A new lease of life: Three steps to success for the NHS

BRIEFING PAPER

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Addressing the NHS crisis means improving productivity, which *is* possible as previous experience has shown. This briefing makes proposals for increasing efficiency, shifting care away from the district general hospital towards fewer, specialist teams, more neighbourhood care and greater transparency.

KEY POINTS

- The NHS is losing public and professional confidence: waiting lists are unacceptable, experienced staff will be in shorter supply, bed numbers are likely to remain static.
- Previous experience shows productivity can be increased in healthcare: early diagnosis and testing kept HIV/AIDS under control, mortality rates from coronary heart disease have fallen dramatically and the cost and length of stay for hip and knee replacements has fallen.
- Patterns of demand for healthcare have shifted, with the number of patients with long term conditions like respiratory, cardiac, diabetes and anxiety/depression set to rise from 5.3 million in 2020 to 9.1 million in 2040.

RECOMMENDATIONS

- The NHS should move away from the district general hospital model and replace it with 'Dynamo centres', delivering acute services in fewer locations.
    - This could improve productivity by 20%, making more efficient use of specialists' time, and reducing the overall number of hospital beds and staff.
- It should invest in integrated neighbourhood teams, which maintains continuity of care and is more cost effective than hospital-based care, and could reduce admissions by 30%.
- Data on the costs and productivity of different services should be routinely collected and published to drive diffusion of effective methods.
- Integrated Care Services should be given control over their capital spending, with dedicated funds for maintenance and development that can be carried over from one year to the next.

INTRODUCTION

In this paper we set out a strategy for the National Health Service to make it fit for the rest of the 21st Century.

The NHS is losing public and professional confidence. It is drifting towards a three-tier system: access for patients in more affluent areas, limited access in deprived areas and a flight to paying for private care. We need immediate and realistic steps to reverse the decline.

Current efforts to recover are staked on centrally defined programmes for large increases in staffing and the New Hospital Programme. We present evidence in the first section as to why these programmes are not likely to deliver.

We set out a new strategy, including the first acute services strategy for NHS hospitals since 1969. It is based on three key initiatives which can produce results within two years and a changed, fully sustainable NHS in ten. We have drawn on the Long Term Plan, but it lacked focus on the core proposals and it was too cautious for the dire reality of the situation.

The first initiative is to raise productivity by 20% in acute services by leaving behind the district general hospital model. The district general hospital (DGH) is no longer relevant in the context of modern demand for health services, largely people with long term conditions. Instead the NHS should develop Dynamo Centres – acute services concentrated on fewer sites –to take full advantage of the scarce time of highly trained teams.

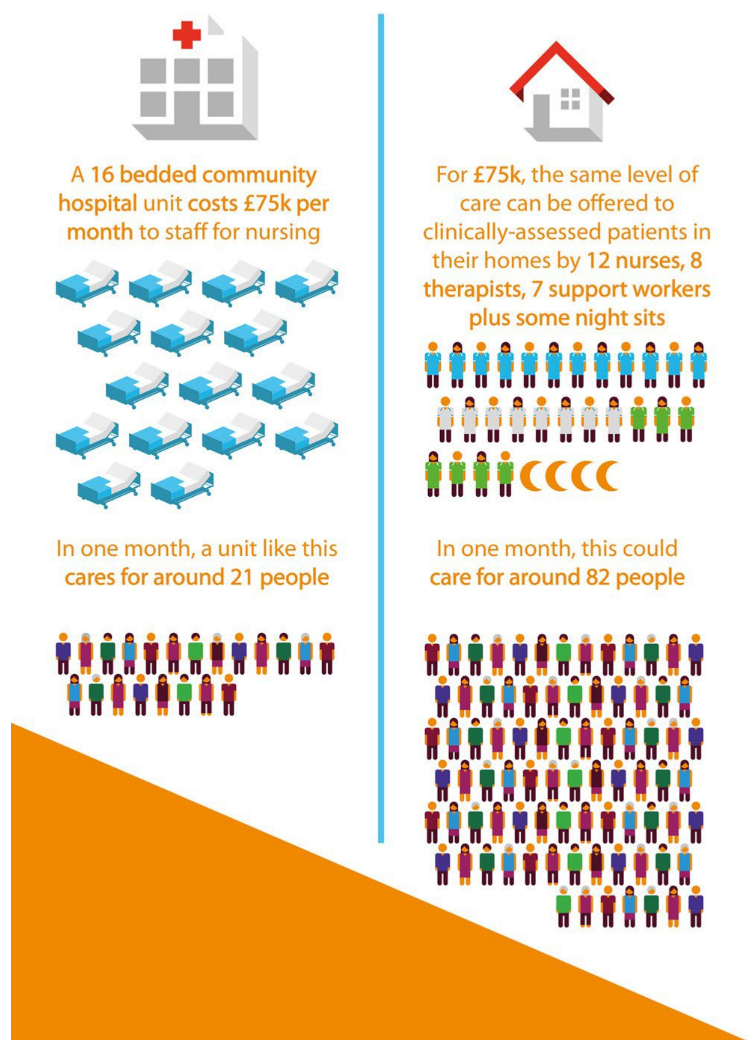
Most hospital trusts will be affected. Overall numbers of hospital beds and hospital staff should fall. Funds set aside for the extremely costly New Hospital Programme can be used to invest in new facilities.

