TIMES Health Commission

A report into the state of health and social care in Britain today

Editor's letter

The Times Health Commission was set up in January last year to take a long, hard look at the NHS and social care system. Its aim was to consider the future of healthcare in the light of the pandemic, the opportunities presented by new technology, the ageing population, workforce pressures, an obesity crisis and growing health inequalities.

This year-long project has been chaired by the Times columnist Rachel Sylvester supported by a distinguished team of 18 commissioners with successful backgrounds in business, medicine, science, sport and policy.

It follows the success of the Times Education Commission and is part of the paper's commitment to informing public debate and shaping policy ideas as well as reporting the news.

When we first discussed setting up a health commission a year ago, the subject seemed important and timely but since then the urgency of the issues under consideration has only grown.

The NHS is facing the worst crisis in its history. The waiting lists, ambulance delays, struggling A&E departments, overwhelmed GP surgeries and social care backlogs mean that fundamental change can no longer be avoided.

The British economy is suffering as a result of rising levels of ill health and a record number of people are off work with long-term sickness.

The health service is consuming an ever rising proportion of public spending and the pressures on it have never been so great. This is simply not sustainable.

The NHS is reeling from the impact of the Covid-19 crisis, but many of the problems predate the pandemic. It is time to take stock and rethink healthcare, from top to bottom, to look at what other countries do better or differently, and to create a system fit for the modern world.

The commission is one of the broadest inquiries into health ever held in Britain. It has examined funding, technology, staffing, management, patient safety and public health. It has heard expert evidence from a wide range of witnesses including politicians, doctors, scientists, cultural figures and business leaders.

It has visited hospitals, GP surgeries and care homes in this country and around the world. It has commissioned economic analysis, business surveys, opinion polls and focus groups to get as full a picture as possible of what is working and what is not functioning properly.

We want the commission to be a catalyst for change. The NHS will be a defining issue at the coming general election and this report contains clear, deliverable, evidence-based policies that are popular with the public. I would urge all the political parties to support its recommendations and to bring about the reform that the country needs.

Tony Gallagher

THE TIMES

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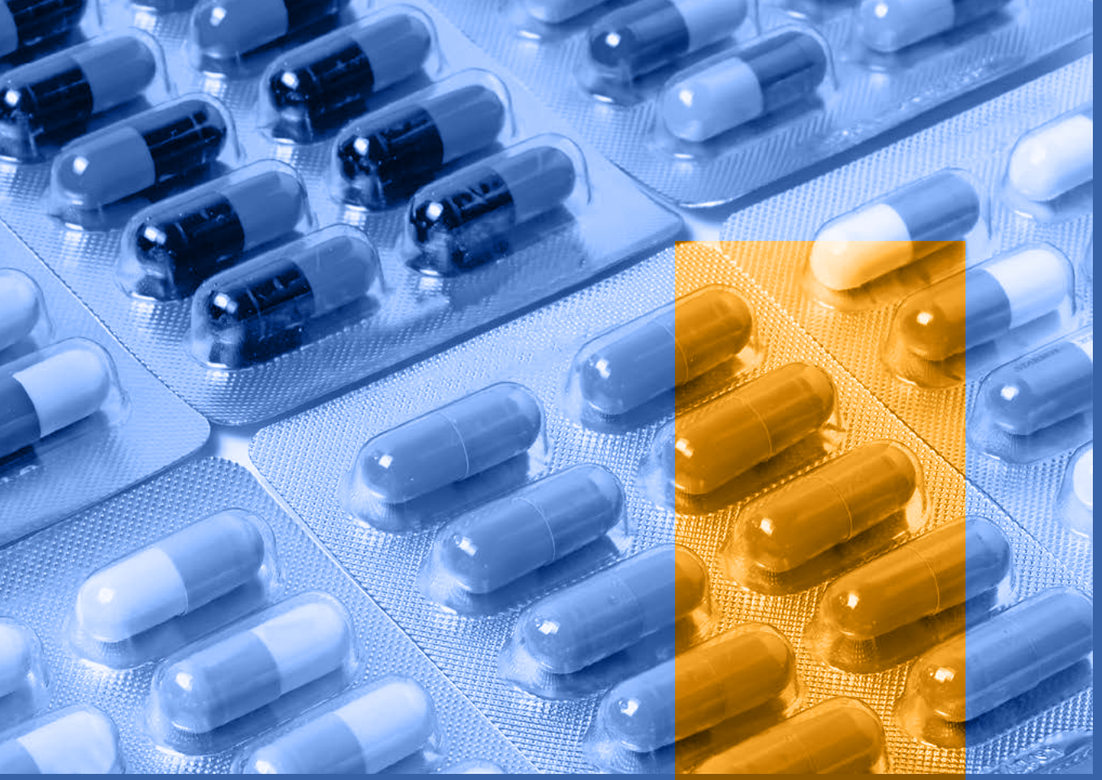
Report compiled by Rachel Sylvester, chairwoman of the Times Health Commission



Foreword

The Times Health Commission was given the task of suggesting reforms to improve the NHS. It proposes three core principles that have the potential to create a healthier Britain

It is not difficult to spot the problems in the NHS. The soaring waiting lists, over-run A&E departments, queueing ambulances and struggling GP surgeries are clear for all to see. The Times Health Commission's job, however, was to find solutions. Our remit was to identify the causes of the difficulties and suggest reforms that would make the system work better.

At first it seemed a daunting task but as we listened and learnt over the course of a year the answers began to emerge. There was, in fact, a remarkable level of consensus. Three core principles became clear and underpin this report, backed up by detailed research, case studies and recommendations. First, the system must be rebalanced away from hospitals and a greater emphasis put on prevention and community care. We have a National Sickness Service formed for another age and we must create a National Health Service fit for the 21st century. This means diagnosing disease more quickly and treating people closer to home. It involves intervening earlier to stop people reaching crisis point or needing hospitalisation. And it means transforming the culture around food and fitness to make the healthy choice the easy one for all.

Second, health is an intricate ecosystem so there is no solution that does not involve reform of social care. Successive governments have failed to deal with this issue and the consequences are being felt in overcrowded hospitals and by the millions of people who cannot get the support they need. The ageing population means that we can no longer afford to put it off.

Third, technology has the power to transform healthcare. A scientific revolution is under way that will enable the system to become more personalised and predictive. Exciting medical breakthroughs are ushering in a new age of cures. There is in fact enormous cause for optimism amid the doom and gloom but the health service needs to look to the future rather than idolising the past. The NHS and social care system must seize the extraordinary opportunities on offer in the modern digital world to empower patients, liberate clinicians, improve services, drive efficiencies and create a healthier Britain. Other countries have done it and so could we.

The commission, set up last January, has been evidence-based and sought to learn from the best examples in this country and abroad in a dispassionate, clear-sighted, non-ideological fashion. It was supported by a prestigious group of expert commissioners from the worlds of medicine, business, policy, science, food and sport.

With a remit to consider everything from hospitals to GP surgeries, social care to the obesity crisis, health inequalities to the NHS workforce, the commission has been one of the broadest inquiries into health ever conducted in this country. Through fortnightly evidence sessions, patient panels, domestic and international visits and interviews, the commission heard from more than 600 witnesses. They included doctors, nurses, midwives, receptionists, social care professionals, patients, regulators, public health officials, bereaved families, chefs, an architect, a fitness guru, a Nobel prize winner, a former prime minister and ten former health secretaries.

The commission also visited dozens of hospitals, care homes, GP surgeries and research laboratories, including visits to Japan, Denmark, Israel, Ireland and Spain. We spent two days in a hospital and went out on a shift with an ambulance crew to understand what it is like on the front line of the NHS.

The recommendations contained in this report are pragmatic, practical, deliverable and could be taken up by any political party or government. There is a ten-point plan of policies that we believe would make a genuine difference but the commission would argue that a broader mindset change is also required.

It will take a national effort, from business, individuals, health professionals and politicians to create a healthier Britain.

A ten-point plan for health

1. Create digital health accounts for patients, called patient passports, accessed through the NHS app, to book appointments, order prescriptions, view records, test results or referral letters and contact clinicians.
2. Tackle waiting lists by introducing a national programme of weekend high-intensity theatre lists to get through a week of planned operations in a day and create seven-day-a-week surgical hubs.
3. Reform the GP contract to focus on wider health outcomes, ensure prompt appointments and restore continuity of care. Encourage more super-practices and create community health centres.
4. Write off student loans for doctors, nurses and midwives who stay in the NHS. Debt should be cut by 30 per cent for those staying three years, 70 per cent for seven years and 100 per cent for ten.
5. Introduce no-blame compensation for medical errors with settlements determined according to need to ensure families get quick support and encourage the NHS to learn from mistakes.
6. A National Care System giving the right to appropriate support in a timely fashion. Equal but different from the NHS, it should be administered locally and delivered by a mixture of public and private sectors.
7. Guarantee that all children and young people requiring mental health support can get timely treatment and rapid follow-up appointments. Publish data on waiting times for all mental health services.
8. Tackle obesity by expanding the sugar tax, taxing salt, implementing a pre-watershed ban on junk food advertising and reducing cartoons on packaging to minimise children's exposure to unhealthy food.
9. Incentivise NHS staff to take part in research and put the case for research to their patients by giving 20 per cent of consultants and other senior clinicians 20 per cent protected time for research.
10. Establish a Healthy Lives Committee empowered by a legally binding commitment to increase healthy life expectancy by five years in a decade.

The Commissioners

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Chairwoman of the Times Health Commission and a Times columnist

Waheed Arian
Afghan refugee, doctor of the year and Times person of the year

Sir John Bell
Regius professor of medicine at Oxford University

Dame Jane Dacre
Former president of the Royal College of Physicians and emeritus professor of medical education at UCL

Lord Darzi of Denham
Surgeon and former health minister

Sir Andrew Dilnot
Warden of Nuffield College, Oxford, and chairman of the Dilnot commission on social care

Henry Dimbleby
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Baroness Finlay of Llandaff
Former president of the Royal Society of Medicine and professor of palliative medicine

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Researcher and reporter

"FROM CRADLE TO GRAVE AND DUSTMAN TO DUKE.

The health service is woven through the nation's emotional life but it has become more like a sickness service

Aneurin Bevan, the architect of the National Health Service, summed up its founding principle in 1948. "Illness is neither an indulgence for which people have to pay; nor an offence for which they should be penalised," he said, "but a misfortune, the cost of which should be shared by the community." Seventy-five years later the television presenter Sir Michael Palin explained the defining quality of the NHS slightly differently. Describing his experience of open heart surgery at St Bartholomew's Hospital in London, he told the Times Health Commission: "When I had the operation it was how people spoke to me, how they helped me after — human being talking to human being — that was just as important." He suggested that the "humanity of the medical profession" was at the heart of its appeal. "We have ambulances waiting outside hospitals. I would like it not to be struggling that way but whenever you have contact with the doctors and nurses it's inspiring. Most people's eyes moisten when they talk about the treatment they've had. People feel gratitude."

The health service may be a political shibboleth but it is also woven through the emotional life of the nation. Its promise to care equally for everyone from the cradle to the grave and from a dustman to a duke has always had a powerful hold over the public imagination. That sentimental attachment was clear as people stood on their doorsteps clapping for healthworkers during the pandemic. It was evident in the children jumping on hospital beds who formed the centrepiece of the London 2012 Olympics.

Now, though, the NHS is cracking under the pressure of spiralling waiting lists, packed A&E departments and overwhelmed GP surgeries. Staff are burnt out, patients are getting sicker and hospitals are crumbling. The social care system is struggling to keep up with rising demand. Life expectancy is falling. The UK lags behind comparable countries when it comes to cancer survival. A record 2.6 million people are off work with long-term illness. Britain has become the most obese country in western Europe and there are huge health inequalities, with devastating economic and social consequences.

Patients are rapidly losing faith in the institution that Nigel Lawson famously said was the "closest thing the English people have to a religion". A YouGov poll for the commission found that more than two thirds of people think that NHS services are bad, 80 per cent think they have got worse and 39 per cent are not confident they would be there for them in an emergency.

This is despite the fact that healthcare staff are working harder than ever and the health service is absorbing an ever greater share of public resources. The Department of Health and Social Care budget has climbed to more than £180 billion of which NHS England accounts for about £155 billion. About 38p of every pound that the state spends on public services goes on the NHS. Other departments have faced cuts over the past decade but the health service has been protected.

Since 2010, spending on health has risen by 42 per cent but that on education has increased by only 3 per cent. Lord O'Neill of Gatley, a former Goldman Sachs banker and Treasury minister, said: "We need to step back from the crisis of waiting lists, ambulance times, cancer and say, 'Hang on a minute, what are we doing as a country?' How can it be that we're spending so much on health relative to education? It's crazy that we seem to be never-endingly happy to spend more and more taxpayers' money on seemingly very inefficient things. Unless we invest properly in preventative health the rest of it is just highly wasteful."

The NHS is already the sixth biggest employer in the world, with 1.6 million staff, behind only a handful of institutions including the People's Liberation Army of China, Walmart and Amazon. The Institute for Fiscal Studies (IFS) predicts that by 2036 the NHS could employ almost half of all public sector workers and about one in eleven of the entire English workforce. The proportion would be even higher if social care staff were included. This is simply unsustainable. As Paul Johnson, the IFS director, put it: "Increasingly our public sphere looks like a health service with a state attached rather than the other way round."

Matthew Taylor, chief executive of the NHS Confederation, is convinced that an urgent rebalancing of priorities is required. "The system is unaffordable as it is currently configured," he said. "You can get to the point where health and care no longer consume an ever-rising proportion of GDP but only through transformative change. We need to minimise the time people spend in hospital. We have to stop seeing health as this enormous hole into which we pour resources and realise that a healthier population is a more productive, economically active population."

The mythology surrounding the NHS is powerful. That was clear in last year's anthropomorphic 75th "birthday" celebrations. The playwright Sir David Hare argued that it was part of a national story dating back to the 1940s "about what happens when the soldiers come back saying we don't want the world to return to how it was in the 1930s. We fought for the common good, and the common good will be expressed through our National Health Service. That myth still has huge potency today." Yet the reality, he said, was that despite some excellent care, including the treatment he received for leukaemia and Covid, the NHS is a "geographic lottery".

The health service must look to the future rather than idolising the past. There are many brilliant, dedicated people doing fantastic work but there is also huge variation in performance and a persistent inability to spread innovation or ensure that the worst learn from the best. It is time for a radical rethink based not on irrational sentiment or ideological certainty but a hard-headed analysis about changing needs and the opportunities offered by new technology.

The NHS must evolve from what it has become — a reactive sickness service — into what its name promises: a more proactive health service. In 1948 the average life expectancy was 66 for men and 70 for women; now it is 79 and 83. When it was created the NHS existed to provide treatment for infections and injuries. These days most of its work involves managing chronic long-term conditions such as diabetes, arthritis, asthma, cancer, dementia and heart disease. The ageing population and the growing number of years that people are living in ill-health are big drivers of the gap between demand and capacity in the NHS. Mental illness and obesity are growing problems. The solutions do not lie in pouring more money into treating the sick; the emphasis must shift towards doing more to keep people well.

The health service and the politicians whose electoral success depends on it remain fixated on hospitals but the new reality means that the NHS must transition towards prevention, early diagnosis and community care. The number of Britons aged 85 and over is forecast to double over the next 25 years, so social care is an urgent priority and reform can no longer be delayed.

There needs to be a mission to create a healthier Britain. People must take responsibility for their own health and employers need to feel engaged in the wellbeing of their staff. The government needs to get over its phobia of the "nanny state" and help to create an environment in which the healthy choice is the easy one.

The political debate goes round in circles about funding and pay, staff shortages and bed numbers, but solutions are emerging that will be much more potent drivers of change. Technology has the power to revolutionise health and social care for the 21st century in the way that it has transformed banking, shopping, dating and entertainment. Personalised medicines, precision gene therapies, robotic surgery, AI diagnostics, wearable health trackers and predictive data analytics are not futuristic fantasies but a reality. If embraced by the NHS they will boost productivity, improve clinical outcomes and rebalance the relationship between doctor and patient.

Medical research is moving faster than ever, offering fresh hope to the sick. Sir Patrick Vallance, the former government chief scientific adviser, told the commission that medicine was entering a "new age of cures" that could transform healthcare. Evidence presented to the commission suggested that the revolution in science and technology could be transformative and make much more difference than another structural reorganisation or tinkering with funding.

The former Conservative leader Lord Hague of Richmond described the combination of "information technology with biotechnology" as "one of the most important developments of the century, or even one of the most important in the history of human civilisation". He told the commission: "It is going to lead to the possibility of providing healthcare that is so much more personalised to address future conditions and to adjust the response of health services and drugs to the precise individual." The gains for the NHS "would be so great that the health service would be able to cope without some fundamental change in the organisation or method of payment for the NHS. That is in the box of 'open at your peril'. You don't have to be brave as a politician, you have to be suicidal to open that box."

There are many reasons to be pessimistic about the present but science and technology offer a genuine cause for optimism about the future. Robotic surgery has improved clinical outcomes for patients and reduced hospital stays. Artificial intelligence diagnostic tools are saving lives by identifying disease more quickly. Algorithms will soon boost the ability to predict and prevent illness, with personal risk scores based on genetics and lifestyle. The NHS is trialling a blood test designed to detect more than fifty types of cancer and a blood test for early Alzheimer's is around the corner. Drug discovery is accelerating. Scientists used AI to discover an antibiotic that can kill a superbug that is resistant to all other forms of treatment. The pandemic has shown that new threats can come out of nowhere but there are also astonishing opportunities opening up.

Sir Tony Blair drew a contrast with the NHS that he inherited after the 1997 general election and set about tackling waiting lists by boosting funding and increasing patient choice. "The debate about the future of the health service is completely different today," he told the commission. "I don't think you can make the case we should be spending more. We're now not an outlier in terms of health service spending. The big change is to do with the way people can be diagnosed and treated and cured. There is a revolution in science and technology going on, which is really the game-changer for medicine and for healthcare. It allows you to shift from a service that's treating people when they're ill to a service that's focused on wellbeing, on prevention, on how people can live more healthy lives."

Embracing the opportunities offered by science would give much-needed hope back to NHS staff and patients, Blair said. "Unless you can reignite optimism then everyone just looks for someone to blame, whether it's immigrants or wealthy people. The point is, the advances of medical science and technology are immensely exciting. The things we can do today are things we've never been able to contemplate being in existence."

> "Increasingly our public sphere looks like a health service with a state attached

The commission does not believe there is a magic money tree that can be shaken to shower the NHS with yet more cash but it has identified some specific additional spending, particularly on social care, technology and diagnostic equipment, that should accompany reform. The UK has spent considerably less on capital investment than other countries over almost twenty years and the evidence suggests that this is one of the drivers of poor productivity. There are also savings that could be made both in the short term, through better use of resources, and in the medium term, by reducing the cost of ill health. We would urge the Treasury to see any additional funding as an investment that will be repaid many times over.

The following chapters will set out a series of recommendations to create a fairer, more efficient, more productive and more patient-focused health service. They apply primarily to England, because health is a devolved matter, but the commission has drawn on evidence from the whole United Kingdom and many of the policies will be relevant across the four nations. Among other measures, we propose a digital health account for all patients, a national care system, a new GP contract, an innovative approach to waiting lists, a loan forgiveness scheme for medical staff, a guarantee of mental health support for young people and a concerted effort to tackle obesity and preventable disease. In every case the proposals are evidence-based, where possible they are costed and most draw on successful initiatives that are working somewhere in the world. Some of the reforms could be introduced immediately, others will take time to have an impact and should be considered for inclusion in the political parties' election manifestos but we do not want this report to sit on a shelf, gathering dust.

There have been at least a dozen commissions and inquiries over the past 25 years that have made recommendations about the NHS and social care. Most have largely been ignored. It is now time to act. The NHS is a powerful political tool, because of its place in the voters' hearts, but even with an election around the corner this is not the moment for point-scoring at Westminster. With millions of employees off work because they are unwell and tens of thousands of children absent from school with mental health problems, the economic as well as the physical health of the nation is at stake. A long-term approach is needed to rise above party politics and move beyond the annual emergency handouts to allow more strategic planning. The costs of illness are rising exponentially and we cannot afford to carry on as we are. It is only by creating a healthier Britain that we will unlock the country's true potential.

“HOSPITAL CAN BE A PLACE WHERE YOU FEEL SAFE.

IT’S ALSO QUITE SCARY.

Roland Sinker, chief executive of Cambridge University Hospitals NHS Trust

The scale of the problem

The NHS is breaking records for all the wrong reasons — lengthy waiting lists, delayed responses, staff shortages and poor outcomes — but simply addressing funding may not be the best answer

One evening Waheed Arian came out of the accident and emergency department in Coventry where he works as a consultant to find 14 ambulances lined up outside the hospital. "I had to open up each ambulance and look inside and decide which patient could come in because we only had two beds," he said. "They were all suffering, they should all have had a bed. The NHS is under such stress that we are being asked to do things that we shouldn't be doing."

This is the human reality underlying the statistics about the crisis in the health service. Patients are waiting in hospital car parks and medics are struggling to do their jobs. Arian, an award-winning doctor, came to Britain as a refugee from Afghanistan more than twenty years ago. He compares the psychological impact on staff working in the NHS to the trauma of fleeing a war zone. "Many of my colleagues are already so traumatised by the pandemic, they haven't had the time to really process what's happened. There's a hopelessness. You see that there are people who are ill, you're trained to treat them and you can't do it."

As the annual winter crisis turns into an apparently permanent state of emergency, the NHS is breaking all the wrong kinds of records. The waiting list for routine hospital treatment in England stands at more than 7.6 million, nearly 3.4 million higher than before the pandemic. More than a million patients are waiting for more than one non-emergency procedure such as a hip replacement, knee surgery or physiotherapy and some need up to five. Although the backlog fell slightly at the end of last year, it has more than tripled since 2010. The latest NHS data showed that in 355,000 cases the patient had been waiting more than a year and in 95,000 they had been waiting more than 65 weeks. Industrial action has added to the strain on the health service along with new waves of Covid and flu. Sir Julian Hartley, chief executive of NHS Providers, said the health service was facing a "perfect storm".

