What do we want from the next Prime Minister?

A series of policy ideas for new leadership: Health and Social Care

Robert Ede, Dr Sean Phillips, Yu Lin Chou

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Policy Exchange

About the Authors

Robert Ede is an award-winning healthcare policy specialist, and leads the Health and Social Care Unit. He joined Policy Exchange in 2020 following seven years in consultancy where Robert advised private and third sector organisations across a range of issues including NHS estates, vaccinations, dementia, and genomics. Robert acted as the Prize Director for the Wolfson Economics Prize 2021 on the subject of hospital planning and design. He has degrees from the University of Oxford and the University of Exeter.

Dr Sean Phillips is a research fellow in the Health and Social Care Unit. He joined Policy Exchange in December 2020 from the University of Oxford, where he recently completed a DPhil in History. He previously worked as a consultant in Berlin on matters relating to digital health and emergent technologies in healthcare, advising consumer health, insurance, and start-up clients.

Yu Lin Chou is a Research Fellow in the Health & Social Care Unit at Policy Exchange. She previously worked in international development consulting where she focused on the econometric evaluation of health system efficiency. She has a master's degree in Development Studies from the University of Cambridge and a bachelor degree in Philosophy, Politics, and Economics (PPE) from Vrije Universiteit Amsterdam.

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Contents

About the Authors 2
Expert Insights 5
Summary 7
Section One: Boosting Access 10
Section Two: The Longer Term 25

Expert Insights

The new administration must work with the NHS and social care leadership to reduce the number of priorities imposed on the system. If everything is a priority, nothing becomes a priority. As the most immediate pressures of winter ease, the Prime Minister and their team should identify a small number of things that he or she wants to achieve in health and care and ensure that they have the resources and right people in place to deliver the change. The proposals should be understandable to everyone and be focussed on improving quality of the NHS offer by improving patient experience, health or clinical outcomes or safety of care. Associated measures of progress should be simple and meaningful, without increasing the burden of data collection on a stretched NHS. The package outlined by Policy Exchange offers a series of proposals around core principles of timely access, quality of care and compassion which the Government would be wise to consider seriously.

Professor Sir Bruce Keogh Chair, Birmingham Women's & Children's NHS Foundation Trust; Former National Medical Director (2007-18)

Our NHS and social care services are in crisis and prioritising is not easy, especially when the stakes are so high. Yet patients and the public can play a vital role in helping decision-makers understand where to focus.

Patient insights can help the system both manage the current pressures better and get ahead of demand. Here are five priorities drawn from what people say to Healthwatch:

*The NHS is targeting those who have waited the longest to receive treatment – **but people tell us they need more help whilst they wait**; such as pain relief, support with mental health and better communication from the NHS so no one feels forgotten.*

*Other **people need better initial access to services including GP services, NHS dentists and assessments in social care**. Overlooking these risks storing up significant issues in the medium term.*

***Support for long term conditions** (including long COVID) must be enhanced and become more proactive so people don't find themselves joining the queue for operations unnecessarily – or dying early.*

A generation of young people need better access to mental health services *– or we risk overwhelming the system for adult support longer term.*

Improve performance measures in A&E and ambulance services to rebuild public trust in the NHS being there in moments of crisis.

The proposal set out by Policy Exchange provides a solid framework, and if implemented in partnership with people and communities they create a way to build a consumer focused health and care service for the future.

Louise Ansari, National Director, Healthwatch England

As a clinician, all I want is to be able to do my job well; *to do that I need to work in a system that allows me to see the patients I was trained to assess and treat with minimal delay and should admission be necessary, be assured that an appropriate bed is available. I want to work in a facility that is designed to facilitate the delivery of a modern and safe emergency medicine service and one that is staffed with a workforce that consistently matches demand.*

That is not the reality in many emergency departments at the moment. *We struggle to accept zero notice patients, and are forced to make difficult trade-offs. Emergency procedures are performed inside ambulances. Arrivals are seen in communal areas not designed for clinical assessment. Patients are left on ventilators without staff oversight. We overlook the deterioration of a patient as we cannot observe everyone in a crowded waiting room.*

The principal reason behind this is the lack of flow within urgent and emergency care. *This itself is a symptom of difficulties of moving patients within the hospital into the wider health and social care system. We need to make sure patients are able to access the right care in the right place at a time that is appropriate for their condition. We need to be able to discharge patients home or to another care environment the day they are ready to leave. Flow is crucial and has to be the focus. Whilst it feels the ED and Ambulance is the battlefield, it is not where the battle will be won.*

Dr. Sue Robinson, Consultant in Emergency Medicine, Cambridge University Hospitals NHS Foundation Trust; Regional Clinical Advisor Emergency Medicine, NHS England

Summary

We have reached a crossroads in health and care delivery in England. Performance across all key NHS metrics is in decline. Record waits across general practice, emergency and planned care have led to the biggest single observed fall in public satisfaction with the NHS. The issues within the NHS are interwoven with social care, where a lack of available residential beds is delaying discharges and impacting flow across the hospital. Quality is another major issue within social care; two thirds of people who use the services are dissatisfied and the workforce and provider market are fragile.

Things will get worse over the coming autumn and winter. There is a genuine risk of a complete loss of public confidence in the NHS, and public services more broadly. The new Prime Minister and their Health and Social Care Secretary will therefore need to drive action, and positively maximise their powers of direction in two principal areas in health and care:

- **Access.** Ensuring citizens can access the services they need – with an immediate focus on initiatives which can hit the front line and achieve impact in the next 18 months.
- **Transformation.** Introducing reforms and additional resources that can put the NHS and social care sectors on a sustainable longer-term footing, by reorienting towards personalised and preventative care.

This briefing sets out sixteen ideas focused against delivering on those two areas. Some are ambitious and would seek to deliver against both priorities, expanding access whilst enabling longer-term transformation. Others are tactical and short term in their nature. We have also suggested continuity in some areas of policymaking – where good initiatives under the previous Prime Minister must be given time to bed in. Existing headline commitments – covering new hospitals, extra GP appointments and nurses – must be delivered.

This mix is deliberate. The enormity of the issues facing the NHS is hard to overstate. The gloomy performance outlook is fuelling talk of more fundamental reform, with an open discussion on a departure from the current taxpayer-funded, free-at-the-point-of-use model. Whilst we understand the public anger at deteriorating performance, Policy Exchange believes that a wholesale change of this type would distract from the most pressing priorities.

Spending at the Department of Health and Social Care will reach

£188.6bn in 2024/25.[1] The ideas in this document should be delivered from within that funding envelope. There are some exceptions: additional funding is proposed for social care, NHS pensions and capital spending – areas which we believe can unlock the biggest benefit. We hope that setting a narrower set of priorities will help make transparent choices around what is deprioritised.

This approach should be viewed as a temporary measure given the wider economic outlook. The only long-term route out of this crisis is through reducing demand on the NHS. This must begin with fixing the pay and conditions of the social care workforce, and lifting the quality and offer of care in that sector. More broadly, we need to shift our entire mindset towards policies which protect and enhance health, rather than reinforcing a system around treating sickness with medicalised healthcare. Efforts to promote good health have eluded successive Governments. It will not be easy. But when faced with the NHS taking up ever higher proportions of day-to-day public spending, this becomes a more significant political challenge. In the second half of the document, we have tried to extend our canvas beyond the NHS and social care sectors in assessing some of the potential options to improve health, with a particular focus on the early years of life.

Short-Term

Introduce the following policies and actions to expand access in the short term:

- Action 1: Update the Rights within the NHS Constitution, with ambitious yet realistic targets on general practice, elective care and emergency department access that reflect clinical risk and public priorities.
- Action 2: Tackle the backlog in planned care with better use of shared decision making, and address disparities, by prioritising children facing the longest waits for planned care. The objective is to eliminate all paediatric waits longer than 52 weeks for this group by March 2024.
- Action 3: A massive scaling up of Virtual wards over autumn and winter, to free up hospital beds and reduce bottlenecks in emergency departments.
- Action 4: Introducing an emergency £800m uplift in funding for the Better Care Fund (from the current £7.2 to £8bn) to expand the offer of the hospital discharge policy.
- Action 5: Launch a scheme to invite retired GPs and nurses to come out of retirement to work in the NHS.
- Action 6: Expand the role of community pharmacies and assets housed within local government to deliver routine vaccines and immunisations, freeing-up GPs to focus on wider clinical care.
- Action 7: Scale up data analytics capabilities across the NHS to ensure intelligent deployment of resources, maximising the

1. Figures taken from the Autumn Spending Review 2021, *HM Treasury*, 23 October 2021 [link]

positive learnings from the COVID-19 pandemic.
- Action 8: Reform NHS pension rules and their relationship with consumer price inflation.

