The NHS at 75: A Reality Check and New Priorities

PAMPHLET

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The NHS' long anticipated workforce plan is finally here, but it won't be enough to reverse the health spiral of decline. This pamphlet outlines ways of trying to fix some of the NHS' problems, by proposing much more devolution of decision-making on services, both regionally and locally, and with a bigger focus on population health and prevention of ill health.

KEY POINTS

- A combination of circumstances – Brexit, COVID-19, austerity, and two reorganisations thrown in – created an existential threat to the NHS.
- Public satisfaction with the NHS and social care is at an all-time low, 29% and 14% respectively.
- The long-awaited Workforce Plan faces formidable challenges: currently there are 112,000 staff vacancies and is on a trajectory for this to grow to 360,000 by 2037.
- To survive another 75 years, and beyond, policymakers must radically reform the NHS to meet changed expectations and demographics, and reckon with the damage done over the past decade or so that has landed the NHS in its current mess.

RECOMMENDATIONS

- Radical change required to save the NHS includes: devolution of expanded community services; concentrating specialist services on fewer sites; more standalone surgical hubs and more diagnostic capacity in the community, and a robust plans for improving population health and prevention of ill health, with a new independent Office of Public Health.
- There are three big changes needed at the centre for the pursuit of the radical reform agenda:
    - **Reforming DHSC**: A more businesslike approach is required. If the business's delivery systems need changing – as they do – then DHSC top management should be capable of understanding how to do that
    - **Quangos and efficiency reviews**: The DHSC needs to have a more organised and transparent programme directed at improving efficiency and productivity

- **Workforce planning and delivery**: Treasury and DHSC negotiating a new longer-term system for NHS and social care remuneration with six key features.

INTRODUCTION

Approaching its 75th birthday, the NHS is bogged down in a quagmire. Its workforce is in turmoil over pay and working conditions. It has no credible plan for its workforce or how it might recover from the damage done in the last decade: austerity budgets, an expensive and failed reorganisation, Brexit and the COVID-19 pandemic. The public dissatisfaction with both the NHS and social care has now reached unprecedented levels. With high inflation, low economic growth and serious fiscal constraints there is little scope for any government to spend their way out of trouble. In any case, pumping large sums of money into the current under-performing NHS would be a questionable investment of taxpayer money.

This combination of circumstances represents an existential threat to the NHS, whatever its iconic status. In the UK there is a professional and political mindset that the NHS is bound to survive, no matter what. But in many other sectors and industries, technology and public preferences have changed rapidly; and organisations that couldn't adapt went to the wall. There is no Ark of the Covenant that says this couldn't happen to the NHS, whatever politicians may assert in a 2024 election campaign and some NHS staff may believe.

No economic forecaster is suggesting that whoever is in charge of the UK economy for the next Parliament will have much fiscal headroom to supply extra funding to the long queue of public services asking for it. Making the NHS a special case would have to be at the expense of other public services, unless the UK increases borrowing or raises taxes. Neither are attractive political or economic choices when improved services will take time to deliver.

Today's working age population, who largely fund the NHS, were born at least a quarter of a century after the NHS started. They are likely to have a lower level of emotional attachment to it in today's more questioning age. On its current performance they would be right to question its relevance to them, either now or in their own old age. Their patience is likely to wear thin. Those with resources can buy private care and are doing so now. There is plenty of investment money around to expand private healthcare, backed up by private insurance. Health professionals who feel exploited and poorly paid have plenty of opportunities to monetise their skills outside the NHS, either in the UK or abroad.

This pamphlet has been written to confront this challenging reality. The time for sugarcoating and wishful thinking has passed. The NHS and social care are in too bad a state for there to be any easy solutions or quick-fixes. It starts by outlining the damage done over the past decade or so that has landed the NHS in its current mess. The next section is about the public's levels of dissatisfaction and what they most want fixed. The third section is a reality check on the challenges a struggling NHS faces in an uncertain world, with no credible and affordable rebuilding plan. The final section outlines how we might start to rebuild the NHS and give it a chance of reaching its centenary. It examines cheaper and more effective ways of delivering services and replacing traditional centralisation with a more devolved NHS.

Just before publication, Prime Minister Rishi Sunak launched an NHS Long Term Workforce Plan on 30th June to increase the capacity to train more doctors, nurses and other NHS staff. The Government will provide £2.4 billion over five years to increase training capacity and change the skill mix in NHS staffing. This is a long-overdue initiative, as is made clear later in this pamphlet. But the plan faces formidable challenges, admitting as it does, that currently there are 112,000 staff vacances and is on a trajectory for this to grow to 360,000 by 2037. Given the time it takes to establish this new training capacity and the length of time it takes to train skilled staff, it is likely to be 2030 before the NHS sees large numbers of new staff in place.

In the meantime, the plan claims it will make strenuous efforts to improve the retention of NHS staff. However, it less than clear how this will be done when so many NHS staff are dissatisfied with their pay and working conditions. The plan seems to lean heavily on new ways of working, digitalisation and improved productivity to fill the staffing gap in the near future; these are not areas where the NHS has shown much enthusiasm in the past. Moreover, the new plan is silent on the shortage of social care staff on whom the NHS relies so much. As welcome as the NHS Long Term Workforce Plan is, it lacks the radical changes in service delivery and governance that this pamphlet suggests that the NHS needs.

A DECADE OF DAMAGE AND DECLINE: 2011 TO 2021

Before 2010 there had been a decade when NHS funding was increased to the EU average. Adult social care was funded in line with more generous eligibility criteria than now. Patient choice had been improved and there was more provider competition both within the NHS and with the private sector. A start had been made on providing more services outside hospitals. Performance management using targets had improved patient access to GPs, A&E and cancer services to a level far better than now. In 2007/8 the then NHS regulator, the Healthcare Commission, rated 60% of NHS trusts 'excellent' or 'good'[1]. From 2001 to 2010 public satisfaction with NHS increased from 38% to 70%.[2]

The Gordon Brown government was less keen on choice and competition but kept funding growing at around 3% a year. The financial crash of 2007/8 made some NHS belt-tightening inevitable. But the real shock to the system came in 2011/12 with George Osborne's austerity measures providing an annual increase for the NHS of only 0.3% in real terms.[3] This was the start of some very lean years for the NHS. According to the Health Foundation, the decade after 2009/10 was the lowest ever decade for NHS funding increases.[4] Inevitably this has restricted staff pay over a long period of time. In 2012, Danny Boyle tried to lift people's spirits with his Olympics extravaganza celebrating the NHS. With hindsight, this now looks like a colourful papering over of the NHS cracks.

During this decade the NHS had to learn a hard lesson. It could no longer assume that its iconic status would protect its funding, as had been done for much of its history. It was slow to improve productivity significantly or to develop new and cheaper ways of working. In some areas, like competition and patient choice, it went backwards. Helping the NHS to adapt to this real-world wake-up call was not helped by an ill-conceived NHS reorganisation.

In July 2010, the coalition government published its plans for what it called 'Liberating the NHS.'[5] In 2011, the government introduced the Health and Social Care Bill, said to be the most wide-ranging reforms of the NHS since 1948. The then NHS Chief Executive, David Nicholson described the reforms more colourfully as so big it was visible from space. All did not go well. The Bill was heavily criticised by the NHS and across the political spectrum. The prime minister stepped in and paused the Bill for a major review and amendment before it completed its parliamentary passage.

The Bill was finally passed in 2012 and most of the reforms were implemented in April 2013. These changes involved the creation of many new organisations. It dominated NHS work for three years and was said by opponents to have cost £3 billion that the cash-strapped NHS could ill afford. Just when the NHS needed to be focused on doing more for less and improving its productivity, its staff were absorbed in an unpopular reorganisation and changing jobs, with some staff leaving the NHS altogether. In less than a decade there would be another Act undoing much of the 2012 legislation.