Of course, millions of individuals get excellent care from healthcare staff who are working their hearts out in difficult circumstances but the system is not functioning as it should. The health service heading for one of its worst winters since records began. In December almost a third of people attending A&E spent more than four hours from arrival to admission, transfer or discharge. The number of patients waiting more than four hours on a trolley because no bed was available rose to 148,000; more than 44,000 waited for longer than 12 hours, almost 19 times higher than in December 2019.

Tim Cooksley, president of the Society for Acute Medicine and a hospital consultant in Manchester, told the commission that the situation in the health service was worse than at the height of the Covid crisis. "It is now accepted that there will be patients in the corridor when you arrive at work. That's undignified, it's unreasonable, it's a totally inappropriate environment to be looking after patients," he said. "A staff nurse who should be looking after six patients is being expected to look after twenty patients. You're leaving every day thinking you've not done a good job. At the moment people don't see any light at the end of the tunnel. They're leaving in droves."

Every part of the system is affected. Ambulance response times have soared and at one point last year patients were waiting on average 90 minutes for category 2 calls (which include suspected heart attacks and strokes), five times the goal of 18 minutes. Performance has since improved but is still way outside the target. In December the average response time was 45 minutes and 57 seconds, more than double the target.

Terry Hicks, a paramedic with the East of England Ambulance Service, described the "moral injury" that staff felt when they knew they could not reach patients in good time. On one day last year 600 people in his region were waiting for an ambulance. "We couldn't get to patients and we knew that because we were delayed, their conditions were getting worse," he said. "It wasn't uncommon for a crew to go and pick up a patient first thing in the morning and still be sitting outside the hospital at the end of their shift."

Amanda Pritchard, chief executive of NHS England, told the commission that the NHS was under "extreme pressure", like nothing she had seen in 25 years. "We all thought Covid would be the most challenging thing for the NHS but actually I think it arguably is more challenging now because of the level of disruption and also the scale of the demand that is on the NHS," she said.

The doctors' strikes have undoubtedly compounded the problem but they are not the only explanation. The NHS came out of the pandemic with a much higher backlog for planned operations than many other countries. The Organisation for Economic Co-operation and Development found that between 2019 and 2020 there was a 46 per cent drop in hip replacements and a 68 per cent drop in knee replacements in the UK. The EU average was 14 per cent and 24 per cent. In Italy, Portugal and Spain, where fewer operations were cancelled, waiting lists have stabilised. The commission visited a hospital in Spain where virtually no elective surgery was delayed throughout the lockdowns. In Denmark waiting lists are almost non-existent.

Meanwhile, the physical infrastructure of the NHS is crumbling as a result of a sustained underinvestment in capital spending. Analysis by the King's Fund health think tank found that the health service needed to spend £11.6 billion to return its run-down buildings and equipment to a suitable condition. This is not about a lick of paint but ensuring safety for patients and staff and preventing serious disruption caused by leaking roofs, weak flooring, broken lifts and outdated IT. The commission heard of one hospital where leaking pipes fused the electrics, created a fire at the same time as a flood and blew the doors off in the maternity unit. Another hospital has more steel props than beds in its dilapidated buildings.

Patients are suffering and staff are running on empty. Steve Wallis, a senior consultant in the emergency department at Addenbrooke's Hospital in Cambridge, said: "The pandemic was scary because no one knew what was happening.

It was all changing very quickly and people were running through Armageddon scenarios. Whereas what it feels like now is the line out of *The Lion, the Witch and the Wardrobe*: 'It's always winter but never Christmas.'"

Charlotte Summers, professor of intensive care medicine at Cambridge University, who led the critical care response to Covid in her area, said staff were still dealing with the emotional consequences of the pandemic. "There are rates of post-traumatic stress symptoms and severe anxiety that exceed those observed in people who saw combat in Afghanistan," she told the commission. "It is inevitable that we will have to deal with another pandemic, in my working lifetime I suspect. So if we do not learn the lessons, we're going to have a workforce that has been harmed, that we haven't supported and that we're going to be asking in however many years' time, to do it all over again."

There is a similar sense of exhaustion among family doctors. Professor Kamila Hawthorne, president of the Royal College of GPs, said: "We have two thirds of GPs saying that they don't have enough time to see patients properly, and fear for patient safety as a result of that. The stress that people are under is so huge that large numbers of people are threatening to leave."

The performance of the health service is suffering. In international league tables the NHS scores highly on fairness but poorly on outcomes. Britain's cancer survival rates lag behind those of comparable countries and the UK has the second-highest maternal death rate among eight high-income European countries. There is a greater premature mortality rate across numerous diseases in England than in other similar nations. The rate of years of life lost in 2016 was 50 per cent higher for ischaemic heart disease than in France or Spain, 60 per cent higher for lung cancer than in Finland or Sweden and 50 per cent higher for stroke than in Austria.

Life expectancy has fallen and a growing number of people live for a greater proportion of their life in ill-health. Professor Yvonne Doyle, NHS medical director for public health, said there was an "underlying pandemic of ill health" driven by highly preventable conditions caused by lifestyle choices. In the first six months of last year there were an extra 28,000 deaths in the UK compared with the average over the previous five years. The Health Foundation estimates that, on the current trajectory, it would take 192 years for the government to achieve its target of a five-year improvement in healthy life expectancy.

Dame Jane Dacre, former president of the Royal College of Physicians, who chairs the Commons health and social care select committee's independent expert panel, said the government had not achieved a "good" overall rating on any of the pledges reviewed. "We found maternity [care] 'requires improvement', mental health 'requires improvement', pharmacy 'requires improvement', cancer services were 'inadequate', workforce was 'inadequate' and digitisation of the NHS 'inadequate", she said. "Healthcare is a bit like the M25: however much you widen it there are still traffic jams. People are getting older, they're getting sicker and their expectations are higher. It's a bottomless pit of need."

Michelle Mitchell, the chief executive of Cancer Research UK, said England was "world-lagging" rather than "world-beating" on the diagnosis and treatment of cancer. Only three quarters of people with an urgent cancer referral are seen within two weeks, against a target of 93 per cent, and less than 60 per cent of people who have received a diagnosis start treatment within 62 days, against a target of 85 per cent. "We haven't met the cancer performance waiting times since 2015. You cannot blame Covid and strikes for what has been a number of years of underperformance," she said.

Members of the commission's patient panel and focus groups repeatedly expressed their frustration with the inefficiencies of the NHS as a system, while often praising the care they had received from individual members of staff. Louise Ansari, chief executive of the patient watchdog Healthwatch England, said confidence had fallen significantly in the past decade and the calls to her organisation's helpline explained why. One nurse-turned-patient had spent 14 hours in a corridor with no bell, no curtain, no privacy. A man in North Yorkshire with suspected appendicitis was told to stay in his car overnight when he turned up at A&E. An elderly woman in Shropshire had a fall and was left on the kitchen floor for 21 hours.

There were many stories of people "discharged at night, discharged into their front gardens" without a care package or a number to ring. It is "not just the spreadsheets of ambulance transfers", Ansari said. "Patient safety is a huge concern." There is also a frustration with poor communication. "Ordinary people are confounded when there should be a seamless service for them."

Despite having been protected for more than a decade from the Treasury axe, the health service has a serious productivity problem, particularly in secondary care. Hospitals employ more doctors and nurses than ever but analysis by the Institute for Fiscal Studies found that extra funding was not translating into more care and the health service was carrying out "substantially fewer" appointments and operations than before the Covid crisis. In October 2022 the NHS handled 14 per cent fewer emergency admissions, 14 per cent fewer outpatient appointments and 11 per cent fewer elective and maternity admissions than in the same month in 2019. As Sir John Bell, regius professor of medicine at Oxford University, put it: the NHS "seems intent on pursuing the Battle of the Somme strategy: hire more doctors and nurses and send them into the fray. It creates no measurable progress and costs a fortune."

There are many extraordinary people doing exceptional things in the NHS, saving lives every day, but the system as a whole seems unable to learn from its innovators. The institutions have not adapted. Hospitals are disconnected from GPs and the NHS from local authorities, with patients shunted between the uncomprehending constituent parts. There is a culture of box-ticking and risk aversion. Retired doctors who volunteered to help with the Covid vaccine programme were required to take 18 training modules, including one on preventing terrorism. Far from being a vast monolithic bureaucracy, the health service is a series of fragmented and competing fiefdoms, encircled by an alphabet soup of quangos and regulators.

There are 42 Integrated Care Systems (ICSs) in England that were set up in 2022 to commission local services. In each area there is also an Integrated Care Partnership (ICP), which includes social care and other community providers, and an Integrated Care Board (ICB) that is responsible for planning health services and managing the NHS budget. In principle, the ICSs are a good idea as they are supposed to bring together health and social care as well as public health and community services but in reality they are so boxed in by national targets that it is hard for them to make a real difference or to innovate. One ICB chairwoman, who arrived from the private sector, was astonished to find that there were 127 arm's-length bodies overseeing the NHS.

Dame Julie Moore, a former nurse who was chief executive of University Hospitals Birmingham between 2006 and 2018, lamented the merry-go-round of commissioning bodies in the NHS. "We've gone from area health authorities to PCTs to GP fundholding to CCGs. We went through STPs to ICSs and ICBs. Every time that happens there's a cadre of people who've got experience and knowledge and see yet another change and a whole pile of them take redundancy and go. Then we promote the people that were working as deputy to a level up so it costs a lot of money and it has yet to achieve anything at all. Local commissioning in itself sounds like a good idea — a local commissioner purchasing services for its local population — but all anybody has ever done is aspire to the national standard of waiting times and the rest of it. They've been set up to do a job that they just have not got the resources to do." She once worked out that it was costing £2 million a year simply to "feed the beast", or provide all the reports that were required for regulators and commissioners.

"Then there are all the intermediate bodies that the health service funds," she said. "The last time I counted it was 247. The absolutely classically bad one was when [the former health secretary] Matt Hancock wanted NHSX because it sounded really sexy and there already was NHS Digital. I met with the chief executives of both and they both told me, 'Well, we're strategy, the other's implementation,' yet neither of them did what was needed, which was to give guidance to trusts who are quite naïve about IT."

Politicians love playing with what the former cabinet secretary Sir Jeremy Heywood called "the biggest train set on Whitehall" but even those who have got their hands on it acknowledge that the fiddling has gone too far. Jeremy Hunt, the chancellor and a former health secretary, said the NHS was being "micromanaged to death" and was "dreadfully inefficient" because of excessive central control. "An average hospital will have 100 targets, a GP will have 78 targets," he told the commission. "There is literally no healthcare system in the world that micromanages every single person to the extent that we do in the NHS. That makes it very, very difficult for any NHS manager to innovate because if you put a foot wrong you'll be missing a target."

Patricia Hewitt, the former Labour health secretary and author of a recent government review of integrated care systems, agreed that too many central targets had led to managers "gaming" the system and the disastrous neglect of patients. There should, she suggested, be no more than ten national priorities.

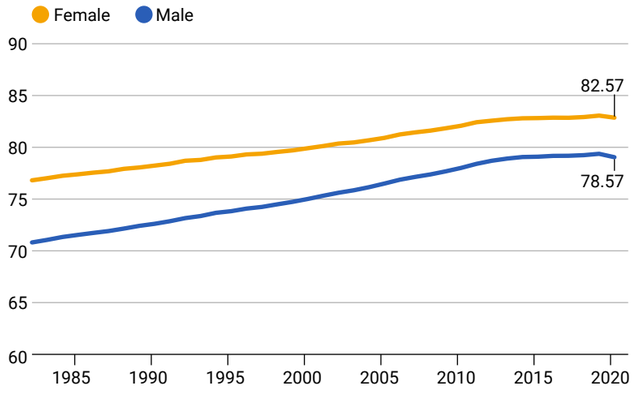
The high turnover of staff is also a problem. Experienced clinicians are often replaced by junior staff who are more risk-averse. The public policy experts Rachel Wolf and Sam Freedman identified this as a key driver of the "productivity puzzle" in the NHS. "Headline staff increases do not tell the whole story," they wrote in a report for the Institute for Government. "It is almost certain that the surge in NHS churn over the last two years has drained the NHS of both institutional knowledge and more experienced staff's time."

The fundamental problem is that too many people end up in hospitals, the most costly place to treat patients, because of failings in other parts of the system. Nearly one in five of the people attending A&E are doing so because they cannot get a GP appointment. At the other end of the pipeline, the lack of social care means that more than 13,000 hospital beds are filled with people who are medically fit to be discharged but cannot go home. There is a revolving door of the frail and elderly coming in and out of hospital. One in six emergency admissions of people over 75 occur within 30 days of the person last being discharged. A study by Age UK found that in 2019-20 there were 855,000 emergency admissions to hospital of older people that could have been avoided with the right care at the right time.

When it costs £1,000 to keep a patient in hospital for a night compared with £100 at home, this is a clear misuse of resources. Yet the social care system is in an even greater state of crisis

Living longer

Life expectancy at birth for males and females in the UK



SOURCE: ONS

127

The number of outside bodies overseeing the NHS

than the NHS. There are 152,000 vacancies in the sector and 2.6 million older people who have needs that are not being met. This is making life a misery for the individuals and causing anxiety for their families but it also has a devastating knock-on effect on the health service.

Those who can afford it are seeking alternative routes to treatment and care. The commission's YouGov poll found that 15 per cent of patients had paid for a private operation or GP appointment in the past year. A majority had funded the treatment from savings. "Hip ops are up by 186 per cent, and knees by 176 per cent," David Hare, chief executive of the Independent Healthcare Providers Network, said. "People who are struggling to access a GP are looking for a private GP. All of the big insurers are reporting about a 20 per cent increase in the number of what they call 'insured lives', most of that through employers. The big driver for that is pressure in accessing NHS services. If you've been cancelled once or twice on the day you eventually think to yourself, 'Am I ever going to get this done? I'll explore my private options.'"

There are economic and human consequences to the rising tide of ill health. A record 2.6 million people are off work with long-term illness and analysis for the commission found that ill health among working-age people was costing the economy £150 billion a year, the equivalent of 7 per cent of GDP. The cost has increased about 60 per cent in the past six years and there is an additional cost of about £70 billion in lost income tax, benefit payments and NHS budgets. The study, by the consultancy Oxera, warned of a "substantial risk" of long-term economic damage if nothing is done to reverse the rising cost of sickness. "Addressing this challenge is not only socially desirable but an economic imperative," it said. "Without adequate interventions of sufficient scale, there is a substantial risk of long-term scarring to the UK economy if more people fall into the downward spiral of declining health and leaving the labour market, which can further exacerbate health problems."

Andy Haldane, former chief economist at the Bank of England and chairman of the government's levelling-up advisory council, told the commission: "For perhaps the first time since the industrial revolution, health factors are acting as a serious headwind to UK economic growth. They are contributing significantly to a shrinking labour force and stalling productivity." He said the stresses had been building for at least a decade before the pandemic. "Covid now appears to have tipped them into a tailspin, which without serious surgery they seem unlikely to recover from. Now is just the moment to be rethinking the fundamentals of UK health and healthcare, to restore its stability and resilience and, with it, improved patient and healthcare worker satisfaction and economic growth."

The pressures are only going to increase. Almost one in five of the UK population is over 65. By 2050 it will be one in four. Over the next 25 years the number of people older than 85 in England will double to 2.6 million. In many ways this is something to celebrate but it also creates challenges. Andrew Bailey, governor of the Bank of England, suggested that the ageing population posed a long-term threat to the economy and would ultimately have a greater impact than the war in Ukraine or the pandemic.

> "This is the worst crisis I've seen in the system in thirty years

Already the NHS is struggling to cope with the growing number of patients with long-term conditions such as diabetes and heart disease. The Health Foundation predicts that 9 million people will be living with serious illnesses by 2040, an increase of 37 per cent. New threats are emerging. The surgeon and former health minister Lord Darzi of Denham described antibiotic resistance as the "silent pandemic" that could be more deadly than Covid. "In 2028 there will be as many people dying of infections that are resistant to antibiotics as died from infections in 1928 prior to the discovery of penicillin," he warned. Climate change is increasing the risk of future pandemics and spreading the prevalence of some diseases.

Politicians who are no longer on the front line are willing to face up to the scale of the challenge. The former Labour health secretary Alan Milburn told the commission that the NHS was running up against fundamental demographic and cultural trends. "This is the worst crisis I've seen in the system ever in thirty years around health policy," he said. "It is not a temporary phenomenon. Of course you've got the collision of the post-Covid effect, staff shortages [and] waiting lists but underneath there's something much more profound. The problem essentially is, how do you move care from being episodic, largely based in hospital, to instead focus on the important thing, which is to improve health? Somewhere between a quarter and a third of people who are in hospital today need never be there, providing they are diagnosed and treated early enough. One in five hospital readmissions can potentially be prevented. I think we've reached an inflection point. I've stopped talking about reforming the system, it's now about reinventing it."

Sajid Javid, a former Conservative health secretary and chancellor, recalled that when he arrived at the Department of Health and Social Care he had a briefing from his civil servants. "I was told that the NHS is the second most admired institution in the UK after the monarchy. People said, 'Handle it with care, it's really delicate, don't break it.' Then I was told, 'The second most important thing you must know as secretary of state is that most people believe it's not working, it's not delivering for them.' I said, 'So my job is to fix it without touching it?' They said 'Precisely.'" He argued that "fundamental change" was needed to ensure that the supply of healthcare could keep up with surging demand but, "The politicisation of the NHS severely deters serious discussions about the problems it faces."

Some say that a new funding model is the answer and point to the social insurance systems around Europe. The evidence presented to the commission suggests that this is not the answer. Sally Warren, head of policy at the King's Fund, which has studied all the alternatives, said it would not solve the problems facing the NHS. "I spend my life in policy think tanks with people saying, 'Isn't X the magical solution to this?' If you look at all of the work that's done on international comparisons, the general consensus is that there is not a particular funding model or delivery model that is either particularly good or particularly bad. There's nothing to suggest that by suddenly moving to social insurance we'd get better outcomes. It would be a distraction."

The key question is not how a country raises the money but how it spends it. There is a risk of muddling up cause and effect. Israel, for example, funds its healthcare through a social insurance system but on a visit there the commission heard that the real source of its success was its widespread adoption of technology. Germany, where health insurance is compulsory, has better health outcomes than the UK but it also has more than three times as many hospital beds.

The commission looked closely at the case for charging for GP visits but in Ireland, where patients pay €60 for an appointment, doctors and patients said the system was backfiring. Edel Murphy, a programme manager at Galway University, said the fee had put her off taking her teenage son to the doctor when he got a chest infection. "I thought 'he'll be grand' and by the time I took him he had pneumonia and he ended up being admitted to hospital with all the extra cost to the system." Both Ireland and Australia, where patients also pay a contribution, are moving towards more universalism because of concerns about the distorting effect of charges.

The former Tory chancellor George Osborne told the commission: "We are not going to change the funding model of the NHS in Britain. That is a completely impractical suggestion, sometimes made on the Conservative right. I think the country is very committed to a free-at-the-point-of-use, publicly funded healthcare system so I would not waste time and effort on thinking up models that might work in countries like France or Germany." The commission concluded that introducing a new way of paying for the NHS would be a distraction and cause huge disruption and political turmoil without any guarantee that the risks would outweigh any benefits. It is also unnecessary since there are better ways to drive efficiency through the system using technology, data analytics and artificial intelligence.

There is, however, a need for a radical rewiring of the system to reduce the over-centralisation, shift the balance towards prevention and empower patients. The private sector has a key role to play, both in developing the new technologies that will help to drive reform and in delivering more treatments and diagnostic tests on behalf of the NHS. The Oxford University collaboration with AstraZeneca over the Covid vaccine demonstrated the benefits of working with industry on medical research. The health service must get over its squeamishness about business and seek to encourage an entrepreneurial spirit among staff while understanding that companies can make a valuable contribution to healthcare so long as this does not undermine the principles of universal care, free at the point of need.

The number of central targets should be reduced and the focus should be on keeping people healthy rather than just treating them when they are sick. As the former Conservative health minister Lord Bethell argued, a "new health covenant" is required involving businesses, individuals and the government so that creating a healthier Britain is "not just the responsibility of the poor old beleaguered and scapegoated NHS".

Baroness Shafik, a former deputy governor of the Bank of England and president of Columbia University, said that simply pouring more money into the current system would be fruitless. "One needs a radical rethink about the social contract around health," she said. "Prevention is cheaper than cure. The problem is that politicians don't fund prevention because they want to deal with the immediate crisis and prevention is long term and you don't see the benefits for decades."

The scale of the crisis means that a radical rewiring is required, with all Whitehall departments working together to improve the health of the nation over a prolonged period rather than just chasing after the latest short-term political initiative or dealing with the newest emergency. For too long the NHS has had to deal with a "feast or famine" funding regime with annual emergency handouts rather than a strategic approach. There has been too little consistency, not helped by the fact that there have been six health secretaries in the past six years. The NHS has too often been "weaponised" in the political battle for hearts and minds by all sides.

The commission proposes the creation of a new independent "healthy lives committee", empowered by an ambitious and legally binding commitment to increase healthy life expectancy by five years in a decade and reduce the health gap between rich and poor. Following a model similar to the climate change committee, it should be made up of outside experts and hold the government, industry and the NHS to account for the progress in improving health, with clear annual milestones on the path to achieving the goal. It would focus on healthy life expectancy, rather than just overall life expectancy, to help to bring about the necessary mindset shift and encourage a long-term approach with cross-party agreement. It would also be able to provide the economic analysis that backs up public health measures, such as anti-obesity strategies, initiatives to increase fitness and early intervention for mental illness, that are essential for future prosperity.

Sir Michael Barber, the Whitehall veteran who successfully tackled waiting lists as head of Tony Blair's delivery unit and advised Boris Johnson, said the key to achieving change was to focus on a few ambitious targets rather than micro-manage every detail. "It's about having goals, it's about planning, it's about data. It's building routines where you're having an honest conversation, and it's about really solving problems, and not just hoping things will get better. It creates an atmosphere where you're not blaming angrily, you're not shouting at people. You're not being critical. You're saying it looks like we've got a problem, what are we going to do about it?"

48 hours at Addenbrooke's Hospital

The warning lights are flashing on the dashboard at Addenbrooke's Hospital in Cambridge. At the 2.30pm operations meeting in the emergency department there are black and red patches all over the screen. Diane Williamson, the lead consultant, is worried. The colour-coded spreadsheet is supposed to be green. If things are starting to go wrong, then categories turn amber. "When we get into the red we know we have some areas that are under a significant amount of pressure," she says. "Black means we aren't able to function."

