductive medicine and cancer. He was awarded his Doctor of Science in 2001 at Cambridge for work on the complex gene pathways that regulate the growth of blood vessels in reproductive tissue. In addition to his academic and clinical work, he is a Fellow of the Academy of Medical Sciences, the Royal College of Obstetricians and Gynaecologists, the New York Academy of Sciences, and the Royal Society of Arts.

Professor Smith led the creation of Imperial College Healthcare NHS Trust, the United Kingdom's first Academic Health Science Centre (AHSC). The trust was launched in October 2007 by the merger of Hammersmith Hospitals NHS Trust with St Mary's NHS Trust, and by its integration with Imperial College, London.

His pioneering role in establishing the AHSC was recognised in the NHS Leadership Awards, where he was named Innovator of the Year in 2009. The Health Service Journal listed Professor Smith in its 2009 rankings of the top 30 most powerful people in NHS management policy and practice in England, where he was the only NHS chief executive to be included. His contribution to this paper is solely in a personal capacity.

Phillip Blond is an internationally recognised political thinker and social and economic commentator. He founded ResPublica in 2009 and is an academic, journalist and author. Prior to entering politics and public policy, he was a senior lecturer in theology and philosophy, teaching at the Universities of Exeter and Cumbria. He is the author of *Red Tory* (Faber and Faber 2010), which sought to redefine the centre ground of British politics around the ideas of recovering social solidarity through civil association, mutual ownership and shared enterprise.

His ideas have strongly influenced the agenda around devolution and economic and social transformation and as part of his work on rebuilding social and economic mutuality have helped to redefine British and international politics. Phillip's work on devolution and public services extends back a decade, from *The Ownership State* in 2009 to reports such as *Devo 2.0 The Case for Counties* (2017), *Restoring Britain's City States: Devolution, public service reform and local economic growth* (2015),*The Missing Multipliers: Devolution to Britain's Key Cities* (2015), and perhaps most famously *Devo Max – Devo Manc: Place-based public services* (2014). These reports have driven policy change in, economic development, devolution and whole North approaches in the UK.

He has written extensively in the British and foreign press including *The Daily Telegraph, The Guardian*, *The Independent*, *The Sunday Express*, *The Observer*, the *Financial Times*, *Prospect*, *First Things*, *UnHerd*, the *New Statesman* and *The New York Times*. Phillip is a frequent broadcaster, appearing on the BBC and Sky as well as foreign media. Through both his writing and public speaking, he argues for a new economic and social politics that recognises the limits of the liberal policy ascendancy and gives us an alternative to a populism based on ethnicity or sectarianism.