Alongside these organisational distractions the NHS faced problems with the underfunding of adult social care. It relied on social care to stop patients going into acute hospitals unnecessarily and to transferring them home when fit to leave hospital. The system was also unfair to those who needed a lot of social care and had to pay for it by selling their homes. The coalition government set up the Dilnot Commission in 2010 to solve the fairness issue, but failed to give social care the funding needed to maintain services at 2010 levels. I was a member of the Dilnot Commission. It reported in 2011 with proposals for capping individual liability to pay for social care and for a more generous means-test.[6]

The Dilnot proposals commanded cross-party support and legislation to implement them was included in the 2012 Care Act, to come into effect in April 2015. The chancellor later twice delayed implementation of the Dilnot report. Less generous proposals were provided for in the 2022 Health and Care Act, with implementation scheduled for October 2023. But in his 2022 Autumn Statement the current Chancellor again delayed implementation. This time until October 2025, 14 years after these were first accepted.

The Commission also said that adult social care was under-funded, and that the NHS had been funded more generously.[7] The funding shortfall continued increasing, alongside the implementation delays. In 2018, a report by the Health Foundation and the King's Fund stated: "Restoring the system to 2009/10 levels and restoring the level of eligibility that existed at that time… would require an additional £8bn in 2020/21 above estimated plans."[8] In a March 2023 briefing the King's Fund stated: "Prior to Covid-19, government funding for LAs had fallen by 55per cent between 2010/11 and 2019/20, resulting in a 29 per cent real-terms reduction in spending power when combined with increases in council tax".[9]In January 2020, the then prime minister, Boris Johnson, promised to find a social care solution within a year. He told the BBC Breakfast programme that changes would be put before MPs in 2020 and enacted within that Parliament.[10] Unsurprisingly, this didn't happen. Some extra funding was made available as a result of COVID-19 and local authorities were allowed to raise council tax to pay for social care. But there is still no stable funding system for social care that would attract investors or staff. The current reality is shown in the King's Fund briefing already cited. The cost of care and demand continues to rise; eligibility has been reduced; carers receive less support; the workforce is in crisis; and public satisfaction is lower than ever before.[11]

This failure to fix social care has badly damaged the NHS, patients and the social care sector. Acute hospitals have become carers of last resort for many elderly and vulnerable adults who previously could access social care. This has increased NHS costs, demands on hospital staff and prevented more patients having care in their own homes. The impact of this failure was brought home with the COVID-19 pandemic for which the NHS was already ill-prepared.

The country will have to await the findings of the official inquiry into the handling of the pandemic being chaired by Baroness Hallett before there is a considered verdict. This will take several years. But we know already from the gov.uk Coronavirus Dashboard that over 220,000 deaths had COVID-19 on the death certificate. Office of National Statistics analysis in November 2022 estimated that 2.1 million people were living in private households experiencing self-reported long COVID symptoms continuing for more than four weeks.[12] Many of the over seven million people on the NHS backlog will have conditions that have worsened (some fatally) because treatment was delayed.

The pandemic continues to cast a long shadow over the NHS and social care. It exposed shortcomings in how unprepared the NHS was organisationally and in terms of equipment, ventilators and laboratory capacity. There was no contingency plan. The result was panic in central government with money wasted on inappropriate and expensive purchases, many of them never used. It exposed poor financial control in the NHS which has been noticed by the public (see next section). It also revealed how dependent the NHS was on social care when in the spring of 2020 there was a wholesale decanting of patients from swamped acute hospitals to care homes, with little notice or time for preparation.

The outcome from the pandemic would have been far worse without an impressive vaccine programme spearheaded by the private sector and facilitated by an alert independent medicines regulator, the Medicines and Healthcare products Regulatory Agency (MHRA). Hard-pressed local NHS and social care staff were left to pick up the pieces from the lack of preparation in central government. Prior to this they had their ranks depleted by another event, totally outside their control – Brexit.

Throughout the 2016 referendum campaign Brexit was presented, misleadingly, as financially advantageous to the NHS. Little mention was made of the NHS and social care staff who would return to EU countries. For example, the Nuffield Trust estimated that over 4,000 EU doctors left the UK as a result of Brexit.[13] Some of the increased immigration from outside the EU were employed in the NHS and social care; but the numbers are uncertain and visa requirements are more stringent than pre-Brexit. What is clear is that Brexit disrupted previous flows of staff from the EU; and it seems unlikely that the Brexit staffing shortfall has been made good by non-EU incomers.

This shortfall matters given the dependence on overseas staff in the NHS and social care. There are about 1.4 million staff employed in the NHS and of these about 220,000 are from overseas.[14] There are about 1.5 million staff working in adult social care and about 16% are from overseas.[15] This dependence is because we do not train sufficient staff in the UK and have no workforce plan for doing so.

This lack of forward planning has been drawn to the government's attention for many years. Back in 2017 a House of Lords Select Committee strongly criticised the government's failure to produce a long-term NHS and social care workforce plan.[16] It recommended a new independent body to do the job if the Department for Health and Social Care (DHSC) declined to do it. The government rejected the idea then and has only very recently published a long-term workforce plan.

This absence of workforce planning and reliance on overseas staff has created serious capacity problems in these two highly labour-intensive services: about two-thirds of the NHS budget goes on staff costs. The UK now has to tackle these capacity problems when skilled staff, like doctors, nurses, radiographers, physiotherapists and scientists are in high demand globally. There is now fierce competition with other high-income countries like the USA and Australia to secure and retain these highly skilled staff. Yet we are allowing students into our medical schools from competitors and have no credible plan for retaining new UK doctors we have trained at taxpayer expense. The consequences of this planning failure are discussed more fully in the final section.

These damaging events has left the NHS and adult social care systems in a parlous state at a time of low economic growth, fiscal stringency and rising demand. Staff are in turmoil about their pay and working conditions after a decade of austerity, Brexit and COVID-19. The public may have turned out on their doorsteps to bang saucepans in support of the NHS during the pandemic, but they are now expressing strong dissatisfaction with its current performance. Whoever is in government after the 2024 general election will have to address the public's serious concerns and halt the NHS' spiral of decline by rebuilding confidence and capacity.

A DISSATISFIED PUBLIC

It was the late Nigel Lawson, when chancellor, who described the NHS as the nearest thing the British had to a religion. Those believers are now much less enamoured with their national icon. This is revealed in the 2022 British Social Attitudes (BSA) survey. The latest survey shows that public satisfaction with both the NHS and social care is in sharp decline.[17] It found: "Overall satisfaction with the NHS fell to 29 per cent – a 7 percent point decrease from 2021…This is the lowest level of satisfaction recorded since the surveys began in 1983".[18] The survey report suggests that "there is a mountain to climb in recovering public satisfaction to its high of 70 percent in 2010".[19]

The BSA report also reveals which parts of the NHS cause greatest public concern: "Satisfaction with GP services fell to 35 per cent in 2022 This is the lowest level of satisfaction recorded since the survey began."[20] The main cause of this dissatisfaction was the long waiting times for GP appointments – identified by 69% of people. Only 18% of people said they did not have to wait long for an appointment. Meanwhile, "satisfaction with NHS dentistry fell to a record low of 27 percent." This level of dissatisfaction was higher than any other NHS service in the survey.

The hot spot in hospitals was A&E: "Satisfaction with A&E services dropped 8 percentage points to 30 per cent, also a record low. 40 percent of respondents said they were dissatisfied with A&E services, an 11-percentage point increase and a new record level of dissatisfaction. This is the largest change in dissatisfaction in a single year since the question on A&E services was first asked in 1999." Meanwhile, "satisfaction with inpatient services and outpatient services also fell to 35 percent and 45 percent respectively. Despite falling by 4 percentage points, outpatients remain the highest-rated service."

In many of these service areas there was a significant rise in dissatisfaction among those who had recently used a particular service: "In 2019, 70 percent of those who had used or had contact with general practice said they were satisfied compared to just 40 percent in 2021 and 38 per cent in 2022."[21]

There was a similar picture in A&E services: "In 2019 56 percent of those who had used or had contact with A&E services said they were satisfied, compared to 45 percent in 2021 and just 36 percent in 2022." The satisfaction levels of those who had been able to use inpatient and outpatient services were significantly higher than for GP and A&E services. But even here the satisfaction levels were not that great: 57% for inpatient services and 53% for outpatients.