It is a normal Wednesday afternoon with no big incidents or industrial action yet numerous parts of the system are cracking under the strain of the NHS winter crisis. Ten ambulances are heading for the hospital, carrying seriously ill patients, but there are only three beds. Even now, two patients are on trolleys in the corridor. Three doctors have called in sick, which means that the emergency department does not have enough staff for the night shift.

The noise of bleeping equipment is relentless. A man arrives by air ambulance and is rushed straight into a "resus" bay needing immediate resuscitation. He has had a heart attack and already been saved once by a bystander, who gave him CPR and a defibrillator shock, then again by the ambulance crew. His life is hanging by a thread.

Doctors are crowded around a bank of computers in the central hub. One screen displays a brain scan revealing a severe haemorrhage; another shows a patient's heart rate. The atmosphere is calm but tense. Williamson admits there is an intense emotional pressure to dealing with wave after wave of patients, many of them in the twilight zone between life and death. "To say we feel overwhelmed would be an exaggeration but we're very respectful of the risks that we carry," she says. "We need to be very careful not to spread our own anxiety about it to our team."

Many times a day, she and her colleagues have to make agonising decisions as they balance the competing demands of patients and beds. "It's like Tetris all the time," Williamson says. "These are people, you can't just move them in a way you would move objects around. You need the right transport equipment, a trolley that is suitable or a particular type of wheelchair." Out in the walk-in part of A&E, the waiting room is packed. There are security guards at the door to make sure that agitated patients, drunks or those with mental health problems are not a danger to themselves or others. Increasingly, they have to deal with people who are frustrated by the amount of time they have waited. The minor injuries unit is also overflowing into the corridor. There is a boy with a bandage around his head and a girl with a bad foot. Most of these patients will be able to go home later today but some will need a bed.

By 4 pm when staff gather for a trust-wide status update, the Addenbrooke's data analyst is predicting that the hospital will be 11 beds short overnight. Experienced managers fear that this is an underestimate. One immediate staffing crisis has been averted. Some doctors have volunteered to work a double shift in the emergency department to cover for their colleagues who are unwell. But the hospital is now down 27 nurses and 41 healthcare assistants. One patient has waited 16 hours for a bed. A new, unexpected problem has also arisen. Several elderly patients were due to be discharged, freeing up beds, but one vehicle has broken down and another is not back from a long-distance trip. That means the 4 pm deadline for checking into care homes has been missed and the patients will require an extra night on the ward.

This is one of the biggest and best hospitals in the country, a major trauma centre for the east of England with 1,300 beds that also offers highly specialised organ transplantation and cancer services. It is pioneering new technologies including robotic surgery, AI diagnostics, virtual wards and genomics, collaborating with Cambridge University to test ground-breaking precision medicines. It is also part of a health and social care system that is close to collapse.

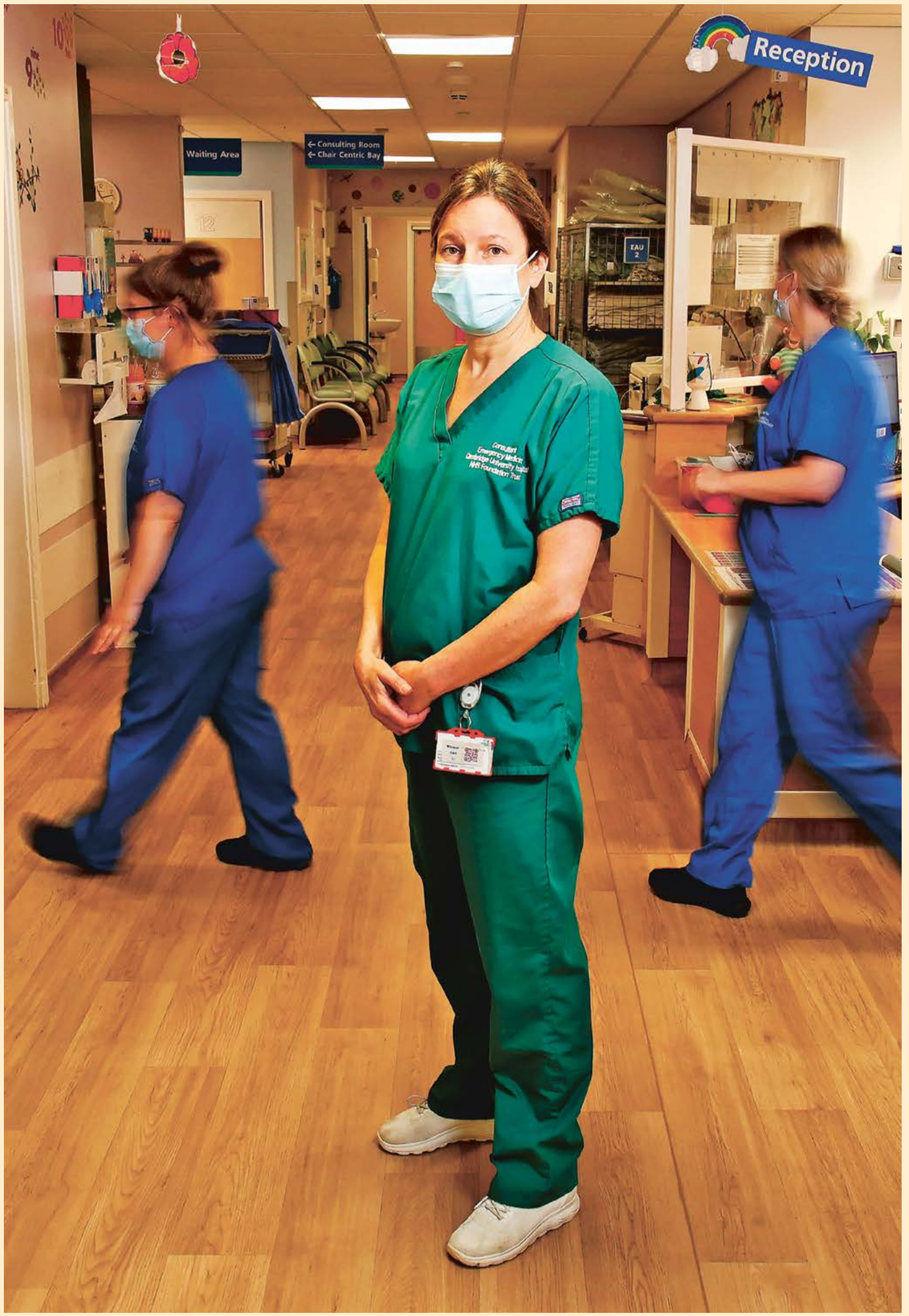
For months it has been at "critical incident level 3", the second highest of four categories. An emergency department that was designed to deal with 40,000 patients a year now gets that number every three months. Typically, the doctors here see between 300 and 350 patients a day but on a bad day that can surge to 420 or more.

Over two days the commission saw the teams in every department making heroic efforts to manage in the toughest of circumstances. It was a constant juggling act of patients, staff and beds. The managers were crucial to the whole process: far from being pointless pen-pushers, they are the logistics experts who free up the clinicians to save lives. Many of the factors that would allow them to properly manage the flow of patients through the hospital, however, are out of their control. About 10 per cent of beds are filled with people who are medically fit to be discharged but cannot be sent home, often because of a lack of social care.

Graham Johnston, the operations manager in the day surgery unit, compares his job to doing "a moving jigsaw where the picture's changing all the time". His aim is to keep the number of cancelled operations under 10 per cent of the total each day but that is not always possible. An operating theatre might be needed at the last minute because there has been a motorway pile-up, or there may be no bed for a patient to go into after surgery. Then there are technical problems. "Some parts of this estate are older. We have issues where theatres might be too cold to operate over the winter, or too hot to operate [in the summer], or there's a leak somewhere, or something's broken."

He once had to tell 20 patients that their operations would not take place that day because the vacuum pressure had gone in the operating theatre. "They were all in the same bay. So I'd take someone out, they'd come back in tears, then I'd take the next person out, they'd come back in tears."

Back in the emergency department, the heart attack patient has been saved and transferred to a ward before being sent to the neighbouring Royal Papworth Hospital for a heart procedure. Exhausted doctors are preparing for another stressful night. "The issue is not that it's harder than it was during the pandemic," says Williamson. "It's that there has been no respite for our services on the front line through the pandemic and we're still at the front line, it's just for different reasons. My whole team has fatigue and it deteriorates your ability to offer care."



Diane Williamson, lead consultant, said her team faced intense emotional pressure that left them fatigued

HIGH INTENSITY TEAMS

It is 10am on a Saturday at St Thomas' Hospital in London and the surgical team are on their 13th operation. One patient has already gone home, two more are in surgery and another couple are in the anaesthetic room. "We're flying through," says Imran Ahmad, the consultant anaesthetist. "We're not rushing; we're being efficient."

The hospital has introduced an innovative method for tackling the elective surgery backlog called high intensity theatre (HIT) lists, which run once a month at weekends. The doctors can get through an entire week's operations in a single day as part of a meticulously planned blitz of the waiting list.

Under the HIT list model, two operating theatres run side by side, with the lead consultant surgeon overseeing both. As soon as one procedure is finished the next patient is already under anaesthetic and ready to be wheeled in. There are two teams of theatre staff on duty, including six surgeons, four anaesthetists and eighteen nurses.

The surgery itself proceeds exactly as normal but everything around it is speeded up. Nurses are on standby to sterilise the operating theatre and instead of taking 40 minutes between cases it takes less than two. The only delay is the 30 seconds it takes for the antibacterial cleaning fluid to work.

Kariem El-Boghdadly, another consultant anaesthetist who, with Ahmad, designed the programme, compares it to a Formula One pit stop. "They've got one person doing the rear right wheel, one person doing the front left wheel. It's the same thing. The operating theatre is effectively like that."

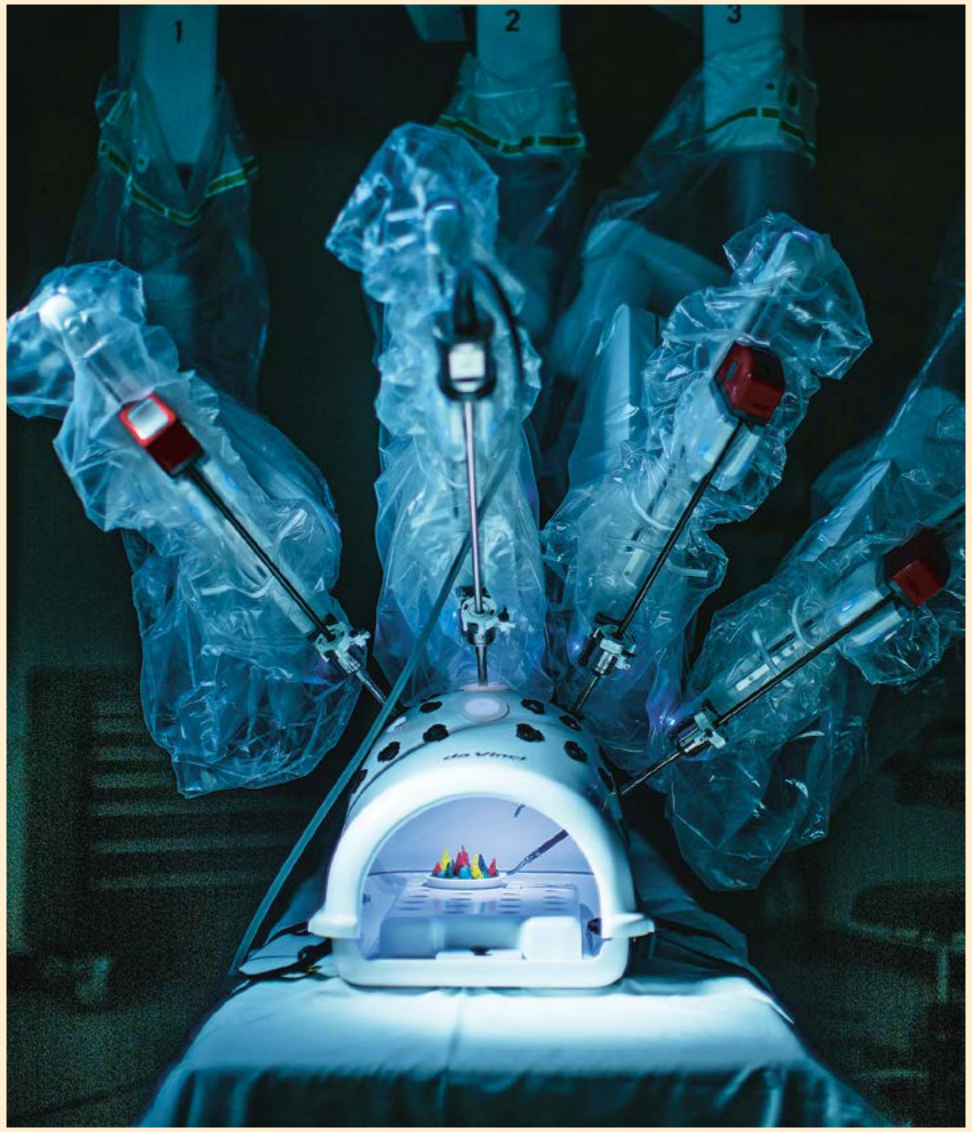
Patients are processed in parallel rather than one after another. "The anaesthetic happens whilst another patient is being operated on, and as soon as patient number one is done and leaves the operating room, the second patient has come in the operating room already anaesthetised," he explains.

The consultant surgeon "is bouncing from one theatre to the next doing the critical phase of the operation" with more junior surgeons assisting.

By lunchtime the HIT list team had got through 21 operations on 20 patients. Normally they would carry out six such procedures and be working all day. The HIT list cleared a third of the hospital's gynaecological oncology backlog in a morning.

El-Boghdadly said the programme had been successful with many different types of surgery. "We've substantially reduced our waiting lists in various specialties. Normally, you'd do three knee replacements in a day, potentially, four if you're lucky and with the HIT model, we did twelve a day."

ROBOTIC SURGERY SCHOOL



A robot with four arms rotates over an operating table while trainee surgeons push surgical instruments into a simulated abdomen. On the other side of the lab a doctor looks into a console displaying a 3D image of the inside of the plastic patient. He manipulates the scalpel and tweezers remotely with his fingers, then presses pedals to zoom the camera. "It's like playing a video game," says Ahmed Mohamed, 40, one of the surgical trainees. "You have to immerse yourself in a 3D virtual world."

This high-tech operating theatre in Newcastle is part of the first robotic surgery school in Europe. Students gain hands-on experience as part of a three-year course, created by the Newcastle Surgical Training Centre in partnership with Intuitive, which makes the Da Vinci surgical systems that are widely used throughout the UK.

About thirty trainee surgeons from NHS trusts across the northeast of England are enrolled in the course, which is designed to train the next generation of doctors in the latest technology. The centre plans to double the number of students this year before introducing the programme nationally. The aim is to give all trainees in England the chance to become proficient in robot-assisted surgery. Until now surgeons have only been able to learn to use a robot once they have qualified as a consultant.

Abraham Joel, 41, who completed medical school in India before becoming a trainee surgeon in Newcastle, was one of the first to sign up. He takes any opportunity he can to use the simulator, completing computer game-style challenges against the clock. "This is the future," he says. "Doing this programme puts us in a good place at the start of our consultant career."

He thinks older surgeons, used to conventional instruments, are "having to unlearn something then learn something brand new. It's much easier for us because we have never known anything else."

In the past, surgeons had to complete a minimum of 50 hours on a simulator before performing a robot-assisted operation on a patient. Now the centre has changed the rules and they only have to demonstrate that they can complete certain tasks. Professor Alan Horgan, a consultant colorectal surgeon and director of the centre, says younger trainees pick it up more quickly than experienced consultants. "Some of them reach the same level of competence in ten hours," he says. "The younger generation take to these new technologies quickly. They're used to video games so they have the technical dexterity and they feel comfortable doing something while looking at a screen rather than the patient."

The first robotic operation in the UK using a Da Vinci machine was carried out in 2000 at St Mary's Hospital, London, by Lord Darzi of Denham, a member of the Times Health Commission.

Hospitals and waiting lists

Hospitals are the most costly way to manage health and yet they have become the first resort for many patients. There are more imaginative solutions than simply building more ‘sickness factories’

There are brightly painted bicycles in the corridors at Aarhus Hospital in Denmark. The doctors and nurses use them to get around the 500,000 sq m estate, which serves 350,000 people on the Jutland peninsula. Some patients arrive by helicopter from up to 90 miles away but those walking into A&E tap their medical card on to a reader, giving the clinicians instant access to their records. Despite its size the hospital has a personal touch. There are no wards in the gleaming new blocks. Instead, patients are treated in individual rooms, reducing infection rates and improving recovery times. Nor do alarms ring relentlessly. If someone asks for help then a message is sent directly to their nurse. A patient hotel means that people can be moved quickly out of acute beds.

This is the first of a new generation of super-hospitals that have helped to turn the Danish health system into one of the best in the world. It has improved outcomes and driven efficiency by bringing urgent treatment into large specialist centres, harnessing the power of technology and transforming community care. The emphasis is on keeping people out of hospital. In England about 10 per cent of hospital beds are taken up by people who are well enough to go home after treatment but in Aarhus the figure is less than 3 per cent. The council has a legal duty to provide social care for any patient who is fit to be discharged. If the municipality cannot do so then it has to pay for the hospital bed.

The balance of spending on healthcare has shifted as part of a national change in priorities. When the Aarhus super-hospital replaced four smaller hospitals in 2022, the total number of beds fell from 1,300 to 850. “We got a budget cut of 8 per cent when we relocated here but the efficiency is very much higher,” Poul Blaabjerg, the chief executive, explained when the commission visited the hospital. “We treat a lot more patients with fewer resources. There has been a big reallocation of tasks from the hospitals to the municipalities.”

Since embarking on its health reform programme in 2007, Denmark has halved the number of hospitals and reduced in-patient bed days by a fifth while increasing outpatient appointments by 50 per cent and investing in social care. Despite widespread public opposition at the start, patient satisfaction is now high. Cancer outcomes have improved, waiting times are low and people can book appointments, see test results or order prescriptions via an app. The Ministry of Health says it is turning hospitals from cathedrals — high-status power centres attracting resources and knowledge — into lighthouses that help patients to steer their own course. A similar shift is needed in this country.

Aneurin Bevan described hospitals as the “vertebrae of the health system” but the world has changed since 1948 and there are now many more patients with multiple co-morbidities and long-term conditions. Acute hospitals should be for the sickest patients; they should not be holding bays for the elderly or processing depots for those needing a diagnosis. As Sir John Bell explained: “We need to pivot to more community-based prevention if only to provide the demand management so hospitals become more viable. We will still need hospitals but in the current system they don’t work.”

This is not to say that the NHS should emulate the Danes and embark on an immediate round of hospital closures. The UK has 2.4 beds for every 1,000 of the population compared with 7.8 in Germany, 6.9 in Austria, 5.7 in France and 5.5 in Belgium. Even after its bed reductions, Denmark has 2.5 per 1,000 people and more doctors per capita than Britain. Many hospitals in this country are running at 95 per cent capacity and some are at more than 100 per cent. The recommended level is 85 per cent.

Two thirds of the NHS budget is now spent on services provided by hospital trusts, up from 63 per cent in 2015, but only 9 per cent is spent on primary care. The number of hospital consultants has grown by 26 per cent since 2015 but the number of GPs has fallen by almost 7 per cent. Hospitals are paid on the basis of activity rather than outcomes, which creates perverse incentives, sucking patients into the most expensive part of the system.

Politicians like nothing better than to announce hospital-building programmes, even if the 40 new ones pledged by the Conservative Party at the last election have not materialised. MPs are haunted by the memory of Richard Taylor, the doctor who in 2001 won the parliamentary seat of Wyre Forest as an independent by campaigning against the closure of the local hospital.

Lord Clarke of Nottingham, former Tory chancellor and health secretary, is an exception. He told the commission cheerily: “I closed more hospitals than most people had hot dinners because we really had got a terrible collection of Victorian dumps which needed replacing with modern hospitals.” He said, though, that it had frequently involved tremendous battles with his parliamentary colleagues and the voters. “I found that every time you wanted to close one you got an enormous petition. They ignored the fact that you were replacing it with better, newer facilities.”

He recalled visiting a particularly “dangerous and unsuitable” maternity unit. Even the doctors working there admitted privately that it should close but nobody would say so publicly and the site was surrounded by protesters who thrust a baby into his arms. “The problem with reforming anything in this country is that a huge section of the public would defend anything that they’re used to and there are some members of parliament who think that the way to get local popularity is to support the objectors,” Clarke said. “Far too much emphasis and priority is given to the hospital service and it always has been.”

> “I closed more hospitals than most people had hot dinners

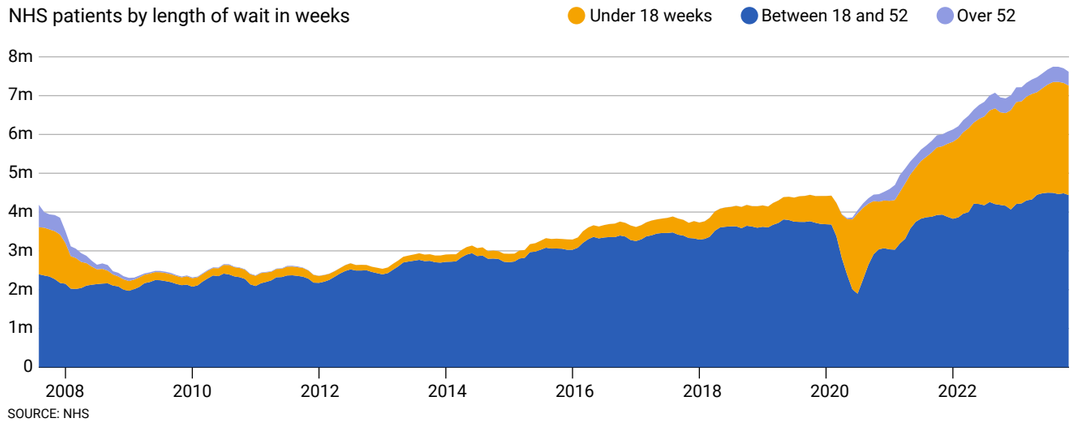
The excessive focus on secondary care has had a damaging effect on the wider health system. Only 15 per cent of those on the waiting list for elective surgery have had a decision made to admit them for treatment. Most are not waiting for hip replacements, knee operations or cataract removal; they are waiting for diagnostic tests or results. The UK has the fifth lowest number of CT and MRI scanners in the OECD. Almost 1.6 million people are waiting for tests and scans compared with about a million in 2019, before the pandemic. Nearly a quarter have been waiting more than six weeks.