Long Term

Consider the following wider reforms to transform how care is delivered, most of which would need to be taken forward over a full parliamentary term:

- Action 9: Expand the long-term capital investment plan, with a ring-fenced financial uplift to ensure improvements to the NHS estate across primary, community and secondary care to bring the spending on capital to above the OECD average.
- Action 10: Transform the role of general practice within primary care, shift towards a new model of scaled, integrated primary care, reframed around a unified front door called 'NHS Gateway', enabled by a shared care record.
- Action 11: Increase the clinical-led offer within 111, growing the proportion of clinical-led telephone and video calls from 50% to 80% by 2024. Incorporate 111 and video consultation within the NHS App giving the public access to NHS care 24/7.
- Action 12: Expand investment in diagnostics and imaging across the NHS, including transforming outpatient pathways.
- Action 13: Introduce a Commercial Technology Unit within NHS England, modelled on the Commercial Medicines Unit and the Vaccines Taskforce, with a remit to make national-level deals on innovative diagnostic technology.
- Action 14: Introduce a long-term workforce plan for the social care workforce, with redesigned remuneration structures and career progression. Within this workforce plan unveil a 'My Year in Care' scheme, modelled on the Duke of Edinburgh Award and National Service, giving school leavers 12-month placements in care prior to further education or employment.
- Action 15: Introduce an NHS Data Graduate Training Programme. This would represent a significant expansion of the Analyst and Informatics strands within the existing NHS Management Trainee Programme.
- Action 16: Initiate a national conversation to improve health and reduce demand on healthcare.

Section One: Boosting Access

The new Prime Minister should introduce a series of policies and actions to expand access to health and care over the next 18 months.

Core elements of health and care provision are in decline:

- **General Practice:** Public satisfaction has fallen to the lowest level in history. Only half of people can get a GP appointment at the time they want, and only 56% reported a good overall experience, compared to 71% in 2021.[2]
- **Elective care:** Waits from referral to treatment have increased to 45.7 weeks by June 2022 – a doubling of the wait time compared to three years ago.
- **Emergency care:** Only 70% patients are now seen within four hours, against an official target of 95%. Official figures show that nearly 30,000 people were delayed by over twelve hours on trolleys in July 2022 – although evidence from individual trusts suggests that figure is likely to be much higher, with informal reports that up to 1,000 additional patients a month may be dying in emergency departments because of long waits.[3]
- **Social Care:** 15% of people are satisfied with their care received, with a majority of those who were dissatisfied said that it was because they were unable to access the care they needed. The understandable focus on discharging patients from hospital is also having a knock-on impact – with nearly 300,000 still awaiting their first assessment of their health and care needs.[4]

Beyond these, there are significant delays in accessing care in specialist pathways in mental health, cancer, and neurological services. This is alongside overlooked areas such as addiction and eating disorders, and community services, where there is reported to be a waiting list of more than one million.[5]

The challenge is stark. When first published in 2019, the NHS Long Term Plan contained a list of pledges to improve outcomes across major health conditions.[6] Fast forward to the present day, it is *access* not *outcomes* which will define the debate ahead of the next general election. Polling on healthcare priorities has demonstrated that access to routine services such as GP appointments and elective care is the number one public concern on the NHS.

2. The GP Patient Survey 2022 Results [Link]
3. Rebecca Thomas, 'Revealed: 'Apocalyptic' A&E waits that could be driving 1,000 deaths a month', *The Independent*, 2 August 2022 [Link]
4. ADASS Survey: People Waiting for Assessment Care or Reviews, *Directors of Adult Social Services*, 2 August 2022 [Link]
5. Emily Townsend, 'NHSE leak reveals 1m patients on hidden waiting list', *Health Service Journal*, 1 August 2022 [Link]
6. The NHS Long Term Plan (January 2019) [Link]

How can the Government and NHS England get access back on track? The first action should be to prioritise. Both the Government and NHS England have historically struggled to issue a narrow set of instructions. The Annual NHS Mandate for 2022/23 set out the Government's instructions to NHS England based around five objectives. The Annex contains a further 13 priority commitments. [7] NHS England produces its own set of 10 priorities for the system within its operational planning guidance for systems, the most recent of which was published on Christmas eve.[8] In addition, last week NHS England published a separate set of eight objectives for operational resilience as we look toward the winter.[9]

Whilst there is some cross-over, a set of 13 commitments, 10 priorities, and 8 specific priorities for this winter is together likely to be too extensive to be deliverable, especially in the absence of any ranking system to differentiate their relative importance. Several priorities – for example to eliminate 12-hour waits in emergency departments – feel detached from the current reality on the ground where patients spend several days on trolleys. Others have observed that 'policy hyperactivity' from Whitehall and NHS England could backfire, with local leaders asked to work towards too many disparate initiatives set by the centre at the cost to the things that matter most.[10]

Achieving success will require good political judgement. The Health and Care Act 2022 gives the Health and Social Care Secretary several significant new powers. The Government must now be judged by their ability to intervene with precision and effectiveness when it matters. This document makes a number of suggestions.

In Section One of this paper Policy Exchange has chosen to set out a series of ideas which can contribute towards meeting a single objective: expanding access to better meet patient's needs. In some areas the implementation of the policy would support other desirable objectives, for example in reducing disparities, or in supporting the health and care workforce. In most instances we have drawn on our most research, including *Saving a Lost Decade* (2020), *A Wait on Your Mind?* (2021), *Realising the Research Effect* (2022), *At Your Service* (2022) and *Devolve to Evolve* (2022). More detail on these ideas is outlined in the following pages.[11]

Action 1 – A Refreshed Set of Patient Rights

The Government should signal to the public and the NHS that **access is the singular priority for the next 18 months.** Existing resources will be directed towards expanding access, with a focus on timely and convenient care. A good patient experience is increasingly understood to be as important as the clinical outcome. Any expansion will be done in a way that does not impact patient safety. We propose that this is outlined within a refreshed **Set of Rights within the NHS Constitution** involving the following elements:

7. NHS Mandate 2022-23, *DHSC*, 31 March 2022. [Link]
8. Priorities and Operational Planning Guidance, *NHS England*, 24 December 2021 [Link]
9. Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter, NHS England, 12 August 2022 [Link]
10. Nigel Edwards, 'Policy hyperactivity unsupported by additional spending will not tackle fundamental problems facing health and care', *The Nuffield Trust*, 15 June 2022 [Link]
11. These reports are available via the Policy Exchange website [link]

Box 1– The NHS Constitution for England

The NHS Constitution sets out the principles and values of the NHS in England and rights for patients, public and staff. It was first published on 21 January 2009 and given legal effect by the Health Act 2009. The Secretary of State, NHS bodies as well as independent and third sector providers supplying NHS services are required by law to take account of the Constitution in their decisions and actions.[12]

The Constitution sets out seven key principles:

1. The NHS provides a comprehensive service, available to all irrespective of sex, race, disability, age, sexual orientation, gender reassignment status, religion or belief.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism
4. NHS services must reflect the needs and preferences of patients, their families and their carers.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

This gives patients a series of rights which include (but are not limited to):

- The right to state a "preference for using a particular doctor within your GP practice, and for the practice to try to comply";
- The right to choose which hospital you're referred to for an outpatient appointment for a physical or mental health condition;
- "Right of access to your own health records and to have any factual inaccuracies corrected";
- The "right to have any complaint you make about NHS services acknowledged within three working days".

Despite this, awareness of the Constitution is low both between the public (where only around one-quarter of the public say they are aware of it) and those who work in the NHS, where a minority of staff (49%) are aware of it, according to an assessment published in January 2022.[13]

The Secretary of State has a legal duty to review and republish the Constitution at least every 10 years (the next is due by January 2025).

- ***A revised target for 95% of patients who require admission to be admitted within four hours.*** The original target is for all patients attending A&E to be admitted, transferred, or discharged within four hours.

