Low costs and results in two years: Four steps towards a new NHS

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June
2025

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Introduction

The Ten Year Plan will soon be on the launchpad. How to escape from the gravitational pull of the existing system? The plan needs momentum quickly and for this we need basic changes by April 2027.

The move away from a hospital-orientated, fragmented health and care system has been advocated many times since the Family Doctor Charter in 1966 and the "Primary Care Led NHS" strategy of 1996. There is great urgency because patients and communities are not well served by the present system.

We have a rise in long-term illness. The unexpected development is a sicker population. The main users are no longer patients with infectious diseases or injuries from industrial accidents. They are people with long-term conditions which often have mental and functional as well as physical effects. They can experience a spiral of decline which threatens well-being and capability. They benefit from early diagnosis and continuity of care.

The problems of frailty in old age are very real but the much bigger hidden problem is that of greater disability in all age groups with rising demand from teenagers to the middle-aged. The Health Foundation has estimated that the numbers of 20-69 year-olds living with major illness in England will rise from 3 million in 2019 to 3.5 million in 2030.

The NHS needs new core programmes for these younger groups who are not helped by economic inactivity and revolving door hospital admissions. The problems are greater in deprived areas. In 2021, by ages 50-54, only 23.7 per cent of people in the most deprived decile rated their health as very good compared to 49.5 per cent in the least deprived.

The second reason for urgency is to face up to the economic imperatives of a new era. The age of high increases in NHS spending is coming to an abrupt end. The position looks grim with moves to contraction of services and staffing.

We set out here a very different approach: how the NHS can start a transition to better services at lower cost. The key move is to shift from high-cost hospital services to lower-cost out-of-hospital services which can organise early diagnosis, continuity of care and personal contact rather than a place on a waiting list.

We have the wrong balance of services. Given recent history, we are likely to shrink out-of-hospital services to reduce pressure on the hospital sector. Whether spending is up or down, the balance is likely to get worse.

The out-of-hospital services can provide better access quicker and help to reconnect the service with its customers. As Sir Jim Mackey has pointed out, only 21 per cent of people are satisfied with the NHS (British Social Attitudes).

As part of the transition we set out moves to decentralisation to unlock local responsibility and local initiative. Centralisation leads to an increase in scale and difficulties in completion. Centralisation leads to a future of ailing white elephants. Localisation can use local knowledge and local resources to deliver service improvements. The recent announcement of a £100 million fund for improving primary care premises is a welcome example of what could be done, with projects completing in months not years or decades.

Four strategic moves which should start from July.

1

Reduce admissions through neighbourhood teams

The first move would fund and staff stronger neighbourhood teams which would have the aim of reducing emergency admissions by 5 per cent by April 2026 and by 10 per cent by April 2027.

The winter of 2025-26 can be the first without a "crisis". As is much discussed, any large Trust has 100-150 beds which are occupied by patients who could be discharged. Every extra day in hospital makes discharge more difficult. Lancashire and Cumbria have set up joint teams between Trusts and social services to plan discharge in advance. The team works with carers and organises support from home care and local primary care. They give small grants to unpaid carers to help with care for the first few days. Leeds and Harrogate are also working on discharges, by buying time from home care services.

The current NHSE guidance for 2025-26 sets four "national priorities":

1. "Reduce the time people wait for elective care."
2. "Improve A&E waiting times and ambulance response times."
3. "Improve patient access to general practice. Improve patient experience and improve patient access to urgent dental care, providing 700,000 additional urgent dental appointments."
4. "Improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds and improve access to children and young peoples (CYP) mental health services to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019."

The problem here is that the priorities address the symptoms rather than the causes of queuing and waiting lists. They hurry along the worry and the excess demand for hospital treatment without stopping the flow at source.

The missing priority is the first phase of investment in neighbourhood teams. The NHSE companion document on neighbourhood teams is both detailed and vague. It lacks any clear statement of the central aim of the teams which should be to raise patient confidence in treatment outside hospitals so as to contain then reduce admissions. This central aim should be clearly defined: to reduce emergency admissions by 10 per cent within two years.

The main pressure for admissions is from patients with long term conditions where the symptoms have suddenly worsened into crisis. Exacerbations from COPD and chest pains from heart disease are the most common crises. These crises are key transitions in a spiral of decline. Aging for people with these conditions can fit Hemingway's definition of bankruptcy: "It happens gradually then suddenly."

In such crises effective help is needed, but not hospital admissions. A hospital admission reduces confidence in independent living. Symptoms may be alleviated but harried staff do not have the time or the expertise to reverse the spiral of decline. For such patients, hospitals are about preventing death not improving social functioning and quality of life.