Opportunities, as well as illnesses, are being missed. The testing company InHealth runs 19 community diagnostic centres in high streets, railway stations and shopping centres, seeing more than 400,000 NHS patients a year for MRI and CT scans, x-rays and ultrasound tests. The units operate 14 hours a day, 7 days a week, 363 days a year, meaning that each scanner churns through 33 per cent more patients than comparable equipment operated by the NHS. Productivity is boosted by a digital booking and scheduling system, which groups people with similar conditions together to minimise the adjustments needed between appointments, shaving vital minutes off each slot. By being outside hospitals, the company says it can make the best use of its assets and it is more convenient for patients. The NHS benefits because, in return for a long-term contract, InHealth builds the facility, buys the equipment and provides staff. There is no need for high upfront costs or lengthy delays since the firm can typically open a centre within six months of signing a lease.

The NHS has opened about 130 community diagnostic centres across England and another tranche is due to open by March. It is a step in the right direction but about half the centres are in hospitals and only one in five are outside a traditional healthcare site, which means they are not fulfilling their original purpose. The evidence presented to the commission suggests that the same level of investment in diagnostic centres is needed as in the last spending review: about £1.6 billion. This should be used partly for new facilities and partly for upgrading small sites to larger ones. The new centres should where possible be in the community to make testing more convenient for patients and reduce the pressure on hospitals. Involving the private sector would minimise capital expenditure and accelerate the programme. The scheme must also take full advantage of AI diagnostic tools as they become available. This will both speed up results for patients and alleviate workforce pressures by reducing the number of radiographers required.

The economic as well as the human cost of the elective surgery backlog is high. Analysis carried out by LCP Health Analytics for the Institute for Public Policy Research think tank found that cutting waiting lists could boost the economy by £73 billion over five years by getting people

The backlog



SOURCE: NHS

back to work. Professor Dame Sally Davies, former chief medical officer for England, said the research showed that a flourishing NHS should be seen as "a springboard for growth not just a cost to be contained".

The NHS must get much better at moving patients smoothly through the system. That means improving the productivity of operating theatres and reducing the length of time people stay in hospital after surgery, as well as ensuring there is adequate social care for them when they are ready to leave. Lord Rose of Monewden, the Asda chairman, compared the flow of people through a hospital to the flow of products through a supermarket. "The most important thing is the pipeline. You make sure the right goods are coming in and you get them out as fast as possible," he said.

Turning this around will not be easy but it is possible. Some hospitals are using the power of data to drive efficiency with remarkable results. Chelsea and Westminster reduced its waiting list for elective surgery by 28 per cent before the strikes threw a spanner in the works. By replacing numerous Excel spreadsheets with a unified data platform, the hospital tripled the productivity of administrative staff and increased the use of operating theatres by more than 8 per cent. An automated text message went to all patients to weed out those who no longer needed treatment. Bruno Botelho, director of digital operations and innovation at the hospital, said staff sickness levels had fallen significantly and public satisfaction had risen following the introduction of the new system. "Of course it's about reducing the waiting, making the best use of the resources we have and providing better outcomes for patients but it's also about engaging staff and bringing the organisation together to deliver transformation." In Wales, Hywel Dda Hospital had a 35 per cent reduction in the number of beds filled with patients who were medically fit to go home after introducing the Frontier AI tool made by Faculty, which predicts discharge dates. If replicated across England this could liberate 4,500 beds.

Other parts of the NHS are struggling just to get the basics right. In 2022 administrative errors caused the cancellation of 12,600 operations. Some hospitals are routinely wasting up to 20 per cent of their surgical sessions because the patient is not ready in time or a member of staff is absent. More hours are lost because operating theatres start late or finish early. In one trust the average late start was 39 minutes and the average early finish was 90 minutes, meaning that half the four-hour session was not being used. That was seen as a good result.

Sir Neil Mortensen, former president of the Royal College of Surgeons, told the commission that because of a lack of support staff and beds some surgeons were only able to operate "one or two days a week" even though they were available to work full time. "We have highly trained surgeons; we don't have enough theatre capacity," he said. One surgeon, Eric Chemla, said he had quit his NHS job to run a waffle stand because he had become so frustrated by the inefficiency. He was supposed to spend a full day operating every Friday in a busy London hospital but "it never happened in a normal way", he said. "Every week on Thursday evening I'd have a phone call from bed management telling me, 'We have no beds for your patients tomorrow, which one are you prioritising? Could you cancel three out of six cases?'" When the patient did come in the operation would often be cancelled at the last minute. "They would say, 'The notes have been lost'" or there would be no porters. "After a period of time, management called and said, 'Mr Chemla, it seems that you don't have much activity. Maybe we could reduce your operating list into a half-day.' It was so ridiculous, I had waiting lists of hundreds of patients." The final straw came when he was in the middle of surgery and the lights went out in the operating theatre. He had to complete the operation with his iPhone torch strapped to his head.

There is enormous variation in the quality and efficiency of care around the country. In Worcester, patients have a 2.6 per cent chance of an emergency readmission within 30 days after a knee replacement but in Stoke it is 10 per cent. In Northumbria the average length of stay after knee replacement surgery is 1.4 days but in Bradford it is 6.7 days. The cost implications are huge. If the worst performers could match the best then the NHS would be transformed. Some NHS hospitals carry out eight to ten cataract operations in a day, which is standard in the independent sector, but others get through only three or four. One region was doing four, then buying in the same number from the private sector at a cost of £1,500 each. By doubling the throughput in its own operating theatres the NHS saved £6,000 a day just on cataracts in a single area. In another part of the country there is a vast discrepancy between the amount of time orthopaedics patients stay in hospital after an operation: in one hospital it is five days, in another just down the road it is two and a half. An extra 5,000 joints could be replaced every year if both hospitals were operating at the same level. The Getting It Right First Time programme, set up to improve patient safety and productivity, has already saved the NHS £1.45 billion since 2012 under the leadership of the surgeon Professor Tim Briggs.

> "We have highly trained surgeons; we just don't have enough theatre capacity

The hedge fund manager Sir Paul Marshall argued that transparency was a crucial tool. "Data is the most radical and disruptive thing in any walk of life because it reveals bad management, it reveals bad practice, it challenges vested interests, it liberates the customer," he said. In the education world, giving parents more information about schools has had a transformative effect on performance. The same should happen in health. The NHS has an internal interactive tool called the Model Hospital, which ranks all hospitals in the country on hundreds of key metrics covering everything from surgical outcomes to the cost of hospital food. A user-friendly version of this fascinating data source should be made public to help to drive up standards and give patients the tools to make an informed choice about their care.

Lord Darzi of Denham, the surgeon who helped to successfully tackle waiting lists as a minister in the last Labour government, believes that the health service needs a more entrepreneurial approach. "I brought European surgeons across, put them in hotels for a week, fed them. They operated from morning to evening. We cleared 3,000 cases in about three and a half months. I brought back retired surgeons, they came and reviewed all the people on the waiting lists. We removed 20 per cent of the patients." Hospitals in his view should be fully staffed seven days a week. "British Airways does not leave its planes on the tarmac over the weekend." At the moment half of NHS hospitals close their operating theatres at the weekend. The number of elective surgeries such as hip replacements falls by 80 per cent on Saturdays and Sundays. The NHS must be a truly seven-day operation for the sake of patient safety as well as efficiency. When this was introduced for palliative care in Wales, staff were originally resistant but ended up welcoming the move as they saw the benefits.

In London, Guy's and St Thomas' has started running regular high intensity theatre (HIT) lists, which get through a week's operations in a single day at weekends. Two theatres run side by side, with extra staff and a rapid turnover of patients. The anaesthetist who devised the idea compares the eight-hour shift to a Formula One pit stop, with a number of parts of the process going on at the same time. It has been remarkably effective. They can do 12 knee replacements instead of 3 in a day and 25 varicose veins cases rather than 5. The turnaround time between operations is a couple of minutes not half an hour and the surgeons work for 95 per cent of their day instead of 40 per cent. The commission recommends that monthly HIT lists should be used in 50 hospitals to tackle the elective waiting list. They should then become a regular part of the NHS's work programme in future to keep the backlog under control.

Surgical hubs, separated from emergency care, are another innovation that have proved effective. There are 94 of these ring-fenced units around England, ploughing through elective operations undistracted by acute cases, and another 35 are in the pipeline. Some are attached to hospitals, others are in standalone facilities. More than 90 per cent of trusts report a positive impact on waiting times and activity levels and almost three quarters report that staff morale has improved as a result of being able to deliver a better service to patients. The programme should be expanded around the country to ensure that all patients have access to surgical hubs. These should operate seven days a week 8am to 8pm and could be run by the private sector. Staff could be pooled across hospitals and encouraged to pick up extra weekend shifts through "surge" rates.

Justin Ash, chief executive of Spire Healthcare, said a quarter of his company's 925,000 patients were from the NHS last year and it would be able to expand its health service provision to help to tackle the backlog. "We did it during the pandemic," he said. "The independent sector is 400-plus surgical hubs. It makes complete sense to use those that are already built rather than invest more capital to build NHS ones. More could be done and it would make a big difference to waiting lists." He added, however, that the private sector needed some predictability from the NHS. "It needs to have a mindset, which is, 'we're going to collaborate' and a planning horizon of a couple of years, not a couple of weeks."

Over time the NHS should aim to separate "hot" and "cold" (acute and planned) care altogether as much as possible, creating specialist emergency centres and distinct elective hubs. In Northumbria the specialist Emergency Care Hospital in Cramlington is a 24-hour acute hospital for the most urgent cases. The trust's general hospitals in Ashington, Hexham and North Tyneside have urgent treatment centres for more minor conditions and are also "centres of surgical excellence" where most planned operations are carried out. Since the reorganisation in 2015, the results have been outstanding across the board. Northumbria Healthcare is the best-performing organisation in the country for access to urgent and emergency

care. Although some people have to travel further to A&E, they still end up seeing a specialist more quickly. Waiting lists for elective surgery are low and only 60 people have been waiting for more than a year, partly because the hospitals were able to continue operating during the pandemic.

Sir Jim Mackey, the chief executive who introduced the reform and is now moving to run Newcastle Hospitals, is convinced that separating emergency and elective care is the way forward for the NHS. "That's the big innovation," he said. "It works because you remove the risk of somebody having something planned and then a clinician having to judge whether the people coming in in an ambulance should go first. The teams don't conflict with each other; both feed off each other instead."

Northumbria Healthcare also employs its own salaried GPs and manages 11 GP practices across Northumberland and North Tyneside, providing care for 135,000 patients. Next it is moving into social care with about 50 care workers who are paid the same rate as NHS staff. Mackey hopes the innovation will improve coordination and give carers more time to build relationships with patients. "When you have an independent domiciliary care provider, you might get a chiropodist going in to deal with their nails, then a district nurse pop in to check on a wound later on. We want to join it up. Over time I think we'll be able to do it to a very high standard and have more chance of keeping people out of hospital." By removing the barriers, the whole system has become more efficient. "We're seeing 20 to 30 per cent more people in our emergency hospital than when it opened and at that time the trust had about 1,000 to 1,100 beds. Now we've got 800," Mackey said. "So in eight years we've managed to remove about 300 beds, see more patients and improve the whole performance."

There needs to be much greater fluidity between the different parts of the NHS and social care. Wolverhampton has pioneered "vertical integration" with primary, secondary and community services all working together. Like Northumbria, the trust employs its own GPs, who are on a par with consultants and can do shifts in the hospital as well as in their surgeries. The bureaucracy is reduced for family doctors and the hospital has been able to build links in the community. "As far as we're concerned we manage the whole shebang," David Loughton, the chief executive, said. "We've never approached a GP practice; the GPs have approached us. From a GP perspective it's very much about a portfolio career. We've got specialist practitioners in physiotherapy. A lot of them have jobs within the acute trust but they also do sessions within the GP practice so we've got movement that way as well. We're looking at acquiring retail premises to move a number of GP practices into."

The best hospital chief executives are not interested in empire-building; they want to minimise the number of patients they treat. Roland Sinker, chief executive of Cambridge University Hospitals NHS Trust and NHS England's national director for life sciences, said he would love to reduce his number of inpatient beds. "We need to be building the smallest possible hospitals that accommodate people for conditions that really have to come to hospital," he said. "Hospital can be a place where you feel secure and safe; it's also quite a scary environment and you can be quite vulnerable here."

There are good examples from around the country where the NHS is trying new approaches to keeping people out of hospital. The London ambulance service has introduced "A&E on wheels" taking consultants out to emergencies with a fleet of Skodas fitted out with hospital equipment rather than bringing patients into the emergency department. In Cambridgeshire ambulance paramedics are encouraged to "Call Before You Convey" to check that the person really needs to go to hospital. In Surrey, Hampshire and Berkshire, NHS Frimley is using technology to reduce admissions. Within moments of a patient sitting down in an A&E waiting room their GP is sent an alert and if they would be better treated at the local surgery they can be called and redirected. Patients at home who are recording a higher than usual blood pressure reading, or temperature change, are being called by medics within hours to offer support. By joining up records between different services, Sam Burrows, the chief transformation and digital officer at NHS Frimley, said they were "supercharging" their approach to prevention. "If the NHS only sees patients when they become so sick that they have to be seen it will run out of beds, staff and money very quickly," he said. In a pilot group of about 3,000 patients, A&E attendances dropped by 30 per cent and hospital admissions by 40 per cent.

The layout and balance of hospitals must be rethought. Adrian Boyle, president of the Royal College of Emergency Medicine, argued that "inflexible" wards should be replaced by individual rooms for the sake of patient care as well as privacy. "We're making people sicker in hospital by putting them in open bays." There need to be more "step down" beds, where patients can convalesce before they are ready to go home but without taking up a costly fully equipped hospital bed. These could be staffed by nurses, with a doctor on call if required.

More patients should be cared for at home with virtual wards allowing staff to monitor their vital signs remotely. Outpatient appointments must also be streamlined. One senior consultant suggested that about a quarter of these follow-up meetings could be scrapped altogether and many more moved online, saving time and money. In many cases patients are able to manage their own condition and should be given a choice about whether they need a follow-up appointment at all.

In Essex the surgical team has introduced an AI tool to predict which patients were most likely not to show up for an appointment, using non-clinical data including weather patterns, road traffic and the person's behaviour. The hospital rings those who are at the top of the list to remind them about the appointment. Some either cancel or rearrange; others confirm that they will attend. If there is no response from the patient then a "back-up booking" is made to ensure that the consultant's time is used to the full. Rarely two people turn up for the same slot and then both are seen. "I don't get non-attendance any more," Tony Young, the medical director who is also head of the NHS's clinical entrepreneur's programme, said. "Every slot is filled. They're paying me to see 12 patients in a morning clinic and I see 12 patients. Before we had this system, sometimes three wouldn't turn up. Imagine if you rolled that out across the country." Typically, 12 per cent of people do not attend, meaning that 12 million appointments are wasted around the country. When each outpatient appointment costs £165 this means almost £2 billion of potential savings.

Charities also have a role. Maggie's cancer centres, attached to 24 hospitals, have the time and space to offer humanity and a cup of tea to patients away from the busy clinical setting. They are deliberately created to look different from an NHS institution, with buildings designed by world-renowned architects, and offer benefits advice as well as psychological support to people who have had cancer diagnosed. Laura Lee, the chief executive, said that when the charity started 25 years ago she assumed that it would be obsolete by now because its compassionate approach would have been absorbed into the mainstream. "Actually the opposite has happened. We're more needed than we were then because the hospitals, possibly quite rightly, have become much more focused on the technical surgery side. Cancer is as much a mental challenge as it is medical and that isn't something the NHS is set up to support. They don't have to view themselves as the only provider of healthcare."

Thomas Heatherwick, designer of the London Routemaster bus and the Olympic Cauldron, created the Maggie's centre in Leeds as a building to "lift the spirits" of patients. It is set on a slope covered in plants and surrounded by gardens next to St James's Hospital. Too often, he explained, hospitals look like "sickness factories" rather than places to help people to get well. "As a person interested in how you shape the world around you, the worst spaces I know of are health spaces," he said. "It is astonishing that fear and cost have driven us towards that. There was a hospital which had two different courtyards, one that had greenery in it and one that didn't. The people who had views of greenery got better one day earlier than the people who didn't. In the zeal and excitement of needing to build thousands of houses and hospitals we built phenomenally inhuman things. We understand now that health isn't just about your body, it is also about your mind and your emotional state and they're all interlinked. I believe imagination is key to health."

Louise, 42, an estate agent from Stevenage, found herself at the sharp end of health service pressures when her 90-year-old grandmother had a fall (Claire Bithell writes). "She was in the heat of the sun. We couldn't get an ambulance for about six hours. She had to queue outside the hospital, in the ambulance."

The Times Health Commission heard voters' views about the NHS in four focus groups run by Public First. They painted a stark picture of the challenges faced by the public in staying healthy and getting access to good-quality healthcare.

At hospital on a strike day with her two-year-old daughter last year, Victoria, 38, from Stevenage said her experience had been heartbreaking and agreed that the NHS was at breaking point but the experience had not dented her support for NHS staff. "It is really sad that we went through the pandemic and everybody realised how important our healthcare was ... and showed their appreciation," she said. "And since then there's just been no changes made and now people are working horrific hours, stretched to the maximum, to take care of us."

Many had experienced delays because their health records were not easily accessible. Juliet and her husband felt "lost in the system" when the London clinic treating him for his rare autoimmune condition closed. "Communication was zero," she said. "They said they had sent a letter; we got it about four months later. We were trying to contact them via the email address they gave because they didn't want us to make phone calls but nobody responded."

The challenges of eating well and doing enough exercise, especially in the cost of living crisis, was a common theme in focus groups held in Blackpool and Esher, Surrey. Amanda, a waitress and mother of two from Blackpool, was persuaded by her son to buy some "beautiful, proper English strawberries" from a farmers' market. They cost £5.90 for a small punnet but they went bad after a few days. She understood why families may make different choices: "How many chocolate biscuits [she could have bought with that money], I could have had treats for every day."

Edith, from Esher, felt that the government could do more to improve health. "I find some of their strategy, like sugar taxes, are kind of a little bit stop and start, short sighted. It's not a holistic picture. People do need to take responsibility for their own actions as well ... but obviously so many people are now in this really scary poverty rut."

Tess Foundling, left, and Jade Lockwood have worked together for a year as an ambulance crew in London

“I’VE BEEN ASSAULTED, SPAT AT AND BITTEN.

Jade Lockwood, emergency medical technician

A day in the life of an ambulance crew

The ambulance announces “999 mode activated” and the crew is off — blue light flashing, siren blaring — to the first emergency of the day. The commission joined a team from the London Ambulance Service for a 12-hour shift. Jade Lockwood, 31, an emergency medical technician, was driving. “You might start feeling sea sick,” she warned, weaving between the traffic and careering through red lights in Hackney. Her colleague Tess Foundling, 30, sits calmly in the back of the vehicle. She is a paramedic who trained in Australia and has been working in London for four years.

The team has been called to a police station where a man in his forties is complaining of chest pains. He is in custody, having threatened a police officer and a nurse at the hospital. “He’s a handful,” the policeman standing guard tells the paramedics.

Lockwood opens the hatch and starts to talk to him while Foundling looks up his medical history. He is known to the mental health team and is a drug user who had been found unconscious the day before. He claims he has a brain tumour but there is no evidence of that in his records. “We are here to help you,” Lockwood says. “We’re from the ambulance service not the police.”

This calms the man. The police officer is nervous to go into the cell but Tess asks him to unlock the door and walks in alone. The man lets her check his blood pressure and heart rate, then prick his finger to test for infection.

He wants to go home but is persuaded to go back to hospital. “So much of what we deal with is to do with mental health,” Foundling says. The ambulance arrives at the hospital and the patient is put into the care of the doctors.

Foundling and Lockwood have been working together for a year and seem to instinctively understand each other. Often they are going into dangerous situations, sometimes in the middle of the night, with no back up.

“I’ve been assaulted a few times, I have a scar on my wrist where a patient bit me,” Lockwood says. “I’ve been spat at and seen another crewmate punched in the face.”

Last year there were 49 sexual assaults and 516 physical attacks on ambulance crew members in the capital.

The next job comes through and it is serious. A woman in her thirties has collapsed in the street and is having a seizure. It is just around the corner so the ambulance arrives within minutes. The crew grab an oxygen canister and mask that they put over the patient’s mouth.

As the woman comes round she insists she is fine, but she is shaking and clearly disorientated. There is no ID in her pockets and she is refusing to give her name or date of birth. “You’re not in any trouble but we’re worried about you and we need to know what’s going on,” Lockwood says.

Eventually the woman gives her details. She is a drug user on day release from a psychiatric hospital. She has taken “ice”, or crystal meth, that morning, which could have affected her brain. It is back to A&E, which is now packed but the ambulance team are able to hand over their patient.

Lockwood thinks the ambulance service is increasingly picking up the pieces for problems in the rest of the health service. “People find it very difficult to get a GP appointment so in frustration they call 999 or 111.” The London Ambulance Service deals with more than five thousand 999 calls a day. There are eight hundred high-intensity users who ring more than five times a month. One man, with high anxiety, called a hundred ambulances in six months.

Lockwood and Foundling work a rotation of 12-hour shifts with four days off in between each run. Foundling is paid about £31,000 a year and Lockwood £27,000.

There have been some horrendous cases in their year together. One day they found a woman locked up in a flat with two broken legs and only a cardboard box to sleep on. She had jumped out of a first floor window to escape the man who was taking advantage of her but he had found her and taken her back upstairs then abandoned her with nothing to eat. Foundling recalls: “Her fingers came through the door, she was covered in faeces and maggots.”

