The Strategy Unit.

Response to '*Change NHS: A health service fit for the future*'

2nd December 2024

Contents

This document contains the Strategy Unit's contribution to the consultation to help develop the '10 Year Health Plan'. It is set out as a question-by-question response.

We begin with broad views on what we want to see from the Plan, and our take on the value of analysis within it. Subsequent responses go into more detail on each topic.

As such, it represents a narrow selection of our work; readers interested in the breadth of what we have done should see the Strategy Unit website or contact us on strategy.unit@nhs.net. We would also welcome comments on the views set out here.

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The Strategy Unit is a specialist NHS team of nearly 75 people. Hosted by NHS Midlands and Lancashire, our mission is to improve health outcomes and reduce inequalities by increasing the quality of decision making.

To achieve this, we provide high-grade applied, multi-disciplinary analytical services. And we help people make practical use of the results. The Strategy Unit proposition is therefore simple: better evidence, better decisions, better outcomes.

The response below should be seen in this light. We are NHS employees, animated by the values of public service, committed to helping the NHS be the best it can be. And we have a technical contribution to make around the generation and application of evidence.

The Strategy Unit is therefore interested in 'the how' as well as 'the what' of the 10-Year Health Plan. And so, alongside specific suggestions and results from our analysis (provided in response to each question), we are also making a more general case for the better use of evidence in decision making at all levels.

The tone and territory for the Plan

The above helps explain what we want to see included in the 10-Year Health Plan. At first glance this might sound paradoxical, but we want to see maximal ambition combined with maximal humility.

We want maximal ambition because, as an NHS team, we want a vision and direction we can commit to. This is not a minor point. We recruit and retain highly skilled people who are in demand, and who have choices in the labour market. We cannot offer the best remuneration - but we can offer a commitment to public values and the common good.

What is the long-term direction for health and care services? Having received Darzi's diagnosis, what will be done to improve care? What significant choices and trade-offs does that present? How will these choices be navigated? What choices will the NHS make where values conflict – between efficiency and equity, for example? What mechanisms will be used to improve care? Competition? Collaboration? Incentives? Choice and voice? Peer review? Commissioning? (etc). Fundamentally: what is the guiding light for the next decade?

We want a Plan that articulates responses to these kinds of question. We want a Plan that sets a direction we can commit to as NHS employees.

And we want maximal humility because the Plan should – as far as possible - stop short of detailing 'what to do'. The best Plan would be heavy on direction, light on detail. It would make the big decisions, navigate the broad choices and fundamental trade-offs. It would chart a course in a way that only national policy can do. And it would do all this recognising that the NHS is already over-centralised: prescribing 'must dos' for local areas, or mandating nationally driven 'rollouts' would make that worse. Delivery should be local by default; subsidiarity should be the watchword.

Analysis as a route to improvement

Humility also means being relentlessly empirical and realistic. All ideas and initiatives are theories; these theories should be tested empirically and learnt from. And so, especially because the Plan is for the long-term, it should emphasise the generation and cumulation of learning. The planning and delivery of care is – in large part – amenable to the application of rigorous research and analysis.

Research and analysis are a bedrock for durable improvement. Many service questions are recurring; our ability to navigate them should increase with the accumulation of evidence and experience. We must continually learn from what works and – critically - what does not.

And yet the opportunity for learning is frequently missed. This is not only - or even mostly - a technical problem. Instead, it is: partly because 'political' (big and small P) incentives tend away from empirical investigation (given the possibility of uncomfortable truth); partly because learning has not been designed in to specific initiatives; and partly through lack of attention to the core disciplines of policy and programme design.

To make this more specific, taking learning seriously would mean that evaluation – at all points of the policy and service cycle – should be used as described by the Cabinet Office-HM Treasury 'Evaluation Task Force'. For example, national programmes would be designed with evaluation in mind: they would follow a path of incremental testing (allowing results to be seen) instead of big-bang single rollouts (which make success, or harm, needlessly difficult to detect). 'Might' *is* right. The Plan is an opportunity to be clear about this.