12. The NHS Constitution for England, *Gov.uk* [link]
13. Fourth report on the effect of the NHS Constitution, *DHSC* (January 2022) [link]

This was criticised by some as arbitrary and distorting of clinical priorities. Following the 2018 review led by NHS England, a bundle of ten metrics was developed which is currently being field piloted in several trusts.[14] A full national rollout is imminent pending Ministerial approval. However, research has since shown that mortality increases significantly when patients wait longer than five hours before being admitted.[15] The evidence is that far from arbitrary, time-based targets save lives. Whilst a good patient experience and outcome is multi-dimensional, there is also innate effectiveness in a simple target which both citizen and clinician can easily understand. Any decision to remove a target must be undertaken with care. The current four-hour target is well-established, widely known and appears to be supported by clinical evidence on mortality for those admitted. We therefore believe that the rollout of the new basket of measures should be adapted. The final rollout of the set of operational diagnostics should be accompanied by a consolidated set of publics facing metrics. This should not include the 12-hour zero tolerance target. Early evidence from the pilots suggests that this is leading is normalising exceptional waits of up to 11 hours in A&E.

The four-hour target should remain as an integral part of the retail offer to patients on ED performance, but with resource directed towards the sickest patients. Under this Policy Exchange proposal, the incentives would be to prioritise patients which are most likely to require admission following a rapid initial triage. The revised promise to patients would broadly look as follows:

- If you come to A&E, you will be triaged within 15 mins.
- If you are a priority case (i.e., requiring admission) then you will get a hospital bed within 4 hours.
- If you are non-urgent you may have to wait longer, or the system may direct you to another part to access care.

This revised Set of Rights establishes a clear expectation for both clinicians and service users. The move would be popular. Evidence from Healthwatch England shows that the most popular measures with the public are quality of care, rapid initial assessment, and the prioritisation of the sickest.

- ***A new 'split' in the Referral to Treatment target for elective care.*** Research from Policy Exchange published in July 2021 found that 80% of the waiting list are awaiting a decision from a consultant on whether they require treatment or a diagnostic test.[16] This is an enormous unknown clinical risk for the NHS. One–fifth of all cancer diagnoses are picked up through a non-cancer referral from general practice. The uncertainty that the patient holds prior

14. 'What's going on with A&E waiting times?', *The King's Fund*, 26 May 2022 [Link]
15. Simon Jones & Chris Moulton et al. 'Association between delays to patient admission from the emergency department and all-cause 30-day mortality', *Emergency Medicine Journal*, Vol. 39, No. 3 (2022), 169-173 [Link]
16. Robert Ede & Sean Phillips, 'A Wait on your mind', *Policy Exchange* (July 2021) [link]

to receiving a decision or diagnosis also represents a significant individual burden. Under our proposed target, the revised offer to patients would look as follows:

- You will receive a diagnosis and decision within eight weeks (to be known as 'referral to decision')
- You will then commence consultant-led treatment within ten weeks following diagnosis ('decision to treatment').

The total 18-week target will remain unchanged, but in effect two stricter deadlines will be imposed to incentivise Trusts to shorten the current time taken to give every patient their first consultation. The NHS in Wales is currently exploring this option too in order to encourage faster diagnosis.[17] This would have the added advantage for the UK Government in bringing the waiting list down at a faster rate. The vast majority of 6.6 million currently on the treatment do not require surgery. Shifting the incentives to clear patients at the top of the funnel is therefore grounded in a strong clinical and moral logic. However, it will not happen overnight. Current waits from referral to a decision/diagnosis are more than nine months.[18] Interim milestones for ICSs would therefore be introduced, accompanied by appropriate financial incentives, for example for bringing time to decision / diagnosis to below three months by March 2024.

- ***A new commitment to expand choice and access within primary care, including the offer of an appointment within seven days.*** In many parts of the country, patients' ability to access primary care is not as good as it should be. The latest GP Patient Survey results reveal declining satisfaction and a wide disparity across the new 42 Integrated Care System (ICS) footprints.[2] The General Practice community is responding to the increase in workload and is on track to meet the Government manifesto target of delivering 50 million more appointments, but output-based targets do not resonate with a public. Consumers of healthcare are increasingly expectant of a service which offers choices to suit their lifestyles—hence demands a shift towards personalised care. A new national commitment within the NHS Constitution to emphasise that patients have the right to be offered an appointment with a primary care healthcare professional within seven days would signal that the new administration will focus on the things that matter most to patients. Delivering against this goal will require careful coordination across the primary care landscape. As we have outlined in previous research, demand can be divided into cohorts. Whilst an episodic user seeks speedy access and values convenience; those with complex needs (both clinical and social) require coordinated support both within and beyond the GP surgery. Why would a guaranteed offer within

17. Our programme for transforming and modernising planned care and reducing waiting lists in Wales, NHS Wales (April 2022) [Link]
18. Rob Findlay, 'Elective volumes rise as covid measures ease', *Health Service Journal*, 14 July 2022 [link]

seven days speak to these distinct groups? The answer is that the implementation of the target should be accompanied by measures which boost choice. If a patient wants to see a preferred GP, they may be asked to wait longer than seven days in some instances. In areas which are under-doctored, patients will be offered the choice of an appointment with GPs or other primary care healthcare professionals based in neighbouring ICS geographies to meet the seven-day offer, using telephony or video consultation. Evidence shows that only a minority of patient requests for care stated a preference for in-person face-to-face consultation.[19] Delivery of this system will need to be underpinned by the seamless transfer of the patient record across primary care, and new reimbursement approaches to allow for neighbouring-area providers to reimburse for consultations. Tying this together would be new metrics to assess patient experience in accessing and booking appointments – one area where there has been an alarming decline in patient satisfaction over the past 12 months.[20]

Preparatory work on a refreshed NHS Constitution should begin immediately following 5 September, with the new measures unveiled this winter. The changes should be formally communicated to the NHS via a revision to the Mandate, using the new flexibilities and Ministerial powers of direction contained in the Health and Care Act 2022, an area which Policy Exchange strongly endorsed.[21] Delivery should predominately come from within existing allocations and is therefore likely to require a reprioritisation of existing resources.

The refreshed Set of Rights will be applicable to everyone using NHS services in England. These will be insufficient for meeting the capacity challenges alone, but evidence does show that if planned well, targets can improve performance. Our proposal is that ICSs will have an assurance and oversight role in the implementation of the new refreshed Set of Rights, with the legal consequences of consistently failing to meet them set out clearly.[22]

Action 2 – Tackle the backlog in planned care with better use of shared decision making and prioritise children facing the longest waits for planned care.

The Government and NHS has already shown progress in addressing the backlogs in planned care which have grown substantially during the pandemic. During the first half of the year the numbers of those waiting more than 104 weeks for treatment has been reduced 23,000 to a few hundred – effectively achieving the first milestone within the Elective Recovery Plan.[23] Policy Exchange welcomed the plan when it was published in February 2022. Apart from action on pensions (which we address later) the fundamentals are already in place to work through the backlog – there just needs to be a ruthless focus on delivery. Any proposals should build upon rather than disrupt current progress.

19. 'Analysis finds 10% of patient care requests indicate a preference for face-to-face GP consultation', *The Health Foundation*, 17 March 2022 [Link]
20. According to the GP Patient Survey 2022 just 53% of users find it easy to get through to their practice by telephone, compared to 68% in 2021, see The GP Patient Survey 2022 Results [Link]
21. Robert Ede, 'Taking back control? The forthcoming white paper should be cautiously welcomed', *Health Service Journal*, 8 February 2021 [Link]
22. Nick Davies, Graham Atkins & Sukhvinder Sodhi, 'Using targets to improve public services', *Institute for Government*, 16 June 2021 [Link]
23. NHS England. Delivery plan for tackling the COVID-19 backlog of elective care. February 2022. [link]

A further suggestion to expand access within elective care would be to **encourage greater use of shared decision making in surgical pathways and in follow up appointments.** We need to move beyond the paternalising notion of the NHS 'looking after' patients, and instead consider care a partnership between the multidisciplinary team with the patient at the centre. 'Shared decision making' simply means fostering a more collaborative process in determining the right course of treatment for a patient, rather than relying on a one-way process where the patient becomes a passive recipient of care. The aim is to give greater weighting to treatment options, balance of risks and benefits and to "build in what the patient knows best about: their preferences, personal circumstances, goals, values and beliefs".[24] The introduction of My Planned Care shows that the Government recognises the need, but efforts to put information and power in the hands of patients should go further.[25] The evidence suggests that greater use of shared decision making could also significantly reduce the current size of the waiting list. The Royal College of Anaesthetists has consistently found that 15% of patients across the UK who have multimorbidity and frailty choose not to undergo major surgery when all the benefits, risks and alternatives are discussed.[26] This has been corroborated by the Getting it Right First-Time programme which has suggested that properly informed patients will reduce the rate of futile surgery and also complaints from relatives, whilst also saving money.[27] Whilst only around 20% of the current elective waiting list will ultimately require surgery, the proportion needing surgery is higher among longer waiters.[28] Whilst in practice many experienced surgeons embed these principles as part of their routine practice, there is the potential to embed this more widely across the speciality. Effective use of shared decision making could therefore make a significant contribution to meeting important political targets such as eliminating those waiting more than 65 weeks by March 2024.