Dusk is falling as the final job comes in. A man in his fifties has fallen off his bicycle while practising jumps in the BMX park. There is a lot of blood and the handlebar of the bike has gone straight through his leg causing a 10in gash.

“Every ambulance crew has what we call the swan approach: calm on the surface but the legs are frantically going under the water,” Foundling says.

GPs and primary care

Doctors are burning out and deserting general practice, patients cannot get appointments and an ageing population will only increase demand. There are ways of spreading the load but action is needed urgently to stop the system crashing

Claire Murphy is a GP in the sleepy market town of St Neots, nestled around the banks of the Great Ouse in Cambridgeshire. There seems little to fear in this rural idyll, famous for its medieval castle, nature reserve and meadows. Yet being a family doctor here has become increasingly dangerous. One day a patient arrived at the surgery in an "aggressive, agitated" state. "He was slurring and he smelt of alcohol," Murphy said. "We got him into a side room. He slumped to the floor so I knelt down beside him. The first thing he did was pull a knife out of his trousers. I was on the other side of him so I didn't see it but another doctor grabbed his hand."

It was terrifying but, as paramedics took the man off to A&E, Murphy just carried on working. "I had somebody with chest pains in the waiting room, I had other patients to call and I had the management board the next morning. It was only half way through that meeting that I thought, 'Actually, I don't feel great.' I had gone on to autopilot, made sure that everybody else was OK." Her father was a GP in the practice where she now works and she grew up in the town. When she started out as a doctor it was impossible to walk down the high street because everyone wanted to talk. That has all changed. The emotional toll of the role is enormous. "It's the volume of work. Every night I get the kids to bed, get the laundry on and then I log on and finish my day job. I could be doing blood tests or letters until 11 or 12 at night." Often she will visit the sick and dying in the evenings or at weekends. "I swore a Hippocratic oath. That's my moral duty as a doctor. I can't just say, 'Well, it's 6 o'clock on Friday night now, you can just call 111 or go and sit in A&E for four or five hours.'"

The headlines may be dominated by ambulances outside hospitals and waiting lists for elective surgery but the crisis in primary care, arguably the real front line of the NHS, is at least as great. The average number of patients each GP is responsible for has increased by nearly 17 per cent since 2015 and now stands at almost 2,300 people. Last October 2.6 million patients waited more than four weeks to see a GP, up from 1.9 million the previous year. The Office for National Statistics found that one in four adults could not get a GP appointment when they needed one and nearly one in three had difficulty contacting their practice. Satisfaction with GPs, as measured by the British Social Attitudes Survey, plummeted from 68 per cent to 38 per cent between 2019 and 2021, a more dramatic fall than for any other part of the health service.

With more than 37 million appointments a month and almost 800 fewer full-time equivalent GPs than in 2019, doctors are working harder than ever but struggling to keep up. Kamila Hawthorne, chairwoman of the Royal College of GPs, told the commission that a quarter of surgeries were at risk of closing because of workload pressures and staff shortages. "We need far more GPs than we currently have and there's a real fear that we're going to lose a shedload more before things turn around," she said. Surveys suggest that 25 per cent to 40 per cent of GPs are thinking of leaving the profession in the next five years. "That would be catastrophic for the NHS."

Family doctors see more patients each month than A&E departments do in a year. Amanda Doyle, director of primary and community care at NHS England, said GPs were delivering half a million more appointments a week than before the pandemic but "there's a mismatch between demand and capacity" driven by the growing number of older people. "GP practices see the whole population, but the real driver of the workload is the over-65 population who have more and more long-term conditions. They have five times as many GP appointments as teenagers do, and that population has increased by almost 30 per cent." Record numbers of people are training as GPs, with 4,000 recruited every year, Doyle said. "But what we are not managing to do is to retain experienced GPs."

In 2022 the Health Foundation estimated that England was missing the equivalent of 4,200 full-time GPs. NHS England predicts that 12,000 more GPs will be needed over the next decade to meet patient need. The latest GP Worklife Survey found that a third of family doctors in England planned to quit within five years, including three fifths of those over 50. Anita Raja, a GP in Birmingham, moved to the UK ten years ago, having trained in Pakistan. Now many of her colleagues are opting to go to Canada, Australia or New Zealand because it is so stressful working for the NHS. "We are all just drowning, every single day," she said. "I personally know five GPs who have left. At the moment I have four very close friends who are in the process of moving to the Middle East. These people are fantastic GPs, they have been trained in England and we are losing them because they've just had enough. To get into medical school you need to be an A-star student, these are highly intellectual individuals. Why would they want to stay in an environment which is so abusive to them?"

Dame Clare Gerada, former president of the Royal College of GPs, said family doctors were fed up with being treated like second-class citizens. "There is no parity of esteem. Across the world, whether publicly or privately funded, whether via social insurance or national insurance, countries are trying to create general practice as we have in NHS yet we are rapidly undoing ours. I am so sad about my wonderful profession being in such a state and being so undervalued. Without general practice the NHS would fall over. We have fifteen times more consultations per day than A&E and five times more than hospital outpatients appointments. We do more, to a greater degree of complexity, than any other GPs in the world. Yet, instead of being praised and protected we are dismissed and scapegoated."

Sanjay Gadhia is a GP at the Lakeside Surgery in Corby, Northamptonshire, and chairman of the Lakeside Partnership, which oversees eight practices across thirteen sites. His Corby team looks after almost 50,000 patients in one of the most deprived parts of the country. He typically works a 12-hour day starting at about 7.30am and the surgery is open in the evening and at weekends, but he said patients were getting "crosser" all the time. "We had two of our receptionists assaulted a few months ago. The patient picked up a chair and threw it at one of the receptionists, then picked up the computer and hit the other one." A few years ago Gadhia was taken hostage in a consulting room. "There was a patient that we knew had a history of being aggressive. He suddenly went in front of the door and told us he had a knife in his pocket. We were in there for about an hour and a half."

Patients, who are used to instant gratification, often have unrealistic expectations about what GPs can deliver. "We're an open door and people see us as a solution for everything," Gadhia said. "We get all sorts. Sometimes it might be, 'What do I do about my housing and my benefits?' Or 'My partner's having an affair. My child's failed his entrance exams. The school will only allow

Northamptonshire and Cambridgeshire GPs, from left Kathryn Newell, Angela Hartley, Claire Murphy and Sanjay Gadhia

38%

Level of satisfaction with GPs in 2021, down from 68% two years earlier

my child to wear swimming goggles if they have a letter from the GP. My employer said if I want to wear trainers I need a letter from my GP. My neighbour's built a fence and it's stressing me out. I'm going on holiday to this place, what do I need to take?' We may sit back and look at it and go, 'That's a bit silly,' but for the patients it's often that we are their only point of contact." Another GP said one patient had asked advice on how to cook their Christmas turkey.

Family doctors are picking up the pieces for other bits of the welfare state and at the same time the bureaucracy they have to deal with has increased. Angela Hartley, a GP in Kettering, Northamptonshire, said she had to spend up to 40 per cent of her time on paperwork. "You need a degree in accountancy just to navigate the funding streams that are coming into primary care," she told the commission. The schedule on her computer is a daunting mass of coloured boxes, each representing a ten-minute appointment. Guidance from the British Medical Association suggests that doctors should have about 25 consultations a day in order to be able to deliver the right quality of care. "Most GPs are doing twice that," Hartley said. "In the morning surgery I'll have 19 patients that are booked in. I'll have ten admin tasks, which invariably lead to me phoning those patients as well. So that may be 29 patients to contact in the morning and a similar number again in the afternoon," she said. "We've become robots. You feel overwhelmed every single day. There's not a day where you go home and think 'I've done my job really well and I feel satisfied that I've completed all my work.'" Almost 60 per cent of GPs are reporting anxiety, depression and stress.

The commission heard from many witnesses that the GP contract, agreed in 2004, was overly bureaucratic and outdated. One particularly bizarre anomaly is that it is held "in perpetuity" which means that a doctor can sell it on or even hand it to a relative if they are a qualified medic. GPs get about £100 per patient per year to pay staff and run their practice but a big tranche of their funding comes through something called the Quality and Outcomes Framework. This is supposed to incentivise doctors to earn money for chasing targets. In reality it means that they have to spend hours filling in forms with hundreds of boxes to tick, each worth only a few pence. It is so time-consuming that some surgeries now have more admin staff than doctors.

Patricia Hewitt, a former Labour health secretary, who studied primary care as part of a government review, told the commission: "The current GP contract is not fit for purpose. It needs to be reformed." The commission agrees. A new GP contract is needed to ensure that patients can get appointments in a timely fashion and protect continuity of care for those who need it. The focus should be on health outcomes rather than box-ticking minutiae with a smaller number of targets designed around patients. This will give doctors more time to focus on the bits of the job they love. The priorities should be set locally, with a greater share of the primary care budget distributed through the Integrated Care Systems rather than from Whitehall. GPs must be encouraged to see the bigger picture of population health rather than just having their eyes on the ten-minute appointment schedule.

There is no "one-size-fits-all" model. The primary care system should continue to include a mix of GP partners and salaried doctors for the foreseeable future but the balance is likely to shift because more of the younger generation are choosing to be employed rather than run their own business. In 1990 more than 90 per cent of GPs were partners; now it is only half and the proportion is dropping rapidly. The new contract must prepare for this shift by incentivising more collaboration within primary care and between GPs and hospitals.

Super-practices, bringing together several GP surgeries, are a good way of sharing the administrative burden and reducing back office costs, just as multi-academy trusts have done with schools. As Hewitt, who is also chairwoman of the Norfolk and Waveney Integrated Care Board, put it: "We need primary care working at scale and we need it working within integrated neighbourhood teams. At the moment the contract gets in the way of doing that." GPs should be encouraged to be more pro-active, working closely with pharmacists, nurses, social prescribers, physiotherapists and mental health professionals. "Instead of waiting for patients to come to the NHS, we need to be taking the NHS and a whole range of other support services out to patients themselves," Hewitt said. "And we do that by using smart data systems to identify patients who are most at risk. That's personalised, pro-active care around individuals, their families and the most disadvantaged and left-behind communities."

This does not mean losing the personal touch. A number of studies have shown the benefits of patients having a regular doctor. Martin Marshall, professor of healthcare improvement at University College London and a former chairman of the Royal College of GPs, said: "The evidence is really clear and really consistent, carried out over decades in many different countries, that if I see a patient who I know and who I've developed a trusting relationship with then they are more likely to be satisfied with the consultation. They are more likely to follow the advice that I give them. They're more likely to get a better clinical outcome. They're less likely to go to the emergency department and less likely to be admitted to hospital."

In theory, patients do have a "named doctor" but the system is so dysfunctional that many rarely see them. Marshall said having more chains of GP practices could help by reducing the amount of paperwork doctors have to do. "The mantra is, 'Get big in order to stay small.' You want something that is local and personal, but behind that you need an infrastructure to deliver what's expected, to be able to do the population health work, to be able to do data-driven quality and improvement work, so you need scale." He said the existing GP contract was "micro-managed nonsense" and he had himself, with enormous regret, given up practising as a doctor at the age of 61 because of the impossible workload. "I wasn't feeling safe," he said. "On an average day I was seeing between 50 and 60 patients and I was working 12 or 13-hour days."

New ways of working must be developed to help GPs to cope. Although some patients will always need one-to-one appointments, group consultations can be a good way to help people to manage and reverse long-term conditions such as diabetes, asthma and arthritis. In trials, these have been cost effective, reduced pressure on doctors and improved outcomes for patients as they encourage peer-to-peer support.

Clare Fuller, author of an NHS "stock take" on primary care, said there were not enough GPs to provide care in the way that it was done forty years ago so the NHS needed to take a much more varied approach. "East Surrey has a population of about 200,000. They've identified 600 people who are the highest users of healthcare. Those 600 people over the last year had 1,800 A&E attendances, they had 450 outpatient appointments, 400 inpatient admissions and they had 54,000 contacts with their GP. That is why the profession is exhausted and why people can't get in [to see their doctor]. We need to organise things differently, with neighbourhood teams around those most complex people to remove some of the demand."

Although GPs are the face of primary care, they are part of a bigger system that includes nurses, mental health specialists, pharmacists, physician associates, social prescribers, community link workers and health coaches. Primary care works best when these health professionals work together and patients see the right person at the right time. In Hull the fire service is involved in the frailty clinic. When an elderly person has a fall, it is a firefighter rather than a paramedic who goes out to help them. Physician associates are welcomed but must be regulated by the General Medical Council to give them credibility and align them with other health professionals.

Dentists provide vital services to keep the population healthy and optometrists can help to spot conditions early. The annual cost to the UK economy of blindness and untreated hearing loss has been put at £63 billion yet often problems are preventable. There are two million people in the UK who are at risk of sight loss caused by glaucoma, but less than half of them are receiving treatment because their condition has not been detected. The high street chain Specsavers suggested that one in five patients being treated in hospital in England for the condition (60,000 to 100,000 people) could be discharged to community services if funding streams were tweaked to allow optometrists to do more. Scotland, Wales and Northern Ireland all have a national minor eyecare service provided by NHS primary care optometrists but in England services are limited to sight tests and spectacles.

Pharmacists should be incentivised to do more prescribing, consultations and community care. There have been some steps in the right direction and pharmacists are now able to prescribe a handful of drugs including the oral contraceptive pill. From 2026 all newly qualifying pharmacists will be independent prescribers but pharmacists told the commission that the financial incentives were still misaligned. According to Community Pharmacy England, funding has been cut by 30 per cent in real terms and many pharmacies are struggling with recruitment. Between July 2017 and July 2023, nearly a thousand pharmacies closed and deprived communities have had the biggest decline. Janet Morrison, chief executive of Community Pharmacy England, said: "We've got a scheme where we're funded to test blood pressure but then we send everyone back to the GPs if they've got a problematic score. Why don't we keep those people with us and then provide them with long-term management? There are lots of other conditions like diabetes, asthma and respiratory disease where we could be doing more ongoing support."

Adie Williams, a pharmacist in Bristol and the Royal Pharmaceutical Society's patient advocate, has experimented with blood pressure clinics in the local pub. "We looked at the data for our local area and realised that our population had some of the worst cardiovascular outcomes in the city. We knew some of the patients with the highest-risk profiles weren't coming in so we took a table every Friday and did blood pressure checks."

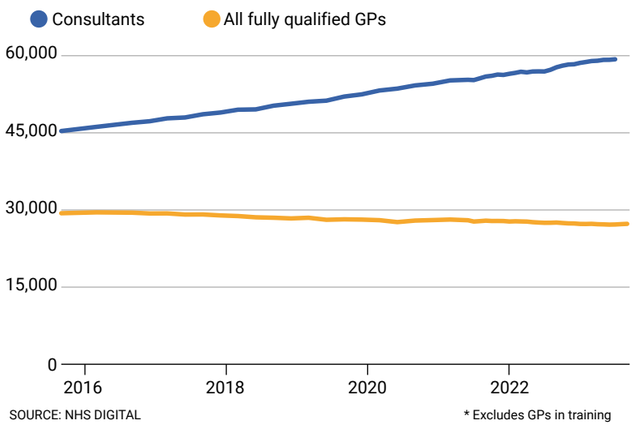
Thorrun Govind, chairwoman of the Royal Pharmaceutical Society, said the government's warm words were not matched by reality. "These new services never come with extra funding. When you're working in a community pharmacy, it just feels like you're being stretched in ten different directions," she said. "We spend a lot of our time telling people what we could be doing instead of getting on and doing it. Do you want to embrace us and get with the programme, work with us, fund us and embrace us as part of the NHS as a solution? Because we do offer solutions."

There is more that pharmacists could do with medicines optimisation to prevent patients taking unnecessary drugs, reduce wastage and

> "I wasn't feeling safe. I was seeing between 50 and 60 patients and working 12 or 13-hour days

Different paths

Number of fully qualified GPs* and NHS consultants



SOURCE: NHS DIGITAL

* Excludes GPs in training

improve safety. With an ageing population the use of multiple medicines is increasing but up to half of drugs prescribed for long-term conditions are not taken as intended. Between 5 and 10 per cent of all hospital admissions are medicines-related, and two thirds of medicines-related hospital admissions are preventable. Economic analysis suggests that 237 million medication errors occur each year in England, costing the NHS more than £98 million a year, using 181,000 bed days and contributing to about 1,700 deaths. Overall it is estimated that at least £300 million of NHS-prescribed medicines are wasted each year. There are significant savings to be made and pharmacists have the specialist knowledge to identify them. More money could be saved by speeding up the process of licensing generic medicines. According to Mark Samuels, chief executive of the British Generic Manufacturers Association, bureaucracy is delaying the switch from monopoly-priced medicines to generics by up to a year. "We calculated that in the last six months [of 2022] alone that cost the NHS an unnecessary £128 million in its drugs bill."

The role of the GP as the "gatekeeper" to healthcare must evolve, with patients able to self-refer to a specialist for certain conditions such as dermatology and musculoskeletal problems. This will free up doctors' time and give individuals a greater sense of control over their health. The barriers between primary and secondary care should be broken down. That could involve GPs being employed by hospitals or consultants doing outpatient appointments in the community.

A new network of purpose-built community health centres should be built, starting in disadvantaged areas. As well as GP surgeries, they could include diagnostic centres, outpatient clinics, family hubs, dentists, pharmacists, obesity support or frailty clinics as well as other services such as employment and housing advice, depending on local need. The commission heard that about a quarter of GP surgeries were "not fit for purpose" and 80 per cent were "not fit for the future". The Local Improvement Finance Trust (Lift) public-private partnership model offers a good way of funding the network, reducing the upfront cost to the NHS. The health centres could be used to help to regenerate town and city centres. In York the local hospital has put its phlebotomy, ophthalmology and rheumatology departments next to the leisure centre so people can have blood taken after a swim. In rural areas the network could use a "hub and spoke" model, with a large central unit linked to several smaller surgeries.

Around the country, the commission saw how collaboration was improving care for patients and making life easier for clinicians. In Cambridge one of the large GP practices has set up a joint programme with the neurology department at Addenbrooke's Hospital that has already significantly reduced visits to A&E. The family doctor Tim Wright and the neurology consultant Nush Gunawardana meet every two weeks for an hour on Teams to discuss patients who may have neurological problems or unusual headaches. Already the number of letters going back and forth has been cut by 60 per cent and referrals have been reduced by 15 per cent. "The patients are getting seen by the right person in the right place at the right time instead of bouncing around the system and you're preventing unnecessary workload," Wright said. In the old days, if he was concerned about a patient he had to dictate a letter, get it typed up by the secretary who sent it to a secretary at the hospital, who showed it to the consultant, who then wrote back. "You're removing a huge tranche of administrative process by having a one-hour meeting every fortnight." He is convinced that a similar approach would work in other specialisms.

> "We must move more to personalising preventive care

Technology, used smartly, can improve the connection between doctor and patient. Although some people will always need to be seen in person, digital triage systems can quickly direct people to the right medical professional and ensure that face-to-face appointments are available for those who really need them. The eConsult system, which is used in a third of GP surgeries and covers 25 million patients across the UK, was created by a group of doctors who were frustrated by the overflowing waiting rooms and long queues for appointments. Instead of hanging on a phone line during the 8am rush, patients answer a series of questions online, following an algorithm created by the GPs. They can also upload photographs of a rash or injury. Cases are prioritised automatically by the system so the doctors know which patients are the most urgent. Some patients are referred to a pharmacist, nurse or physiotherapist instead of a GP. Murray Ellender, chief executive of eConsult and a GP with the Hurley Group, which runs 13 practices in London and the southeast, said about 80 per cent of cases could be closed without bringing the patient into the surgery. "That's great for patients but it's also more efficient for the clinicians. You're only bringing in the people you really need to bring in and then you could potentially give them longer."

The GPs do not have to respond to messages in real time so it enables more flexible working. "A doctor can come in in the morning, do 15 eConsults, go to drop the kids off at school and come back and continue. That wouldn't be possible in normal practice," Ross Dyer-Smith, another GP with the Hurley Group, said. His practice has GPs all over Britain and the world working on its "e-hub", although there is always somebody in the surgery for those who need to come in. "We've got people in Canada, Italy, Greece, France, the Netherlands, New Zealand and Dubai," he said. "Our recruitment went up ten times. When you haven't got enough GPs you have to think of a different way of doing it."

The Modality Partnership, an award-winning super-practice with 250 GPs, has a team of 20 virtual life coaches based in Mumbai working with more than a thousand patients to improve their health and deal with long-term conditions such as diabetes. Since the programme was introduced five years ago coaches have absorbed 426 hours of GP time. Patients have had an average 10 per cent reduction in body weight, 7 per cent reduction in cholesterol and 85 per cent reduction in medication use. Vincent Sai, the chief executive, said primary care needed to be transformed to deal with a changing patient population. "It's things like that that will make a difference, because it's not just the standard 'Let's do more with less,'" he said. "It's just doing it differently, being more targeted." He explained that, with 11 per cent of his partnership's patients taking up 47 per cent of appointments: "We must move more to personalising preventive care, tailoring to the situation of the population."

There has to be a better public understanding of the services that are available and how and when to access them, as well as an expectation that patients can often manage their own conditions. Matthew Taylor, chief executive of the NHS Confederation, believes there should be a new "social contract" on health. "We need to give people more and we need to expect more from people. Instead of a model of medical experts handing pills to passive patients there should be a partnership." This is the approach taken by the Bromley by Bow Health Centre in east London, which is built around a café, artists' studios and a garden. Patients can be prescribed a session in one of the allotments or a pottery class and during the pandemic the practice collaborated with the English National Opera with singing classes to help people to recover from the coronavirus. Sir Sam Everington, the GP who helped to create the centre more than thirty years ago, sees medicine as a shared venture. "You're empowering the patient," he said. "The concept is: 'It's not my body it's yours. I'm here to help you.' In the consultation rooms we sit next to patients. I don't wear a tie, never have in 34 years. All my patients know me as Sam. My social prescribing about a month ago was to advise a man to divorce his wife."