This would save money and harm. To take a recent example, there has been national encouragement for the widespread use of risk stratification tools in primary care. The essential theory here was that risk (typically of unplanned and urgent care) could be spotted and averted. In practice, it seems that the opposite was achieved: use of these tools *increased* use of unplanned care. And, using 'design stage evaluation' our assessment was that this was not likely to be because of inaccurate risk stratification tools – but because of a poorly thought through theory of change. A more incremental, empirical and modest approach would have averted waste and harm in this case.

A more empirical and humble approach would also help reset relations between national and local bodies. We have seen local organisations and systems submit plans where they knew there was no possibility of achieving agreed targets, but more realistic plans (based on past trends and previous experience) had been rejected by regulatory bodies. This is wasteful. And the gap between proclamation and reality is where cynicism grows. It is a gap that need not exist if a more empirical approach is taken: better use of evidence would improve culture and relations; it would also allow the honest and patient accumulation of knowledge.

At heart, the above shows that we would like to see the Plan recognise the value of analysis. This does not mean more automated dashboards drawing on big data lakes and AI driven digital solutions. It means highly skilled analysts working closely with decision makers: understanding their questions and helping them through the answers.

This further means recognising the value of the analyst workforce - and the importance of the analyst-decision maker relationship. We see enormous headroom for improving the way the NHS produces and uses intelligence. Good practice is rare, not the norm. The Strategy Unit commits to improving this - and we are asking that the Plan provides meaningful encouragement.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

In principle, there is a long-standing apparent consensus on the need to make this shift. In practice, it has proved stubbornly difficult to achieve. The biggest challenge might therefore be apparent intractability – although the experience of many Northern European nations suggests that change is a possibility, if resources follow policy statements.

Related to this, there is a knowledge problem. Evidence from our work points in several different ways, and it seems that there are some fundamental gaps. **Challenges** here include:

- The relationship between provision of community services and levels of hospital activity might not be as assumed. The founding theory is that 'more contact with community services means less contact with hospital services'. Yet our recent analysis found the opposite: that decreases in community service contact rates were associated with decreases in emergency admission rates. This is a very significant question mark over evidence in this area. It is not settled; it is not true for all groups and all circumstances (see end of life below); but this does need further investigation.
- Changes to organisational form are a common policy instrument. The record here is ambiguous at best; it suggests placing little faith in this as a route to improvement. For example:
  - In 2008, the Transforming Community Services programme asked Primary Care Trusts to: 1) Vertically integrate their community services with an acute trust; 2) Horizontally integrate with a mental health trust; or 3) Set up a stand-alone community trust or Community Interest Company. Each option had its claims and proponents, and many hours were invested making changes. But our evaluation found that organisational form made no perceptible difference to emergency admissions for older people.
  - Some changes of organisational form do seem to achieve intended effects. Our evaluation of Royal Wolverhampton Trust's incorporation of several GP practices found that this change was associated with a modest, but statistically significant, reduction in unplanned hospital admissions. There was roughly 1 fewer admission per 1,000 registered patients per month after vertical integration: a reduction of about 13%. But to what extent would this local solution generalise to other areas?

There are many other (fundamental) challenges here - relating to urgent Vs important priorities, power and the different status of the professions, fragmentation following supply-side competition, workforce shortages (etc) – that others will cover in more detail than we can. The issue of social care is more fundamental still. There is already a sense that these services are the limiting factor,

and that efficiency in hospitals is now contingent upon provision in social care. Again, this is too big a topic and will be covered well by others.

In the face of these challenges, we would point to the following **potential enablers**:

Demand for end of life care is going to rise: prepare services and the public for this

Deaths are set to rise, driven by demography and mortality rates. All other things equal, the larger the number of people dying in a population in a given year, the greater the demand on health services.

Our analysis of end of life care in the Midlands showed opportunities to reduce waste and suffering in current provision. It showed significant inequities in access to care and resulting outcomes. It also highlighted significant coming demand for hospital care: if patterns of care were not changed, our estimate for the region was 1,200 beds (roughly a large teaching hospital) by 2030. This would be over-medicalisation on a grand and expensive scale.