The neighbourhood team is not a frill or an optional extra but an indispensable step towards improving patient outcomes. This alternative to admissions can reduce waiting for younger patients with severe problems in cancer or neurological illness. It can also reduce the stresses and costs from a revolving door hospital system, with staff demoralised.

Local responsibility for managing waiting lists

2

The second move is to empower local teams to tackle waiting lists and waiting times. Effective management of lists on a personal basis, together with the introduction of neighbourhood teams, can deliver the 18-week target by April 2027.

There are 100,000 consultants and GPs in England. A referral means that a clinician has made the best available choice for a patient. On average each consultant or GP has been responsible for 70 referrals. The consultant, with the health team, should contact these patients and find out how their situation has changed. Their need for treatment may have become very urgent. The need may have changed so that a different service might be more effective. For some the need may no longer be there.

The consultants who made the decisions should be in contact with patients, for some personally and for others through their teams. The aim would be to mobilise all local treatment resources. The NHS has invested more than £1 billion in hubs and CDC. It is time to use local initiative to make the most effective use of this large new resource. This would also be a key area for integration through making use of home care services.

For next year and beyond there is a wider message about the need for focus on the Trust and ICB areas with many high risk patients. There is no surprise that Birmingham, Liverpool and Plymouth are on the risk for critical incidents. They have aging populations with many high-risk aging patients. Lancashire and Cumbria would have been in this group but has taken local initiative.

The move to A&E is in part the result of anxiety. It is the health equivalent of the Northern Rock queues in 2007. The answer lies in building confidence through continuity of care. Lancashire and South Cumbria ICB has a history of local initiative on integration.

3 From deficits to investment

The third move would be to empower ICBs and local teams to improve services now. All funds for maintenance and development should be combined into a single payment which could be used for development across primary, secondary and social care. This would be a major step towards integration, managed by ICBs.

The ghost of the 40 Hospitals Programme haunts the NHS. The Government has now made a serious attempt to lay it to rest with a programme in five-year phases. There is some preliminary work finishing off six projects, four of them in Dorset. Seven hospitals with RAAC will be in the 2025-30 phase plus seven smaller projects and new hospitals in Hillingdon and North Manchester.

For the 2030s there will be larger schemes which will be funded from a capital spend of £3 billion a year. The largest schemes, £2 billion or more, are reserved for starts around 2038, so could not be in use before 2043.

The concept of a phased programme with secure funding is sound. Wes Streeting has also set a new standard in producing cost estimates. However, there are three serious defects in the approach:

1. there is no mention of the key aim of developing an integrated service. The word integration does not occur in the document. The programme is likely to pull the NHS away from primary and out-of-hospital care. We need an acute service strategy which will help in designing projects and fully use the opportunities for integrated care, specialisation and hubs.
2. the regional impact for schemes which cover the next decades is patchy with a tilt towards the South. Dorset makes a good start with four schemes in the programme followed by the rebuilding of Poole Hospital.
3. there is no direction to special help for areas of deprivation with their very different levels of need.

For 2025-30, four of the RAAC schemes are in East Anglia and only two of the 13 in the North. The 2030-35 programme has three clusters: near the M25 with Harlow, Watford and Whipps Cross; in the East Midlands with Leicester and Kettering, and in the South West with Taunton and Torbay. For 2035-39, six of the nine schemes are in London or the South.

The plans only address "crumbling" in about thirty of the acute Trusts. Could there be an approach which really does address the crumbling across the whole NHS? Such a plan could draw on the very good experience of developing modular projects for surgical hubs and CDCs. There have also been numbers of developments in London,

Newcastle, Cumbria, Birmingham and Scarborough promoted by acute Trusts. These have come out on time and under budget. There could be more collaboration with the private sector and private capital for these smaller schemes. A range of smaller developments, including new sites for integrated care, could be delivered quickly.

The National Infrastructure Commission under Sir John Armitt has addressed some of the same needs as the Streeting plan, for a longer-term approach with secure funding. But it has added a key factor of local initiative. For transport there has been progress in devolving budgets to City Regions ("Government should move away from centrally allocated funding pots for transport and instead implement flexible, long-term, devolved budgets for all local authorities responsible for strategic transport"). This has been done for Mayors in Greater Manchester and the West Midlands.

The better approach for the NHS is at establish a capital fund, paid to ICBs. The fund would take over the £3 billion a year allocated for the waves. To this would be added the funds for repair and maintenance and for developing integrated care. The £3 billion would fund an average of £75 million per ICB and the other funds could double this to £150 million. The ICBs in conjunction with PCNs and Trusts would be able to use this fund so as to promote the three missions.