As Kevin Lavery, a former local authority chief executive and now CEO of the Lancs and S Cumbria ICS, has said:

> *"If we had a blank sheet of paper, we would not plan to have seven elective care centres, six A&Es, five separate and expensive sets of support services. We would not plan to spend over £300 million on temporary staff at premium rates and spend two thirds of our money on treating illness, and one third on care and community. The solutions are pretty obvious; we need a major clinical productivity and reconfiguration programme with single clinical networks, increasingly moving to single sites so that ultimately we have two or three elective sites."*[1]

The second is to reduce hospital admissions by 30% through integrated neighbourhood teams. Integrated care is much more cost effective than hospital-based care. It is also the way to restore continuity of care, including the personal link between GP and patient.

Figure 1: Cost advantages of integrated vs. in-patient care



Source: Northern Devon Healthcare NHS Trust, 2016

The third is an introduction of a new metric of cost of service as the key driver of change. The NHS has talked about a new care model for several years, but the pace of change is so slow that it amounts to paralysis. Local managers need to drive change on the evidence that earlier diagnosis, out-of-hospital care and concentration of acute services will both improve services and keep them financially sustainable.

In previous iterations of reform, NHS leaders looked to change structures of commissioning. What is needed is for actual services to change. Integrated Care Systems should remain in place, with a clearer responsibility for value for money and performance, and greater control over capital spending and specialist commissioning.

The Labour Party has set out positive support for integrated care and – crucially – has signalled that it will rethink investment into the New Hospital Programme. It can complete its programme with our proposals on acute services and a metric on costs. Labour cannot simply follow the model of the Blair government – the public finances will not allow the expansion in budget and staff that took place between 2000 and 2010.

CURRENT OUTLOOK: PERFORMANCE AND RESOURCES

Waiting times: an unacceptable level of service

Current lengths of elective waiting (see Table 1) represent an unacceptable level of service. As the National Audit Office (NAO) has argued, they are highly damaging to many patients.[i]

Table 1: Elective waiting list and waiting times, England

May of each year	Total list (million)	> 18 weeks (million)	> 52 weeks
2015	3.2	0.2	752
2016	3.7	0.3	1,162
2017	4.0	0.4	1,744
2018	4.3	0.5	3,264
2019	4.4	0.6	1,255
2020	4.0	1.5	27,000
2021	5.3	1.7	337,000
2022	6.7	2.4	333,000
2023	7.5	3.0	385,000

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

[i] "Prompt treatment has clear benefits for individuals. The longer a patient has to wait for treatment, the longer they may experience pain, anxiety or other symptoms. Such effects may temporarily reduce quality of life, prevent people from working, or lead them to seek relief through additional visits to the GP or urgent and emergency care services, placing further strain on the NHS. For a subset of conditions, including but not limited to cancers, undue delay may cause permanent reductions to life expectancy as once treatable illnesses become untreatable. Clinical negligence claims can result from delays in diagnosis or treatment. Patient representatives and health experts we have spoken to have told us of patients' concerns about cancellations of their treatment and that longer waiting lists can increase the risk that patients might get 'lost in the system'. (National Audit Office, 2021)

Difficulty in increasing elective activity

Key NHS England ambitions to increase levels of hospital activity have been difficult to achieve so far. Its internal target for completed elective pathways in 2022-23, relative to 2019-20, was 102%. The outturn was 95%.[2]

On the overall elective activity target, the NAO concluded: "To return to the 2019-20 level and then reach 129% within three years would be an historic feat. For comparison, before the pandemic it took the NHS five years (2013-14 to 2018-19) to increase completed elective pathways by 18%."[3]

Emergency admissions

Also of great concern are the trends in A&E attendances and emergency admissions (see Table 2 and 3). Both attendances and admissions have returned to the rising trend visible before the pandemic.

This indicates that the new service model promised by the Long Term Plan (2019), including for example a rise in same-day emergency treatment, has yet to take effect.