Whilst the NHS must focus on increasing the amount of activity, this must also be done in a way that addresses disparities in access. Research shows that you will wait longer for elective care if you live in a deprived area or have lower educational attainment.[29] Partially because of this, attendance at A&E is nearly twice as high for the most deprived areas of England compared to the least deprived.[30] Tackling inequalities in outcomes, experience and access is one of the four core priorities of the new Integrated Care Systems, which become legal entities in July 2022.

Within elective care, Policy Exchange proposes that the NHS is asked to prioritise the **treatment of children**, with the intention to **eliminate all waits longer than 52 weeks for these two groups by March 2024** (one year ahead of the target for the general population).[31] This will be controversial. Other groups in society also experience disparities in their care, why should those under the age of 18 be prioritised above others?

There are 367,079 children on the waiting list for planned care. More than 14,000 of these have been waiting for more than one year.[32] We should find this unacceptable. No group is immune from the negative

24. Shared decision making, *NHS England* [link]
25. My Planned Care, *NHS England* [link]
26. Ramai Santhirapala, 'Shared Decision-Making Hub Launched', *Centre for Perioperative Care* [link]
27. 'Letter to the Times: "Treating the Elderly"- Mark Cheetham [National Clinical Lead-General Surgery, Getting it Right First Time, NHS England], *The Times*, 1 August 2022 [Link]
28. Ian Eardley, 'Tackling the backlog', *The Bulletin (Royal College of Surgeons of England)*, 30 June 2022 [link]
29. Jonathon Holmes & Danielle Jefferies, 'Tackling the elective backlog – exploring the relationship between deprivation and waiting times', *The King's Fund*, 27 September 2021 [link]
30. 'People living in most deprived areas twice as likely to attend A&E', *Hospital Times*, 10 September 2020 [link]
31. Delivery plan for tackling the COVID-19 backlog of elective care, *NHS England* (February 2022) [link]
32. 'QualityWatch- Waiting list for planned paediatric hospital services', *Nuffield Trust*, 18 February 2022 [link]

consequences of a long wait for treatment or surgery, with significant knock-on impacts including for those in employment or with caring responsibilities. However, long waits for care are particularly harmful for children, impacting on their mental and physical development at a critical time in their life with longer term impact on educational attainment and life chances. In some instances, for example, surgery for a cleft lip, treatments need to be given by a specific age or development stage to achieve the maximum benefit.[33]

Research from the Royal College of Paediatrics and Child Health have found that children in England have some of the poorest health outcomes in Western Europe.[34] The growth in paediatric outpatient attendance has also increased very rapidly since the early 2000s, placing a greater burden on elective services. Whilst international research suggests that parents can be accepting of waits in the region of three months, there is very limited acceptance of waits longer than six months.

Prioritisation of this group should be agreed and communicated nationally. The system already operates a system of prioritisation on the basis of time waited (hence considerable progress on eliminating the number of patients who have waited more than two years for treatment) in close association with clinical need. Such an approach would need to be underpinned by strong data fundamentals. Introducing a tougher target to treat children who have been waiting longer than a year by March 2024, one year ahead of the population at large, would demonstrate the Government's commitment to addressing disparities as we look towards the next general election. Delivering against the target would likely require better safeguarding and building up of resource within paediatrics, which is occasionally redirected towards services for adults.

Action 3 – Urgently free up hospital bed capacity, with accompanying investment in community care

Beyond elective care, there is a need to address the fundamental issue of patient flow within hospitals. This is the primary cause of the delays in ambulance handovers and long waits within the Emergency Departments. We recommend a **massive scaling up of virtual wards over this coming autumn and winter, to free up hospital beds and reduce bottlenecks in emergency departments**.

Work is already underway in this area. In a letter issued to ICS and Trust leadership on 12 August, NHS England called for a further rapid expansion of virtual wards, including 2,500 within community settings.[9] We have concluded that this could go further.

Virtual wards are remote services which enable patients to be cared for at home.[35] The patient is provided with monitoring equipment and they/their carer is asked to take readings (for example blood pressure, or oxygen levels). Virtual wards existed prior to the pandemic, but their wider adoption during COVID-19 has encouraged NHS England to call for ICSs to establish 40-50 virtual beds per 100,000 population by December 2023. This would equate to around 23-25,000 virtual hospital beds across

33. Jeff A. Hammoudeh & Thomas A. Imahiyerobo et al., 'Early Cleft Lip Repair Revisited: A Safe and Effective Approach Utilizing a Multidisciplinary Protocol', *Plastic Reconstructive Surgery Global Open*, Vol. 5, No. 6 (June 2017) [link]
34. 'Child health in England in 2030: comparisons with other wealthy countries', *The Royal College of Paediatrics and Child Health* [link]
35. 'Virtual hospital care at West Herts, *West Hertfordshire Teaching Hospitals NHS Trust*, 8 April 2022 [Link]

England.[8] Earlier this year, the Royal College of Emergency Medicine suggested that a further 4,500 staffed beds should be made available across the United Kingdom ahead of the coming Winter.[36] The rollout of virtual wards is supported by £450m in funding available in two tranches. Early reports suggest that the original 25,000 target may be missed. Several clinical leaders have also raised concerns about the model; suggesting that it will struggle to be extended beyond initial clinical specialisms such as cardiology and respiratory medicine and highlighting the issues that arise from shifting complex care from hospitals and into community settings where the district nursing workforce is particularly depleted, losing nearly half of its workforce from 2010 to 2017.[37] Any approach which introduces a new pathway or redefines old ones must be supported by additional capacity in the community and must not rely upon extra work being undertaken by general practice to support it.

Greater hospital bed capacity can also be created through smarter utilisation of independent sector capacity. Current volumes of NHS referrals handled by the independent sector remain below the pre pandemic baseline. [38] Capacity is not being maximised. Systems should identify those inpatient or day case specialties which could safely be moved into independent sector settings over winter to protect and ensure elective activity continues, especially given the threat of influenza and novel COVID variants. The greatest opportunity is likely to be in orthopaedics. This approach will help free up bed (and theatre) capacity for patients on emergency care pathways. To ensure value for money, trusts should look to 'bulk book' for the winter but ensure that payment is only made based upon activity delivered.

Neither virtual wards nor greater independent sector usage are without drawbacks. However, these must be carefully balanced against the emerging crisis in emergency medicine. Whilst attendances at A&E are broadly consistent with both 2021 and 2019, the ability to either admit, transfer or discharge patients has been significantly compromised.[39] This is as much to do with the back door of the hospital as the front door. Delays in discharge continue to be among the principal factors limiting flow within the hospital, and therefore the ability for admissions from the emergency department. Less than half of patients deemed medically fit for discharge are sent home on the same day.[40] Often this is because the patient is awaiting a care package, or community or nursing home placements.

Improving patient flow has proved an elusive policy objective for decades. Research within the Canadian healthcare system suggested that many initiatives struggle to achieve positive results because they focus too narrowly on the process, at a cost of the necessary understanding of the defined population and appropriate capacity required.[41] Capacity is the limiting factor in the short term; it will be exceptionally tricky to expand the beds in the residential care sector in time for the coming winter. However, action is required to avert a collapse of emergency care over winter.

