The NHS: Decline and fall, or resurrection?

Changing the delivery and governance of a national icon

BRIEFING PAPER

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SMF Social Market Foundation

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The NHS is in serious decline, plagued by extensive and deep-seated issues and facing immense pressures from the pandemic and Brexit. In this briefing, Lord Warner sets out a change programme that could reverse the decline – involving radical but necessary steps.

KEY POINTS

- The National Health Service (NHS) is in serious decline – struggling to recover from the devastating impact of the pandemic and Brexit.
- The issues are deep-seated and more extensive than the pandemic's treatment backlog. The future sustainability of a tax-funded comprehensive NHS is now open to doubt.
- Throughout its history, the NHS has focused on treating ill-health, even as the disease profile of the UK has vastly changed.
- Rising demand will mean the NHS is unable to provide services to all, ushering in a two-tier health system that no longer provides free universal care.
- Politicians must be much braver in making major changes to the way the country structures and delivers health and care services.

RECOMMENDATIONS

1. **Reform public health and prevention** – by creating an independent public body, the Office of Public Health, which will make decisions on policy and resource distribution
2. **Expand community health services and social care** – rather than expanding hospitals, much more of the NHS capital should be allocated to community health facilities, including GPs
3. **Consolidating specialist health services** – create a new system for determining the consolidation of specialist health services on fewer sites
4. **Creating elective surgery and diagnostic hubs** – NHS England should be directed to establish either surgical hubs or standalone surgical centres to undertake elective surgery
5. **Reforming workforce planning and delivery** – DHSC should be given new powers and a long-term budget to meet future NHS labour demands

FOREWORD

By James Kirkup, Director of the Social Market Foundation

Few people can match Lord Norman Warner's experience of public service policy design and delivery. All of his long and distinguished career, as an official, an adviser and a minister, has been about helping the state provide better services for the people who need them.

That is the guiding principle of this paper: doing what is necessary to ensure that services get to the people who need them. Sadly, "necessary" does not always, or even often, mean "popular". There is no doubt that some of the measures recommended in this paper will strike many readers as politically difficult. Some voters do not take kindly to talk of hospital closures. Some have strong feelings about the NHS using privately-owned resources to deliver healthcare.

And sadly, all too often politicians go with the flow of such opinions, rather than having the honesty and courage to tell the public that some of the things they think about health and the NHS are wrong. Sometimes closing hospitals and allocating scarce resources more efficiently elsewhere is the right way to get the best care for the most people. Political debate about private sector provision of public services is even more dismal; of late, some perfectly sensible politicians haven engaged in conversations about the supposed threat of "privatising" general practice, rather than explaining to voters that GP practices are in fact already private organisations that are paid to supply services to the NHS.

In short, we need a better public conversation about the NHS. Until we get it, major reforms of the service are indeed likely to remain politically impractical. But as Lord Warner shows here, without those major changes, the mounting pressures on the service, especially those arising from an older, heavier population, will eventually compromise its ability to deliver. And voters are likely to feel even more unhappy about the failure of the NHS than they do about changes in the way it works.

They may even reward politicians who show themselves equal to the big, long-term challenges this report addresses. Anyone who aspires to lead, either a political party or a country, must surely demonstrate the courage and look beyond short-term headlines and take difficult decisions in the long-term interest of the British public. This paper is therefore not just a blueprint for saving the NHS from decline and failure, it is also an invitation to politicians to show genuine leadership.

INTRODUCTION

Nigel Lawson once described the NHS as the nearest thing the British had to a religion. During the pandemic the public banged saucepans in support of the NHS. The national icon the Government urged us to save is now in serious decline. It is struggling to recover from the pandemic, right after the Brexit loss of staff. It is losing the confidence of the public. The problems are deep-seated and much more extensive than the pandemic's treatment backlog. The future sustainability of a tax-funded comprehensive NHS is now open to doubt.

This briefing outlines the fall from grace and sets out a change programme that could reverse the decline. There is no quick fix and no easy path to take for politicians, the public, or health and care staff. There would need to be significant changes at the top of the Department for Health and Social Care (DHSC), the way the NHS delivers services, and the approach to public health and social care. A far better system would be required for planning and delivering the health and care sector's workforce. To implement changes of the kind proposed here would require decisive action by ministers and a degree of cross-party support. That is what saving the NHS will take because to succeed, disruption of service delivery systems is now inevitable, whoever governs.