This fund could be carried over across years and used flexibly. It would promote expertise among a wide range of contractors in regions. There would be a momentum for development and optimism across the NHS. It could stop the crumbling across the whole NHS, not just in a few patches. Health teams could fit the developments to local needs in deprived areas and learn much from the successes of devolution across public services.

Unleash local initiative

4

The fourth move is to look to local initiative as the key driver of progress.

Any discussion of the three missions (hospital to community, analogue to digital, prevention) has to start with realism. The NHS has not achieved the three missions, in fact it has registered a degree of failure on all three. Immense amounts of money have gone into hospitals with a few scraps to out-of-hospital services. Most recently these services were made to pay for higher national insurance while the acute services were exempt (no integration here). Secondly the NHS has failed on the basic safety requirements for communication. Thirdly, there has been more progress with prevention, through screening, but there has been little extra funding and intensive, imaginative effort in deprived areas. We need to free up the local can-do spirit, to use the great abilities of so many NHS staff more fully.

The shift to out of hospital services depends on stronger teams, as described above. Staff flexibility is easier at the local level, building on local associations. The new "neighbourhood health service" needs contributions from primary care, from acute and mental health Trusts and from social care. At the national level the focus is on professional differentiation not on teamwork. These local teams can plan local services to fit patient needs. They can also develop joint programmes, with a local manager in charge. Local achievement will reignite a sense of pride among NHS staff.

On digital, it is time to draw on local initiative and local expertise. There has been very limited progress on national models. Acute Trusts have made extensive investments without consulting with primary or social care, using American models. Under national leadership, the systems have become more divided, not less. The common sense "must do" is that any team treating an NHS patient should have access to the same information on diagnosis, treatment and allergies. This common access is vital for patient safety. This is not happening anywhere, after thirty years of effort. The systems now put together by staff for their own personal use are now way ahead of the NHS.

On prevention, the databases are there in primary care. There are local associations with local teams from schools to care homes. There can be useful efforts at the national level but much of this is wasted as the communication is with people who have already got the messages. Programmes targeting high risk communities, as was done in the Halve it programme for promoting early diagnosis in HIV (now extended),are likely to be most effective. With risk factors already reduced for many, the challenge is with addictions and the hard to reach.

Delayed discharge is an example of a longstanding issue where local initiative is the route to success.

Recently BBC reporters spent 24 hours at the Royal Free Hospital in London. They were told that across three sites there were 275 patients who were medically fit to be discharged. This is typical of most large hospitals across the NHS.

This is not a new problem. Williams et al, in the 2015 British Journal of General Practice, reported there was a "dearth of empirical research on the problem". They found from their survey of 600 patients that one in five were experiencing adverse events within three weeks of leaving hospital.

In 1969, a pioneering study of 533 patients in London and the South, "Home from Hospital", by Muriel Skeet, found that there were problems after discharge for 45 per cent of patients. She reported on the small number of the most severe: "Mr B age 87 years. Widower. Untreated carcinoma of the prostate with metastases. Doubly

incontinent. Confused. Sent home to daughter over sixty years old. No community services arranged by the hospital." Mrs A "sat in bed or on the commode all day 'waiting for the end to come'".

The NHS can bridge the gap between medical fitness and discharge confidence. This is an opportunity to make a reality of integration. There is a huge resource in home care teams: 12,000 providers with 700,000 staff. This resource hardly existed two decades ago. It has already helped to bring about a reduction of 50,000 places in care homes even as population aging seemed likely to increase need. 80 per cent of these providers rate CQC good or better.

There is resistance by Trusts to paying for home care. The view is that local government should pay – but for discharge it is in the interests of the NHS to define and to buy services. The investment here can help patients and staff morale.

The new service could be run as part of virtual wards with home care staff on call. This is needed with shorter length of stay for patients with frailty. Long stays when discharge is delayed will lead to further decline followed by readmission.

The NHS team can work with local home carers, first of all using staff with the Care Certificate. Longer term there could be a joint programme for additional training in post discharge support including medical checks. The service would offer up to four weeks free home care, to give people the time and confidence to settle back.

Conclusion and recommendations

How do the four initiatives fit with the new environment i.e. a different, enlarged generation of patients and the new era where improvement must come from productivity? We return to the message by Benjamin Moore in 1911: "It is method more than money that we want in order to combat and conquer in our battles with disease."