And our analysis for Macmillan Cancer Support - which looked at 400,000 adult deaths in 2021/22 – found that an additional 10 community contacts in the last 90 days of life was associated with an 18% reduction in the risk of dying in hospital. Community contacts also reduced multiple A&E attendances, out-of-hours visits to hospital, and additional unplanned care.

This is a slow-moving and foreseeable problem, with an apparently community-based set of solutions. Moving this on would benefit from national efforts, not least to lead a conversation with citizens about the role of medicine and how services can support a good death. There may also be a case for a national service specification for more community-based end of life care. There is certainly a case for addressing current inequities in access and outcomes.

Provide a visible – and consistent - measure of hospital activity that could be mitigated

To support our demand and capacity modelling work for the New Hospitals Programme, we analysed approaches designed to avoid hospital-based activity. This was detailed, thorough work. It examined which types of hospital activity might be mitigable across multiple services. And it also considered how this might be done, looking at three mechanisms: de-adoption; diversion/substitution; and prevention.

Having now built the model, there is now a consistent national method for scaling activity potentially amenable to 'the left shift'. Moreover, there is evidence on the mechanisms for achieving this.

The model is free to use, built in open-source software; it is a national business critical model; it has passed NHS data science peer review processes; it has been run for 20 systems; and it could be used by other areas to provide a comparable set of results. The model could also therefore be used

to scale and plan for 'left shift' activity for local health systems – and track progress over time. This could be an extremely powerful enabler.

Incentivise continuity in primary care

Continuity of care in primary care has positive effects in terms of reducing demand for both secondary care and further primary care. And yet continuity has declined over time. We show possible causes of this here, but our hypothesis is that – in an effort to increase access and input-output productivity - national policy has contributed to the problem. Our suggestion here is that continuity receives far more emphasis in national policies, programmes and contracts.

Consider equity when shifting care and managing waiting lists

Our analysis of community services in the Midlands showed that access was broadly 'progressive'. Notwithstanding some subtlety, we found that patients living in deprived areas had better access to post discharge community services than those from less deprived areas. One argument for shifting the balance of care towards primary and community services is that it would mean the NHS is playing a more positive role in counteracting health inequalities.

This can usefully be seen in contrast to our work on elective care. Here, it is clear that the poor will suffer if efficiency is the main measure of efforts to reduce waiting lists. This already seems to be the case. It was not always so. Our analysis showed that in 2003 access to elective care was broadly neutral between socio-economic groups; this started changing in around 2007-8; and from 2010 onwards a clear gradient opened up. This occurred while multiple policies and strategies set the aim of reducing inequality.

But local action can only go so far, and national management will encourage and shape local strategies. So the Plan could usefully take a position (or at least initiate work) on the trade-off between efficiency and equity when it comes to reducing waiting lists.

To what extent does the NHS value equity? How – on what dimensions - would it assess progress? (Our suggestion is socio-economic group and gender). And if the NHS wanted to recover the position of 2003, how – in broad terms - would it do it? Our work on strategies to achieve greater equity suggested just a few routes; we also provided case studies, an ethics review, a legal review and public engagement.

Understand the way that clinical risk is defined and operationalised

Do we know how management of clinical risk affects flows through systems of care? Our analysis shows that decisions to admit are influenced by factors other than clinical risk: the busyness of ED and the occupancy of inpatient beds, for example. If demand is reduced somewhere in a system, admissions criteria will be recalibrated and won't necessarily go down overall. And individual clinicians face disincentives to carry risk.

So can admission thresholds be made clearer and more objective? And can managerial systems act to support individual clinicians as they hold risk? And how does this work for peripatetic services like district nursing, where risk might be less visible?

Test contractual mechanisms

The NHS has seen success in the past through the use of 'payment by results' (allied during the 2000s to significant funding increases) to incentivise activity in secondary care and thereby reduce waiting lists. There is no equivalent in community based services. The data and pricing for these services is generally poor. Detailed work – which we have started, working for NHS England - to develop pathway-based currencies is needed.