I. A LITTLE HISTORY AND CHANGING SERVICE NEEDS

The idea of an NHS started 80 years ago with the 1942 Beveridge Report when, on average, people lived a couple of decades less than now. Beveridge's central idea for a satisfactory post-war welfare state, was that Britain needed "a national health service for prevention and comprehensive treatment available to all members of the community."[1] This idea of an NHS free at the point of clinical need has dominated public and political thinking on health policy ever since. Unfortunately, the prevention part has never really been delivered and now the comprehensive treatment bit is being whittled away.

Since 1948, the NHS has been focussed on the treatment of ill-health rather than prevention. Its resources – funding, workforce and management effort – have been concentrated on acute hospitals, the most expensive part of the healthcare system. During this time, treating physical ill-health has received much more attention than mental health. The extra years of life gained may not have been healthy years. Britain's disease profile has also changed dramatically since 1948, largely as a result of lifestyle choices. All this has increased the scale, complexity and cost of the health and care system.

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 are at their highest since the 2008 financial crisis.[2] Despite efforts to deter people from smoking it still accounts for nearly a fifth of all cancers.[3] 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 eight tube stops eastwards on the Jubilee Line between Westminster and Canning Town, was found to have a seven-year difference in longevity.[4] More recently, evidence has suggested that longevity has stopped increasing.

These changes in demography and disease profiles have had a major impact on both the NHS and its partner service, adult social care. The funding for both services to cope with this extra demand has been erratic under successive governments. With the NHS it has usually followed a path of feast or famine. Adult social care has been underfunded for nearly two decades, relative to demand. Health and care services now face a major crisis on funding, workforce resilience, and the way services are delivered and distributed geographically.

II. THE PERFECT STORM

The NHS now faces a 'perfect storm'. For most of the decade before the pandemic started in 2020, the NHS was expected to cope with increased demand with annual funding increases of about 1% a year in real terms. Its annual costs were increasing by at least 2 or 3 times more. In the UK's most labour-intensive industry, there was no long-term workforce plan for recruiting and retaining staff. Unsurprisingly, the NHS was failing to meet most of its performance targets and patients were waiting longer for treatments, including cancer sufferers. In 2017, the then prime minister committed to a long-term NHS plan (produced in 2014 by NHS England) and increased funding.[5] But before much of this could be implemented, Brexit and the COVID-19 pandemic intervened.

The NHS's problems have been made worse by the continuing failure to fund adult social care adequately. In 2018, an authoritative independent report suggested that an extra £8 billion was needed.[6] This funding failure has had a disastrous effect on services for elderly and physically disabled people, unpaid carers, staff, investors in the care sector and on the NHS. Care services have been reduced, along with staff recruitment. Hospitals have been unable to discharge patients when fit to go home because of the shortage of social care. Adult social care is a neglected, poor relation of the NHS, as was demonstrated during the pandemic.

These funding and staffing problems, together with the pandemic, have led to a massive backlog of patients awaiting NHS services. The workforce is exhausted, depleted in numbers with no credible plan to put things right. The House of Commons Public Accounts Committee (PAC) set out the backlogs position in its report of March 2022. This revealed that the DHSC "has overseen years of decline in the NHS's cancer and elective care waiting time performance."[7] The NHS had not met the 18-week maximum waiting standard for elective care since February 2016, nor the eight key standards for cancer since 2014.[8] At the end of December 2021, six million patients were waiting for elective care.[9] At the same time only 67% of patients with an urgent referral for suspected cancer were treated within 62 days.[10]

This is not the full story. A feature of the pandemic was that very large numbers of patients did not access routine NHS services. The PAC considered there were between 7.6 million and 9.1 million 'missing' referrals of patients for elective surgery and between 240,000 and 740,000 'missing' urgent referrals for suspected cancer.[11] We have no idea how many of these missing referrals have died or are now seeking NHS treatment. The PAC was not impressed with the arrangements for measuring NHS performance on tackling the backlog with the extra £8 billion of revenue and £5.9 billion in capital that the Government had promised.[12] There is little clarity on the inevitable geographical variations in clearing the backlog.

This situation is made worse by the workforce crisis. Health care depends on people – doctors, nurses, scientists, therapists, care assistants, porters and many others. They take time to recruit, train and deploy in a world where there is intense international competition for skilled staff. The UK has depended heavily on overseas health and care staff and lost many experienced staff as a result of Brexit. We now face a lengthy period of health and care staffing shortages.

On the current evidence, the waiting lists for NHS treatment will remain high until well into the next Parliament. Publicly funded adult social care is unlikely to improve much in this timeframe. Geographical variations in the quantity and quality of health and care services are likely to widen. The Government's 2019 Election pledge to build 40 new hospitals is in disarray. Patients have noticed the service deterioration, and public support for the NHS is declining. Dissatisfaction is being increased by the flow of adverse news stories about a wide range of NHS services, not just waiting times. This situation raises serious questions about the NHS business model of delivering so many services through acute hospitals and its neglect of public health, mental health and community health services, including GPs.