1. Stronger neighbourhood teams can reduce emergency admissions by 10 per cent in two years (April 2027). This is key to integration with contributions from primary, social and acute. Patients gain from continuity of care, not disconnected episodes brought on by crises. ICBs should plan a transfer of staff, including experienced doctors, from hospitals to community services. They should distribute a leaflet to every household with simple advice on how to keep fit and improve your health.
2. Local responsibility for waiting lists can deliver the 18-week target within two years (April 2027). Rebuild patient confidence through continuity of care while they are on the list. Build relationships between health teams and their patients. Raise productivity through a network with shared data on cost and quality of care for CDCs and Hubs.
3. New accessible funding for improvement should mean that 50 per cent of repairs are carried out within two years (April 2027) and capital programmes for integrated care services have started (and completed April 2030). Actions and solutions carried out by ICBs, and local teams build momentum on dealing with long running problems. Local communities need to see the NHS as a powerful force for better solutions, not a source of endless apologies for lack of progress. Local choices focus on value for money. Faster actions contain costs.
4. Use the abolition of NHS England to achieve clear local management initiative within two years (April 2027). Florence Nightingale cleaned up Scutari hospital within months. Local management can deliver responsibility and build links to the local community. Prevention should be linked to other local services (education, housing) to deliver on the three missions. Use the limited funding to raise value and deliver new kinds of flexible services in the new patient era.

Key references for an NHS improvement in 22 months

Regina Herzlinger. Market Driven Health Care. 1976.
A key source on the hub concept. "What makes the Shouldice experience such a positive one? ... The overwhelming reason for its success is clear focus on only one surgical procedure."

DHSS. Priorities for Health and Personal Social Services in England. HMSO, 1976.
"The level of resources which will be available over the few years means that difficult choices will have to be made." The Ministers (Barbara Castle and David Owen) set out a clear plan using programme budget data for improving national outcomes and raising productivity through day treatment and joint programmes with social services.

M.Buxton, R.Acheson et al. Costs and Benefits of the Heart Transplant Programmes at Harefield and Papworth Hospitals. HMSO, 1985.
Costs were 40 per cent lower at Harefield because patients were discharged to a hostel for the post-transplant support. Showed that it is vital to identify comparative costs to maximise service to patients.

NHS Management Inquiry ("Griffith Report"). DHSS, 1983.
"Case for stronger management and budgeting". "At no level is the general management role clearly being performed by an identifiable individual. In short, if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge."

Benjamin Moore. The Dawn of the Health Age. 1911.
First to identify the "effectiveness gap". Doctors and teams are available but not delivering known therapies to patients, using evidence on measles and TB. First to recommend a National Health Service. Earlier Sir Gilbert Blane had shown how the Royal Navy had reduced the sickness rate 1779-1813 from 1 in 2.45 in service to 1 in 10.75 through better food, clothing and hygiene as well as lemons.

Florence Nightingale. Notes on Nursing. 1859.
Continuity of care "working with the reparative process which nature intended". See also Lavinia Dock. A Short History of Nursing. 1938.

Muriel Skeet. Home from Hospital. 1951.
Pioneering study of home care needs of discharged patients. Shows vital importance of community services.

Nick Bosanquet and Brenda Leese. Family Doctors and Economic Incentives. Gower. 1989.
Study of general practice development in six areas. Showed power of initiative for improving services locally. Success of the Family Doctor Charter. (Due partly to support from Laura Kuenssberg's grandfather, a GP in Edinburgh.)

Nick Bosanquet et al. The Effectiveness Gap in COPD: a Mixed Methods international Comparative Study. Primary Care Respiratory Journal. 2013. 22(2) 209-213.
Case studies for COPD Treatment in UK, France and Finland. Showed how Finland reduced hospital admissions by 40 per cent by continuity of care by primary care nurses. Programme for asthma reduced the number of Finns on disability benefit for severe asthma from 8,000 to 1,000.

Oannis Papachristou and Nick Bosanquet, Journal of Public Health Policy (on line). Improving the prevention and diagnosis of melanoma on a national scale: A comparative study of performance in the United Kingdom and Australia. 2019.

How the successful programme for prevention and early diagnosis had worked in Australia and UK failure to follow in high incidence areas such as the North West.

Nick Bosanquet. Evaluation of Four Layer Bandaging for Venous Ulcers. 1991.
In trial showed that compression bandaging could heal 80 per cent of venous leg ulcers within 12 weeks.

OECD. Does Health Care Deliver? 2025.
Survey of patient perspectives in 19 countries. Patients want the "three t's": timely treatment, tailor-made treatment (personal care programmes and continuity of care), trouble-free treatment.