36. 'RCEM Acute Insight Series: Beds in the NHS', *The Royal College of Emergency Medicine* (May 2022) [Link]
37. Alison Leary, 'Saved bed days: the ultimate currency', *British Medical Journal*, 7 July 2022 [Link]
38. The figures differ by specialism with ophthalmology caseloads above the pre-pandemic baseline, but the majority of specialisms remain below it. See Sebastien Peytrignet & Jay Hughes et al., 'Waiting for NHS hospital care: the role of the independent sector', *The Health Foundation*, 28 July 2022 [link]
39. 'A&E Attendances and Emergency Admissions: Statistical Commentary', *NHS England* (June 2022) [Link]
40. Joseph Plewes, 'What the latest data tells us about delayed discharges', *NHS Confederation*, 10 February 2022 [link]
41. Sara Adi Kreindler, 'Six ways not to improve patient flow: a qualitative study', *BMJ Quality & Safety*, Vol. 26, No. 5 (2017), 388-394 [link]

What can be done? The 'least bad' option will be to shift as much in-patient care to remote settings as is reasonable without compromising patient safety. This is likely to require additional investment, including video conferencing capability to allow for enhanced remote monitoring, and greater emphasis on senior nurse leadership within the virtual ward rounds. It will be important to involve the CQC from the start of the project to ensure that the necessary independent evaluations of the impact on safety and outcomes have been undertaken. This should be accompanied by a package of targeted support for community care and district nurses who will support the hospital care team. One immediate measure would be to uplift the NHS mileage rate from the current 56p per mile for the first 3,500 miles to cover the first 10,000 miles (reflecting increased petrol prices, and that nurses may have to adapt their working practices to reach a wider number of patients in virtual wards).[42]

Action 4 – Expand the Better Care Fund

The measures to grow virtual wards should be supplemented by an **additional, emergency uplift of £800m to the Better Care Fund and action on social care workforce pay.** The Better Care Fund (BCF) is a pooled budget shared by local authorities and the NHS, intended to encourage better coordination of health and social care services locally.[43] The NHS is required to make a minimum contribution to the fund which amounts to £4.5b in 2022/23. This is supplemented by the Disabled Facilities Grant and the improved Better Care Fund – with the three combined contributions reaching £7.2bn for the current financial year. We recommend that the BCF receives an £800m uplift which will be entirely ring-fenced for social care services. This would go towards both domiciliary and residential care; allowing Local Authorities to secure places within residential care at appropriate market rates, and also to fund home visits for assessment – particularly through expanding the centralised funding pot within the existing Discharge to Assess scheme. This scheme was used effectively during winter 2021/22 – with evidence showing that £594m in implementation during the first half of the year led to a 28% reduction in hospital patient says over 21 days. The £800m should be one off, non-recurrent funding, found from within existing DHSC budgets to help the sector get through the winter.

On pay, Policy Exchange has set out a longer-term proposal under Action 14.

42. NHS Mileage Allowances FAQs, *NHS Employers* (March 2022) [Link]
43. Adult social care funding (England), *House of Commons Library*, 11 February 2022 [Link]

Box 2 – What is the Better Care Fund?

Initially announced during the June 2013 Spending Round during the Coalition government as an 'Integration Transformation Fund', what is now called the Better Care Fund (BCF) was launched in 2015.

It is a single, pooled budget for health, social care and housing services which seeks to enable "older people, and those with complex needs" to manage their "own health and wellbeing and live independently in their communities for as long as possible". In practice, the BCF funds home adaptations for disabled people, and assistive technologies, such as like stairlifts and ramps.

The fund represents a collaboration between the Department of Health and Social Care (DHSC), Department for Levelling Up, Housing and Communities (DLUCH), NHS England and Local Government Association (LGA) and requires integrated care boards (ICBs) and local government to agree to joint plans, owned by the health and wellbeing board (HWB).

The BCF current pooled budget includes £4.5 billion of funding from the NHS, £2.1 billion from the 'improved Better Care Fund (iBCF) grant' to local authorities, and £573 million from the Disabled Facilities Grant (DFG). The NHS contribution has increased by 5.66 percent since the last settlement. iBCF has increased to £2.14bn and the DFG has been maintained for 2022-23 at £573 million.[44]

Action 5 – Launch a re-entry scheme for retired GPs and nurses

If the Government is to stabilise primary care in the short term it will require several interventions on the workforce. One proposal would be to **launch a scheme to invite both retired GPs and nurses to come out of retirement to work in the NHS.** Research suggests that most GPs retire in their mid to late 50s - roughly a decade before the default retirement age. A recent survey of 800 GPs also found that 1 in 8 wish to retire before reaching 55.[45] More than 700 GPs retired last year, so what would it take to lure them back? Common factors cited for early retirement given include workload and the current pension taxation rules. Flexibility should be targeted into these two areas. Under the scheme a 'limited scope of practice' would be created through potential reforms to the Performers List regulations. GPs would be encouraged to come out of retirement, and work in surgeries. They would not be on the Performers List in the same way as a fully operational GPs but would perform several of the core functions within the practice. Any scheme would need to be developed with care to not create perverse incentives (for example encouraging registered GPs to switch onto the new programme).

For nurses, the proportion leaving the professional register has been stable – actually falling slightly since 2016. In a year period from September 2020 to 2021 around 19,000 (3.5%) left the register. Some choosing to leave have highlighted the low staffing levels as a motivation behind wanting to leave, highlighting how departures can lead to a spiral in particular organisations as a smaller group of staff and left to pick up a higher burden of work.

45. Caitlin Tilley, 'Half of existing GP workforce intends to retire at or before 60', *Pulse*, 7 June 2022, [link]

44. 2022 to 2023 Better Care Fund policy framework, *Gov.uk*, 19 July 2022 [link]

Efforts have already been underway to encourage recently retired staff across the workforce to return.[46] Two practical solutions to further accelerate progress here would be showing greater flexibility in the NMC readmission process, and introducing a consistent, national policy on the pension rules associated with 'retire and return' – as this is currently inconsistently applied across the NHS.

Action 6 – Expand the role of community pharmacy

Other measures will be required to free up capacity within general practice and to stabilise primary care more widely, with well documented issues in access to NHS dentistry. We believe that **the Government should expand the role of community pharmacies in delivering appropriate services to patients, to free-up GPs to focus on wider clinical care.** Community pharmacy does not represent a 'silver bullet' to boosting uptake and reducing workloads, however, the deployment of the COVID-19 vaccine does demonstrate that it represents a viable setting for activities such as immunisations, and opportunities to boost cooperative working between pharmacy and other providers, including improving data sharing should be undertaken.[47] As Policy Exchange will outline in a forthcoming report, we envisage pharmacy delivering a greater proportion of 'out of hours' or weekend immunisations, where GP practices are unable to do so. This would be best achieved through a locally negotiated contract, which brings together qualified providers (general practice, pharmacy, local authorities) to collaborate to achieve high vaccine coverage rates, rather than a system which has asked them to compete against each other.

Action 7 – Rapidly accelerate the use of data analytics within the NHS

The Department of Health and Social Care should oversee **the rapid scaling up of data analytics capabilities across the NHS to ensure intelligent deployment of resources**, maximising the positive learnings from the COVID-19 pandemic.

The NHS has enormous amounts of data accumulated over nearly 75 years. However, data alone does not produce insights. Raw data – ambulance handovers, long surgical waits, failed calls to a GP reception – must be managed, cleaned, and analysed, before it can then be interpreted and taken forward to inform decisions.

The use of modern data science techniques is patchy across the NHS. It is likely to be even worse in social care. The recent Goldacre Review found a 'culture of duplicative working behind closed doors, for national and local analytic teams; and a strong reliance on outdated and inefficient means of data management and analysis, using "point and click" tools such as Excel.' Too much of the secondary care data ecosystem involves analysis using old technology to create dashboards or spreadsheets which are then fed into national performance publications, often published several months in arrears.[48]

46. 'Enabling the workforce for elective recovery', *NHS England*, 4 May 2022 [link]
47. This will necessarily be a segmented offer given the complexities associated with each of the vaccines comprising the current routine schedule
48. Ben Goldacre, *Better, broader, safer: using health data for research and analysis*, *DHSC*, 7 April 2022 [Link]

The situation is worse in primary care. Policy Exchange's research on general practice, outlined in our final report, *At Your Service* highlighted that demand in general practice is – except in a small minority of cases – neither well understood, nor systematically recorded and analysed.[49] We found no studies which provide a comprehensive and granular break down of activity in general practice by query/complaint and resolution (for instance).[50] Whilst some alert systems have been integrated in recent years to flag acute pressures, many practices report limited capacity to record demand patterns. Some Local Medical Committees collect information on an individual practice and voluntary basis, but there is no unified understanding of pressures nationwide, with no common definitions of extreme pressure or unsustainable demand, leaving the debate about pressures in general practice open to media and stakeholder sentiment, rather than definitive data.

This has a material impact on access to services. If leaders cannot anticipate demand or understand where it has surfaced elsewhere in the system, then appropriate allocative decisions cannot be made. The status quo leaves the NHS in 'react' mode – rarely able to identify problems before they emerge.