III. NEGLECTED COMMUNITY SERVICES – A SPIRAL OF DECLINE

The primary focus of the NHS is on acute hospitals, whose top management has provided most of the NHS's leadership over many years. Until recently, NHS media stories were usually about whizzy new diagnostic kits, leading-edge surgery and new wonder drugs. Little media attention was paid to bread-and-butter issues and the services that were used by most people. Day-to-day reality is that over 90% of NHS encounters are with GPs, pharmacists, and many other primary care professionals. While everybody was encouraged to 'Save our NHS' during the pandemic, this really meant saving our hospitals. This was demonstrated in March 2020, when NHS hospitals were told to discharge large number of patients to care homes without testing them for COVID-19. Inevitably, care home deaths increased at that point.

This acute hospital focus has resulted in the neglect of primary care, public health, mental health, and social care. GPs have been taken for granted and DHSC has failed to ensure an adequate future supply or distribution to cope with increasing patient demands. Six thousand extra GPs were promised in 2019 but barely a quarter of this number are in place now.[13] Many GPs have left the NHS or gone part-time. The Royal College of GPs have recently said that 20,000 GPs plan to retire or quit the NHS in the next five years because of their working conditions.[14]

Many GPs are complaining about having to undertake more consultations a day than is safe and then missing diagnoses, for example, of dementia. A recent survey suggests that a third of GPs want to put appointments on hold as staff shortages bite.[15] At this year's conference of local medical committees, a motion was passed, with 70% approval, for the British Medical Association (BMA) to renegotiate the GPs' NHS contract to include "workload limits to protect all general practice staff and patients."[16] That would mean many patients being unable to access an NHS GP and then turning up in A&E, relying on pharmacists or going private, thereby increasing GP shortages in the NHS.

NHS dentistry had been shrinking for decades. Although the number of registered UK dentists has been rising in recent years, fewer want to work under the NHS contract. A recent Times analysis of the NHS website suggests nearly 9 in 10 dentists are refusing to take on new NHS patients, including children.[17] Rural areas like Somerset and Lincolnshire seem particularly short of NHS dentists. Specsavers has expanded its audiology business as NHS service availability has shrunk.

Over the years expenditure on mental health has been inadequate. It was not until 2016 that mental health services were given parity of esteem with physical health services, in terms of funding. This change has started to improve funding for mental health, but it is highly doubtful if this improvement now meets the current post-pandemic demand for mental health services. In a recent survey of GPs, about 60-70% said they were working beyond their competence in dealing with both adults and children with mental health issues – with some children waiting longer than 18 months for specialist services.[18] The Royal College of Psychiatrists have said they are seeing record referrals for specialist services but there are not enough psychiatrists to cope.[19]

The NHS has a high dependence on adult social care, both in preventing people being admitted to hospital and for returning them home when safe to do so. The systematic neglect of social care for over a decade has been well-documented and is discussed more fully in the next section. The extra funding promised so far falls well short of what is needed to fix adult social care; and leaves the NHS keeping patients in hospital longer than necessary because no social care is available. In some areas, publicly funded social care is close to collapse.

These examples demonstrate the neglect of community-based services, which in turn increases pressure on acute hospitals. This increases the risk of headline-grabbing hospital service failures and personal tragedies. The roll of dishonour grows, along with the empty promises to learn lessons and avoid repeating mistakes. The A&E numbers soar, as do the pictures of ambulances queueing outside the hospitals to deliver sick patients. In turn, fewer ambulances are then available to respond to other emergencies.

The NHS now finds itself in a spiral of decline with no credible escape plan. And things could get worse, given our neglect of public health warnings. A recent World Health Organisation (WHO) report says Britain will be the fattest nation in Europe in a decade: currently we are third after Turkey and Malta.[20] Excess weight is directly linked to 13 cancers, heart disease, Type 2 diabetes and musculoskeletal conditions. According to the WHO report we are ahead of other European countries in adopting a lifestyle with

more screen time, online food deliveries, and exposure to junk food advertising.[21] Takeaways are higher in fat, sugar and salt, and the portions are larger than meals prepared at home. This is a league table the NHS doesn't want to be top of.

The NHS has been in crisis before. It has a tendency to believe in its own invincibility and that no government will allow it to collapse. Governments have tended to encourage that view and have usually thrown more money at the problem without too many questions asked. Periodically, there is a look at changing the NHS funding system away from general taxation. No government has been convinced about making that change, although the Thatcher government gave more serious thought to such a change than most.