In Spain the commission visited Ribera Salud, a private healthcare provider that is known for its highly integrated system. The company receives €1,000 per year from the regional government for each person in the area regardless of their age or underlying health conditions. This budget must fund treatment for everything from cancer surgery to car crashes, Covid intensive care units, hip replacements and smoking-cessation services. Although the services are privately run, all medical care is free for individuals and the outcomes are excellent. There is a strong financial incentive to keep people out of hospital and encourage them to stay well. A study by Harvard Business School found that Ribera Salud ran the highest-quality hospital in the region with 25 per cent lower costs. Alberto de Rosa, the company's president, said its success relied on seeing primary and secondary care as one system to deliver personalised care with data shared between GPs, hospitals and individuals through an app. "We don't talk about patients, we talk about citizens because our interest is to maintain our citizens as healthy as possible," he said. "Prevention is important but even more important is a predictive model and population health management. You have to tailor a solution for each individual."
A similar change is required in this country to rebalance the relationship between doctor and patient while creating a seamless connection between primary and secondary care.

Case study
A one-stop shop for frail older people

If an elderly person in Hull has a fall at home they are rescued by a firefighter rather than a paramedic. It is part of a programme being pioneered by the Jean Bishop Integrated Care Centre, which opened in 2018 as a one-stop shop for frail older people.

There are two full-time firefighters seconded to the NHS "falls team" as part of a £250,000-a-year contract between the fire and health services. They have received basic medical training so that they can safely lift people and make checks including blood pressure and heart rate.

Matt Sutcliffe, assistant chief officer at Humberside Fire and Rescue Service, said the collaboration was already reducing the number of hospitalisations. "We're doing about ninety to a hundred calls a month. These are the ones where somebody has fallen out of their chair or fallen out of bed. We're on the scene within an hour."

The frailty clinic, which aims to allow more older people to live independently, is seen as a model for the future of community care in the NHS. It brings together doctors, physiotherapists, social care workers, nurses and firefighters under one roof.

More than 12,000 frail older people with long-term conditions have been treated by the team since the centre opened. Between 2019 and 2022 the centre contributed to a 13.6 per cent reduction in emergency hospital attendances among people over 80 and a 17.6 per cent drop in A&E visits by patients living in care homes.

Ukrainians return to a war zone to have their teeth fixed

Ukrainian refugees are returning to the war zone for dental treatment because they cannot find a dentist in the UK. The Times Health Commission heard that the crisis in dentistry had become so acute that a growing number of patients were weighing up the cost and risk and deciding that it was better to travel to Ukraine for care. “What more do we need to know about the crisis in British NHS dentistry than that?” Shawn Charlwood, chairman of the general dental practice committee at the British Dental Association (BDA), said. “You return to a war zone to get your dentistry done because it’s easier.”

Others are resorting to DIY dentistry. Some patients are pulling out their own teeth with string or creating fillings or home-made dentures. “People are living with chronic pain, chronic swelling, unable to eat, unable to speak, unable to sleep, unable to work,” Charlwood said. “They are becoming so desperate that they are taking matters into their own hands. You’re then seeing the spillover into general medical practice, because people can’t get access to dental practice. And so doctors are becoming overwhelmed, A&E is becoming overwhelmed with dental problems. I think broadly the word ‘crisis’ is overused but we have been in a crisis situation for many years. There was a problem before the pandemic and that merely exacerbated and highlighted the yawning gaps.”

More than 26,000 children were admitted to hospital in 2021-22 to get teeth pulled out under general anaesthetic because of preventable decay. Tooth decay is now the leading cause of hospital admissions for six to ten-year-olds. In 2021-22 there were 83,000 A&E attendances for dental problems.

About 12 million adults in England have not seen an NHS dentist in the past two years and 5.7 million children have not had an appointment in the past year, the recommended maximum intervals between check-ups. More than six million adults tried and failed to get an appointment in the past two years and 4.4 million simply did not try because they thought they would fail.

Last year hundreds of people queued from 5am outside one dental practice in Norfolk after it announced that it would be taking on new NHS patients.

The number of NHS dentists in England has fallen to the lowest level in a decade, with a growing number handing back their contracts to retire or focus on private work.

In 2022-23, 24,151 dentists were recorded as performing NHS work, more than 500 fewer than before the pandemic. Although the NHS workforce plan promises to increase dental student numbers by 40 per cent, there is a growing problem with retention. A BDA survey found that more than half of dentists have reduced their NHS commitment and 75 per cent plan to cut back on their health service work in the year ahead.

Louise Ansari, chief executive of Healthwatch England, said NHS dentistry was second only to accessing GP services as the top issue for patients. “We are very concerned that the crisis in NHS dentistry is contributing to widening health inequalities, with those who can’t afford private dental care or without health insurance not being able to afford timely care.”

Dentists say the postcode lottery is getting worse and will cost lives, owing to missed oral cancer cases. Only 52 per cent of children in England saw an NHS dentist in the past year and 40 per cent of adults have seen an NHS dentist in the past two years. Analysis by The Times of data from 338 local authorities found stark regional disparities, with parts of Lincolnshire, Devon and Norfolk now “dental deserts” with virtually no NHS access, leaving some patients with no option but to go to A&E with tooth ache or to try to pull out their own teeth.

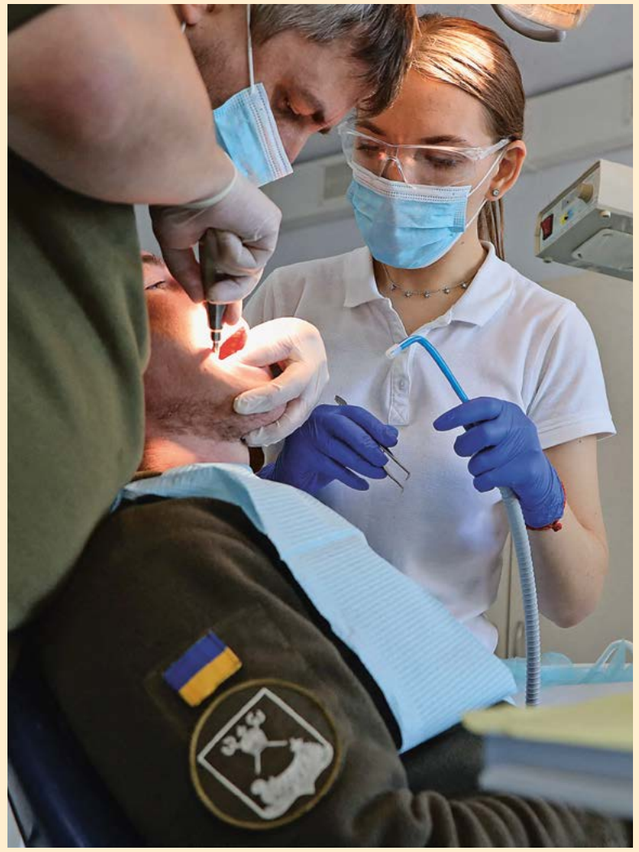
Only 14 per cent of children in Breckland, Norfolk, saw a dentist in 2022-23, making it the worst dental blackspot. For adults the worst area is North Kesteven in Lincolnshire, where only 11 per cent have seen an NHS dentist in the past two years.

The evidence presented to the commission suggests that fundamental reform of the NHS dental contract is required to prioritise prevention and improve access. Last year the Commons health and social care select committee denounced the contract as “not fit for purpose” and it was right.

Under the existing arrangement dentists are paid for NHS “units of dental activity” rather than for each person they treat. This acts as a disincentive to do complicated work or take on new patients with high needs.

Eddie Crouch, chairman of the BDA, said these perverse incentives were pushing the system to breaking point. “A patient may walk in and need hours and hours of treatment, but you will only be remunerated the same for that as you would do if they needed half an hour’s worth of treatment,” he said. “The patients that need the treatment the most, sadly, are the ones that are least welcome in the practice, because it puts you under financial pressure for the practice to survive. Because you will under-deliver on your units of dental activity, you will spend more money on their treatment that is costing you more money to provide than the NHS is prepared to pay you. So you become a charity.”

Dentists should be given a fee for each patient on their list, which would encourage them to focus on preventing tooth decay rather than just treating problems once they arise. Dentistry must also be seen as an integral part of primary care, with dentists included alongside GPs in new health centres. “The system is so broken that we’re facing £500 million of the budget that will not be spent by dentists, because they cannot recruit and retain dentists to the NHS service to deliver care,” Charlwood said.



Mobile dental units treat Ukrainian troops in Kharkiv and Mykolayiv. In Britain, refugees from the fighting have found it so difficult to access dentistry that they have travelled back home to the war zone

Workforce and culture

It's all about the people, the commission was told repeatedly. The NHS is supposed to be a caring institution but it is a flawed employer. Bullying, sexual assault, arrogance and hierarchical attitudes are rife, to the detriment of patients

Kevin Fong understands better than anyone what happens to the human body and mind in extreme situations. As the consultant anaesthetist responsible for major incident planning at University College London Hospitals, he deals with devastating car crashes and appalling terrorist attacks. He has worked with Nasa on space medicine and, during the pandemic, he was the national clinical adviser on emergency preparedness, resilience and response.

At the height of the Covid crisis, he conducted a survey of thousands of doctors and nurses in more than forty hospitals. "We saw extremely high levels of reported symptoms of mental illness amongst our frontline teams, using a standardised scoring system which exists as a measure of post-traumatic stress," he told the commission. "We got rates, on average, amongst our respondents of 46.5 per cent at the peak of the 2021 wave, which compares with, if you surveyed the general population, rates of about 3 per cent outside of Covid. The highest rate published before our study was in British military veterans who had served in a combat role in the Afghan conflict, and that was 17 per cent." He thinks that his health service colleagues are injured and not enough is being done to help them to heal. "When I turn up for work on the air ambulance we spend about half an hour checking the kit. Somehow we do not make those checks on ourselves. The NHS is inefficient, but not in the way that we ordinarily think. It's inefficient with its human resource, which is the most reprehensible of all inefficiencies."

There is, Fong said, no solution to the crisis in the NHS that does not involve better understanding the needs of the 1.6 million people who work in it. "There have been five reorganisations since I was first studying medicine in the 1990s. It's akin to switching the NHS off and switching it back on again and hoping that something magical is going to happen in the reboot, and it almost never does. We've changed commissioning structures, we've changed regional and national structures. It's always about structures; it's never about people. The big cultural change we need is to recognise that the needs of the patient and the needs of the staff are aligned, that you cannot care for the patients if you do not care for the staff." At the moment, he said, people working in the NHS felt as if they were in Alice in Wonderland's Red Queen Race, "in which all the running you can do is only enough to stay in the same place. It's very difficult to strategise and create new ways of doing things because you're just focused on getting to the end of the day."

The NHS may be an organisation founded on the principles of care and compassion, but the experience of people working in it is often shockingly bad. In the latest staff survey, more than 30 per cent said they felt burnt out. Almost 40 per cent found their work frustrating or emotionally exhausting and 45 per cent had felt unwell as a result of work-related stress in the previous 12 months. Only a quarter said there were enough staff at their organisation for them to do their job properly and almost a third often thought about leaving. These are not sustainable figures for an organisation in which human beings are the most important resource.

The fall in productivity in the NHS is at least partly related to the poor wellbeing of staff. The Institute for Government has calculated that 500,000 staff days are lost to mental ill health every month. Doctors are twice as likely, and nurses four times as likely, to take their own lives compared with workers in other professions. When it started in 2008, NHS Practitioner Health, which supports doctors, had 200 patients a year. Now it has 200 medics seeking help every week. Almost all reach the threshold for a formal diagnosis of mental illness; about a third have had suicidal thoughts. There is an inevitable impact on their work. A report from the Healthcare Safety Investigation Branch, published last February, found that "harm is happening" to patients because of the "significant distress" among doctors and nurses in emergency departments.

The number of vacancies in the NHS has dropped from a peak of 130,000 in December 2022 to about 112,000 but more than one in ten nursing posts are still unfilled. Since 2019 there have consistently been more than 40,000 nursing vacancies in the NHS. The health service in England is spending more than £3 billion a year on agency staff, which undermines the sense of camaraderie, makes it harder to build a team spirit, reduces efficiency and is costly. One trust paid £5,200 to a recruitment company for a single doctor's shift as it struggled to find staff to care for patients. Recruitment companies are tempting doctors and nurses to work for them by offering shopping vouchers, cinema trips, iPads and beer. The owners of these agencies post photographs on social media of their £1 million boats and £40,000 watches.

Amanda Pritchard, chief executive of NHS England, admitted to the commission that the health service was over-reliant on agency staff and said that such workers should be the exception rather than the rule. She argued that the health service also needed to become more self-sufficient and less dependent on foreign workers. "It was the Windrush generation that came and helped found the NHS," she said. "We've always had an incredibly valuable supply of staff coming internationally but we have got to a place now where I think, honestly, we are over-reliant on our ability to recruit from overseas. Demand for healthcare is only going to grow around the world over the coming years and that means greater competition for skilled staff."

Last year's NHS workforce plan included a doubling of medical school places, a 50 per cent increase in GP trainee places for junior doctors and 24,000 more nurse and midwife places a year. There will also be a rise in apprenticeships and a consultation on accelerated medical degrees. These are all welcome — although the lack of anything on social care in the workforce plan was a glaring omission — but the NHS also needs to get much better at retaining and developing the staff that it already has.

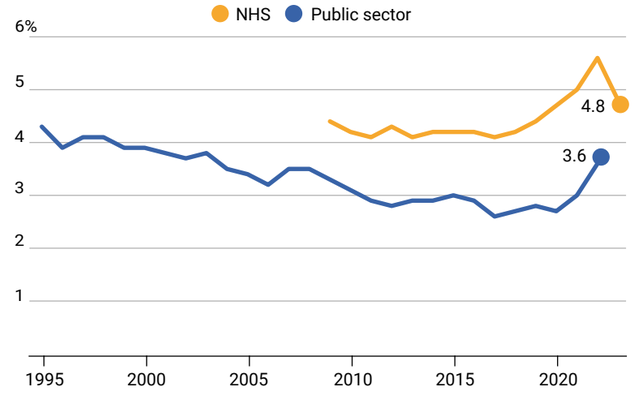
In 2022 nearly 170,000 workers left their health service jobs, a record exodus of staff and an increase of 13 per cent on the previous year.

1.6m

The number of people working in the NHS

Off sick

Comparing the yearly NHS and public sector sickness absence rates



SOURCE: NHS DIGITAL, ONS

More than 27,000 cited work-life balance as the reason they were quitting, which was higher than the number who left because they had reached retirement age. Between April 2018 and September 2023, almost 45,000 working-age nursing staff and midwives aged 21 to 50 left the profession, more than the number of nurse vacancies. The staff leaver rate in NHS trusts increased from 9.6 per cent in the year to September 2020 to 12.5 per cent in the year to September 2022.

The number of doctors taking early retirement from the health service has more than tripled over the past 13 years, although new changes to pension rules may stem the flow. A study published in The Lancet last August found that 48 per cent of healthcare workers had either considered or acted upon changing or leaving their roles. Experienced staff are quitting and being replaced with more junior people, which is harming productivity. Mark Porter, a GP in Gloucestershire and The Times's medical columnist, described a "downward death spiral, where people are leaving, they can't be replaced, it puts more stress and strain on those that are there. They leave and the whole thing is falling apart."

There are problems across the medical workforce. According to the Royal College of Ophthalmologists, three quarters of eye clinics do not have enough consultants to meet current demand and more than half have found it more difficult to recruit consultants over the past 12 months. There has been an increase in vacancy rates in pharmacies, with 16 per cent of pharmacy roles and 20 per cent of pharmacy technician jobs unfilled. Significant shortages also exist in radiography, prosthetics and podiatry.

In a competitive global market for health workers the NHS is not the only available potential employer for highly trained staff. Billboards outside hospitals are plastered with adverts promoting jobs in sunny Australia. Latifa Patel, chairwoman of the representative body at the British Medical Association, said the NHS was "haemorrhaging" doctors at every level. "If the NHS was a house, everybody is looking at the front door but meanwhile there's a fire in the kitchen and you've not got a sofa and the whole house is falling apart behind you," she said. "We've spent so long trying to battle the waiting lists that we've lost sight of what's going on inside the NHS. We have a culture which allows bullying. We have clear discrimination within the NHS. We know why doctors are leaving but we'd rather train newer models than work on the models we currently have. I don't understand the logic. We're creating a workforce for Australia, New Zealand, Canada and elsewhere because we're unable to keep our staff in the NHS."

It was a message reinforced by Sarah Clarke, president of the Royal College of Physicians, who warned: "The NHS is nothing without its people."

Pat Cullen, the general secretary of the Royal College of Nursing, argued that the NHS would never be put back on a stable footing unless a greater value was put on staff. "Our nurses are leaving in droves to work in supermarkets, retail, any other job that will give them a couple of pounds extra an hour and less stress and more sociable hours," she said. "Unless they address the crisis within our workforce the health service is going to continue to fall over this precipice. It's on life-support." She said patients were being put in danger by staff shortages. "Nurses are clear that significant care is being left undone. They do not have enough time to get around their patients. There are too many in their area and not enough nurses. That's very high risk." Money was not the only issue for nurses, she insisted. "There are significant levels of violence and aggression. They've had urine thrown on them. Some of our nurses are subjected to sexual violence within A&E."

The strikes have focused attention on pay but the problems with the NHS workforce go way beyond money. The commission heard that there was often nowhere for NHS staff to get a hot meal so clinicians worked 12-hour shifts with nothing to eat but crisps from a vending machine. Many hospitals do not even provide somewhere to make a cup of tea or sit down for five minutes during a stressful day on the wards. Some have no lockers where people can store their belongings so they are repeatedly robbed. Baroness Finlay of Llandaff, a palliative care consultant and crossbench peer, said the poor facilities were having a terrible impact. "I know one hospital where the staff toilets didn't flush for seven years. The staff had to leave the department to go for a pee. That just can't be right. If people can't get a decent drink, if when they're stressed they can't sit down for a few minutes in a decent area, they take all that trauma home with them. In the hospice I used to say to staff, 'When you go in the broom cupboard somebody's been in there before you crying. Come on, we'll sit down and have a cup of tea.' But recently I was told I wasn't allowed to have a cup of tea at the nurses' station at 11 o'clock at night on a ward. That's madness. If we don't look after the staff how can we expect them to care for other people?"

In an age when individual autonomy feels increasingly important, NHS employees often have little control over their lives. This is understandable to some extent when rotas need to be filled in a busy hospital department but it has gone much too far and working for parts of the health service has now become all but incompatible with modern family life. Medics are unable to book time off 18 months in advance to get married. The commission heard of one junior doctor who got confirmation that she could have a day off for her own wedding four weeks before the date but could not go on honeymoon because she was not allowed to take the time off as holiday. Trainee surgeons can spend more than four hours a day travelling to and from work, making it almost impossible to juggle a career with a family. The phrase used by the traditionalists is "knife before wife", one female surgeon said, even though many in the profession are women and modern men want to be caring husbands and fathers too.

Dame Jane Dacre, former president of the Royal College of Physicians, said it was indicative of outdated attitudes that were all too prevalent across the health service. "The NHS hasn't moved on enough from the 1950s," she said. "We don't treat the workforce well enough, we don't have enough recognition of people who are different from the white, male, privileged background that the hierarchy has traditionally seen. We waste resource in the workforce because we don't train enough people to start with and then we're careless with them and we lose them. The NHS workforce is 80 per cent female, the nursing workforce is 89 per cent female, but we don't have universal nursery provision. There are some really obvious things that we can fix that would help the workforce to feel valued." The gender pay gap in medicine has fallen slightly in recent years but still stands at almost 13 per cent, unusually wide for a single professional group. "Women are prevented from reaching the highest levels of a profession whose pay structures and culture are not compatible with an increasingly female workforce," Dacre said.

Bullying and buck-passing are rife in an organisation that thrives on hierarchy. Sexual harassment and racial discrimination go unchecked. In 2022 more than half of doctors experienced or witnessed verbal or physical abuse. Nearly a third of female surgeons have been sexually assaulted by a colleague and two thirds have been sexually harassed. A third of black and minority ethnic health staff have suffered racism or bullying and, despite making up a quarter of the workforce, hold only 10 per cent of the most senior positions. Nonhlanhla Nyathi, a senior nurse who came to the UK from Zimbabwe, described her experience of racism in the NHS: "I was bullied into believing I didn't deserve the ward management position. I was bullied into believing I couldn't write or speak English. I was put in a box that I'm troublesome, I'm challenging, I don't know anything, I need to keep quiet and sit down."

Of course this is not the whole picture. There is huge variation across hundreds of organisations in a vast network that spans the country but the commission heard repeatedly and from many angles about the cultural problems in the NHS. General Sir Gordon Messenger, the former vice-chief of the defence staff appointed in October 2021 to lead a review of leadership in the health service, said he had been shocked by what he found. "Too frequently we saw things that a good well-functioning organisation wouldn't tolerate," he told the commission. There were "too many examples of discrimination, harassment and poor interpersonal behaviours".

He highlighted "finger pointing and responsibility avoidance" as the characteristics that surprised him most. "They both stem from the workforce feeling that they are individuals, that they are alone," he said. "Too often people don't want to put their head above the parapet because they'll get shot down. Too often they don't want the spotlight on them, and that natural instinct to build a team around a problem I don't think existed strongly enough."

He drew a contrast with the culture inculcated by the armed forces. "There are things that the military do in terms of building teams and building identity beyond the individual that I think could be applicable to the health sector and the social care sector," he said. "If you're an individual within the military you feel very well supported and looked after by the structures around you. You're appointed based on your experience and what they perceive to be your talent. In the NHS too often this is about a tap on the shoulder or who you know. I am by no means asserting that if you get this right, suddenly everything else falls into place. What I am saying is that looking after the workforce, training and developing the workforce and turning that workforce into a collective culture — which is well-led, which is motivated, valued, inclusive, resilient — is an absolutely foundational part of it and if you don't do it you're painting the bedrooms without fixing the roof."

Victoria Atkins, the health secretary, suggested that the power of the "old boys' network" that has been challenged in other workplaces appeared to have "stayed entrenched in the system" for longer in the NHS. "I was absolutely shocked to read the reports of female surgeons, the sexual harassment they were facing, that is absolutely unacceptable," she told the commission. "You assume that the NHS, being a system that cares for us, [has] care at its very heart." The health service needed to do more to "ensure that the culture is respectful and dignified and caring, not just to patients, but to colleagues as well," she said. "Why aren't we providing hot meals? How can we thank members of the workforce, not just doctors, but nurses, anaesthetists, others who are working through the night, or at the end of a long shift? How can we say to them, 'Thank you, you're really valued'? How can we help people juggle that work-life balance? We need to look at it in a much more modern way in the NHS."