The survey also drew attention to the fact that between the 2021 BSA survey and this survey's fieldwork period, "the waiting lists for planned care in England grew by a fifth to 7.1 million in September 2022, with similar lengthening waiting lists in Scotland and Wales."[22] People were also asked for their three top reasons for dissatisfaction. It is clear the main reason was long waiting times for GP and hospital appointments: this access problem was identified by 69% of people; 55% of people blamed staff shortages for their dissatisfaction; 24% blamed government reforms. That is not a vote of confidence in the 2012 or 2022 reorganisations.

The survey revealed some interesting views on funding the NHS and how it uses money. There is far from universal support for simply giving the NHS more money from general taxation. Although half the people in the survey said they were dissatisfied due to lack of government funding, 32% felt the NHS wasted money. When asked their preferred option for raising more money for the NHS, the "most popular option among respondents was that the NHS needs to live within its own budget (chosen by 28 per cent of respondents)." Although 43% opted for higher taxes, more than half these people wanted it to be a hypothecated tax for the NHS, not general taxation. There was only a small minority supporting some form of co-payments such as hotel costs in hospital, a £10 payment for GP or A&E visits.[23]

This survey also revealed that, whatever the current problems, there remains strong public support for the post-war Beveridge vision of an NHS free for all at a time of clinical need: "93 percent believed that the NHS should definitely or probably be free of charge when needed, with 75 percent saying definitely… 84 percent said that it should or probably be available to everyone, with 69 percent stating definitely."[24]

Taken together with public views on funding systems it is difficult to see much support for politicians moving away from a tax-funded NHS. However, there seem to be two important qualifications to that support. First a view is developing in the public's mind that the NHS should live within its budget. This suggests that those in charge should pay more attention to NHS efficiency and good financial management. Second, if taxes do have to go up to fund the NHS, then they should be hypothecated taxes rather than increases in general taxation. This would fall foul of longstanding Treasury doctrine. Ministers may have to consider who they upset – HM Treasury or voters.

The situation in social care was dire, with only 14% of respondents satisfied with social care. Dissatisfaction was high across all age and income groups, sexes and supporters of different political parties. The main reason for this dissatisfaction was "that people don't get the social care they need (64 per cent)." In support of this people said that pay, conditions and training of staff was inadequate and there was not enough support for unpaid carers.[25]

Using data from Skills for Care the report states: "For the first time since records began, the workforce has shrunk and the vacancy rate in the sector has reached a new high, with 165,000 vacancies in social care in England in 2021/22." Using data from the Association of Directors of Adult Social Services, the report goes on to say: "From April to June 2022… an estimated 1.1 million hours of home care (2.5%) could not be delivered due to workforce shortages. In addition, waiting lists are long: in August 2022

an estimated 245,800 adults in England were waiting for an assessment of their needs, with 33% of people waiting over six months."[26]

With this level of public dissatisfaction, it is extraordinary that social care's shortcomings have not been fixed. Since 2010 there have been five governments, an independent report commanding cross-party support and the opportunity to do so provided by three Acts of Parliament (the Acts of 2012 and 2022 already mentioned and the Care Act of 2014). It seems an act of gratuitous political vandalism not to fix the problem and so reduce the pressure on the NHS. After this history it is crystal clear that any tackling of the NHS' problems must be accompanied by measures to put the funding and workforce of adult social care on a stable, fair and sustainable footing.

This latest BSA report demonstrates that public satisfaction with both the NHS and social care has descended to unprecedented low levels, 29% and 14% respectively. Public support remains strong for the NHS being available to all and free at the point of clinical need. But support is less wholehearted than previously. Nearly a third of people think NHS wastes money and 28% wanted the NHS to be required to live within its budget. A tax-funded NHS is still the preferred option for most people, but there seems growing support for that to be a hypothecated tax. The public's priorities for improvement are clear: speedier access and reducing the backlog. Clearly these are priorities for action politically; but tackling these priorities on their own won't make the NHS resilient enough for the future.

Ministers and their civil servants now have to find answers to three difficult questions. Can the NHS be improved fast enough to restore public confidence and prevent a significant drift to alternative providers? Can they train, recruit and retain staff in sufficient numbers fast enough to prevent further NHS decline? Can they make the necessary changes in an economically and fiscally challenged world where money will be in short supply, whoever is in government?

This is a challenging agenda for any government. And those who think a left of centre government would throw more money at the problems should read a recent interview with the Labour Shadow Chancellor: "We've said we want to get debt down as a share of GDP… It's getting close to 100 per cent and I want to get that on a downward trajectory. We will cover day-to-day spending through tax receipts, and that is the fiscally responsible thing to do, then, subject to that, we will invest."[27]

A STRUGGLING NHS IN AN UNCERTAIN WORLD

There is much chatter in policy-wonk world and among some politicians about the need for radical NHS reform. In March 2022 former health secretary, Sajid Javid, said patients face ever longer waits for treatment without radical NHS reform because finances are unsustainable.[28] As already indicated, the public is going off just pumping more money into the NHS. What is little discussed is how difficult it is to build a New Jerusalem in the UK's current situation. In the rush to promote new ideas, too little attention is being paid to how to engineer change with little money, disgruntled staff in short supply, little consensus on priorities and no Beveridge around with a plan. The constraints are formidable. We need to remember the Rolling Stones are still singing: "You can't always get what you want."

Major change usually requires extra investment; but the state of the UK's economy makes extra money scarce. The IMF considers that the UK remains the worst performing leading economy in the world this year with 0.3% growth in GDP and is unlikely to be growing at more than 1% next year.[28] These depressing forecasts are shared by the OBR and the Bank of England. Inflation shows no signs of returning to the historical lows of the recent past. These financial realities make it difficult to both increase capacity and to reduce NHS staffing turmoil with a credible plan for improving staff pay, recruitment and retention.

Much of this turmoil has its roots in the lengthy period of public sector pay restraint since 2010. If we want NHS staff to work differently and more productively it will be a hard sell without improving staff pay and service conditions significantly. Staff holding grievances and distrusting their employers are less likely to be up for the new ways of working that the NHS requires. For example, the NHS may need to become an organisation with a smaller but better paid workforce; and with some current functions outsourced or done more cheaply if that provides better value for money. Some NHS services in some places may need a haircut.

Alongside continuing workforce issues, there is another winter to survive, another pay round to navigate and the inevitability of a general election within a year. That election campaign will have the future of the NHS as a major issue. New workforce challenges won't stop simply because the UK is having an election. Sheer burnout could cause staff to leave the NHS. Overseas workers could shift their allegiance to other wealthy countries offering better terms than the UK, especially if immigration rules are tightened. Equally worrying is the active recruiting of UK trained doctors and nurses by countries like the USA and Australia with attractive pay and lifestyle options. Indeed, the latter are overhauling their migration policies to target professionals from Britain and other countries.[29]

The current reality is that fixing the NHS and social care in a single Parliament cannot be done. Some politicians now recognise that a 10-year recovery plan may be needed. The big question is, will the public accept this and wait patiently for this to be done? Although the BSA survey shows people still strongly supporting a tax-funded NHS, their support seems unlikely to be endlessly elastic. The current evidence on reduced capacity and longer waiting time is not encouraging.