A variety of other reforms have been tried, particularly reorganisations. The NHS was reorganised in 1974, 1991, 2002 and 2012 and we now have another one with the Health and Care Act 2022. Each reorganisation promises improvements and consumes a lot of money and staff time, but few have made much fundamental difference. The 2022 reorganisation seems likely to follow this pattern.

Some past reforms like markets and competition, more patient choice, and robust performance measurement have had some beneficial impact, but they haven't shifted the NHS culture significantly and haven't always endured Ministerial changes. Resurrecting some of these past changes would help to improve the supply side of the healthcare system but they will do little to reduce expensive demand. That can only be achieved by changing significantly what services the NHS delivers and how this is done in a properly funded partnership with adult social care. The NHS has to move its service effort more upstream by tackling potential ill-heath, rather than waiting for patients to become so ill that they end up in hospital.

IV. BUILDING BACK BETTER

COVID-19 has presented the NHS with unprecedented challenges which the NHS looks like is trying to tackle without fundamentally changing its approach to service delivery. Even before the pandemic waiting lists were lengthening. It is difficult to see the NHS removing the backlog with more of the same, given the likely state of the public finances and neglect of social care. This would leave the NHS facing a future in which lengthy waiting lists and rationing become endemic, with bad consequences for patients. This will lead to further decline in public support for the NHS and to those who can afford it, going private. If this happens, why would an already exhausted and disenchanted workforce not continue to leave? The spiral of decline is set fair to continue and is likely to accelerate unless a new approach is tried.

This new approach would mean taking a long hard look at the Government's election pledge to build 40 new hospitals by 2030. To date only six projects – that all predate the 2019 election – are reported to have been started. Only one – a cancer centre in Cumbria – has been completed. In a recent House of Lords debate, Lord Stevens – the former NHS England chief executive – drew attention to the fact that the size of the NHS capital programme for the next three years was insufficient to start a hospital building programme of the size promised.[22] It is clear that the poor state of some hospitals will require some rebuilding. However, the lack of a clear funding

commitment by the Treasury to build 40 new hospitals could be good news. It provides an opportunity to change the priorities for new buildings – see below.

To reverse the NHS' downward spiral, six key problem areas require urgent attention.

1. Controlling service demands by radical reform of prevention and public health
2. Delivering many more services in the community closer to home, rather than in expensive and often inappropriate acute hospitals
3. Rethinking the delivery of elective surgery and access to routine diagnostic tests
4. Concentrating more specialist services on fewer acute hospital sites
5. Fixing the problems of social care
6. A new plan for reskilling and ensuring a more appropriate health and care workforce

Public health and prevention

When William Beveridge wrote his report in 1942, he placed prevention alongside treatment in defining the role of the new NHS.[23] In 80 years, under governments of all political persuasions, that parity has never been close to achievement and has now been largely abandoned, despite greater need for it. The NHS is an ill-health service with little direct or significant influence over policies affecting the nation's health. Demand for its services is virtually outside its control. Below the Prime Minister, it is difficult to say who is responsible for preventing ill-heath.

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 their report. When NHS England (NHSE) was established a decade ago, it appointed a CMO but neither he nor NHSE can 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 has barely kept pace with inflation over the past decade or so. The CMO at DHSC has no powers of direction over local authorities and can only give advice to Ministers who are free to ignore it – and do, from the Prime Minister downwards.

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 the May government. Even now, a commitment to curb the advertising of junk food is being delayed. Unless this

ramshackle system is overhauled, obesity and other UK lifestyle choices will overwhelm the NHS. Proposals for reform are made below.

Expanding community services

Over 15 years ago, a serious attempt was made to move more NHS services from hospital to the community, but then was dropped. It started with a major public consultation commissioned by ministers called 'Your Health, Your Care, Your Say'. A large cross-section of the population was involved, and it culminated in nearly a 1,000 people meeting in Birmingham to consider and vote on their priorities for NHS change. Their top four priorities were: an annual health check, with GPs doing more to help them stay healthy; much more support for mental health and wellbeing; more help for unpaid carers; and a trained nurse for the first point of contact. They wanted more services provided closer to home. In-patient hospital care didn't feature in their priorities.

In January 2006, a government White Paper (Our Health, Our Care, Our Say) was published reflecting the public's priorities.[24] A range of new community services were proposed and piloted, including talking therapies and cognitive behaviour therapy, a 'Life Check' service, and more choice of GPs.[25] Ministerially-led negotiations with clinical leaders identified the best prospects for moving work out of hospitals: ENT, trauma and orthopaedics, dermatology, urology, gynaecology and general surgery. 20-30 pilots were set up with independent evaluation. At the time there were 45 million outpatient appointments a year, half of which, for some specialties, could be provided in community settings.[26]

Ministers stopped the closure of community hospitals and started a programme to invest more in them – opposed by many officials and NHS leaders. A Social Enterprise Unit was set up so that voluntary organisations and social enterprises could play a bigger role in the NHS. A start was made in taking seriously community-based mental health services accessed through GPs.