There needs to be a change quickly across a range of care settings if the nation is to unlock the untapped potential in NHS data. We are supportive of the move towards Trusted Research Environments – secure spaces in which analysts, researchers and innovators can combine or work separately on data, with varying levels of success. A Federated Data Platform, currently being procured, will look to bring together data sets to create a 'single source of the truth' – following the successes associated with the use of the Foundry software during the vaccination and PPE programmes. The contract is worth up to £360m and will be awarded for five years.[51] As we look beyond the initial contract term, it will be important for the NHS to create the conditions for a competitive market for these solutions rather than relying on any single software provider. Efforts to create a Federated Data Platform will undoubtedly hit cultural and legal barriers in parts of the NHS, including general practice where individual GP surgeries are the data controller and processor for their patient list. Policy Exchange has previously recommended moving toward a process of joint controllership of data, emulating the approach taken in Scotland.[52]

The NHS needs to become much better at incorporating the voluminous data it collects from the users of its service. Approximately 200,000 written complaints are sent to hospitals and GP surgeries each year, whereas Healthwatch received more than three quarters of a million pieces of individual feedback. This data is rarely used for quality improvement within practices, with some clinicians "sceptical about the reliability and validity of surveys, feeling they could not provide enough qualitative detail".[53] There is a moral obligation to use these insights to drive improvements, yet too often that opportunity is missed. A small investment in analytical capacity to incorporate patient experience into new data platforms could represent a major breakthrough in moving the

49. Sean Phillips, David Landau & Robert Ede, 'At Your Service: A proposal to reform general practice and enable digital healthcare at scale', *Policy Exchange, 4 March 2022* [Link]
50. NHS Digital has since April 2022 expanded the information recorded nationally to include 'Actual Duration', enabling a better understanding of GP appointment length, but the latest figures show that for ca. 6m appts a month, no data is currently recorded or there are 'data errors' [link]
51. 'NHS Federated Data Platform', *Gov.uk*, 25 July 2022 [link]
52. Letter – Community Health & Social Care Directorate, Primary Care Division, 27 November 2019 [link]
53. For a review of the literature, see Beccy Baird & Luca Tiratelli et al., 'Levers for change primary care: a review of the literature', The Kings Fund (April 2022) [link]. For an analysis of the use of patient experience metrics and issues in delivering quality improvement at practice level, see Jenni Burt & John Campbell et al, 'Improving patient experience in primary care: a multimethod programme of research on the measurement and improvement of patient experience', *NIHR: Programme Grants for Applied Research*, Vol. 5, No. 9 (2017) [link]

NHS towards being responsive to the consumers of its services.

Action 8 – Reform NHS pension rules and their relationship with consumer price inflation

The Government should **consider changes to the interrelationship between consumer price index (CPI) and the annual allowance (AA) for public sector pensions and address the problem of GPs and consultants seeking early retirement.**

Currently, many doctors are choosing to reduce their working contribution to the NHS or seek voluntary retirement because of the way that their NHS pension scheme interacts with the taxation policy set by HM Treasury. Pension growth in a defined benefit scheme, such as the NHS pension, which exceeds the annual allowance (AA) is subject to additional tax charges. The current annual allowance is £40,000. Originally, the legislation ensured that only growth above inflation was assessed as the rate of CPI used to revalue benefits in the Career Average Revalued Earnings (CARE) section of the NHS pension was the same rate of CPI used to uplift annual allowance calculations. However, this changed in April 2016, when pension input periods were amended to align with 6th April to 5th April. This caused a disconnect in the rate of CPI used for annual allowance calculations and the rate of CPI used to revalue CARE benefits in the NHS pension. The design of the legislation has created two unintended consequences: when CPI rises, members are now assessed for the growth in benefits including inflation. When CPI falls, the annual allowance growth can be negative. Negative growth is zeroed and cannot be carried across to other pension schemes within the same tax year or carried back to previous tax years to offset historic tax charges.

With inflation set to reach 11% this Autumn, many medical staff are likely to be hit with a significant tax bill. There is a misconception that this issue only impacts on the top earners in the NHS – often very senior hospital consultants. However, this is not the case, as the CPI disconnect impacts all practitioner members of the 95/08 scheme and all members of the 2015 scheme. Many salaried GPs, on incomes of £60,000-£110,000 are affected. A junior GP with an accrued pension of just £22,400 will use up their entire £40,000 annual allowance in 2022/23 solely due to the application of the anticipated September CPI rate of 11% to their existing benefits. There is evidence that this is pushing many clinicians into retirement, or to consider cutting down their sessions significantly.

A remedy to the current approach to the CPI disconnect would involve amending the 'appropriate percentage' mechanism as set out within s235 of the Finance Act 2004. An 'appropriate percentage' would be to match the rate of CPI used by a scheme to uplift its CARE benefits, which is either the rate of CPI before or after the tax year starts depending on scheme. As part of this HM Treasury could also consider allowing negative growth to be carried across to other schemes within the same tax year or carried back to previous tax years to offset historic tax charges. These required changes would lead to some reduction in the repayment charges to HM Treasury.

However, it would be more than offset by additional income tax receipts, which would also support the delivery of significantly more activity across the NHS during a period of workforce scarcity. These changes should be announced for consultation as part of the upcoming November Budget.

NHS pensions is a fiendishly complex policy area with numerous issues. We have chosen to focus on one: the CPI disconnect. There are further issues that should be looked at, including introducing a centralised 'Retire and Return' policy which can clarify the taxation and pension implications of returning to work in the NHS on a temporary basis (as recommended in Action 5).[54] We would propose that the new administration commissions an **independent review of NHS pensions** and their interactions with taxation policy. The review should commence in 2022 and report by January 2023 to inform the Spring Statement.

54. 'Workforce: recruitment, training and retention in health and social care – Third Report of Session 2022–23 Report', *House of Commons Health and Social Care Committee*, 20 July 2022 [link]

Section Two: The Longer Term

Alongside the eight ideas outlined above, Policy Exchange has set out eight further reforms which the new Prime Minister and their Health and Social Care Secretary may wish to take forward, many of which would require a full parliamentary term or longer. We will expand on many of these through follow up research in the coming months.

Action 9 – Increase capital investment on health and care infrastructure to above the OECD average

Effective capital expenditure correlates with improvements in productivity and clinical outcomes and can ensure the Government delivers on long-standing goals for system improvement – from modernising healthcare facilities to hard-wiring 'digital transformation' across NHS settings.[55] Yet the UK has historically underinvested in capital, with its budgets too often 'eaten into' by day-to-day operating costs. The result is an ageing (and in too many places, deficient) NHS estate.[56] A 2020 National Audit Office report found that 14% of the hospital estate alone predates the formation of the NHS.[57] That estate meanwhile houses a lack of diagnostic equipment, limited bed capacity (compared to key comparator countries) and dated IT infrastructure.[58]

The most recent Government recognised this problem, introducing a jointly sponsored New Hospital Programme (NHP) and a pledge to deliver 40 new hospitals by 2030 as well as one hundred 'one stop' Community Diagnostic Centres.[59] DHSC has meanwhile committed to uplift its allocation for capital to £11.2bn by 2024/5 (up from £4.7bn in 2015/16). These are welcome developments, but in recent months, reports have emerged suggesting cuts to capital budgets with the NHS having to fund the additional uplift in NHS pay from within current budget allocations. This would be deeply unwise.

The next Prime Minister should not allow for capital revenue to be transferred to shore up day-to-day revenues. But there is still a lingering question about how to fund the wide variety of capital requirements from existing budgets. Despite significant uplifts negotiated during the last Spending Review, demand will outstrip resource.[60] Modelling has estimated that the cost of the 40 new hospitals (on top of eight existing schemes) will range from £12bn to £20bn. Currently only £3.7bn has been made available.[54] This has led to warnings from local health leaders about the impact of a possible delay to the NHP, including to patient safety.[61]

55. A plan for digital health and social care, *DHSC*, 29 June 2022 [link]
56. 'NHS buildings repair backlog soars to £9.2bn in England', *Financial Times*, 14 October 2021 [link]
57. Review of capital expenditure in the NHS, *National Audit Office*, 5 February 2020 [link]
58. Joshua Kraindler, Ben Gershlick & Anita Charlesworth, 'Briefing – Failing to capitalise: Capital spending in the NHS, *The Health Foundation* (March 2019) [link]
59. David Duffy, 'What the budget means for hospitals', *Hospital Times*, 28 October 2021 [link]
60. Autumn Spending Review 2021, *HM Treasury*, 23 October 2021 [link]
61. NHS Confederation. Lack of capital funding risking patient safety and impeding waiting list recovery: new poll of NHS leaders. 14 June 2022 [link]

The new Prime Minister would be wise to reaffirm the Government's commitment to delivering the 40 new hospitals by the 2030 deadline, and to expedite the publication of the refresh of the DHSC Capital Strategy to give certainty over the funding horizon.