GP services are deteriorating rapidly. A survey by the trade magazine, Pulse, quoted in the Times in August 2022 showed that 474 GP surgeries had closed since 2013 and patients had to travel further to see a GP.[30] Around the same time, a Royal College of GPs poll showed that 42% of GPs intended to quit or retire in the next five years; and that GP numbers were the lowest since 2015. The Royal College's Chairman was quoted as saying GP care "will go the way of dentistry."[31]

The waiting list backlog is even more daunting. The official NHS backlog has stayed stubbornly around seven million. The April 2023 NHS data shows the hospital waiting list reaching a record high of 7.4 million.[32] In March 2023 the National Audit Office (NAO) said in a report that NHS England would not reach its recovery targets for reducing cancer and elective surgery waits.[33] The report was particularly concerned about the lack of progress in meeting the target for cancer patients to be seen by a specialist on GP referral. A report by the Institute of Fiscal Studies around the same time echoed these concerns. It concluded that: "The more fundamental challenge is that the NHS has so far struggled to increase the number of people it is treating from the waiting list each month. As a result, the overall size of the waiting list has continued to grow."[34]

It seems improbable that the public will wait patiently for five to ten years, or more, for the NHS to get round to reforming itself. At the very least it will expect to see much faster progress on improving the key services that matter most to them: GPs, A&E, access to cancer specialists, and elective surgery. It will also expect to see big improvements in social care where the failure to invest looks like an NHS own goal. If improvements in these areas do not start to happen at pace and scale, no politician – of whatever stripe – should be surprised if the public looks outside the NHS for treatment and care.

This has already started to happen, despite cost-of-living problems. If this change happens at scale, it will divert scarce doctors, nurses and other staff from NHS work and only increase the demand for higher NHS pay. We live in a democracy. There is nothing to stop people spending their money on non-NHS treatment and care if the NHS is failing to meet their needs. There is nothing to prevent new service providers entering the health and care market to meet changing public preferences, providing they meet regulatory requirements. The road to a two-tier NHS looks well and truly open, with parts of the population moving away from the NHS for some services where the NHS is performing badly.

Those in the NHS who believe that, whatever happens, people will stick with the NHS should reflect on what has happened in other sectors. If new service providers offered better options than existing providers, people changed their behaviour. There is nothing so sacred about non-emergency health and care to suggest people will stick with a poorly performing NHS if there are affordable alternatives. It has already happened with dentistry, optical services, audiology, physiotherapy, and elective surgery. It is starting to happen with GP and diagnostic services, as well as specialist consultations. People will change their spending priorities to relieve pain. They can buy health insurance or max their credit cards to ease financial pain.

The NHS provider landscape is itself changing without government involvement or possibly even awareness. A recent report by Laing and Buisson featured by the Times Health Commission suggests that 1 in 20 GP surgeries are now owned by chains.[35] The largest chain is owned by the UK arm of a large US healthcare insurance company who consider that patients should give up on the idea of family doctors. If GPs, who are independent contractors, wish to sell their practices to a large company for a capital sum, they can do so and later obtain their NHS pension. It also looks as though a new generation of GPs may be more interested in working part-time on a salaried basis than taking on the job of running a GP practice as an independent contractor. The 1948 GP model is living on borrowed time.

Many NHS consultants are part-time and have the right – guaranteed by Nye Bevan – to practice private medicine. If they choose to expand their private work and reduce their NHS work, there is little the NHS can do about it, other than boost NHS pay significantly. If the private facilities have better diagnostic and administration capability, then doctors have every professional incentive to shift the balance between their NHS and private work. This capacity to supplement NHS salaries favours particular specialties and over time may well affect the specialties that doctors choose when they qualify. This, in turn, could well create more NHS shortage specialties as has already happened in maternity, paediatrics and psychiatry.

The more the pay of NHS doctors looks uncompetitive internationally, the greater the incentive to shift to more private work or even leave the UK altogether. In this complex medical workforce market, simply expanding medical school places does not guarantee more NHS doctors. It could, without some conditionality on future employment, simply improve the pipeline to overseas and private practice. This outcome would be massive waste of taxpayers' money.

Many NHS trusts are already having to using recruitment agencies to fill posts. According to the Times the NHS paid these agencies £3 billion in 2021 for recruiting staff.[36] These staff were usually paid at higher rates than NHS employees. It looks as though they are more concerned with their current earnings and control over their working arrangements than they are with the deferred gratification of a future NHS pension. In these circumstances it doesn't look as though the present system for centrally negotiating pay and conditions of service is fit for purpose, however much the Treasury prefers it for control reasons. A more responsive local labour market approach may well be necessary: see next section.

In this world of uncontrolled health and care change, NHS management – political and professional – is struggling to impose the old order and secure service improvement. This was brought out in a report by the National Audit Office in November 2022.[37] This said that declining productivity in the NHS is putting plans to tackle long waits for treatment and cancer care at serious risk. The NAO said NHS productivity had fallen by 16% since the pandemic; and criticised a "reduced management focus by NHS trusts and NHS England on cost control and operational rigour." If the NHS is to achieve long-term sustainability it has to improve significantly and at pace its productivity and its management of costs and performance. These were areas the NHS was struggling with even before the pandemic.

In summary, the NHS is now operating in conditions of great uncertainty about its future in the minds of staff and the public. For over a decade there has been a continuous decline in the capacity of the NHS and social care to meet the demands on those services. The UK now faces a period of economic and fiscal stringency that make it difficult to see how its health and care system can be rebuilt in anything like its current form. Other public services also need refurbishment and face serious workforce challenges so governments cannot just focus on the NHS. Whoever is in government after 2024 will find it extremely difficult to increase health and care capacity and to reform delivery systems, particularly without an affordable workforce plan that meets the needs of a reformed system rather than the current one.

Matters have been made worse for the NHS by the scandalous failure to repair an adult social care system too reliant on unpredictable periodical financial handouts. Nothing much will change for publicly-funded social care until higher pay for staff is guaranteed and budgets are maintained at higher levels. No solution is in sight. What has popped up recently is renewed interest in a National Care Service (NCS) and free social care. The affordability of such a change remains in doubt, as does the desirability of centralising another bit of the health and care system when greater devolution looks a better bet – see next section.

The present government's extra funding and recovery plan for the NHS should improve emergency services and access to primary care to some extent, although the NAO remains doubtful over progress. Improvement in all service areas is highly dependent on workforce capacity and its funding. Recruiting and retaining staff remains a major problem for both the NHS and social care. As a new pay round approaches there remains bad blood from the past and some disputes still unresolved. The absence of a credible and affordable workforce force plan for both the NHS and social care presents a formidable challenge to those trying to manage services or change their delivery. Matters are not helped by the poor condition of many NHS buildings that too often suggests the NHS as a bad employer. It remains doubtful if improvement will happen fast enough to stop more people moving to private treatment.

The UK now has a health and care system that looks increasingly as though it is unaffordable, undeliverable and ineffective. The absence of a credible repair plan creates a political and managerial void that both staff and public can reasonably expect to be filled at some point, with a realistic picture of a future health and care system. In developing ideas for rebuilding that system, it would be worth having regard to a recent article by William Hague in the Times with the heading "New mindset needed for this age of disruption."[38] It argued that in tackling current economic and political problems, we needed foresight, not hindsight. – in other words, 2020s vision, not 1940s. The article concluded "As old models collapse, across many walks of life, we will need more than new models, [we will need] a new mindset." Rebuilding the NHS requires us to figure out how we should do things differently.

REBUILDING HEALTH AND CARE: WHAT'S THE PLAN AND WHO'S IN CHARGE?

Applying a new mindset involves asking some fundamental questions. For example, why have we never delivered the Beveridge vision of an NHS embracing both prevention and treatment? Have we worshipped too much at the shrine of medical science and medicalised too many social problems? Why have we stuck with the idea of delivering so much treatment and care through the most expensive part of the system – the acute hospital? Why do we obsess so much over the privatisation of service delivery when other countries use a multiplicity of providers – public, private and voluntary? Do we really need to control so much service delivery from the centre? Have we been too trusting and asked too few questions about NHS performance and productivity? Probing these questions will be challenging for some staff but even more so for those currently in charge at the centre.

Excessive central command and control

The NAO has repeatedly raised doubts about NHS productivity, efficiency and financial management. This in turn puts a big question mark over the effectiveness of the current command and control system at the centre. If they have this control, why can't they make the NHS more businesslike? Over the years, the centre has repeatedly considered that NHS problems could be traced to faults in NHS organisation. That has led to expensive and disruptive top-down re-organisations producing little beneficial change. After so many of these – two in the last decade – perhaps we should call into question whether the problems are more to do with an excess of central control itself.