As the Care Quality Commission has argued, rising emergency admissions have contributed to the "gridlock" that has hindered the NHS over the last three years. Difficulties in discharge into social care has made it harder to free up hospital beds. That in turn prevents the flow of patients out of emergency departments, which hinders disembarkation from ambulances, which prevents ambulances responding to emergency calls. The whole situation is made worse by difficulties in accessing primary care.[4]

Table 2: A&E attendances and emergency admissions, England

Q2 of each year	All A&E attendances (m)	Emergency admissions (m)
2016-17	6.0	1.4
2017-18	5.9	1.5
2018-19	6.2	1.6
2019-20	6.5	1.6
2020-21	5.0	1.4
2021-22	6.3	1.5
2022-23	6.2	1.5
2023-24	6.5	1.6

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

Outlook for staffing and bed numbers on current policies

One certainty for the next 10 years is that the number of experienced staff will show some decline with growing problems of retention and early retirement.

Even if it is delivered, the Long Term Workforce Plan would only alter the staffing mix from 2040 onwards. While the expansion of medical education is due to start in 2025, graduates will be consultants or GPs in 2040.

The Plan will be difficult to deliver within current budgets. It aims for a 60% expansion from 1.4 million staff to 2.3 million staff by 2040. Costs will rise not only due to pay and benefits but also because of extra activity and a larger estate generated by new staff. Overall, the planned increase is faster than the increase since 2010 (which was 239,000 more in 12 years), an increase which was only afforded by a reduction in real pay.

The Long Term Workforce Plan rightly stresses the need for more staff to work in the community, but it is far from clear how this specific increase is to be funded. The only data quoted are on nurse staffing for 2022-23 showing that hospital nurse staffing had risen 4% and that community nurse staffing had risen 2%. The 10-year comparison (see Table 3) would have shown a sharp rise in adult and general nurse staffing and an actual fall in district nurse numbers.

Table 3: Numbers of nursing staff

July of each year	Adult and general (all)	District nurses (1st and 2nd level)
2013-14	163,039	5,388
2014-15	167,674	5,088
2015-16	169,872	4,457
2016-17	172,886	4,442
2017-18	173,243	4,077
2018-19	174,526	4,329
2019-20	179,554	4,269
2020-21	188,632	4,410
2021-22	196,150	4,262
2022-23	204,545	4,029
2023-24	217,370	4,180

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

The Workforce Plan also has little to say about the effects and inevitability of change. As new teams develop, the training investment will need to change. In the wider economy, many new jobs (digital/green) did not exist twenty years ago. The NHS needs a plan, but it also needs local flexibility if the hope of a service with quicker adaptation to change (Bazball NHS) is to emerge.

Bed numbers

In immediate practical terms, it would be realistic to expect that numbers of acute beds will be static in the next 10 years. The New Hospital Programme are mainly replacements. There would in any case be problems in staffing any more beds.

The New Hospital Programme has now been shifted into cohorts with much of the funding available after 2030. For example the Preston Trust has been awarded funding from 2030 but, with time needed for design and construction, the new Royal Infirmary is not likely to be completed till 2040.

The NAO report (National Audit Office, 2023) on the New Hospital Programme detailed its lack of relevance for the foreseeable future. Revisions in the scheme have meant that only two hospitals will be built before the end of 2025.[ii] It is highly likely that future projects will be delayed or cancelled due to rising costs.[iii] As the NAO set out, forecast costs for the first 17 schemes (those in cohorts 1 and 2) increased by 41% between 2020 and 2023.

Meanwhile, the NAO also showed that the NHS hospital maintenance backlog has doubled since 2014 from £4.7 billion to £10.2 billion. There is little point devoting funding to an increasingly uncertain new capital programme if the trade-off is faster deterioration of the existing estate. (It is worth noting that the fall in NHS bed numbers over the last thirty years is highly positive response. It is a positive response to advances in surgical practice, such as minimally invasive surgery, which has enabled a much greater number of day cases. Some argue that an ageing population requires much higher bed numbers. As later sections of this paper explain, new patterns of demand should lead to new kinds of supply, not more of the same.)

Capital funding

More generally on capital funding there is a hidden tension between national policy (the New Hospital Programme) and the power of Foundation Trusts in the cities.

These Trusts have moved ahead with projects in London, Birmingham and Newcastle which have been designed and, for some, completed much faster than the national programme. The large Trusts in the cities also have more access to funds for maintenance.

This means that the NHS is seeing the development of a two-tier hospital system. The hospital Trusts in deprived areas have less access to capital and to permanent medical staffing. They also have a higher workload from emergency admissions.

For primary care, uncertainty about the future of general practice has meant that investment by GP partnerships has come to a stop. There is no investment from the old sources of GP partnerships and no new system for investment for integrated care.