Relatedly, enthusiasm for outcomes-based contracts has waxed and waned. Through learning from some high-profile errors, advances in analytical techniques, and related evaluations we know more than before and should be less naïve in our hopes. Carefully designed – and analytically credible – contractual mechanisms could be used as enablers in shifting incentives and thereby care. But this is a clear area where a big bang national roll-out should be avoided.

Be clear about the purpose

There is a final, perhaps more foundational, enabler of this shift. It is for the Plan to be clear about the rationale for community-based services. We see some risk that the value of these services becomes articulated solely (or at least too greatly) in terms of reducing activity in hospitals. This is an important, but very partial, reason. It should be seen in the context of other values, such as patient experience or reducing carbon emissions, for example.

Articulating the purpose of these services in this way would guard against 'catch all' mantras. It cannot be right that shifting care into community settings is right for all services under all circumstances. So when is it right? And for what purposes? And how would we know if it was working? (etc). We make a similar point for prevention below.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Advances in technology are clearly a route to progress in providing better care. This is a well-supported case, with no shortage of supporting examples. And so, rather than remake the same points, our contribution here is to look at the downsides of technology. These are underappreciated, underexamined, and – in some cases – high risk.

Our recent discussion document on the downsides of digital illustrates several specific risks presented by increasing use of technology. For example, these included:

- Making services more transaction and losing the vital 'human element' of care.
- Changing the nature of clinical work, making it less satisfying.
- An emphasis on narrow (typically organisational) efficiencies, not accounting for tasks that are displaced (typically onto users) and may – in aggregate – create inefficiency.

But the project also revealed deeper underlying trade-offs and risks. For example:

That the benefits of technology are typically about efficiency. What about other values?

The promise of doing more with less (or the same) is important – especially for an NHS (and a UK) with growing concerns about productivity. And yet values in healthcare extend beyond efficiency. To dignity or equity, for example. Increased digitisation could therefore be inadvertently – and without debate - promoting the value of efficiency at the expense of other values. If so, this would make existing disadvantages worse.

That there are threats to the basic premises of evidence-based medicine

The 'digital downsides' project revealed analogies between technology firms and pharmaceutical firms (innovative, R&D intensive, sources of potential gain and harm, asymmetries of knowledge between buyers and sellers), alongside strong disanalogies in terms of the way the products of these two industries are treated. Without better evaluation and assessment, allied to better regulation, there is a risk that the (hard won) norms of evidence-based medicine are eroded by enthusiasm for digital technology.

That technology encourages a lack of realism among decision makers

Promises, rather than performance, become the currency as decision makers seek solutions to increasingly pressing problems. There may also be a temptation to 'follow the solution' rather than address the problem at hand. For example, breakthroughs in diagnostics using AI may be technically impressive, but our analysis in the Midlands showed that the rapid growth in diagnostic

activity was already not the limiting factor - and that growth in diagnostic activity was in fact causing delays elsewhere in care pathways.

In the main, digital tools are under-evaluated and underregulated; they over-promise and under-deliver. The main challenge to the use of better technologies would therefore be waste and cynicism. And the main enabler would be more empirical work to examine actual effects of technology as deployed (alongside routes to report harms) in real world situations.

Finally, and on a more detailed note, it may well be that the limiting factor is getting the basics right, rather than seeking innovative new margins. Our experience of working with NHS analysts suggests that increasing their ability to download and use (pretty standard) open-source analytical software would be a simple change that would unlock real value.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

England does not have an obesity problem because of an undersupply of Ozempic. Our teenagers do not have poor mental health because of a lack of CBT. The causes of ill health typically lay beyond the reach of services; but the consequences rest squarely with them. The NHS is part of the society within which it operates: its health reflects our health. The signs here are worrying, with wide and growing inequalities of outcome reflecting wide and growing inequalities in condition.

There are technical dimensions to this debate, but the essence of the case for prevention is political. If, for example, there are trade-offs between commercial incentives (e.g. to sell ultra-processed food) and paying for the consequences of these actions (e.g. in treating heart disease), then these trades have to be managed politically.

Obesity suggests itself as a useful test case. We will have made the shift to prevention to the extent that we avoid (expensively) trying to treat our way through this problem. And, perhaps less obviously, our recent work on deaths of despair (from alcohol use, substance use, suicide, and mental ill health) also provides a possible test case: we are already struggling to treat the problem, and prevention means concerted cross-sectoral action.