Tables

Table 1: NHS staff numbers, FTE, 2010, 2020 and 2025
Consultants and district nurses: January of each year. All GPs: March of each year

	2010	2020	2025	% change 2010-24
Consultants	35,513	49,378	58,636	+ 65
GPs	39,409	34,359	38,173	- 3
District nurses	7,016	4,060	3,851	- 45

Source: NHS Digital

Table 2: People's assessment of own health, Census 2011 and Census 2021

		2011	2021
Male	Very good	45.5	47.9
	Good	34.6	34.2
	Fair	13.9	12.8
	Bad	4.6	3.9
	Very bad	1.4	1.2
Female	Very good	44.5	47.1
	Good	35.1	34.2
	Fair	14.5	13.2
	Bad	4.6	4.3
	Very bad	1.3	1.2

Table 3: Change in reported "very good" health by age group between Census 2011 and Census 2021

Under 1	6.3
1 to 4	5.4
5 to 9	2.0
10 to 14	0.7
15 to 19	-0.6
20 to 24	-1.2
25 to 29	0.4
30 to 34	-0.3
25 to 39	-0.2
40 to 44	1.1
45 to 49	1.9
50 to 54	3.4
55 to 59	5.7
60 to 64	5.8
65 to 69	6.0
70 to 74	6.7
75 to 79	6.2
80 to 84	4.6
85 to 89	2.5
90+	1.0

Table 4: Comparison of healthcare in most and least deprived deciles, England, 2021-22

	Most deprived decile	Least deprived decile
Bed days, million	4.9	3.3
Emergency admissions	770,000	500,000
Finished consultant episodes, million	2.1	1.7
Mean age of patients, years	48.2	58.8

Source: Hospital Admitted Patient Care Activity, 2021-22, NHS Digital

Table 5: Local authorities in England with the highest projected population growth between mid-2018 and mid-2028

Local authority	Population growth over 10 years	% population change
Tewkesbury	15,200	16.4
Tower Hamlets	50,800	16.0
NW Leicestershire	16,300	15.9
Dartford	17,000	15.5
Daventry	12,800	15.2
South Derbyshire	15,800	15.2
South Norfolk	20,400	14.8
Corby	10,100	14.3
Blaby	14,100	14.1
Cotswold	12,500	14.0

Source: Office for National Statistics

Table 6: Projected total number (millions) of diagnosed cases for the 10 conditions with the highest impact on health care use and mortality among those aged 30 years and older, including demographic changes, England, 2019 and projected for 2040

Source: "Health in 2020 – projected patterns of illness in England", Health Foundation

	2019	2040	% change
Dementia	0.6	1.0	45
Constipation	1.0	1.5	45
Heart failure	1.2	2.1	92
COPD	1.7	2.3	37
Atrial fibrillation	1.8	2.6	51
Chronic kidney disease	2.2	3.0	34
Cancer	2.4	3.2	31
Anxiety or depression	3.7	4.2	16
Diabetes	3.8	5.7	49
Chronic pain	5.2	6.9	42

Table 7: Elective waiting list and waiting times, England

Feb of each year	Total list (million)	> 18 weeks (million)	> 52 weeks
2017	3.8	0.4	1,676
2018	4.0	0.5	2,485
2019	4.3	0.6	2,188
2020	4.6	0.8	1,845
2021	4.8	1.7	387,952
2022	6.2	2.3	306,479
2023	7.2	3.0	362,434
2024	7.5	3.2	304,919
2025	7.4	3.0	193,516

Source: NHS England, Consultant-led Referral to Treatment Waiting Times Data, July 2023

Table 8: A&E attendances and emergency admissions, England

Q4 of each year	All A&E attendances (m)	Emergency admissions (m)
2017-18	5.9	1.5
2018-19	6.2	1.6
2019-20	5.6	1.5
2020-21	4.3	1.4
2021-22	5.9	1.5
2022-23	6.0	1.5
2023-24	6.8	1.7
2024-25	6.7	1.6

Source: NHS England, A&E Attendances and Emergency Admissions

Table 9: Comparative price levels for health, 2017, US=100

Switzerland	139	New Zealand	72
Iceland	138	Japan	71
Norway	120	Germany	68
Sweden	110	France	66
Israel	110	Chile	59
Ireland	106	Greece	57
Luxembourg	102	Portugal	55
United States	100	Slovenia	54
Canada	92	Korea	48
Finland	90	Mexico	47
Denmark	88	Estonia	42
Netherlands	86	Slovak Republic	34
United Kingdom	83	Hungary	32
Austria	82	Latvia	31
Italy	82	Lithuania	30
Spain	76	Poland	29
Belgium	75	Czech Republic	28
Australia	72	Russian Federation	18
OECB36	72	Turkey	17

Source: OECD, 2019