[ii] "It now expects the first scheme that will count towards the 40 new hospitals commitment – the Dyson Cancer Centre, in Bath – to open in late 2023. The second – Shotley Bridge Hospital, in County Durham – is expected to open in late 2025." (National Audit Office, 2023)

[iii] Ibid. "NHP has affordability challenges to address in its third programme business case, which may reduce the scope of future hospitals or cause it to delay more schemes until the 2030s."

There will be pressure to spend on urgent hospital maintenance which will reduce investment for integrated care.

For social care there has been one joint centre in Hull (the Jean Bishop Centre). The call for transformation has not been followed by a funding system which would make it a reality.

SUCCESSES IN IMPROVING HEALTH PRODUCTIVITY

The NHS has shown that health services can escape from the menace of Baumol's Law. The Law was first identified in 1967 and named after the post-war economist William Baumol. It has been often cited as a main reason for rising cost in public services such as health and education. His argument was that the costs of public services will always increase because wages rise in industries of low productivity (like string quartets in his example) in line with industries of high productivity. Health services, however, have shown that improvements in organisation and technology can deliver radically improved performance for the same or lower cost.

HIV/AIDS

Early forecasts were that thousands of long-stay beds would be needed for HIV/AIDS patients and that treatment might account for 20% of NHS spending.[iv] In fact, a much improved service has been delivered more efficiently through a combination of early diagnosis and drug therapy.

As with cancer, early diagnosis both improves outcomes and reduces costs. As the National Institute of Clinical Excellence has said:

> *"The financial impacts of diagnosing a person with HIV late are significantly more than someone who is newly diagnosed. This is primarily due to the cost of inpatient resources required for admission, and it has been calculated that HIV care in the first year of diagnosis costs twice as much in people who have been diagnosed late… This is because in the first year there are significant risks of morbidity linked to late diagnosis. Financially the costs each subsequent year for a person with a late diagnosis are approximately 50% greater than someone with an early diagnosis, meaning that early diagnosis is not just beneficial for the person from a clinical perspective, but also from the payer or NHS perspective too (National Aids Trust, 2012)."*[5]

Diagnosis of patients as HIV positive can be carried out by a simple test costing £20, with 100% reliability. Targeting high risk areas has led to a reduction of 10,000 undiagnosed patients after success with the Halve It campaign.

Early treatment though drug therapy can avoid the need for hospital admissions. 80% of people who are HIV positive now work. A few special centres in Manchester, Brighton and Central London give ongoing support.

[iv] Personal communications with Chief Executive Officer of large London NHS Trust.

Coronary heart disease

Statins are a class of pharmaceutical that reduce levels of cholesterol in the blood and so reduce risk of cardiovascular illness and mortality. Introduced in the UK in the 1980s, they have been a key cause in the success story of reduced mortality from ischaemic heart diseases. The age-standardised mortality rate has decreased from 246.5 deaths per 100,000 people in 2001 to 96.1 in 2019.[6]

Surgery has also been transformed by the use of stents. Stents can be implanted using minimally invasive surgery, with much faster recovery times, shorter hospital stays and so lower costs. Coronary artery bypass graft (CABG) operations are now required only for high-risk patients.

Hip and knee replacement

Orthopaedic surgery is a similar example of reducing length of stay and cost over time. Length of stay for primary total knee replacement (TKR) and primary total hip replacement (THR) fell by 11 days and 9 days respectively between 1997 and 2014. Reimbursements to hospitals fell by £1537 for primary TKR and £1412 for primary THR, in line with the reduced length of stay.[7]

The latest Get It Right First Time (GIRFT) guidance (March 2023) sets a default of day surgery or one-night stay.[8] It quotes the example of the South West Ambulatory Orthopaedic Centre:

> *"SWAOC (opened March 2022) has achieved day case rates for THR and TKR of 54 per cent and discharge by day 1 of 99.3 per cent across its first 492 patients [3/492 patients discharged day 2]."*

The GIRFT guidance explains how these methods achieve greater productivity:

> *"… shorter lengths of stay mean these bed spaces accommodate more patient throughput in a week than models with longer lengths of stay".*

A NEW STRATEGY FOR THE NHS

In the following sections, we show how the changing pattern of demand should drive a new service model, under three key headings: specialised acute services, integrated neighbourhood teams and metrics on costs.

Some have argued that a changing pattern of demand, and a larger population of those with long-term conditions, should lead to a much higher number of hospital beds and hospital staff. This is the wrong conclusion to draw. As the analysis below shows, the key response to a changing population is a new model of care based on continuity of care and early diagnosis. This can only be achieved through out-of-hospital care. Efforts to expand the hospital sector further would fail to solve the key problem.