Nye Bevan famously said that "the sound of a dropped bedpan in Tredegar should reverberate around the Palace of Westminster." Seventy-five years on, national accountability for these dropped bedpans still looms large in the way the NHS is run. Since then, we have been obsessed with the 'N' in NHS and pre-occupied with avoiding a so-called postcode lottery of services geographically. This overlooks that it is perfectly possible to have a universal entitlement to a national service without guaranteeing that every service can be made available locally. That is because there isn't the staff, money or expertise to provide a service everywhere. What it is possible to guarantee is entitlement to an NHS service somewhere, although it may require some people travelling further to get it. As some healthcare becomes more complex and expensive more people may well have to travel further anyway to secure their entitlement.

The 'N' in NHS and fears of a postcode lottery are not good arguments for maintaining our excessive London-centric control of England's NHS. Scotland and Wales now run their own NHS without civilisation ending. (Northern Ireland is more complicated, as ever). The time has come to devolve more health and care decision-making in England and to focus it much more on population health. We have not done a good job on preventing ill-health and now is the time to try to do better by 'going local' and giving communities more focus and power to prevent ill health.

Whatever the merits of the 'dropped bedpan' approach in the 1940s it is no longer realistic anyway for the 2020s. Elected ministers are often birds of passage and poorly prepared to exercise detailed control of a behemoth like the NHS. They rely heavily on the advice of their senior civil servants who are themselves more noted for their policy capability than their management experience or acumen. Despite the limitations of central control, ministers still insist on taking considerable powers of direction of local affairs in new legislation.

This approach has given a clear signal to the NHS that the centre doesn't really trust local people to run their local services without a lot of direction from the centre. That in turn causes local management to be very preoccupied with keeping the centre quiet rather than running local services in ways that best meets the needs of their local populations. This centralised system has given a great deal of prominence to the affairs of acute hospitals and their finances and problems. Acute hospital personnel have become the big beasts in the English NHS jungle. Under this centralised system the acute hospitals have secured lots of political attention and, some would say, a disproportionate share of NHS resources. Services outside hospital have, in most areas, been relatively neglected, the consequences of which we are seeing now with GPs, community health services, and social care.

Given the current crisis, the time has come to consider seriously moving away from so much central control and devolving many more operational decisions to regional and local bodies. This would leave the centre controlling fewer, important strategic features of running the NHS. This doesn't mean giving the NHS carte blanche or losing financial control. First is a description of what a more devolved and reshaped NHS would look like, with financial and operational responsibility for expanded community services. Under a more devolved regime, a rebooting of the DHSC would be required as described later.

Devolution of expanded community services

There are four main issues to be resolved with an NHS devolution strategy: how many devolution units or regions to have; what service responsibilities are delegated; how budgets are settled; and the governance and accountability roles of the centre and regions.

Until the 2013 NHS reorganisation there were nine strategic health authorities (SHAs) covering the same areas as the former government regional offices. SHAs were abolished in 2013 but NHS England found it had to reinvent some regional presence and they now have seven regional teams. There is a case both for sticking with the seven NHSE regions or going back to the nine SHA regions. This is largely a matter of political preference. London would be the largest, with an unavoidably large number of teaching and research hospitals. It is bigger than the three devolved administrations combined, each of whom run their own NHS. The populations of any configuration of other regions would be bigger than Wales and Northern Ireland, but only London bigger than Scotland.

Setting up regions only makes sense if they are given big responsibilities independent of Whitehall. They need to be able to run services in a way more suited to the health needs of their populations rather than according to a London-imposed template. They should be given the freedom to rectify the neglect of primary care, community services and public health with a larger budget than now. The aim would be for a political decision to be made at the outset on the percentage of the NHS budget to be provided for acute hospitals and that for community service, with a separate percentage for public health (see below).

The devolved service areas would be primary care (including GPs), community health services, local hospitals (without A&E departments), all mental health services, maternity services and population health (including all public health and prevention services). The purpose would be to increase the services delivered in the community and reduce the use of expensive acute hospital services, with their high overheads and costly maintenance.

These new organisations should assume responsibility for distributing any central grant funding for social care which would remain means-tested and administered by local authorities. They would be free to enhance funding of social care in their areas if this was in the best interests of their populations. Their aim would be to continue to improve the integration of health and social care for patients using existing local structures.

Budgets for these services would be set for each region by the Health Secretary and should be based on a weighted per capita formula that reflected health inequalities. Calculating the initial budgets might benefit from advice from an independent body such as the Audit Commission. The starting point could be existing budgets for transferred services and staffing complements, plus an inflation-proofing for devolved budgets for five years, an enhanced social care budget and additional funding for public health. The regions would have a share of the NHS capital budget and takeover any surplus land or building to refurbish their plant (including GP premises). Regional budgets should be ring-fenced and only reduced by regulations approved by Parliament so that informal funding transfers could not be made to overspending acute hospitals – as has happened in the past.

Below the level of the region there would be no immediate re-organisation with ICSs receiving their budgets from the new regional bodies. Over time it would be open to regions to reshape their local organisations to improve efficiency and generate savings, after consultation with the Health Secretary. Each region would have a governing body (no larger than 15) appointed by the Health Secretary after public advertisement and from people living in the region. The Board would be accountable for the governance of the region and produce an annual report on its performance. Two additional members selected by local authorities in the region should be added to the Board with full voting rights and with responsibility for all social care matters. It would be open to the Heath Secretary to give each Region two or three national priorities each year.

Devolution on this scale would have significant implications for acute hospitals, services to be managed centrally and the roles of the Department of Health and Social Care (DHSC) and NHS England (NHSE). There is also the matter of elective surgery, diagnostic hubs and private sector contracts. First acute hospitals.

Concentrating specialist services on fewer sites

Delivering more NHS services in the community has major implications for acute hospitals, as does elective surgery and diagnostic hubs (see next section). It would force consideration of how many specialist service hospital sites (not necessarily how many beds) were needed. This issue has long been a source of political controversy and a major stumbling block to change. If services are removed at scale from some NHS trusts running acute hospitals, they may well become unviable because of the loss of income. Saving local hospitals can then become a potent political issue at elections, even though changes in service delivery might well lead to both clinical and cost improvements. The scope for local controversy is why a national programme is required to reduce the number of sites for specialist services at scale.

The case for concentrating specialist services on fewer hospital sites rests on improving the quality of clinical care through using expensive and scarce skills and equipment more efficiently and improving outcomes for patients. Many of the headline-grabbing cases of serious NHS failure have suggested some hospitals and their clinicians are out of their professional depths. People have died because they probably shouldn't have been in a particular hospital at the time they were. The 1990s Bristol children's hospital scandal is an extreme example of this. Letting the convenience of a local hospital and its staff trump patient safety is a risky business, however politically attractive it may seem in the short term.

Taking the unpopular decision to concentrate specialist services on fewer sites can have good patient and financial outcomes. This was demonstrated in London when specialist stroke services were concentrated in 8 centres instead of the previous 32. This saved an estimated 400 lives within two years and £800 per patient because they recovered quicker. If the London scheme was applied nationally, it was thought to save about 2000 lives a year.[39]

England has about 200 acute hospitals running a full range of specialist services, but we lack an independent and authoritative clinical appraisal of the patient and cost benefits of concentrating these services on fewer sites. When Professor Lord (Ara) Darzi was a health minister, he wanted to see this approach adopted more widely but little has changed. At this time of crisis, we need to return to this issue and rigorously assess the benefits to patients and taxpayers of greater concentration of specialist services on fewer sites.

This is probably the most politically controversial proposal in this pamphlet. Past attempts at service transfers have usually been slow and strongly opposed – often by local clinicians with a vested interest. At the end of lengthy and expensive processes there has often been a failure of political will at the centre. History strongly suggests that if consolidation is to happen at scale and pace, three conditions need to be met: (a) a time-limited and standardised process by specialty across the country, including public consultation; (b) the process to be managed by a nationally credible group of clinicians for each specialty; and (c) elected politicians not making the final decisions on individual hospitals.