A review of London's NHS by a prominent surgeon, Sir Ara Darzi, called for more healthcare to be provided at home and in polyclinics (opposed by the BMA) with GPs and specialist outpatient consultations.[27] When Darzi, now a Lord, became a health minister, he supported the approach taken in the 2006 White Paper. Unfortunately, his 2008 'Next Stage Review' passed implementation of change to the NHS.[28] With the 2010 election approaching, ministerial appetite for transferring services out of local hospitals evaporated. It has never been revived under successive governments. Now is the time to return to the agenda in the 2006 White Paper and Darzi's 2007 London Review.

Elective surgery and diagnostic hubs

In May 2021, the Royal College of Surgeons called on the Government to create 'surgical hubs' across the country to reduce the large backlog of elective surgery.[29] Ara Darzi had called for this approach 15 years ago.[30] Before then the Blair government had increased NHS planned surgery capacity by contracting with the private sector for new elective surgery centres (ISTCs) to be built and run by the independent sector.

These provided NHS operations at NHS tariff prices and were staffed without recruiting NHS staff. Separating planned from emergency surgery and locating this work outside acute hospitals has been around since the 1990s, but largely ignored by the NHS. The Brown government killed off ISTCs.

The Blair government's use of the independent sector was fiercely opposed by the NHS, despite being little more than 10% of NHS capacity and rated by the CMO as being of at least equal quality. In adding extra capacity at NHS prices, it also provided new purpose-built facilities. These new centres were liked by patients. The public seem supportive of the surgical hubs now proposed by the Royal College of Surgeons. Separate hubs of this kind would also have the advantage of being easier to insulate from the effects of another pandemic. Now that the professional body is advocating separate elective surgery hubs it should be more difficult for NHS leadership to continue resisting this change.

Standalone surgical centres or hubs would reduce the backlog quicker and give patients more choice, particularly if the independent sector was allowed to compete by building and staffing new centres. Expanding elective surgery capacity would almost certainly require expanding NHS diagnostic capacity. That was why the Blair government's contracts with independent sector included an expansion of diagnostic capacity that the NHS badly needed.

Run specialist hospital services on fewer sites

Delivering more NHS services in the community and developing surgical hubs has major implications for local acute hospitals. That was recognised in the reports by Ara Darzi mentioned above. 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 local 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 the delivery of services may be needed on both clinical and cost grounds.

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 Bristol children's heart scandal in the 1990s was 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 be at election time.

Taking the unpopular decision to concentrate specialist services on fewer sites can have a good outcome, as was demonstrated in London when specialist stroke services were concentrated in eight centres instead of the previous 32.[31] This saved an estimated 400 lives within two years and £800 per patient because they recovered quicker.[32] If the London scheme was applied nationally, it was thought to save about 2000 lives a year.[33] England has just over 200 acute hospitals running a full range of

specialist services.[34] However, we lack an independent and authoritative clinical appraisal of the patient and cost benefits of concentrating more specialist services on fewer sites. Lord Darzi wanted to see this approach adopted more widely but little has changed nationally since his time. It is now critical for the future of the NHS that we tackle this issue. A way of doing so is outlined below.

Neglect of adult social care

A succession of governments has failed to fund adult social care adequately and that is still the case. A decade of austerity since 2010 has created a huge funding shortfall. This has reduced the volume and quality of care available for an increasingly frail and dependent population. The criteria for access to publicly funded care services have been tightened to exclude more and more people from services. The problems are worse in poorer areas where fewer people can afford to pay for their own care and local council tax bases are less resilient.

As social care funding and services reduce, the NHS effectively becomes the carer of last resort, with many patients kept in acute hospitals longer than necessary. The lack of local authority funding for social care has caused many service providers to leave the sector or accept only self-payers. The risk of publicly funded social care collapsing in many places was growing before the pandemic. The latest (2022) survey reveals over 500,000 adults waiting for social care, a 40% increase in a year.[35]

To remedy the situation and restore service eligibility to 2009/10 levels, a 2018 think tank report estimated that it would require an additional £8 billion a year.[36] That sum has increased since then but the increases in prospect by 2025 look to be less than half the funding required, with no guarantee that even the lower level will be achieved.[37] Increasing council taxes significantly to make good the shortfall is unlikely to be feasible in most places. The likelihood is continuing shrinkage of publicly funded adult social care and its collapse in some areas. The pressure on the NHS is certain to increase and make it more difficult to reduce the huge backlog of treatments.