Labour Party health mission

The Labour Party has set out a positive "mission" on the NHS, in particular the development of out-of-hospital care.[9] The goal of a Neighbourhood Health Service is a good one:

> *"Labour will shift services out of hospitals and into the community, so that the NHS becomes as much a Neighbourhood Health Service as it is a National Health Service, with healthcare on your doorstep, there for you when you need it. For nearly every sick person the best bed for them to recover in is their own – in their home."*

Crucially, Labour has signalled that it will rethink investment into the New Hospital Programme. This will free up funds for investment on new services and facilities.

Labour's mission states that it will bring down waiting lists by following the model of the previous Labour government.[v] The outlook on growth and public spending is, however, very different to that of the years between 1997 and 2007.

The 1997 Labour Government inherited a benign economic environment with average GDP growth of 3% between 1997 and 2007.[10] Government expenditure on health in real terms nearly doubled in those years.[11]

The most recent OBR economic statement shows a much lower average GDP growth rate of 1.4% for 2023 to 2028.[12] Given the Party's apparent caution on major tax increases, it seems highly unlikely that it will be able to repeat the increase in NHS spending achieved post-1997.

Instead, it should focus on productivity and complete its programme with a new approach to acute services and a new metric on costs, set out below.

A new pattern of demand

At the start of the NHS the demand for health care was mainly about infectious diseases and accidents. The situation is now very different. Demand is composed of three key patient groups:

- Group 1. Citizen healthcare involving prevention and rapid access for minor injuries and health problems.
- Group 2. Patients needing extensive specialized treatment: high risk infants and adults with rare diseases. To this has to be added cancer, the one dreaded disease which now affects numerous people in all age groups and locations. Over the next fifteen years there are likely to be 6 million cases i.e. 10% of the English adult population.
- Group 3. People with long term conditions: respiratory, cardiac, diabetes and anxiety/depression. Within this group, 20% of patients account for most of emergency admissions. Patients in Group 3 can move into a spiral of decline –

[v] "As an immediate priority, Labour will grip the biggest crisis in the history of the NHS. We will do this by getting the basics right and taking long-term, pragmatic, common sense steps. The last Labour Government reduced waiting times by using the private sector, increasing staff numbers and spreading good practice. We did this before. We will do it again."

a combination of physical, mental, economic and care problems especially for people who live on their own.

The Health Foundation and REAL have made estimates of numbers with long term illness (Groups 2 and 3).[13] The total is expected to increase from 5.3 million in 2020 to 8.1 million in 2030 and 9.1 million in 2040.

The great majority of the increase is due to aging but there is also a significant rise for the 20-69 age group from 2.4 million to 3.5 million.

In terms of life years in poor health, this young and middle-aged group contributes to a fall in healthy life years. Already by 2019, illness-free life expectancy was 2.5 years lower than in 2010 (a fall from 47.2 years to 44.9). Further falls are likely in the future. The outlook is for a rise in morbidity – a population with growing health problems.

The rise in the numbers of middle-aged with poor health is little remarked upon, unlike the rise over 70 which commands so much attention – but this could lead to more reductions in quality of life and economic activity over a period when the adult population is rising only by 4%.

The report points out that "conditions typically diagnosed and managed in primary care are projected to increase at the fastest rates". The Long Term Plan showed that these health demands pointed to a very great need for "genuinely integrated teams of GPs, community health and social care staff".

A hospital-centric system in deprived areas

Problems of late diagnosis and poor outcomes are leading to a high level of revolving door admissions of patients of working age in deprived areas. Only for the over-90 age group are there more admissions in the affluent areas. There is a new dynamic of inequality. Lack of support services in the community makes it more difficult to offer day treatment.

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

New geographies of care

ONS population projections have messages for the NHS.[14]

The most important and most immediate change will be from internal migration. By 2028 the London population will fall by 1.04 million as people move to lower housing prices in the spaces between cities. There will also be movement out of Manchester and Leeds. There will be 841,000 international in-migrants for London. Most of the local areas gaining are in the East Midlands, South and West.

There will be local areas in England where 35-40% of the population will be over 65 (North Norfolk, Cumbria, Dorset and North Somerset among others). In others, such as Bradford and some East London boroughs, there will be much higher proportions of young people.

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

All these changes will bring new kinds of pressures. In London there will be great pressure on maternity and child health services which already have severe problems. In many of the smaller areas people are moving into large housing developments where there has been little investment in healthcare or in schools. Tewkesbury, Dartford and Corby are examples.

The future challenge has already emerged in Wantage and Didcot with an Adjournment Debate on the near impossibility of GP appointments. There has been a big expansion in housing with a contraction in primary care.

The challenge for NHS managers responsible for individual population centres ("place managers") is how to change location of practices. The challenge for integrated care systems is to work with the fact that population is not static in numbers or location. These are changes in a changing world. The NHS will be serving very different local populations: young in the cities and much older on the coasts.