There would need to be a designated independent person responsible for starting and managing the specialty change process including the order in which specialties were tackled. A national process for consolidation would be needed that avoided endless unresolved disputes. This could be a two-tier process agreed by the Health Secretary after public and parliamentary consultation on the specialties to be included. The process might even be incorporated in regulations. After that, matters should take their course under this two-tiered process – first clinical and then judicial. The clinical part should be under the umbrella of the Academy of Medical Royal Colleges who might be asked to nominate small panels of experts of national standing for each specialty to be included in the exercise.

There is then the matter of who makes the final decision on specialty consolidations. Historically this would have been the Health Secretary, but I doubt this would be met with public approval in this sceptical age. Weighing up evidence and making decisions is what judges do for a living, often with advice from experts. The Ministry of Justice could be asked to nominate a panel of judges willing to adjudicate in this area after training. All these participants – clinical experts and judges - should be paid for their services.

This is a brief sketch of a new system for determining the consolidation of specialist health services on fewer sites. It needs elaboration if there is the political will to move along this path. For success, elected politicians have to be willing to remove themselves from the final decision-making process. Alongside this change we need a better national plan for elective surgery and diagnostics.

Elective surgery hubs and community diagnostics

There has been a long-standing problem with linking access to diagnostic services and elective surgery so closely to acute hospitals, apart from higher overhead costs. This is because an acute hospital's diagnostic and surgical capacity tends to give preference to emergency cases rather than planned surgery, particularly in winter. Until recently the expectation was that after winter pressures abated, hospitals could catch up on the backlog of planned surgery. The continuation of 'winter pressures' throughout the year plus COVID-19 has exposed the flaws in this NHS approach. The case for standalone surgical hubs and more diagnostic capacity in the community has increased and is consistent with concentrating inpatient services on fewer acute hospital sites.

The Blair government began a process of separating NHS planned surgery from acute hospitals. It contracted with the private sector to build and run new, purpose-built elective surgery centres (ISTCs). These provided NHS operations at NHS tariff prices and were staffed without recruiting NHS staff. All the private sector required was a guaranteed seven-year contract to enable them to build the facility. Alongside this change, the private sector also provided much needed extra diagnostic capacity at contract prices. This use of the independent sector was fiercely opposed by the NHS, despite being little more than 10% of NHS capacity. ISTCs were rated by the Chief Medical Officer as being of at least equal quality to NHS services; and were popular with patients. Unfortunately, the Brown government killed off ISTCs.

NHS surgeons are now making their own case for surgical hubs, not necessarily standalone hubs. In May 2021, the Royal College of Surgeons (RCS) called on the government to create 'surgical hubs' across the country to reduce the large backlog of elective surgery.[40] They revealed that during the pandemic surgical activity levels reduced at more than four times the rate we see in a typical winter.[41] Even before the pandemic, the NHS was not catching up planned surgery postponed in the winter. The RCS returned to the subject of hubs in July 2022 with a new report on 'The Case for Surgical Hubs'.[42]

This report revealed that in the first 12 months of the pandemic, levels of orthopaedic surgery were 59% lower than normal. Surgical activity in the three other largest surgical specialties – general surgery, ENT and urology – reductions were down by 41%, 58% and 40% respectively. It also repeated the RCS advice about using three types of hubs: standalone, hubs within hospitals, and specialist surgical hubs. It also made the point that if surgical hubs were to succeed, they had to have "protected, ring-fenced resource, if they are to have a chance to prove their worth.[43]

The government responded to this advice in August 2022 with an announcement on new surgical hubs.[44] This named 91 existing surgical hubs, but virtually all these were existing hospital units. There was no suggestion that any of these hubs had separate ring-fenced budgets, although it was suggested that beds in these hubs would be ring-fenced for planned surgery. The government promised that over 50 new hubs would open across England to tackle the backlog but only "20 new or expanded hubs" were confirmed. The government was promising "more than 140 hubs will be open across England by 2024 to 2025." It is not clear how many will be standalone or have ring-fenced money separate from the acute hospitals within which they are located. This approach to surgical hubs seems very different from what the RCS was proposing or the Blair government standalone model.

In the August 2022 announcement, the government also stated that "the NHS is changing the way diagnostic services are delivered by opening over 90 community diagnostic community centres across the country in locations such as football stadiums and shopping centres. They have already delivered over 1.6 million checks, tests and scans, offering patients a range of healthcare services closer to home. By 2025 up to 160 will be up and running."

These changes do represent a move in the right direction for planned surgery and community diagnostics; but they still have to be delivered and be shown to have changed NHS acute hospital behaviour. The failure to ringfence the extra funding for elective surgery, as the RCS proposed, is not a good omen. It will be all too easy for the new money to be used to prop up inefficient acute hospitals if elective surgery budgets are not separated. More standalone surgical hubs with separate budgets and management would be a better approach, as would more competition from the private sector and an assertive promotion of choice. There is little evidence that patients are being encouraged to travel to any surgical or diagnostic hub, not just their local hospital.

It remains to be seen if these new hubs protect emergency surgery during winter pressures; or if the new community diagnostics really lead to more community-based diagnosis and treatment for patients. What is needed now are some performance measures and independent audit to show that the NHS has really changed direction on elective surgery and community diagnostics. So far, there is little evidence that these measures have impacted the waiting lists backlog significantly. None of these changes however help much with the major problem of uncontrolled demand.

Strengthening public health and prevention

When Beveridge produced his report in 1942,[45] his vision for a post-war welfare state was that Britain needed "a national health service for prevention and comprehensive treatment available to all members of the community." In other words, he placed prevention alongside treatment in defining the role of the new NHS. In 75 years, under governments of all political persuasions, that parity has never been close to achievement. It has now been largely abandoned, despite a much greater need for it. The NHS is effectively an ill-health service with little direct influence over policies affecting the nation's health. Demand for its services is virtually outside its control. Today public health is a Cinderella service at both central and local levels, with no-one really responsible for driving change or with the budget to do so.

Before 1948, each local authority had a Medical Officer of Health (MoH) responsible for its population's health. At the national level, the then Ministry of Health had a Chief Medical Officer (CMO). Both published annual reports on the state of public health and could advise on changes. Local MoHs were abolished with the arrival of the NHS. The CMO has continued to report on the nation's health but has no budget or powers to do much about what is in his or her report. When NHS England was established a decade ago, it appointed a Chief Medical Officer but neither he nor NHSE can take direct action on public health.

At local authority level, there is now both a Director of Environmental Health and a Director of Public Health. They are not usually chief officers and have to compete locally for their budgets. There is some central funding for public health, but it is not a ringfenced grant and this funding has barely kept pace with inflation over the past decade or so. The CMO at DHSC can only give advice to ministers who are free to ignore it – and do.

There is no credible machinery for driving a public health agenda that would reduce demands on the NHS. Every few years governments lumber into action and produce a public health White Paper after tortuous negotiations with Whitehall departments and interest groups like the food and drinks industry, supermarkets and the advertising world. These interests are past masters of pressurising prime ministers to dilute proposed changes, as was the case with a May government white paper. Even now a commitment to curb the advertising of junk food is being delayed. Unless this ramshackle system is overhauled, obesity and other bad UK lifestyle choices will overwhelm the NHS.

The NHS is now grappling with an obesity epidemic and the resulting increased prevalence of circulatory diseases, cancer and diabetes. Obesity continues to increase among children and young people, as well as the working age population. Alcohol-related deaths have virtually doubled in the last 30 years, with excessive drinking rising fast among women. Despite efforts to deter people from smoking it still accounts for about a third of all cancers. A substantial proportion of the adult population fail to achieve the recommended physical activity levels of 30 minutes of moderate intensity five times a week. Mental illness and stress-related conditions remain a highly common cause of work sickness absences.