Andrea Sutcliffe, chief executive of the Nursing and Midwifery Council, insisted that the workforce was the foundation of the NHS and social care. "So many solutions that people come up with depend on, 'We're going to have this wonderful new machine,' or, 'There's a new building,' or, 'There's a different drug that we could have.' But actually health and social care is about people. It's about the people who are using those services and it's about the people who are delivering those services. It is about so much more than money. It's about us using the resources that we have to the best effect, and paying attention to the environment within which people are working. People are leaving earlier than they anticipated they would because they're burnt out, they're exhausted, they can't get the support from their colleagues. They're not able to deliver the quality care that they would want to. They're not saying, 'We're leaving because of money.'"

The NHS has the largest workforce in Europe and it needs to modernise its employment practices to retain and recruit staff. Flexibility and innovation should be encouraged, the old hierarchies broken down and new career paths created. As Matthew Taylor told his fellow commissioners: "Nothing can be done unless we address workforce: that is the burning platform."

There are some NHS organisations that are exemplary employers, which proves that it is possible within the current funding constraints. Milton Keynes University Hospital has an app that allows doctors and nurses to book the hours they want to work, using artificial intelligence to schedule the rota in the most efficient way. As well as fully flexible working, staff get free parking, free tea and coffee and free breakfast, with subsidised healthy food and free meals for night staff. There are ward staff rooms, which have all been refurbished, and a communal rest space as well as a dedicated room for staff who need to express breast milk at work. The hospital is now looking at creating on-site childcare. "The investment is worth every penny," Joe Harrison, its chief executive, said. "It is about demonstrating we care about and value our staff and there is a great deal of evidence linking staff satisfaction to good patient care." He has created extra space for staff by digitising all the paper records and converting the dusty basement archive into training facilities and consulting rooms.

Sadly, however, this is the exception rather than the rule. The health service across the board needs to become a much better employer in ways that go beyond pay settlements. This includes providing affordable and healthy staff canteens, night transport or parking, a comfortable staff room, private spaces for clinicians to decompress and somewhere to get a hot drink. There should be more on-site childcare and flexible work contracts to allow those with caring responsibilities to remain in the workforce. Technology can undoubtedly help. An algorithm developed by a company called Lantum has transformed scheduling in the hospitals where it has been tested, allocating doctors and nurses more efficiently and flexibly. The Evelina Children's Hospital, part of Guy's and St Thomas' in London, filled a 16-person rota with 11 people and saw its agency spend drop by 80 per cent after it introduced the software. If the results were replicated across England the system could save the NHS more than £200 million and give staff a greater sense of control over their working lives.

There must be zero tolerance to bullying, harassment, assault and racism, with prompt inquiries and action against those found guilty, however senior. Professional development and training must be offered at all levels to give staff a greater sense of career progression. The health service also needs to attract employees with new skills such as data analytics. This will be a better investment than simply training more clinical staff because it will make the health service more efficient and allow doctors to spend extra time caring for patients.

The NHS workforce strategy must be updated and independently verified every two years in a process overseen by the Healthy Lives Committee. It should include social care and computer programmers as well as doctors and nurses. The increasingly important role of non-medics in community care and chronic disease management must also be recognised.

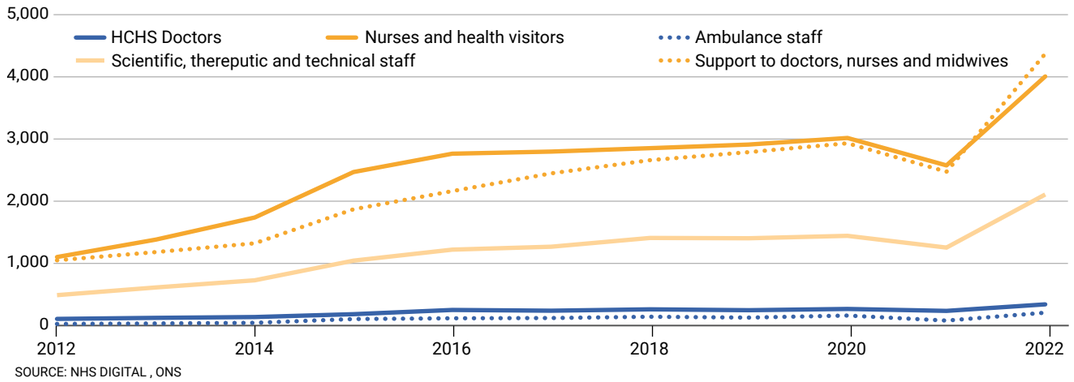
> "Nothing can be done unless we address workforce: that is the burning platform

It is time to stop demonising managers. Good managers are not petty bureaucrats; they are the leaders who can transform an organisation. An analysis by the Chartered Management Institute (CMI) found that the NHS had fewer managers than most companies: they represent about 2 per cent of the health service workforce compared with 9.5 per cent across the wider UK economy. Ann Francke, chief executive at the CMI, said: "Contrary to the caricature of managers somehow pushing pencils and draining money away from vital frontline NHS resources, skilled, accountable managers are crucial if we hope to equip the health service for the future. All the evidence suggests that highly qualified managers, including clinicians, deliver improved results for patients. Better-run hospitals have lower rates of infection and better survival rates in everything from cardiac care to cancer treatment." According to a World Management Survey study, 43 per cent of hospitals scoring above average in management practices achieved "high quality" outcomes, compared with 14 per cent of those below average. As Lord Rose of Monewden, chairman of Asda, put it: "The NHS is crying out for leadership."

On visits to high-performing hospitals and GP surgeries, the commission saw what difference a good manager could make. At the Leeds Teaching Hospitals Trust, one of the largest acute hospital trusts in the UK, a new chief executive — Julian Hartley, now the head of NHS Providers — moved the trust from the bottom 20 per cent of NHS employers to the top 20 per cent in three years by introducing a more collaborative approach. But there is a high level of churn among senior managers as well as clinical staff. An NHS Providers survey found that more than a quarter of executive directors had been appointed since the start of 2021. Commissioners also highlighted a "sticky middle" of more junior managers who hampered innovation because they were too risk averse. As Finlay put it: "Sometimes you feel it's like wading through treacle even to get one staff

Looking elsewhere

Annual leavers from the NHS stating "work-life balance" as the reason for leaving



SOURCE: NHS DIGITAL , ONS

appointment approved. There's a sludging in the system, which doesn't help it be rapidly responsive and doesn't make the staff feel that they're looked after."

There needs to be better training and career development for managers, with the Care Quality Commission's "well-led" category for inspections broadened to include a detailed review of management practices. The NHS Leadership Academy is an existing source of support and should be boosted to ensure that managers have the right skills to build the teams and culture that help the worst to learn from the best.

Medical training must be reformed to include more accelerated degrees and a greater emphasis on teamwork and empathy. Student doctors should be eligible for full maintenance loans throughout their training. At the moment these only cover the first five years. The cost of the Royal College exams that trainees have to take to qualify as doctors should also be funded by the health service. The requirement for junior doctors to rotate all over the country must end to make it easier to balance work and family. Virtual reality technologies have developed rapidly in the past few years, have already proved effective in surgical training and could be used more widely in medical education.

The commission also recommends the introduction of a loan forgiveness scheme for doctors, nurses, midwives and allied health professionals who stay in the NHS after they qualify. The high attrition rates, both during and after training, are increasing pressure on the NHS and driving up costs for the taxpayer. One in eight nursing students drop out during training, one in nine midwives do not join their profession after graduating and one in five nurses have left the NHS within two years, according to the Nuffield Trust think tank. For every five nurse training places, the equivalent of only three full-time nurses join the NHS. For every two GP places filled, only one full-time practitioner joins the GP workforce. Fewer than three in five doctors in "core training" remained in NHS hospitals and community services in England eight years later and half this attrition comes in the first two years. One recent survey found that a third of UK medical students planned to emigrate to practise medicine. When it costs the state about £64,600 to train a nurse and more than £175,000 to train a doctor in England, this is a waste of money as well as talent.

We propose that debt — averaging about £48,000 for each nurse at present — should be reduced by 30 per cent after three years, 70 per cent after seven years and 100 per cent after ten years for those who stay in the NHS. The Nuffield Trust has costed the policy at £230 million a year for nursing, midwifery and allied health professionals and an extra £170 million to include doctors. This would be partly offset by incoming changes to the student loan repayment system. The investment looks highly affordable when set against the benefits of improved retention and lower attrition rates during training. The plan would increase the number of applications to courses while also giving an immediate solution to the workforce crisis by encouraging newly qualified staff to stay in the NHS, resulting in a significant reduction in expensive agency staff.

Patrick Maxwell, regius professor of physics at Cambridge university and chairman of the Medical Schools Council, insisted that simply doubling training places was not enough because it would be ten years before the new recruits qualified as doctors. "I do think it's right to expand the number of medical students but I think more urgent to think about how to retain the doctors who are already there: make it less likely that they'll leave medicine and the NHS, less likely that they'll take early retirement or that they'll go to America or Australia or New Zealand," he said. "Innovation is very empowering." A loan forgiveness scheme would be very sensible, he said. When it came to student loans, "those sums are very big now and [you have to think] how do you avoid it having pretty serious effects for example on what kind of medicine people want to go and do? Do they want not to work in the NHS but in some sort of private medicine where they can make more?"

It is "clearly wrong" in his view that medical students do not get full maintenance loans for their full course. "They end up doing jobs alongside their medical studies. They end up qualifying with more debts and they may have payday loans," he said. "If we're going to double the number of medical students we certainly cannot carry on doing it exactly as we are."

The increase in medical school places also needs a commensurate rise in placement opportunities for trainee doctors. The private sector should be expected to support and fund medical training, including offering work placements to junior doctors and student nurses. The commission heard from private health providers that they would be willing and happy to do this as part of increased collaboration with the NHS.

Anne-Marie Rafferty, professor of nursing policy at King's College London, said there was now an urgent need to break the "doom loop" on workforce. "It's about workload, it's about wellbeing, it's about creating a sense of being valued, enabling people to have their breaks." She said that meant having enough nurses on a shift to look after patients. "There is a lot of research that demonstrates a lot of variation in patient mortality and outcomes and nurse staffing in the NHS. The imperative is to set a minimum level of staffing on each shift that triggers a red flag if breached."

St Bartholomew's Hospital in London has implemented a safe staffing review on every ward, with senior nurses deciding the appropriate ratio of staff to patients, which has improved care and morale. There does not need to be a national fixed "one size fits all" mandated staffing level from which managers can never deviate, and in any case technology will change the needs over time. But there should be guidance about what is safe, with matrons involved in local decisions. In Queensland, Australia, nurse-to-patient ratios were implmented in 27 public hospitals, with wards required to have an average of one nurse to four patients during the day and one to seven during the night in acute adult medical-surgical wards. Within the first two years, 145 deaths had been avoided as well as 255 readmissions, with estimated cost savings of US$2.2 million, and almost 30,000 hospital days saving an additional $20 million. In California, staffing shortages were alleviated by nurses returning to work after ratios were implemented. "The evidence is cast iron: it's better outcomes for patients, better outcomes for staff, lower burnout rates, higher retention," Rafferty said. "It's a win-win all round. Some people say it is cost neutral because you increase staffing but you save on complications, agency fees, readmissions and improved retention rates."

30%

The proportion of NHS staff that reported being 'burnt out' in a recent survey

Improving the working conditions for doctors, nurses and other healthcare professionals is not just important for staff but also for patient safety. The Mid-Staffordshire Hospital scandal, one of the biggest disasters in the history of the NHS, highlighted the connection between poor care and high mortality rates. Hundreds of patients suffered from the most appalling neglect and mistreatment. Some were so desperate for water that they were drinking from dirty flower vases. Many were given the wrong medication, treated roughly or left to lie in soiled sheets for days. Everyone agreed that it must never happen again.

Sir Robert Francis, who led the Mid-Staffs inquiry, told the commission, however, that he feared that some of the lessons that had been learnt at the time were now being ignored. "Amongst those, I would say the importance of staff, not only in terms of getting the right numbers and the right people in the right place. There was a recognition after Mid Staffs that staff needed to be treated better in terms of their working conditions and so on. I think that has been forgotten far too much. We hear a lot about pay ... but I'm absolutely convinced that at least part of the trouble we have today is because the staff do not feel valued. They feel exploited and they are treated in a way which, in a private sector organisation, would just not be tolerated. Their moral obligation towards patients is mercilessly exploited."

He warned that box-ticking was too often replacing a genuine focus on better care and putting patients at risk. "I was keen that places should be staffed to a level which would allow them to be safe. I don't think the current system is safe. You cannot be safe in the back of an ambulance in a queue outside an A&E department but safety has somehow, even within the CQC [Care Quality Commission], got some different connotation, which is about, 'I've got safe procedures.' Without actually, perhaps, enough focus on, 'Well OK, you've got safe procedures if they're being implemented. But are they?' "

Francis said he had hoped that his review would bring about a change in culture to encourage more openness and transparency, with staff having a "freedom to speak up" if they saw something wrong. "I think it's a recipe that could work. I fear there are places where it's not being done. People often say I was talking about regulatory change. Well, I was to some extent, but I was actually talking about cultural change. It never stops so unless you carry on pushing in one direction, you will go backwards. And I fear that, because of the sort of pressures we've got around at the moment, and have done for the last couple of years, there's a real danger of going backwards."

The commission heard many heart-breaking stories from patients and their families that show why this matters.

Roshana Medhian-Staffell, a trainee surgeon, was told that full-time surgery was not an appropriate career for a woman

“I’VE BEEN SEXUALLY HARASSED LOTS OF TIMES.

Roshana Medhian-Staffell, trainee trauma and orthopaedics surgeon

Sexual abuse and misogyny in surgery

Philippa Jackson, a consultant plastic surgeon from Bristol, was discussing a patient with a male colleague when he moved in to give her a hug. “He made some noises and rubbed himself against me,” she said. “And then, as he backed away, he said ‘You probably felt my erection then,’ and he also told me he could see down my top.”

The encounter seemed so at odds with the sterile, clinical setting of the hospital that she wondered whether she had misunderstood the situation. “I didn’t make a fuss because we were about to go into theatre and I don’t think I had properly registered what had happened,” she told the Times Health Commission. Later that evening she was back with the same colleague for an emergency operation. This time his behaviour was even more overt.

She wrote to the hospital detailing the incident but was discouraged from making a formal complaint. “They did an investigation, which was quite superficial. The questions to me were very much focused on, ‘Did you say no? Did you push him away? Did anyone see it?’ You’re made to feel it’s your fault.”

The man was not suspended and shortly afterwards Jackson left for another job. She has no faith in the system to protect her. “I’ve been a patient and it frightens me now to think what’s happening when I’m unconscious.”

One of the most shocking examples of the cultural problems in the NHS was the accounts that the commission heard about sexual misconduct and misogyny in surgery. A survey published in the British Journal of Surgery last September found that nearly a third of female surgeons had been sexually assaulted by a colleague over the past five years and two thirds had been sexually harrassed in or around the operating theatre. There were 11 instances of rape reported by surgeons to the study.

The research paper concluded that sexual misconduct was rife in surgery. Sexual banter and coercion have become normalised.

Roshana Medhian-Staffell, a trainee trauma and orthopaedics surgeon, described a “boys’ club mentality”. One male doctor told her that full-time surgery was “not an appropriate career choice” for mothers. “I’ve been sexually harassed lots of times,” she told the commission. “I’ve had people come into the sluice room [where waste is disposed of] and stand behind me and grind themselves on me.”

Surgery is still one of the most male-dominated parts of medicine. Although women make up more than half the places at medical school only 28 per cent of surgeons and only 15 per cent of consultants are female. There are high drop-out rates among female trainees. Surgical trainees rotate around different hospitals every year, making it hard to combine the role with family life. Female surgeons have higher-than-average miscarriage and infertility rates.

Even the surgical instruments are designed for male hands. Joanna Maggs, a consultant orthopaedic surgeon in Devon, described having to balance on a stool during operations. “The operating table height doesn’t go down quite low enough for me,” she said. “When you’re using big power tools it can feel quite precarious.”

Liz O’Riordan, who retired as a consultant oncoplastic breast surgeon in 2019, said she had experienced sexual harassment in two thirds of her surgical jobs over more than 20 years. “It was usually in theatre, when you're operating next to your boss, your superiors and your peers,” she said. “You're wearing thin cotton scrubs and you have full body contact. It was knuckle brushes on your breasts, touching your bum, comments about your sex life, lewd suggestions to make you blush.” She did not feel comfortable speaking about her experiences until she had stopped working as a surgeon.

One poll by the Nuffield Trust for the governing body of the Royal College of Surgeons of England found that 45 per cent of women said the difficulty of balancing work and family life had made them less likely to pursue surgery and 61 per cent of surgeons regretted the sacrifices they had made for the sake of their career. In 2021 the Royal College commissioned the human rights lawyer Baroness Kennedy of The Shaws to carry out a review of diversity and inclusion in surgery. She was shocked by what she found. “The evidence I had from women was that the culture was very male, the chat in and around the operating theatre for surgeons was often inappropriate,” she said.

The Royal College of Surgeons and NHS England promised to act after the commission published the accounts of sexual misconduct. Now the pledges must be acted on and working patterns reformed.

Patient safety

The devastating consequences of medical negligence in the NHS are made worse for families by a culture of blame that lengthens gruelling legal battles and prevents vital lessons being learnt from tragedy

Martha Mills was a bright, vivacious teenager who loved making silly videos on her phone, going to the park and drinking hot chocolate with her friends. She enjoyed reading, wrote her own stories and talked about being an author, an engineer or a film director when she grew up. “I’m as jolly as a jolly bird,” she used to say when she was young.

Then in 2021, a few days before her 14th birthday, she died of sepsis after a series of catastrophic errors by doctors at an NHS hospital. For her parents, nothing will ever be the same again. “There’s a sense of before and after,” her mother, Merope Mills, explained. “I look back at pictures and it’s like this life exists, this perfect life that you can’t get back to. And part of you can’t quite understand how. Even now it feels unbelievable to us.”

Martha’s father, Paul Laity, said his thoughts revolved around two questions: could he forgive the doctors who failed his daughter and could he forgive himself? “There are moments where I think I could have done something different and she would have been fine. When I visit Martha’s grave absolutely the first thing I always say is ‘I’m sorry.’ ” But he added: “I’m also angry with the hospital ... There was a catalogue of mistakes and inexplicable behaviour, systemic problems but also complacency and arrogance. When we reflect on it every day we don’t cease to be shocked.”

Martha’s death was entirely avoidable but over and over again crucial signs that could have saved her were missed. She was taken into hospital after a bicycle accident. The force of her fall had pushed her pancreas against her spine, causing a laceration and she was admitted to a specialist unit at King’s College Hospital in London. There she developed sepsis but she was not transferred to the paediatric intensive care unit quickly enough to prevent her organs becoming overwhelmed.

The doctors were high-handed, hierarchical and patronising. They knew that she had severe sepsis six days before she died but did not give her the treatment that would have saved her life. After a few weeks on the ward, Martha started bleeding profusely from the tubes in her arm and stomach. “It was very bad,” Merope said. “The nurses were waking me at night saying, ‘We need to change her because it’s gone all over her sheets.’ I’ve still got her blood-soaked pyjamas upstairs.”

When Mills raised concerns she was dismissed as an “anxious mother”. The nurses who registered that Martha was “at risk” were not listened to by the more senior medical professionals. “Looking back on it, I feel we were powerless, I feel we were kept in the dark about a lot of things,” Mills told the commission. “We feel like we let Martha down by trusting the doctors. I kept saying to her, ‘Don’t worry, you are in the best place. They know what they are doing.’ I really thought that was the case and I feel a fool now for thinking it.”

An inquest found that if Martha had been referred more promptly to the paediatric intensive care unit and appropriately treated then “the likelihood is that she would have survived her injuries”. Her parents blame the “consultant is king” attitude in the hospital. “This wasn’t about money,” Mills said. “We thought we were in the best place but in this instance the best place meant the worst place because it came with a kind of hubris, which meant that they thought they were in some way superior.” During the pandemic Martha and her sister Lottie banged saucepans and drew rainbows for the NHS. “We always said to the girls, ‘The NHS is one of the great things about this country,’ and I still think that, but I think that conversation has stopped people talking about the cultural problems in the NHS.”

Martha Mills, whose death from sepsis at the age of 13 led to calls for a “Martha’s rule” giving families the right to activate a critical care review

Mills and Laity have won cross-party support for their campaign to introduce “Martha’s rule” giving patients and families the right to activate a critical care review in hospital. They argue that more patient power will do something to change the attitude of those doctors who think they know best and do not listen to patients and families. The NHS is now implementing the reform and has promised to take on board the lessons from Martha’s death. Yet the commission heard too many heartbreaking stories from families who had lost loved ones and blame institutional flaws.

There are about 11,000 avoidable deaths every year in the NHS due to patient safety failings and thousands more patients are seriously harmed. In the year to March 2023 there were also 384 so-called “never events”, including laser surgery being performed on the wrong eye, ovaries being removed in error and swabs or surgical instruments being left inside a patient. Yet despite a litany of reports and inquiries following trauma and tragedy, the real “never event” is that parts of the health service never seem to learn. Last year the Institute of Global Health Innovation at Imperial College London found that, on patient safety, the UK was falling behind many other countries in the Organisation for Economic Co-operation and Development, including Norway, Finland, South Korea and Japan. The UK ranks 21st out of 38 countries and more than 17,000 lives could have been saved had it performed at the level of the top 10 per cent. Rob Behrens, the health ombudsman, who investigates complaints, believes that patient safety is being compromised by the “toxic” behaviour of some doctors in the NHS. “For all the brilliance of clinicians, quite often they’re not very good at working together,” he told the commission. “Time and again, the handover from one clinician to another, from one shift to another, or the inability to raise the issue at a senior level, has been a key factor in what has gone wrong.” He thinks there is a deep-seated lack of empathy in the medical profession that is embedded right from the start. “Talking to some doctors, the way in which they were trained at medical school, ten or fifteen years ago, emphasised the importance of being self-contained and confident in their judgment about what happens and I think that’s an element which is still there. What should be a collegiate, trusting environment is nothing of the kind.”