Dynamo Centres for specialised acute services

The first element of a new acute service strategy is higher-productivity elective services. The gain to productivity is two-fold. Specific design and team organisation can increase volumes of treatment. Repeated practice by specialist teams leads to higher quality and improved outcomes.

The first acute services strategy since 1969

The last NHS strategy for acute services was set out in 1969 – known as the Bonham Carter Report after the review chairman, the awesome health satrap Sir Desmond Bonham Carter (Committee on the Functions of the District General Hospital, 1969).

The document of 28 pages had merits of realism. It started from the recognition that there was a shortage of hospital consultants. It rejected an earlier plan for 600-800 bed hospitals for populations of 100,000 (partly planned for civil defence reasons) on the ground there were too few consultants to staff them. Instead, it recommended that each population centre of 200,000 (more in urban areas) should have a district general hospital with two consultants in each specialty aiding a core staff of general surgeons and general physicians.

For 20 years this formed a template for acute service development across England. Gradually, and mainly through professional initiative, new service priorities emerged which could not be fitted into the DGH model. First came the pressures from additional services such as transplants and renal dialysis, neither of which existed in 1969. More recently there has been a strong drive to concentrate services such as for severe trauma and stroke treatment on fewer sites. There are now only 27 designated major trauma centres and four centres in London for stroke treatment. Such concentration is only possible with one of the world's best paramedic ambulance services to transfer patients. Most planning, however, is still either project-based or locality-based.

Without a new acute services strategy, the NHS is planning hospitals not a hospital service.

Examples of specialisation

The South West London Elective Orthopaedic Centre (SWLEOC), opened in 2004, demonstrates what is possible. It performs around 5,200 procedures a year, 3,000 of these joint replacements. As such it is the largest hip and knee replacement centre in the UK and one of the largest in Europe. The Centre consists of five operating theatres, a 17-bedded post anaesthetic unit bed recovery area with high dependency and critical care facilities, and two wards of 27 beds (Epsom and St Helier University Hospitals NHS Trust, 2021).

The Centre was rated as "outstanding" in the most recent CQC inspection, one of the few London units to receive such a rating. Inspectors emphasised that "patient outcomes were amongst the best in the country" and that there was an "open and transparent safety culture" (Care Quality Commission, 2016).

In Canada, the Shouldice Hospital is a similar size to SWLEOC, with five operating rooms and 89 hospital beds (Shouldice Hospital, 2021). The hospital specialises in primary inguinal hernias. A recent study found that "the hospital has achieved a 99.5% lifetime success rate while consistently delivering services at a lower cost than other health providers":

> *"While general surgeons typically don't do more than 20 hernia surgeries in a year on average, at Shouldice surgeons perform five to six a day, and as a staff nearly 7,000 operations annually or approximately one-quarter of all abdominal hernia surgeries done in Ontario. The clinical experience and effectiveness are also evident in operational efficiency and staffing levels. At Shouldice turnaround time for surgeries is 10 minutes versus up to an hour at other hospitals and the ratio of staff-to-bed is approximately 1.8:1, while other hospitals in Canada, albeit likely treating more conditions, have a staff-to-bed ratio from 9 to 12.6 per bed. This combination of lean staffing and quick surgical turnaround is a considerable cost advantage for Shouldice." (Economist Intelligence Unit, 2016).*

From hubs to Dynamo Centres

The Department of Health and Social Care has said that around 50 surgical hubs will provide at least 100 operating theatres i.e. two operating theatres per hub. These "hubs" are on a much smaller scale than SWELOC and will not be able to generate the same level of benefit due to specialisation.

The English NHS needs more ambition. Using data from the National Joint Registry, in 2019, there were only five facilities in England that carried out more than 2,000 joint replacements. There were none at all in six NHS regions.

A core challenge for all integrated care systems is to deliver specialised elective services on the model and scale of SWELOC – to be called Dynamo Centres. These will begin with elective treatments and, over time, deliver a whole range of specialist treatments and specialist commissioning.

Table 6: Number of joint operations, 2019, top provider in each NHS region

NHS region	Hospital	Number of operations by operation date
West Midlands	Robert Jones and Agnes Hunt Orthopaedic Hospital	3,779
	Royal Orthopaedic Hospital (Birmingham)	3,042
North West	Wrightington Hospital	3,586
London	South West London Elective Orthopaedic Centre	3,329
South Central	Nuffield Orthopaedic Centre	2,013

Source: National Joint Registry

Beyond the DGH

Dynamo Centres for elective treatment should be seen as the start for investment to a modular system with two main elements.