The NHS has failed to narrow the life expectancy gap between the most deprived areas and the population as a whole. In London, the seven tube stops eastwards on the Jubilee Line between Westminster and Canning Town, were found to have a seven-year difference in longevity.[46] More recently, the ONS has found that longevity in England and Wales has actually reduced.[47]

These changes in demography and disease profiles have driven up NHS demand when both funding and staff are in short supply. The disease profile, especially obesity, will continue to worsen with no improvement in funding and staffing in prospect. The only weak ray of sunshine is a pill to restrict appetite and, possibly, slow down the obesity epidemic. With the NHS in crisis and unable to control demand, it is forced to ration access to services, thereby increasing public dissatisfaction. That rationing is bound to bite hardest in the areas with the worst health inequalities. The NHS will continue to be swamped by the UK's demographic and disease profile unless a more effective public health and prevention strategy – not itself a high-cost item – is put in place nationally and locally.

Any new public health and prevention strategy would need to be signed off by government but with its own funding. Its operational independence needs to be strong enough to stand up to commercial lobbying. This means a scheme with statutory safeguards and a stronger role for Parliament. The governance of policy advice (including on legislation) and the distribution, nationally and locally, of resources for public health should be placed in the hands of a new independent public body, the Office of Public Health (OPH).

This body should be established by legislation that was renewable every 10 years and answerable to Parliament. Its membership should be prescribed in legislation, possibly within a limit of 10-12 members. The government's CMO and Chief Scientific Officer should be non-voting members. Terms of office should be five years, renewable once. It should publish each year an annual report on the state of the nation's health; what it had done to improve it and advice to the government on action to tackle the most serious threats to the nation's health and the NHS. It would be open to government to say what it most wanted advice on.

The OPH budget should be determined by a formula based on a proportion of the NHS budget and inflation proofed. This would be split between national and local allocations. It should be able to add to those allocations through fees and income generation, providing its independence was not damaged. It should be free to appoint its own staff. Its Chair and members should be appointed by the Health Secretary but with the agreement of the House of Commons. The Chair would be, ex officio, a member of a new Central Health and Care Board (see below).

In local government, all counties and unitary authorities should be required to have a Director of Public Health (DPH) as a chief officer, combined, if they wished, with the post of Director of Environmental Health. Legislation would require DPHs to publish annual reports on an area's health in a format (including statistics) agreed by the OPH. These officers would be accountable annually to their local populations for the ring-fenced money passed to them by OPH. This might take the form of a public debate on their annual report.

This greater emphasis on public health and prevention would most likely require changes to the composition of the health and care workforce, the future planning of which has been conspicuous by its absence.

Workforce planning failure and its consequences

A feature of funding both the NHS and social care has been the absence of any long-term planning. Every so often a government boosts NHS funding, as with the Blair government. Usually, these periods of feast are followed by a period of famine – a long one after 2010. The May government boosted NHS funding in return for a five-year plan provided by NHS England. But both the funding and the plan were blown off course by the COVID-19 pandemic. The periods of generous funding have provided a boost to the workforce and bragging rights to whoever was Health Secretary about how many extra doctors and nurse would be delivered. What has remained constant is the absence of any carefully considered future workforce plan. This absence is extraordinary, given that the NHS is the biggest employer in the UK and the lengthy time it takes to train doctors and health professionals.

This short-termism was highlighted by a House of Lords Select Committee report in 2017. It stated: "We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10-15 years.[48] The evidence from the DHSC Permanent Secretary (still in post) indicated that he did not see his department as responsible for long-term NHS workforce planning.[49]

The Committee recommended that if the government was not going to do this long-term planning it should appoint an independent body to do it along the line of the Office of Budget Responsibility. The government rejected this recommendation and voted down an effort to set up such a body in the Health and Care Act 2022. DHSC still failed to publish a workforce plan; but eventually commissioned NHS England to produce one by the end of 2020. Negotiations with the Treasury became bogged down over funding. Meantime, shortages of doctors, nurses and others increase. The Chief Executive of the NHS Confederation said recently there were 124,000 vacancies.[50] Eventually the government published a long-term workforce plan on 30 June 2023.

Assuming all goes well with implementing the new NHS Long Term Workforce Plan, it is likely to be 2030 before the new training capacity produces significant numbers of extra doctors or many new nurses and other skilled professionals. Many vacancies will remain, and the NHS and social care will continue to rely heavily on recruiting doctors, nurses and other staff from overseas. This will require effort, money and a supportive immigration policy. It will also mean NHS and DHSC management doing a better job than they have so far demonstrated at retaining existing staff – again requiring money and effort. The DHSC and ministerial failure to produce a workforce plan before Brexit and the pandemic means there is now an inescapable and high price to be paid. The balance of power has shifted to the workforce at a time of high inflation, high wage demands, and when the NHS and social care are very short of staff. These factors and the current disputes make it very difficult to increase NHS capacity to tackle the waiting list backlog.

At some stage, ministers and DHSC will have to rebuild their relationship with NHS unions and professional bodies if they want improved NHS performance. That requires a more flexible approach to negotiating pay and conditions of service. For example, if some public service workers want to take more income now and have less generous pensions later, that should be open to discussion. Because that is what they are doing now by working through agencies. Performance and productivity deals should be on the table, as should incentives to work more overtime and retire later. We live in an age of personalisation and balancing work with family life. NHS workforce negotiations need to be able to adapt better to that situation.

If devolution is to be a more prominent part of running the NHS, then it would make sense for more pay and conditions of service issues to be negotiated regionally rather than nationally – but retaining a national pension scheme. If devolved administrations can have their own pay negotiations, why cannot English regions, that are often bigger than devolved administrations? The cost of living varies significantly between regions, as does housing and accommodation costs. That variation seems unlikely to reflected in a simple London weighting scheme. This may well be unpopular with the Treasury and some unions, but it deserves a proper analysis and more debate.

Three other workforce issues deserve greater prominence in the way the NHS is run. First, more in-service support for staff to obtain higher qualifications and more rapid promotion. Second, using existing trained staff to take on more roles from doctors, as has happened with prescribing; and which could be taken further with more physician assistants, more paramedics and extended roles for healthcare assistants. Third, extended training of all NHS staff in digitisation, alongside expansion of IT use in the NHS in place of paper records and communication systems (see below). To drive these workforce changes at a time of shortage a new Workforce Directorate should be established in DHSC, as part of a major overhaul of governance at the centre.

Rebooting the centre

Reading NAO reports, the absence of workforce planning, the lengthy failure to fix social care and the mess the NHS is in, it is difficult to escape the conclusion that there is something seriously wrong with the central governance of health and care. This looks to be an endemic problem that can't be fixed simply by an election and change of administration. There looks to be something fundamentally wrong with the central machinery for the governance of the NHS and social care. It looks very much as though any new administration in 2024 will struggle to use the current machinery to bring about the rapid change required.

Simply changing ministers won't fix the problems if the mindset and approach of the permanent governance is not fit for purpose. Of course, new ministers need to be up for significant change, but they also need to realise that this needs to start with their own permanent machinery close to hand. Otherwise, any new change-oriented health secretary will encounter some big cultural obstacles.

There will be opposition to devolving power away from the centre, especially on workforce issues. New ministers should not underestimate the power of the acute sector and its leadership. The acute hospital barons are used to calling the shots on money and service delivery. Third, beware people who talk about the 'NHS family' and oppose any suggestion that change can be led by talented people from outside the 'family.' As the TV series Succession showed, the family can be dysfunctional. Kate Bingham seems to have found this when putting the COVID-19 vaccine programme back on track.

There are three big changes needed at the centre for the pursuit of a radical reform agenda: (1) reforming DHSC; (2) quangos and efficiency reviews; and (3) workforce planning and delivery.

Reforming DHSC

The hypothesis in this pamphlet is that improving the performance of the NHS requires us to change the culture and approach of DHSC rather than keep reorganising the NHS. The underlying reason for this view is that the Department struggles to accept that it has the primary responsibility for running a huge social business with the largest labour force in the UK. Over the years, it has believed that it could offshore management of the business stuff (while retaining the ability to interfere) and stick to traditional civil service policy roles and advising ministers. Unfortunately, it turns out that it's the business stuff that keeps getting ministers into trouble. They are held accountable for solving the problems without the Departmental machinery for doing so. Trying to fix the business problems in a tough economic climate with traditional civil service skills is never likely to work.