The longer central Government declines to fund adult social care realistically, the more likely it is that the NHS will end up expanding its own continuing care services to avoid frail elderly people going into, or staying in, expensive and scarce acute hospital beds. This could lead in some places to the NHS buying nursing home places or funding home care as an alternative to using acute hospital beds. There is now a distinct possibility, in some areas of the country, that the scope of the NHS is being increased by the failure to fund adult social care properly. This is likely to be more expensive than funding adult social care properly.

Failure of workforce planning

The NHS in England has about 1.3 million staff and is the biggest employer in the country. Health and care are highly labour-intensive industries. A prolonged funding squeeze in the decade before the COVID-19 lockdown produced considerable staff shortages. Because no long-term workforce planning has been done, staff shortages in the NHS have now become endemic. The King's Fund reported a staff shortage of about 100,000 in February 2022.[38]

Although the recruitment and training of new staff is said to be improving, a large number of existing staff are continuing to leave, especially GPs. Retaining skilled and experienced staff has become a major problem for both the health and care sectors. The absence of a credible workforce planning system now represents the biggest threat to the sustainability of the NHS and adult social care. That failure can be placed fairly and squarely on central government.

This longstanding problem was highlighted by House of Lords Select Committee report in 2017. It said: "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."[39] The then health secretary, Jeremy Hunt told the Committee: "I would say that workforce planning is an area where we have failed."[40] 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.[41]

This issue was debated during the passage of the Health and Care Act 2022, but amendments to provide independent workforce planning were rejected. The strong suspicion was that the Treasury opposed any independent system in case it produced public expenditure demands. Instead, workforce planning remains in the hands of Health Education England (HEE), whose track record does not impress. HEE is to merge with NHS England in April 2023 with the hope this will improve matters. History suggests otherwise and an alternative approach is proposed below.

V. A NEW GOVERNANCE FRAMEWORK FOR HEALTH AND CARE

The NHS is in dire straits. Without a radical change of approach to the way it's run and governed, its continuing decline looks inevitable. Brexit and COVID-19 have accelerated that decline, but its structural problems were well-established before both. It is losing the support of its staff and the public, and badly lacks a guiding sense of purpose. This will not be provided by the 2022 Health and Care Act. It is on a trajectory of decline at a time of high inflation, war in Europe, and energy shortages. This context means governments are unlikely to be able to spend their way out of NHS trouble. More cost-effective ways are needed for delivering NHS services and conducting its affairs.

Whoever is in Government has a choice. Level with the public about the serious state of affairs and set out a major change programme, likely to last more than one Parliament. Or bumble along as now pretending things will improve. This latter course is highly likely to end with a major workforce crisis. This would result in NHS services becoming less accessible to many people, especially in poorer areas where health and care needs are usually greater. Those with more disposable income will be able to buy non-NHS services more easily, often reducing NHS capacity further. A two-tier health and care sector is already developing and will continue to do so on present plans. Through the fog of government, the end of the Beveridge vision can be clearly seen.

To affect radical change, a new governance framework is required that uses resources – money and people – differently. This new framework will require five strands of work overseen and coordinated by government but managed separately and without

detailed political interference. Those five strands are: public health and prevention; community health and care services (including social care and mental health); consolidation of specialist hospital services; elective surgery hubs; and workforce planning and delivery.

Each strand would have its own budget and accountability structure but would operate under the coordinating leadership of a Central Health and Care Board. This Board would be chaired by the Health and Care Secretary. To encourage public confidence in reforms, the Board should meet in public sometimes and its papers and meeting minutes should be on the public record. Implementing these changes would also require a complete overhaul of the top management of DHSC and a new executive team – see below.

Reform public health and prevention

The present lack of clear leadership and accountability for public health and prevention of ill-health is a major obstacle to a high performing health and care sector. The NHS in particular has virtually no capacity itself to control demand for its services and cannot rely on any other powerful public agency to do the job for it. The outcome of the current ramshackle systems at national and local levels is the UK's worsening disease profile, outlined above. The NHS will continue to be swamped by that profile, especially by obesity, unless some governance strengthening of public health and prevention is put in place. This needs to be outside the day-to-day jurisdiction of government and strong enough to deal with commercial lobbying.

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 would be established by legislation that was renewable every ten years and answerable to Parliament. Its membership should be prescribed in legislation within a limit of 10-12 members, including, ex officio, the Government's CMO and Chief Scientific Officer (non-voting). Terms of office would be five years, renewable once.