First, there would be a concentration of special services on fewer sites, following the precedent of severe trauma care. Some of these centres might be for an ICS and others on a regional basis. These centres would offer rapid diagnosis and treatment. They would have the patient demand to justify consultant staffing on a 24/7 basis, something which smaller centres have great problems in providing. These centres would become national leaders with specialist teams in medicine, nursing and rehabilitation. They would have some inpatient beds but operate largely on day and overnight treatment.

Second, the DGHs would be reshaped over time to be smaller hospitals with an accident and emergency department for rapid local access. These would also cover Virtual Wards and Urgent Treatment Centres. They would be linked closely to out of hospital services and home care to allow rapid discharge and support at home. They would be linked to the specialist centres to allow rapid transfer and transfer of information. The provider collaboratives are showing the way here.

Some may argue that local residents will oppose what will seem to be a downgrading of their local hospital (see the current disputes over reconfiguration of hospitals south of the Humber as an example). The NHS needs to make a much better case of the gains to patients that will result from these changes. Specialisation will lead to improvements in output and also to quality, reducing waiting times.

Given the new requirements for patient travel to specialist centres, the NHS should expect greater use of the Healthcare Travel Cost Scheme, which provides support for travel costs for people on low incomes.

Neighbourhood teams

Neighbourhood Teams (NTs) are the counterpart of specialised acute services. Integrated care is much more cost effective than hospital-based care (see Appendix A).

The excellent Fuller Stocktake showed the value of joint teams in primary care.[15] What is now needed is a clear mission to use neighbourhood teams, including both health and social care staff, to build out-of-hospital services. The measure of success should be a reduction in hospital admissions, and in particular emergency admissions for elderly patients.

The goal should be to reduce hospital admissions to the level of countries such as the Netherlands, which have a much more developed community sector. As the OECD has shown, the hospital discharge rate in the Netherlands (which is a key indicator of hospital activity) is around 25% lower than in the UK.[vi]

Table: Hospital discharge rates, 2021

Netherlands	80
United Kingdom	107
OECD average	130
France	157
Germany	218

Source: Health at a Glance 2023, OECD

Neighbourhood teams – mission and organisation

NTs must have a defined mission: to manage across all out of hospital services so as to improve outcomes for high-risk groups:

- patients with long-term medical conditions, chronic obstructive pulmonary disease (COPD), cardiac, depression who make emergency calls. The team would make immediate contact with a home visit and then provide the most appropriate support. This could be nursing, physiotherapy or home care, to help patients with more confidence to stay at home;

[vi] "Hospital discharge rates – the number of patients who leave a hospital after staying at least one night – are a core indicator of hospital activity. Improving timely discharge of patients can help the flow of patients through a hospital, freeing up hospital beds and health worker time. Both premature and delayed discharges worsen health outcomes and increase costs: premature discharges can lead to costly readmissions; delayed discharges use up limited hospital resources." (OECD, 2023)

- patients in last few months of life, to mobilize local resources and support. The NHS could actually deliver on the aspiration of a good death – to help improve quality of time at a time when there are difficult challenges both to patents and to carers;
- people requiring programmes for early diagnosis in target areas such as cancer and dementia, using local resources including primary care, CDCs and pharmacies; and
- people facing specific challenges such as weight loss or addiction, via local programmes for lifestyle change and health improvement through social prescribing, increased activity and access to support groups.

These neighbourhood teams would cover several practice networks. For large ICSs, several neighbourhoods would come together to form a larger unit (a "Place"). There would be a key manager, a local GP, on at least a half time basis. The team would be recruited with the skills required by local populations. Some teams would be working with local populations where over 65s would be 40% of the local population. Others would be working with young families. Staffing would vary not just with age but with level of deprivation in the local community.

Neighbourhood Teams would have the range of skills which would allow them to take the lead in out-of-hospital care and reduce admissions over time. They would be funded by ICS and by primary care. Patients would gain confidence in the service through both immediate diagnosis and continuity of care. They would lead in referral and management of the services now developing in the out-of-hospital space (home care, CDCs, social prescribing and talking therapies).

They could offer immediate support for many patients at home. Over time there could be investment in joint centres for GP practices and some of these services: but for the immediate future there could be digital communication. Data collection across the services would generate measures of outcomes.

It is clear that the challenge of better health is changing. We are dealing not with short episodes of disease marked by clear physical symptoms, but with long term conditions which have physical and mental elements and which threaten capability for day to day living. Improved outcomes now must mean making progress across these wider effects of illness. The neighbourhood team must have the mix of resources which can deliver along all dimensions for recovery.

Coordination of services

At present we are seeing development of a new set of silos: separate services which are good in themselves but lack co-ordination. These include Community Diagnostic Centres, CORE20PLUS5 programmes, care pathways for long term conditions and public health measures. The Neighbourhood team would manage all these activities to improve outcomes for patients. It should also take opportunity to develop neighbourhood centres for these services.