Overall, while leaving detailed prescriptions to the public health community and others, the Strategy Unit supports strong action on primary prevention to improve the nation's health. As part of the NHS, we want to see maximum benefit for the resources available. This means a willingness to regulate and change environmental conditions, alongside the provision of lifestyle services to support people to make changes.

Our suggestions for enabling this shift are:

Make the most out of people already in contact with services

While we understand the seductive arguments in favour of predictive analytics, our sense is that there is plenty of headroom for prevention in strategies based upon the better management of people that are already in contact with services. For example, our analysis of the physical health outcomes of people with a mental health diagnosis illustrated – for every area of England – disparities in life expectancy and service use compared to the background population. It also highlighted opportunities for preventative support for this known cohort.

Since our initial analysis, demand for mental health services has grown – with children and young people being a notable group within this. This presents a further opportunity for preventative support: helping this group avoid being the long-term users of adult services in the future.

Carefully specify the outcomes of interest

There is some risk that 'prevention is better than cure' becomes an unexamined mantra, removing the need for critical thinking, use of evidence and hard-headed choice making. This risk is exacerbated by the outcomes of interest getting broader as interventions get closer to primary prevention. On one level this is a technical question. On another it shows what we value and guides what services are provided.

For example, the UK's sickness-related productivity problem will create strong arguments for including labour market outcomes in preventative health schemes. These can (relatively) easily be measured in monetary terms, providing decision makers with evidence on the return on their investment. Yet the same would not be true for older adults, or those for whom work is not a possibility: they may gain in health terms, but not labour market terms.

We should therefore be clear about the value judgements inherent in the outcomes we prioritise - reminding ourselves that the NHS is primarily in the business of protecting and improving health.

We would also caution away from apparent economic cases suggesting that creating and administering innovative treatments is good for growth (because economic returns can be seen). Repairing damage is typically a worse use of resources than preventing it; and resources committed to treatments could / would always have been used elsewhere.

Use national programmes to examine questions of resource allocation

The Hewitt review showed that we don't know how much is currently spent on prevention. Yet consensus suggests that it isn't enough. We would add that – to help this debate along – we also don't know how much *should* be spent.

Working this out should be possible in principle. If the aim is, say, to maximise healthy life expectancy, then broadly what proportion of the NHS budget should be dedicated to preventive investments?

There are methods for working this out, which draw upon 'technical' analytical work alongside 'social' engagement and the recognition of competing values. Recent work by our sister team – the Health Economics Unit - in the Midlands using the socio-technical allocation of resources (STAR) method highlighted opportunities for achieving greater health gain by shifting towards a more preventative and community-based pattern of services.

And yet this work also highlighted the practical difficulty (judged to be prohibitive) of actually moving resources, given significant local 'political' pressure implied by shifting resources away from local hospitals.

This presents an opportunity for serious national analysis and action. What – in broad terms – would a more optimal allocation of resources look like? This could be done within service areas and perhaps between them also. The analytical and engagement requirements associated with this mean that nationally-led work is likely to be better and more efficient than many local efforts. Results would give a far clearer indication of what currently is spent on prevention and – critically – what a more optimal allocation would be.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- **Quick to do, that is in the next year or so**
- **In the middle, that is in the next 2 to 5 years**
- **Long term change, that will take more than 5 years**

Some of what we suggest above could be commenced and concluded in the short to medium term. The suggestions that are predominantly analytical – for example using the New Hospitals Programme model to scale 'left shift' activity – fall into this category.

But many of our other suggestions would require knowledge we don't have in order to usefully make suggestions about sequencing. Notwithstanding that, and in extremely broad outline, we would say:

- That the immediate financial position suggests that political capital is probably a more attractive currency to invest than cash; so regulatory activity to achieve primary prevention would be a good place to begin.
- In the medium term, investments in prevention could be ramped up to support this.
- And in the longer-term – hopefully using proceeds of growth, and certainly based on a sounder analytical footing – the shift to a more community-based model of care could be made.

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