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 the new Central Health and Care Board.

In local government, all counties and unitary authorities would be required to have a Director of Public Health (DPH) as a chief officer, combined, if 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 in their annual report for the ring-fenced money passed to them by OPH.

Expand community health services and social care

If more health and care services are to be delivered outside hospitals, budgets must be set up in ways that delivers that outcome. It will not happen through guidance and encouragement. When money leaves central government for local spending it must go to an accountable entity responsible for community services. If there is a body providing both hospital and community services, then the funding and expenditure of the two must be separated. That means the overhead costs of the hospital must be borne on its budget and those of the community services on their budget. Within community services there will need to be separate accounts for mental health, uprated at least 1% higher than the NHS generally.

The budgets for community health services will need to take full account of hospital outpatient work to be transferred to the community. GPs and their staff (plus other practitioner services) should be seen as part of community health services and their budgets included in an enlarged 'community health budget.' In setting up these new arrangements, the aim should be to minimise NHS organisational changes by separating budgets and accountability within existing statutory bodies, using secondary legislation if necessary.

Means-tested social care will have to be handled separately from NHS accounts, but it will be increasingly important to link social care expenditure to NHS accounts to show the extent to which it is keeping pace with NHS expenditure. All this will be a waste of time unless there is a plan, within a single Parliament, to rectify much of the historical underfunding of adult social budget by extra payments of about £2 billion a year. In addition, annual increases for the NHS should be mirrored proportionately in local government funding for adult social care, as proposed by the House of Lords Select Committee in 2017.[42]

These technical changes are essential if government funding is to be shifted over time from hospitals to community and prevention services. They will require a major overhaul of NHS accounts and the linking local authority expenditure on adult social care to the NHS accounts. Many will argue against these technical changes and say they are not worth the effort. But if policy on service delivery is to change, then funding flows and accountability systems must also change. If that is not done, the policy change simply won't happen at scale.

These changes only relate to revenue expenditure. A major structural change to where NHS services are delivered has significant implications for capital expenditure. Rather than expanding hospitals, much more of the NHS capital budget should be allocated to extending and improving community health facilities, including GP accommodation. This is what Lord Darzi was proposing with polyclinics over a decade ago but without political support for change. This will mean a reappraisal of the Government proposal to build 40 new hospitals and using the proposed capital expenditure differently.

This work on budgeting and accounting and revamping the NHS capital programme will require Treasury approval, not least to make changes compatible with government accounting rules. A Health and Care Accounting Taskforce will be required, with

Treasury involvement and an independent chair approved by the Public Accounts Committee.

This change process should be driven by a Chief Operating Officer within NHS England who would become the budget holder and accountable officer for all NHS community services. This person should usually be from a community services background, possibly a GP. They should attend the new Central Health and Care Board and work closely with a new senior appointment for adult social care in DHSC. This new appointment would be from a local government background and have a Whitehall-wide remit on the funding of adult social and its adequacy. They would be a member of the new DHSC executive management team (see below) and attend the new Central Board.

Consolidating specialist health services

This is probably the most politically controversial part of the proposed governance changes. 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 should be met:

(a) A time-limited and standardised process by specialty across the country, including public consultation

(b) The process must be managed by a nationally credible group of clinicians for each specialty, and

(c) Elected politicians should not be expected to make the final decisions on individual hospitals

The NHS England Chief Executive should be made the accountable officer for starting and managing the 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-tiered 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.

Creating elective surgery and diagnostic hubs

This is probably the easiest change to make. There is nothing to stop the Health Secretary from directing NHS England to establish either surgical hubs or standalone surgical centres to undertake elective surgery. A commercial director could be appointed to let contracts to either the NHS or independent sector to build or run these centres for a given volume of work and reasonable period of time. The price of reimbursement should be at NHS tariff prices, so competition is on the basis of quality not price. Independent sector providers would have to meet regulated standards and not divert NHS staff, apart from those already working for them as part of their private medical practice.

The commercial director should report direct to NHS England's Chief Executive for delivering the programme. There should be a separate 5-7-year budget for this programme, including capital provision. Pension funds might be encouraged to invest in developing this sector, including additional diagnostic capacity for NHS use.

Patients should be encouraged by NHS England to travel to any centre of their choice using a high-profile information programme to help patients make their choices. This approach would help make speedier inroads into NHS waiting lists and provide a source of inpatient care easier, to protect patients from infection in the event of another pandemic. Those who say this cannot or shouldn't be done should look at the success of the Blair government in doing this between 2003 and 2007. Waving unjustified anti-privatisation flags over this approach just damages patients by making them wait longer for pain relief.