The importance of personal contact

The Fuller Stocktake stresses the importance of continuity through personal contact with GPs and team members. This raises patient confidence, improves outcomes and reduces A&E visits.

Such personal contact was a vital element in general practice from the beginning. By 1959 50% of people in England regarded their GP as a personal friend.

William Pickles wrote an outstanding work on the epidemiology of country practice in Wensleydale between the Wars. He knew that as a doctor he could not offer cures for children with infectious diseases: but he could offer accurate diagnosis and estimates on outcomes, which were usually positive in an area with good diet and clean air. The doctors tread on the doorstep was a great relief.

The NHS needs to develop new ways of making for continuity with GPs and their teams. Digital should be a key resource for freeing up time for high-risk patients. It is vital for improving medicines adherence and lifestyle for high-risk patients. The TORCH study (Towards a Revolution in COPD Health), which followed up 6,112 patients over three years, showed that poor adherence was a major predictor of higher mortality. For the 4,880 patients with good adherence, mortality was 11.3%. For 1,232 patients with poor adherence, it was 26.4%. Continuity and personal contact are vital for improving outcomes and blocking disease progression.[16]

The experience of Finland has shown how to move forward with out of hospital prevention and treatment programmes. The 10-year primary care-based programme on asthma, from 1994 to 2004, reduced the number of Finns on long term disability benefit, asthma related, from 8,000 to 1,000.

Blackpool Trust has been a pioneer in giving frequent users of A&E a personal health coach. It now has some of the shortest waiting times in A&E, even while working in an area with high deprivation.

A new metric for costs

There is one forgotten aspect to supply: the effectiveness with which the NHS uses its resource. The NHS is a multi-unit service which seeks to promote the productivity of each unit. Any such organization should collect accounting data on costs and outcomes (output).

Such data used to be much more available. For example, the Department of Health Research Report on Heart Transplant Programmes showed that the average cost per patient at Harefield was £10,372 and at Papworth £14,225. The difference was due to earlier discharge at Harefield so as that the immunization programme was carried while patients were living in a hostel.

In the whole history of the NHS, one of the best reports was the 1976 Priorities for Health and Personal Social Services in England. As it said: “Members of the medical profession, while preserving their clinical freedom, must be ready to seek more economical methods of providing health services…”.

Earlier, Martin Feldstein, in "Economic Analysis for Health Service Efficiency", had used the pioneering data on relative costs of maternity units from De Alex Barr of the Oxford Regional Hospital Board.

But now, on top of the failure to produce programme budget data for ten years, there has been an absence of data from NHS England on the costs and productivity of different services. This has to be attributed in part to the resistance of Trusts but also lack of any priority. Yet such data are vital for securing improved value through diffusion of the most efficient methods.

NHS England has recognised in passing the great differences in costs of carrying out transplants, but it has not taken this further, to other areas of specialist commissioning. Such comparison could be a most important initiative for the new commissioners of these services i.e. the integrated care systems.

ICS control over capital spending

If ICSs are to act on new cost information, they need to have greater freedom to invest in new services. The financial system should support local initiative for integrated care.

At present each ICS receives a single budget for revenue spending but funding for maintenance, for capital spending, CDCs, primary care development and so on are in about ten different funds. All of these require the preparation of bids with no certainty that any allocation will actually be made.

Large Acute Trusts can generate their own funds for development and maintenance through borrowing or through payments for specialist services. The current system makes it impossible to deliver a steady consistent approach to developing local services.

We recommend that ICS should be allocated a single fund to cover maintenance and development. The ICS would be able to work out its priorities and develop a plan for meeting them. The ICS would have freedom to carry over funds for this longer-term plan. The Fund would allow development of support for integrated neighbourhood teams and for joint projects with social services.

CONCLUSION

We are setting out here local initiatives by ICBs which would start to bring results in months for shorter waiting times, quicker access and higher staff morale. The NHS needs positives quickly that will bring momentum for further change. There can be immediate contact with people on the waiting lists to find out how needs have changed. Where this has been done, as in Sussex, it is possible to use treatment time more effectively. Integrated neighbourhood teams can begin to work within months.

These initiatives are feasible and fundable. There have already been local successes in stroke prevention and early diagnosis in HIV. Leadership by NHS England should concentrate on programmes such as the stroke prevention programme which can produce results quickly. The way forward is to empower local teams for local leadership in better outcomes. We want a 'Now NHS' using the initiative and commitment of the staff teams that are present.

Our key message is about developing stronger services outside hospital. For this we need to show how results can be achieved quickly. A service cannot succeed if it is adding to hospital workload even further leading to longer waits and poorer outcomes. We need confidence in the first steps to a new direction.

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