It is very difficult to run a big social business like the NHS which is cash-limited and has virtually no capacity to moderate demand for its services. In crisis all it can do is ration what services it can provide. Over time the customer base has changed (older, frailer and with many more lifestyle diseases); but the service delivery model hasn't altered much. In particular, neither the Department nor the NHS has done the long-term planning of its workforce needs in the way a big successful labour-intensive company would do. Words like efficiency, productivity, and business systems barely feature in NHS or DHSC managerial lexicons or conversation. For the most part NHS infrastructure and its maintenance are neglected for long periods, with capital often used to cope with revenue overspends.

Unless there is a major injection of business and managerial thinking and action at the top of DHSC these problems and failings in the health and care sector will go on being repeated year after year. To give the changes outlined in this pamphlet any chance of success and to allow innovation and new technology to flourish, a major cultural change is required at the top of DHSC. That top management needs to grasp that it is not a kind of trade body for the NHS; but, with ministers, it is responsible for running a 21st Century health and care delivery system for the citizens of England. If the business' delivery systems need changing – as they do – then DHSC top management should be capable of understanding how to do that. Those people also need to have the skills redistribute resources – money and people – when the business needs require this.

This more businesslike approach is required if the NHS is to have a chance of surviving. It requires a mindset change and different types of people and structures at the top of DHSC if ministers are to have a chance of driving change successfully. At the top of DHSC there needs to be more people with experience of managing big organisations with varied workforces but able to work within the realities of political life. They are a Chief Executive instead of a Permanent Secretary as the Accounting Officer for the NHS. He or she should be supported by a Chief Operating Officer responsible for workforce and productivity and a Director of Finance and Performance. They should be appointed by the Health Secretary after open competition and the agreement of Parliament, with salaries likely to attract a good field of candidates and five-year contracts, potentially renewable once.

To support this more managerial approach at the top of DHSC the Health Secretary might want to create a new Health and Care Board that he or she might chair or appoint a Minister of State to do. The Board might include the Chief Executive, the Chief Operating Officer, a Director of Finance and Performance, Chief Medical Officer, Chief Scientific Officer, a Director of Social Care, a Director of Health and Care Policy (who could be a Permanent Secretary and accounting officer for the DHSC policy work). The Health Secretary might wish to appoint two or three independent members to the Board. The Chief Executive could decide the membership of his own management team. It should be for the new Board to decide the outcome of the reviews suggested next.

Quangos and efficiency reviews

It is clear that if there was to be a major move to devolution and a transformation of the role and culture at DHSC then there would inevitably be a shake-up of the current quangos. The role of NHS England and the Health Education England would definitely have their roles changed. NHSE could become the agency to oversee specialist hospital services and any changes proposed for them. HEE might no longer be needed if the enhanced workforce role for DHSC (below) was pursued. More generally the role, size and cost of health and care quangos needs an independent review against some rigorous efficiency and effectiveness criteria. The efficiency reviews in the Thatcher and Blair premierships provide models that could be used.

If the DHSC was to become more businesslike there are a considerable number of activity areas that look to require independent review, some revealed by COVID-19 – purchasing, laboratories, clinical trials. Others like IT, electronic records, building maintenance are longstanding problem areas: AI may be a new one. For the foreseeable, future government departments and public services are going to be strapped for cash and short of skilled people. The DHSC needs to have a more organised and transparent programme directed at improving efficiency and productivity. It should pay particular attention to spreading best practice around the NHS, using incentives and, where necessary sanctions. Inconsistency of performance between areas and services has bedevilled the NHS for decades. As has the lack of workforce planning.

Workforce planning and delivery

This is an urgent priority for any government of whatever political stripe. Realistically it requires abandoning the fiction that somehow NHS leadership can handle this. We all know this is a tussle between the Health Secretary and the Treasury, whether the issue is workforce planning for the future or current pay deals. In this tussle it is very easy to see the Treasury as the villain. And sometimes they can be very short-sighted and fail to recognise the importance of long-term planning for such a large labour-intensive business as the NHS. But we have to recognise that all governments have to exercise some control over public sector pay and the NHS is too big to be exempted from those controls.

However, the Treasury also has to recognise the length of time it takes to train and recruit many health and care staff or to change the NHS skill mix. There is also the fact that after Brexit the UK can no longer turn on and off the foreign labour tap to make up for its workforce shortages. The UK also faces strong international competition for doctors and nurses. The current long-running pay disputes and the delays over agreeing an NHS workforce plan provides plenty of evidence that the present system doesn't work.

A new system for health and care workforce planning and pay is required that recognises the role of both sides of this historic argument. An outline of a new concordat between the Treasury and DHSC is set in an Annex. Attitudes on both sides need to change if the best interests of the NHS and its patients are to be served.

A SUMMING UP

The NHS is in a spiral of decline. After a decade of austerity, with Brexit, COVID-19 and two reorganisations thrown in, the NHS workforce is in turmoil. An era of fiscal restraint lies ahead so there's not much money on offer for higher pay or for increasing capacity. The backlog of patients waiting for treatment following the pandemic stays stubbornly around 7 million. Unsurprisingly, the public have unprecedentedly low levels of satisfaction with the NHS and adult social care – 29% and 14% respectively. Just to make things even more interesting a general election beckons in 2024, with the future of NHS centre-stage.

Governments have a choice. Bumble along much as we are now and pretend radical change is not necessary. Or face up to the scale of the challenges and accept radical change is needed, even if there's not much new money to smooth the way and staff are tired and fed up. We have a poor system for reducing demand on the NHS; and for a decade there has been a failure to fix social care. Although the NHS now has a long-term workforce plan, it is still likely to deliver too many services in hospitals rather than in the community where people live. Serious delivery change at the moment is far too slow to prevent further decline.

This pamphlet outlines ways of trying to fix some of these problems but they will not be an easy ride. It takes a hard look at the way we have run health and care with a very centrist approach. It proposes much more decision-making on services, both regionally and locally, and with a bigger focus on population health and prevention of ill health. It proposes some big changes at the centre, with a major rebooting of the top of the Department of Health and Social Care to make it more business-like.

As the eminent British physicist, Ernest Rutherford, once said: "We haven't got the money, so we've got to think." It also wouldn't hurt if a new Michael Heseltine emerged wanting to make his political reputation with an efficiency drive.

NOTE ON THE AUTHOR

Norman Warner is an independent Peer and former Health Minister in the Blair Government. He was a member of the Coalition Government's Commission on Funding Social Care. He was a senior policy adviser to the Home Secretary after the 1997 Election and Chairman of the Youth Justice Board responsible for reforming the youth justice system. He has chaired government enquiries and public bodies, as well as charities. He has been a senior civil servant and worked in local government. He worked in the Thatcher efficiency programme.

ANNEX

New Treasury and DHSC Workforce Concordat

With goodwill on both sides, it would not be unrealistic to envisage the Treasury and DHSC negotiating a new longer-term workforce planning and NHS and social care remuneration system with six key features.

- DHSC ceases to offshore responsibility for both the long-term planning of the health and care workforce and ensuring current needs can be met. Only the Department has the access to other parts of government when major workforce problems have to be resolved.
- DHSC has to become much better equipped to do long-term planning that covers both the NHS and adult social care sectors and looks 10-15 years ahead, using an independent capability whose budget is protected.
- DHSC must acquire an ability to ensure the national capacity for training new staff is adequate and that it monitors the recruitment and retention of staff (including the competitiveness of pay and conditions of service).
- DHSC should examine critically the scope for changing the workforce skill mix to produce greater efficiency and shorten training times.
- The Treasury should give DHSC a firm workforce budget for both the NHS and adult social care that looks five years ahead, can be used flexibly, is rolled forward annually and is accompanied by a further five years shadow budget.
- A limited number of key performance targets should be agreed annually between DHSC and the Treasury, together with a realistic productivity measure.

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