In parallel, there should be an open discussion about how capital is controlled and allocated within the NHS. One option would be to look at the capital reserves held in the system, such as within specialist hospitals which have built up significant cash reserves over the past decade. In an environment of difficult choices, one solution would be to mandate the redeployment of a portion of these reserves in the short term to make up the shortfall on other capital schemes, an issue we explored in our recent report entitled *Devolve to Evolve*.[62] This could be done in a way that is fairer to providers than the current system.

Our proposal is that each Foundation Trust in England delivering specialised services would be audited for their cash reserves. Those with significant reserves would be mandated to divide this as follows:

- One third would be required to go into an 'Community Health Infrastructure Fund'. This would be protected for schemes within the ICS footprint of the Trust (for example a Community Diagnostic Centre, or new High St Drop-in Clinic).
- One third would be ringfenced for 'Nationally Significant Specialised Care'. This would be managed nationally and be allocated towards projects which could benefit a wide population (for example the funding of a new Proton Beam Therapy Centre). HM Treasury rather than the ICB would have oversight of business cases.
- One third would be retained by Trusts for reinvestment in their own schemes as they wish. There would be a streamlined approval process for high performing hospitals, and each Trust would receive an uplift on their individual capital spending limit.

We believe this proposal strikes the right balance, upholding the autonomy afforded by the Foundation Trust model, whilst acknowledging that Trusts are now part of systems and must collaborate with their local partners to develop integrated health infrastructure. It would also be a sensible work-around to the new capital rules which set a system level allocation on capital spending. These rules as set out in the Health and Care Act 2022 are likely to restrict the ability for hospitals delivering specialised care to make nationally strategic, transformational investments.

As highlighted in previous research, Foundation Trusts who have shown good financial management historically should not be penalised. That is why we propose that one third of their surplus cash reserves are retained wholly under their control, for deployment with minimal oversight from the centre.

We estimate that our proposal could free up approximately £1.6bn in capital. This cash is already held within the NHS but due to rigid

62. Robert Ede & Sean Phillips, 'Devolve to evolve? The future of specialised services within integrated care', *Policy Exchange* (May 2022) [link]

restrictions on the total Capital Departmental Expenditure Limit (CDEL) it has not been deployed.

Following the last Spending Review, the CDEL for DHSC is currently set at £10.4bn in 2023/24 and £11.2bn in 2024/25. Under our proposal this would rise to £11bn in 2023/24 and to £12.2bn in 2024/25.

The Community Health Infrastructure Fund would have an important role in transforming the primary care estate. The 2017 Naylor Review identified 30% of GP surgeries to be insufficient to meet the person-centred care vision set out in the Five Year Forward View.[63] Whilst a move to 'Integrated Neighbourhood Teams' and a larger multi-disciplinary workforce in primary care – as advocated in Dr Claire Fuller's recent review – is welcome, many practices are unable to provide the necessary space to take on additional workforce.[64]

The 2021 Wolfson Economics Prize (which was delivered in partnership with Policy Exchange), unearthed a series of credible solutions to improve the NHS estate which ought to be considered, and corresponding with Action 10 below, a long-term plan to improve the primary care estate is necessary.[65]

Action 10 – Transform the role of general practice within primary care

Undertake a 10-year transition for General Practice by introducing a new scaled model of integrated primary care in which workforce planning, estates development, data analytics and change management is supported by ICSs. Relationship-based medicine and 'continuity of care' at practice-level should be supported through the growth of 'integrated neighbourhood teams' (as envisaged in Dr Fuller's recent review).[66]

To address disparities (including the generational issue of under-doctored or underserved areas) in a targeted way across geographies, contracting should become increasingly locally determined with provider contracts negotiated and held with the relevant Integrated Care Board.

These changes should be accompanied by an improved and unified access route to primary care services called 'NHS Gateway,' with standards and oversight from NHS England, but delivered and coordinated at system level.[67] The rationale behind 'NHS Gateway' is to:

a. to introduce a service which assists in determining the clinical setting or staff most appropriate to address user need (increasingly necessary given the growth in multi-disciplinary working and care received across settings);
b. to vastly improve the experience of accessing primary care – particularly booking appointments in general practice, where too many users currently convey a poor experience. Rather than creating an additional route, NHS Gateway would unify all existing access routes under a single banner. Appropriate resource will need to be targeted toward the recruitment and training of 'care navigators', with additional support for those managing

63. 'Independent report – Review of NHS property and estates, and how to make best use of the buildings and land – Naylor Review', *DHSC*, 31 March 2017 [link]
64. 'Next steps for integrating primary care: Fuller stocktake report', *NHS England*, 26 May 2022 [link]
65. The Wolfson Economics Prize 2021 [link]
66. 'Next steps for integrating primary care: Fuller stocktake report', *NHS England*, 26 May 2022 [link]
67. Sean Phillips, David Landau & Robert Ede, 'At Your Service: A proposal to reform general practice and enable digital healthcare at scale', *Policy Exchange, 4 March 2022* [Link]

'first contact', including practice reception staff to ensure the effectiveness of these services.

Utilisation of the NHS App should grow substantially by upholding existing targets to expand its functionality and ensuring 75% of adults are registered on the App by March 2024.[68] Consumers should also be able to assess symptoms, view their medical records, immunisation history and test results, manage medications, and request appointments. Currently 86% of patients book their GP appointments via telephone. Whilst this will remain an important route for many users, shifting volume to the NHS App will represent an important step toward addressing the current '8am scramble' for appointments which staff and patients currently endure. General practice will remain the most appropriate setting to meet the undifferentiated issues that many users present, but 'Gateway' would enable – for example – a greater number to manage minor conditions with confidence at home, such as through use of approved at-home testing kits, coordinated through a community pharmacy pathway.

NHS dental services should be considered within this broader 10-year reform. The decline in the accessibility of dental care has been observed over several years but is now reaching crisis point, with a recent media investigation finding that 90% of dental practices across the UK are refusing to accept new NHS patients for treatment.[69] Far from an 'optional' service, dental care is a foundational element of an effective primary care service which prevents ill-health. The deterioration of the service offer is already impacting on hospital care; emergency tooth extractions are the leading reason for hospital admissions among 5- to 9-year-olds.[70]

Action 11 – Expand the clinical offer within NHS telephony services

Increase the clinical-led offer within 111, growing the proportion of clinical-led telephone and video calls from 50% to 80% by 2024. Incorporate 111 and video consultation within the NHS App giving the public access to NHS care 24/7. In the winter letter from NHS England (dated 12th August) there is a welcome commitment to increase call handlers (4.8k in 111 and 2.5k in 999).[71] Whilst growth in overall numbers will benefit these services, there should be a concerted effort to ensure that recruitment targets growth in a clinician-led offer.

Action 12 – Supercharge diagnostics

The UK has fewer MRI and CT scanners per capita than most OECD countries; this is coupled with a shortage of workforce in diagnostics. However, the demand in all diagnostics services is growing faster than most NHS services—currently, about a third of people have been on the waiting list for a diagnostic test for six weeks or more, compared to 3 percent in February 2020. The NHS has recognised this issue and highlighted in their 2019 Long Term Plan that "capacity in diagnostics services has to kept pace with the growth in demand".[72]

Delayed diagnosis is costly, as early detection improves recovery

68. A plan for digital health and social care, *DHSC*, 29 June 2022 [link]
69. Healthwatch England, *BBC investigation on NHS dentistry – our response.* 8 August 2022. [Link]
70. 'Hospital admissions for 5-9 year olds with tooth decay more than double those for tonsillitis', *Royal College of Surgeons of England*, 19 September 2019 [link]
71. Next steps for urgent and emergency care letter and framework, *NHS England*, 12 August 2022 [link]
72. The NHS Long Term Plan, *NHS England* (January 2019) [Link]

and survival rates—for instance, the 5-year survival rate for patients with metastatic lung cancer is 5% versus 57% for those diagnosed with localised disease using CT screening.[73] Recognising the importance of early diagnosis, we propose expanding investment in diagnostics and imaging across the NHS, including transforming outpatient pathways through an expansion of the Community Diagnostic Centre model. This investment should be coupled with benchmarking at a national level of the productivity and efficiency of these services, given widespread variation across the country.[74]

Action 13 – Maximise the NHS's monopsony (or sole buying power) in Med Tech

NHS England should introduce a Commercial Technology Unit (CTU), modelled on the Commercial Medicines Unit with a remit to make national-level deals on innovative medical technology. The NHS's institutional weakness in undertaking procurement and securing good deals for equipment and services has already been acknowledged at a senior level within NHS England.[75] The CTU would have a centralised procurement function to maximise the NHS monopsony (or sole buyer power) position, with an initial focus on buying diagnostic equipment. This would be a central enabler of a new commitment to make the UK the most competitive market in the G7 for diagnostics investment by the 2030s.