Reforming workforce planning and delivery

This is the most important of the five strands and the most difficult to deliver. There is little compelling evidence of DHSC engaging consistently with this issue or letting Health Education England do so. Skills for Care have done some planning of the workforce needs of adult social care, but they lack the authority or budget to drive change. A fundamentally different approach now has to be devised and implemented quickly. But it has to recognise the Treasury's legitimate concerns about not letting the NHS pay bill balloon out of control, as has happened in the past.

All governments have to exercise some control over the public sector pay bill. The NHS, given its size, cannot 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. In addition, the UK faces strong international competition for doctors and nurses.

A new system for health and care workforce planning and delivery is required that recognises both sides of this historic argument. The Treasury needs to stop micromanaging DHSC, providing there is control of agreed global totals. The DHSC has to agree some key productivity and performance targets. A deal on this basis will require a cultural shift by both parties.

It is possible to contemplate the Treasury and DHSC negotiating a new and longer-term workforce planning and delivery system with six key features.

1. 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.
2. 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.
3. 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).
4. DHSC should examine critically the scope for changing the workforce skill mix to produce greater efficiency and shorten training times.
5. 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.
6. A limited number of key performance targets should be agreed annually between DHSC and the Treasury, together with a realistic productivity measure.

Before such a new approach to workforce planning could be agreed there would need to be major changes to the skill sets at the top of DHSC. These would be necessary anyway if a new governance framework of the kind outlined above was to be implemented successfully.

Reforming DHSC

Hitherto when things weren't working in the NHS, governments thought the best thing to do was to reorganise the NHS, with the Department remaining much as it was. Labour tried combining the posts of NHS Chief Executive and Permanent Secretary but that didn't work and was abandoned. This pamphlet tries a different approach. It tries to limit NHS organisational change and instead focus on central governance and the capability of the top management of DHSC.

It may well be that a large part of the NHS' problems has been the Department's culture and approach. It can be argued that DHSC has lost sight of the fact that it was responsible for running a huge business with the largest labour force in the UK. It thought it could offshore management of the business stuff and stick to traditional civil service policy roles and advising ministers. Unfortunately, it turns out that it's the business stuff that keeps getting the Department and its ministers into trouble. Trying to fix that problem, in a tough political environment, with traditional civil service skills was never likely to produce durable change.

In day-to-day reality, the NHS is a cash-limited social business with virtually no capacity to moderate demand for its services. In crisis all it can do is ration what services it can provide. It largely leaves the rationing decisions to doctors. Over time the customer base has changed (older, frailer and with many more lifestyle diseases); but its service delivery model hasn't altered much. In particular, it has done little longer-term planning of its changing workforce needs or those of a partner service provider, local government. Efficiency, productivity, and business systems don't feature much in NHS or DHSC lexicons or conversation.

Unless there is a major injection of business and managerial thinking and action at the top of DHSC, the problems and failings in the health and care sector will probably go on being repeated. To give the governance framework changes above a chance of success and to allow innovation and new technology to flourish, a major personnel and cultural change is required at the top of DHSC. The cultural shift is to move top management thinking to remembering that its client base is patients and the public – who are basically the shareholders as well. It is not the service providers. They need to be involved in creating change, but they cannot be allowed to be the ultimate arbiters of a 21st Century delivery system for health and care.

This means fundamental change to the traditional civil service system for running DHSC. It needs replacing with a more business-like and managerial structure more suited to helping ministers run the health and care sectors. Here would be a new triumvirate at the top of DHSC to enable ministers to drive change. They should be people with experience of managing big organisations with varied workforces and able to work with the realities of political life. They are a Chief Executive instead of a Permanent Secretary as the Accounting Officer. They 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 5-year contracts, potentially renewable once.

A small DHSC executive management board needs to be constituted by the Health Secretary in consultation with the new Chief Executive but would include a Chief Medical Officer, Chief Scientific Officer, a Director of Social Care and a Director of Health Policy. This board would be concerned with running DHSC but some of its members would be on or attend the new Central Health and Care Board described above.

A summing up

The NHS is in a spiral of decline. Governments have a choice. Bumble along much as we are now and pretend radical change is not necessary. Or face up to this decline and the associated inadequate systems for reducing demand, delivering services and planning the workforce required. They badly need to have a conversation with the public and the NHS about the changes required, as sketched out in this briefing. They could demonstrate their willingness to face up to difficult choices by making changes at the top of DHSC. This would show they were serious about driving reform and improving services and performance. As Giuseppe di Lampedusa suggested in his 1957 classic, The Leopard: "If we want things to stay as they are, things will have to change."

NOTE ON THE AUTHOR

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