Action 14 – Boost the social care workforce by introducing a Social Care Minimum Wage and creating a desirable scheme for recent school leavers

It will be impossible to address the fundamental issues within social care without addressing the underpayment of the workforce. The workforce shortages within social care are more severe than within the NHS, with around 160,000 vacancies. We propose that the new Prime Minister and their Health and Social Care Secretary introduce a long-term workforce plan for the social care workforce, with redesigned remuneration structures and career progression. Currently, the average hourly pay for local authority funded social care is £9.14.[76] It is only marginally higher within privately funded care homes.[77] This compares unfavourably with higher rates within retail and hospitality and is therefore a major contributory factor to high turnover. Whilst social care workers are also underpaid in other European countries, the UK still lags comparator countries such as France and Germany in offering pay which is just 71% of average earnings. Reasonable adjustments may need to be made to improve the retention of the workforce in the medium term. These must be carefully balanced against the economic outlook and the impact of public sector pay increases on inflation. A reasonable and generous offer from the new Prime Minister would be to introduce a new Social Care Minimum Wage, to provide a longer-term model to support the immediate measures outlined in Action 3. This could be pegged to the Real Living Wage (currently £9.90 per

74. 'Independent report – Productivity in NHS hospitals', *Gov.uk*, 11 June 2015 [link]
75. Health Service Journal. NHS could get 'much better deals' by building on 'infamous' drugs procurement'. 28 June 2022. [link]
76. 'Adult Social Care and Immigration: A Report', *Migration Advisory Committee* (April 2022) [link]
77. 2021 UK Care Homes Trading Performance Review, *Knight Frank* [link]

hour in the UK, and £11.05 in London). By comparison as of April 2022 the National Living Wage is £9.50 for those aged 23 or over.

Approximately 70% of the social care workforce are paid below the Real Living Wage, which equates to £19,305 per annum.[78] Bringing all social care employees working aged 23 and over in direct care giving roles onto this wage band is estimated by Policy Exchange to cost £550m per annum.[79] We believe this should be funded outside of existing DHSC budgets. This is a significant recommendation given the wider economic outlook and the multiple pressures on public spending. The increase would also need to be designed in a way to not undermine other policy goals, such as the creation of progression and pay band scales within the profession.

In the immediate term, international recruitment will also have to play a prominent role in plugging existing vacancies and ensuring there are sufficient staffed beds. The Secretary of State for Health and Social Care has already announced the creation of a new Taskforce to "significantly increase" overseas recruitment of health and care staff.[80] Following advice from the Migration Advisory Committee (MAC), care workers were recently added by the Home Secretary onto the list of occupations with shortages. The results of this policy change have been encouraging; the percentage of all new sponsorship applications that were made by employers from the Health and Social Care Sector increased from 18% to 30% between January and December 2021.

Within this workforce plan unveil a 'My Year in Care' scheme, modelled on the Duke of Edinburgh Award and National Service, giving school leavers 12-month placements in care prior to further education or longer-term employment. The scheme would seek to give school leavers an appreciation of the social care landscape for both working-age adults and older people requiring care, whilst helping with inter-generational cohesion. The scheme would have several different routes (e.g., Personal Care Assistant, Deputy Operations Manager) reflecting different skill sets. The *Freiwilliges Soziales Jahr* (voluntary social year) is a broadly similar scheme, established in Germany in the 1950s. Originally designed as an alternative to military service, it has remained as a popular option with more than 50,000 young adults enrolled each year.[81] For this programme to be prestigious and popular, it must have strong national leadership. This has been identified in previous research as a weakness of the social care sector more generally which can lack an influential sponsor within Whitehall. We would therefore propose the creation of a new Chief Care Officer, who would be appointed on a full-time basis within the Department of Health and Social Care. The CCO would perform a similar function to the Chief Medical Officer and be responsible for promoting practice-based insights into policy making. The role holder would work closely with the current Director General for Social Care and Chief Social Worker Role and would become one of the most senior members of the DHSC leadership team. Alongside leading the launch of the new workforce plan, including 'My Year in Care' the CCO would also act as figurehead for media interviews.

78. Skills for Care. Adult Social Workforce Data. 2020/21

79. Skills for Care estimate that 1.1m people are employed in direct care roles. We have assumed that 700,000 people would benefit from a pay rise equivalent to £780 per annum. [Link]

80. Nick Gutteridge, 'Steve Barclay: 'Real sprint' needed to avert an NHS winter crisis', *Daily Telegraph*, 7 August 2022 [link]

81. 'Information for those interested in the FSJ', *FSJ.de* [link]

Action 15 – Foster the next generation of Data Managers in the NHS

Introduce a dedicated NHS Data Graduate Training Programme, as first recommended by the Goldacre Review.[82] The NHS needs to have the right skills and teams at its disposal to analyse and generate insights and conclusions. Only with these pieces can we move from big data to meaningful data. The vaccine rollout demonstrated how data can save lives: identifying the unequal uptake of the vaccine amongst groups and ensuring that public health bodies could target their energy towards those communities.

This would represent a significant expansion of the Analyst and Informatics strands within the existing NHS Management Trainee Programme. The programme would target the brightest and best students, with a prestigious training programme to rival the graduate schemes of Silicon Valley. Whilst pay bands will need to be competitive to attract and to maintain talent, the NHS must leverage the unique opportunity and experience working with its large and unique datasets offers both junior and more senior analysts alike. The Scheme would be supported by an NHS Analyst Service, modelled on the Government Economic Service to encourage sharing of insights and expertise from analysts across the NHS.

Action 16 – Initiate a national conversation to improve health and reduce demand on healthcare

Delivering good health is not just the responsibility of the NHS. We know that where you live, your work and your lifestyle choices are as much a determinant of your health outcomes as interactions with formalised healthcare.[83]

The Government has made a commitment to extend healthy life expectancy by five years by 2035 – being listed among the twelve 'levelling up' missions outlined in the White Paper: Levelling Up the United Kingdom. As Policy Exchange has previously outlined, successive Governments have found such targets challenging to meet.[84]

Whilst the scale of the challenge is well understood (for example the growth in childhood obesity rates), determining a coherent policy approach has proven elusive, with the issues cutting across Government departments and ministerial briefs. To make real progress, we need to stimulate a broader conversation with the public about the right steps forward (and what measures/innovations we ought to adopt) to make substantive progress on totemic issues, such as obesity and mental health. Making our population healthier is the key route to reducing demand on the NHS. Roughly two thirds of the people in inpatient bed days are filled with patients who are admitted due to preventable ill-health. Around half of all GP appointments are for preventable conditions. Addressing this should become a national mission.

82. Ben Goldacre, *Better, broader, safer: using health data for research and analysis*, DHSC, 7 April 2022 [Link]
83. Raghib Ali, 'Levelling Up Health and Longevity', lecture delivered at *Policy Exchange*, 14 March 2022 [link]
84. Richard Sloggett, '*Saving a lost decade*' *Policy Exchange* (November 2020) [Link]

Building a preventative healthcare system will be a collective endeavour, requiring developments in science as well as our communities and public sector institutions. Just as scientific breakthroughs helped to reduce hospitalisation to chart a route out of the COVID-19 pandemic, clear 'demand signalling' from the Government to encourage the pharmaceutical industry to bring forward proportions which can prevent ill health is welcome. We should see further prioritisation in this area, following the Life Sciences Vision.[85] Effective 'demand-signalling' could for instance enable the UK to leverage strengths in immuno-oncology and vaccines to explore potential cancer vaccines (and other therapeutic immunological interventions), supported by the focus that will come from 'ten year' plans covering cancer and dementia.[86]

85. Life Sciences Vision, *Gov.uk* [link]

86. 'NIHR experts welcome Government's 10 year cancer plan consultation', *NIHR*, 10 June 2022 [link]

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Policy Exchange
1 Old Queen Street
Westminster
London SW1H 9JA

www.policyexchange.org.uk