He said that he was “shocked on a daily basis” by what he saw as ombudsman and warned of a “Balkanisation” of health professionals, with rivalries between doctors and nurses or midwives and obstetricians harming patient care. Too often, “organisational reputation has been put above patient safety”, he said. “In the wake of Covid, but even before Covid, we have a deeply unhappy, un-listened to, stressed workforce that is not being properly led, from the board level down.” Doctors have a professional “duty of candour” to be open with patients and families when things go wrong but “there are lots of examples of people not being told the truth. The fines for duty of candour are tiny and it doesn’t change behaviour,” Behrens said. “There’s a toxicity in the relationship between clinicians which doesn’t help patients. We’re going through a cycle in which reports are commissioned, findings come out, recommendations are made. Ministers say, ‘This must never happen again.’ But it does and we’ve got to break that spiral.”

A decade ago, the health ombudsman looked into several sepsis deaths and concluded that there were systemic failings in the NHS’s handling of the condition but people are still dying from sepsis owing to the “same mistakes” that were identified in 2013, Behrens said. Over the past two years, 34 sepsis-related complaints have been upheld. There are about 245,000 cases of sepsis a year in the UK, including 25,000 in children. It is often treatable with antibiotics but about 48,000 people die from sepsis every 12 months because it is so frequently missed.

Melissa Mead’s son William was ten months old when he developed a nasty and persistent cough. She took him to the doctor three times over several weeks but at each visit she was reassured that it was just a normal childhood virus. Then one day, just after his first birthday in November 2014, the nursery rang to say that William was refusing food and had a temperature. He was teething but Mead felt that something more serious was wrong so on her way to collect him she rang the GP surgery again. It was the

depths of winter in rural Cornwall and there were no appointments available but she insisted that William had to see a doctor that day. By the time she got to the surgery his temperature had climbed to 40.1C and he was acting strangely but the doctor who examined his chest and ears insisted that everything was clear. He sent William home and told Melissa to give him some Calpol. "Don't worry it's nothing grizzly," he told her.

The following day, a Saturday, William's temperature had dropped dramatically to 35.4C. "He wasn't wetting his nappies, he was cold to touch. He wouldn't tolerate any clothes on him," Mead said. She did not know it at the time but William had gone into septic shock. She rang 111 but they ignored her concerns, telling her that it was good that she had the temperature under control. William was making a bleating noise, a sign that he was in severe respiratory distress, but the call handler said he was "bound to be whining if he's not feeling well", Melissa said. "I said he was being sick and it was green. They said, 'This is a non-urgent six-hour callback.'" In the morning she went into William's room. "We had blackout blinds so I couldn't see anything. I went over to his cot and I stroked his cheek. He didn't move. I knelt and put my arm through the bar of the cot and I stroked his arm, which was cold. He just didn't stir. I stroked his side and he was stiff. I shot up and I opened the blinds and he was very obviously dead. His eyes had fallen open and he was staring straight through me. He couldn't talk yet. His way of expressing love was through his eyes and he just wasn't there any more."

Screaming to her husband, Paul, in the next room, "He's dead, he's dead, he's not breathing," Melissa rang 999. The woman on the other end of the phone told her how to give her baby son mouth-to-mouth resuscitation. "I couldn't open his mouth to give him rescue breaths because he was in rigor," she said. Three minutes and 44 seconds later, the paramedics came thundering up the stairs. "They started CPR. Obviously they were doing it correctly and it looks violent on a baby. They cut his clothes off and he had red blood all down his left side." Mead was in tears as she relived the horror of that moment. "They turned to me after seven minutes, with the seven words that destroyed my life. 'I'm sorry, my love, but he's gone.'"

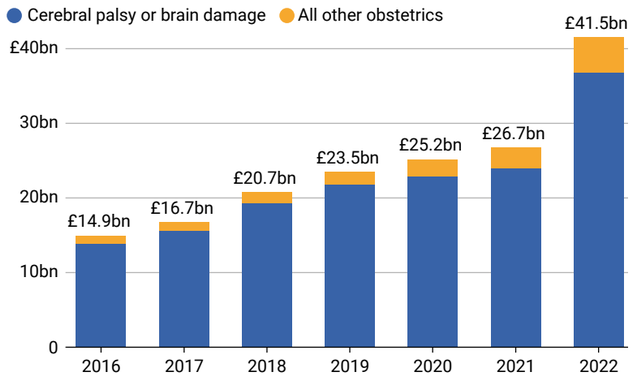
On Christmas Eve, just after Melissa had chosen her baby son's tiny coffin, the coroner rang. She told Mead that William had had pneumonia. When the doctor had examined him and given him the all clear on the day before he died one of his lungs had in fact already collapsed. The cause of death was sepsis, which had developed because the infection had gone untreated. "There is nothing worse than losing a child but knowing that he could have and should have been saved with better care was too much," Mead said.

The commission heard that there is a pattern of behaviour, with families and patients too often dismissed or ignored. Joshua, the son of James Titcombe, who was appointed as an adviser to the Care Quality Commission on patient safety, died when he was only nine days old at the Furness General Hospital, part of the Morecambe Bay NHS Trust, in November 2008 after a series of catastrophic errors. "An infection that could easily have been spotted after he was born wasn't," Titcombe told his fellow commissioners. He described how his family's life had been "turned upside down" by the tragedy but as he came to terms with the loss of his son what shocked him most was the NHS's response to the mistakes that had been made. He worked as a project manager in the nuclear industry, where safety is paramount and, as in the health service, the smallest error could be disastrous. "I was used to a culture of learning. In the nuclear industry if there was a rusty bolt in the wrong place there would be a really thorough forensic investigation and everyone would ask, 'What can we learn from this?' What I experienced from the hospital was the exact opposite of that. There was basically a cover-up. Medical records went missing. There were huge discrepancies between what my wife and I knew had happened and what the staff had reported as happening. It meant the trust didn't learn."

An inquiry, published in 2015, uncovered a "lethal mix" of failings in Morecambe Bay, which had led to the avoidable deaths of 11 babies and a mother between 2004 and 2013. Titcombe now runs the charity Patient Safety Watch. "Healthcare is incredibly complex, just as the nuclear industry is incredibly complex," he said. "Humans are fallible, there will be errors but what we've got to have is a healthcare system that's more resilient to errors so that systems are safer. Most importantly, we've got to have a culture where, when things do go wrong, the response isn't to single out the individual. We've got to have a culture that says, 'Right, this has happened, our priority is to look after the people who've been harmed to help them heal. And it's to learn in a safe way so that we can make the healthcare system safer.' We're making progress, but there's a huge amount more to do."

Costly claims

NHS financial liabilities for obstetrics litigation claims



SOURCE: NHS RESOLUTION

FIGURE AT YEAR-END INCLUDES CLAIMS YET TO SETTLE

Mid-Staffs, Morecambe Bay, Shrewsbury, East Kent: the list of hospital scandals is already long and the roll call of NHS shame is growing. In March 2022 the midwife Donna Ockenden published a damning report on maternity services in England. Her independent inquiry found that disastrous failings at the Shrewsbury and Telford hospital trust had contributed to the deaths of more than 200 babies and laid bare a culture of bullying, anxiety and fear of speaking out. She set out a series of "immediate essential actions", refusing to use the word recommendations because as she put it: "We've seen so many reports where recommendations come and go." She told the commission that, within days of her findings being published she had been contacted by families in Nottingham who had experienced the same culture of cover-ups and lies. She is now in charge of an inquiry there that will be the largest ever conducted in the UK, involving 1,700 cases. "We have all the systems and structures in place that should be able to spot maternity services in difficulty and here we are again," Ockenden said. "Families are having to fight to get answers. There was a failure to learn. Maternity services have to do more to genuinely and meaningfully put family voices at the heart of everything that is done."

While reluctant to use the word "crisis", Ockenden said maternity services were in a dire state, with a "demoralised and exhausted" workforce finding it harder to deliver kind and compassionate care. "We're talking about midwives working 12-hour shifts where they can't even take a loo break, let alone a lunch break. It's not sustainable," she said. "I think that without urgent and rapid action, from central government downwards — on funding and workforce and training — mothers and their babies are not going to be able to receive the safe, personalised maternity care that they deserve and should expect. That should be happening for all mothers across the country on a consistent basis and from what I hear I cannot be confident that that is happening every day in this country." She emphasised that most families did not want revenge or retribution. "Families say to me that they want the legacy of what's happened to their babies and themselves to be positive change: real meaningful lessons to be learnt, not just the glib phrase 'lessons will be learnt'," she said. "For a lot of families there were themes and there were trends and they were repeated. We're not going in the right direction, we're not getting the number of outstanding maternity services increasing in the way that we should. In fact my sense is that the numbers requiring improvement are increasing."

Childbirth is messy, painful and often dangerous but there is something going seriously wrong with maternity care in the NHS. More than half the 139 maternity units are classed by the Care Quality Commission as "inadequate" or "requires improvement" when it comes to safety. Analysis for the Times Health Commission found that the cost of compensating mothers and their families for harm caused by NHS maternity services is now more than double what the health service spends on maternity care each year. The total cost of harm from clinical negligence was £13.6 billion in the 2021-22 reporting year and 60 per cent was for maternity claims, amounting to £8.2 billion for the year. NHS England spends about £3 billion annually on maternity and neonatal services.

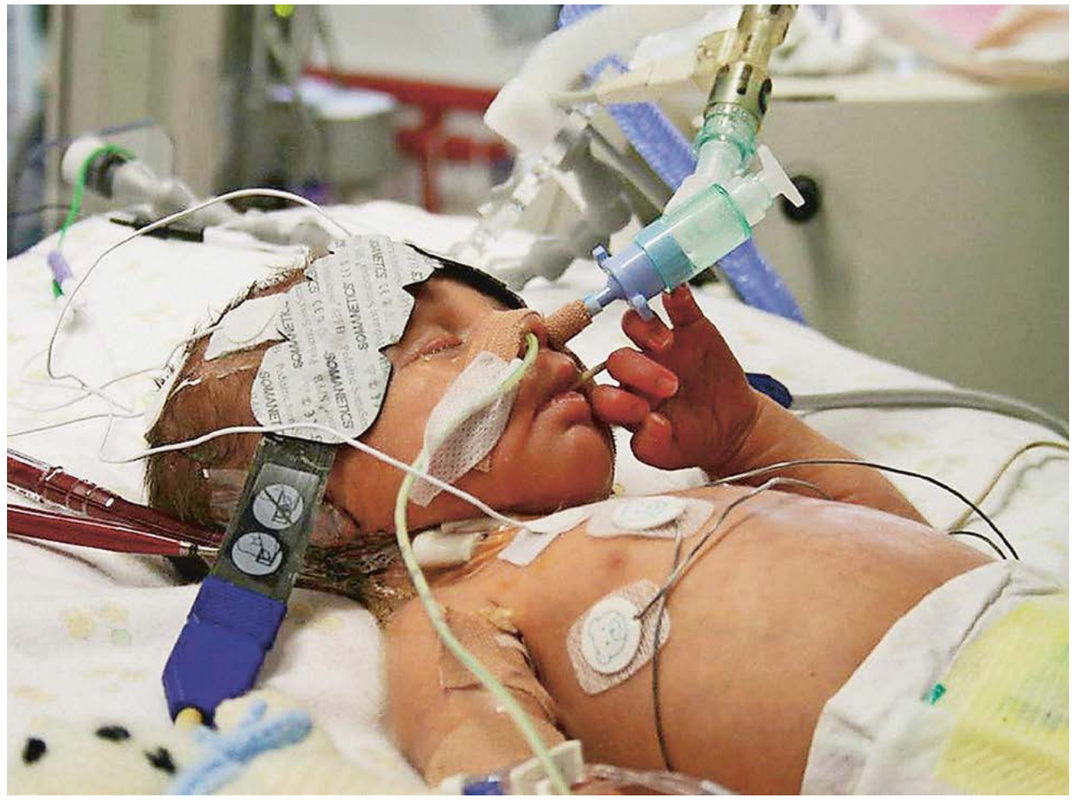
A survey by the parenting website Mumsnet for the health commission found that nearly a quarter of mothers said that the maternity care they received had left them or their baby in danger. Almost a third were not given all the medical care they needed at birth and 9 per cent said their baby did not get all the necessary support. Almost 60 per cent of respondents said they did not feel listened to by healthcare professionals. More than a fifth said the care they received had not been "kind or caring". Several said they had had post-traumatic stress disorder diagnosed as a result of the birth and some reported terrifying flashbacks. One mother had suffered "long-term trauma" since the birth of her baby. Having been refused an epidural, despite having requested one, she said the hospital "used me as a guinea pig for students to do my stitches, without anaesthetic and without my consent. It was barbaric and has put me off having another child." Another described being "left alone and for too long waiting for C-section. My previous scar ruptured and my son suffered a stroke on delivery. He now suffers from cerebral palsy."

Sir Mike Richards, former chief inspector of hospitals who is now chairman of the National Screening Committee, said that it was often the maternity wards that gave him most concern when undertaking Care Quality Commission inspections. "I looked into a whole lot of cases of things that had gone wrong and they were heart-wrenching," he said. "There was one woman who had had a locum midwife who really wasn't up to the job, who didn't call for help soon enough and, when they finally worked out that they needed to transfer the patient up one level into the obstetrics department, the lift was broken. It was just awful."

This is not just about individual error or incompetence, although those exist. Maternity care has a systemic problem. The lines of accountability are unclear because the units are run by midwives but when something goes wrong they have to call in the doctors. The dual power structure is unique in the NHS and there is also a cultural clash between the two professions.

60%

Proportion of mothers surveyed who did not feel listened to by clinicians



Joshua Titcombe died aged nine days after a series of catastrophic errors at Furness General Hospital

Midwives prefer to preside over "natural" births, while clinicians are quicker to turn to medical interventions. It makes it hard for them to work as a team. There is a hierarchy at work that compounds the problem. The midwives resent the doctors and the doctors look down on the midwives, leaving patients caught in the middle.

It is, however, just a more extreme example of the wider cultural problems in the health service. The Times journalist Sean O'Neill, whose daughter Maeve died in 2021 at the age of 27 after a long battle with myalgic encephalomyelitis (ME), described the "fundamental and systemic" failure to deal with a debilitating illness that did not fit into a conventional health service box. "There seems to be a really inbuilt prejudice that ME is either people malingering or it's a psychosocial condition and they need to pull their socks up," he said. "The cultural conservatism of the NHS is absolutely extraordinary. I think what happens with ME is mirrored right across the board. This is about attitudes and education." A similar pattern emerged in a study by Stirling University funded by the National Institute for Health and Care Research that found that children suffering from chronic pain, and their parents, "felt that healthcare professionals did not always listen to their experiences and expertise, or believe the child's pain". After repeated visits to health services "some children and families gave up hope of effective treatment".

Martin Bromiley, an airline pilot, described how his wife Elaine went into hospital in 2005 for a routine operation on her sinuses. It should have been a low-risk treatment but an emergency occurred while she was anaesthetised and she was starved of oxygen for twenty minutes. Thirteen days later she was dead. An independent review found that when things started to go wrong the doctors had not shared their concerns with each other and had also ignored more junior members of the team who tried to broach the subject. Again, lack of teamwork and hierarchical attitudes in the NHS were to blame.

As a pilot, Bromiley specialises in safety protocols. The airline industry has had a 75 per cent decline in the number of passenger deaths since the 1970s, despite a ninefold increase in the number of people flying. It has done so by setting out to learn the lessons from accidents, rather than attempting to apportion blame or cover them up. There has been a deliberate focus on identifying the "human factors" that improve safety as well as the technical procedures that must be followed. "If you behave a certain way it doesn't guarantee you won't have an accident but it gives you a greater likelihood of success and funnily enough it actually makes for quite a nice working environment," Bromiley explained. "It's about being inclusive, asking open questions and listening. What we have in healthcare is a set of systems that often make it easy to get it wrong and hard to get it right. In some cases, the behaviours that I see are disastrous for patient safety. If you can get the culture right then I think it would make safety a lot easier to achieve. It's about how humans interact, how humans work together and how humans best perform." He has set up the Clinical Human Factors Group to try to apply the principles adopted by the airline industry to the NHS.

The continuous improvement of patient safety should be a priority for all modern healthcare systems. There ought to be a virtuous circle in which clinicians work together to reduce patient harm. Yet several inquiries into serious patient safety failings have concluded that the health service is stuck in a vicious circle of buck-passing, cover-up, denial and blame. Actions that would increase patient safety are not implemented consistently and clinicians do not feel confident to speak out. Tensions between professionals create a culture where mistakes are more likely and the hierarchical structure means that the concerns of junior staff members are too often ignored.

These cultural problems are being compounded by a flawed compensation system that discourages openness and makes it harder for the NHS to improve its processes when things go wrong. The cost of medical negligence is spiralling and the commission heard that the total cost of outstanding compensation claims now stands at an astonishing £70 billion, almost half the NHS annual budget. Clinical negligence settlements can total millions of pounds and cases sometimes go on for a decade or more. Doctors, nurses and midwives know that their reputation will be destroyed if the court finds against them. The stakes are therefore incredibly high and the legal nature of the process means that the claimant has to prove negligence to get an award. That makes it very difficult for people in the NHS to admit to, and learn from, mistakes.

If a baby is brain-damaged at birth, the financial damages are calculated on the basis of their potential lifetime earnings. In what seems like an increasingly anachronistic arrangement, the formula takes into account their parents' salaries and education, which means that the largest payouts typically go to the wealthiest families. One London hospital was required to pay £37 million. For families, the process involves an agonising and lengthy court battle that can last for more than a decade during which they have to cover the costs of caring for a severely disabled child on their own.

The legal scholar Sir Ian Kennedy, who has led a number of public inquiries including the investigation into children's heart surgery at Bristol Royal Infirmary, said reform of the compensation system was long overdue. "We have a massive industry called clinical negligence litigation. The more the money claimed, the longer it takes to get it because the hospital or the doctor will resist. The big question is why in addressing this need do we have to find someone to blame?"

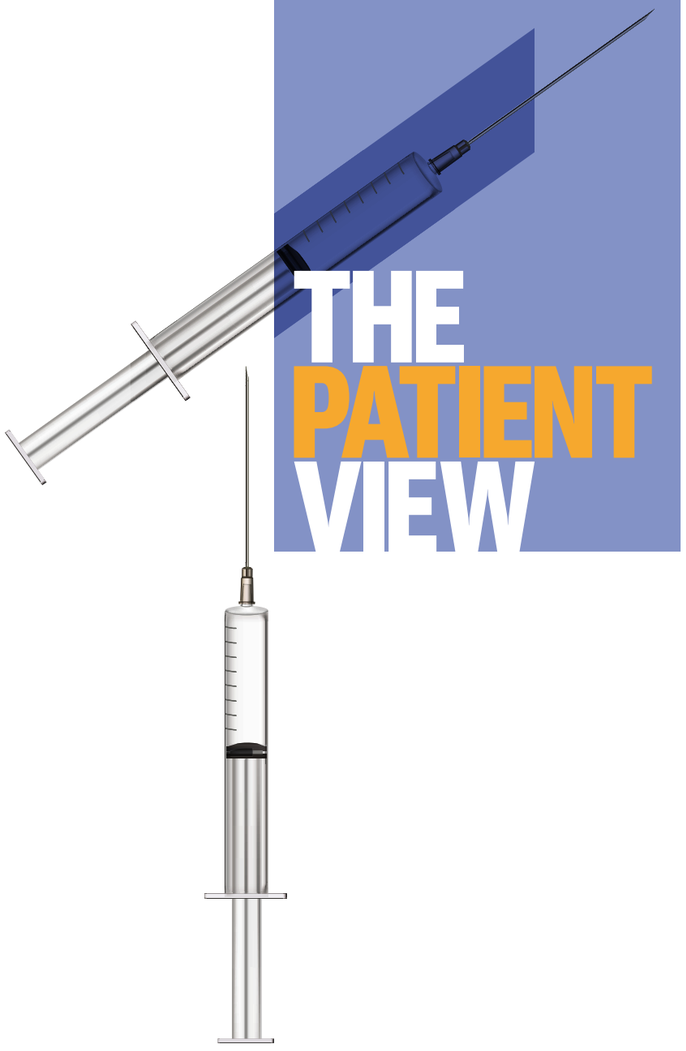
The commission recommends that the NHS should move to a system of "no blame" compensation, with settlements determined according to need rather than through a lengthy court battle. Patients and families would receive money more quickly and the health service would be more able to be honest about what had gone wrong in order to improve. The system would be similar to those in New Zealand, Sweden and Japan. Jeremy Hunt, the chancellor, was among many witnesses who supported such a reform. As health secretary he had been told that the policy was unaffordable because "most people don't sue the NHS when something goes wrong" and so moving to a no-blame system would increase the number of cases. "In fact, New Zealand, which pays everyone from a tariff, no question of blame, costs their health system less as a proportion of total costs than it costs the NHS," Hunt said. He pointed out that there was a "massive cost" to patient safety failings. "When you have a child born with cerebral palsy the doctors feel absolutely devastated, the midwives, the nurses are all devastated. They want nothing more than to be completely open and honest about what happened and learn the lessons and make sure they're not repeated. What do we do? Because lawyers get involved, people clam up, there's a court case, it takes five to seven years and in the end the parent will probably get the money they want, after a hell of a battle. But the one thing that needed to happen, which is that we learn from those mistakes so they're not repeated, is the thing that didn't happen. Someone who used to run one of the safest hospitals in the United States, called Virginia Mason, once said to me: 'The path to safer care is the same as the path to lower cost.'"

> "The big question is why we have to find someone to blame

Donna Ockenden said the present system often left grieving families penniless while they fought court cases that can last more for years. "I've listened to so many families who have been through that lengthy and combative and exhausting process. It cannot be right that until such time as the payments are made that families struggle," she said.

The change should be made alongside other reforms including the promised introduction of "Martha's rule", named after Martha Mills, which would make it easier for families to insist on a second opinion. There are 17 different regulators overseeing patient safety in the NHS. This is confusing, opaque and over-complicated for patients and staff. There should be a review of the regulatory landscape with the aim of creating a simpler, more easily understood system to bring clarity for patients and the health service. The health ombudsman, who can currently only respond to complaints, should have the power to initiate investigations and ensure that the outcomes of inquiries by other bodies are implemented in a timely fashion. Behrens told the commission: "In all professions there needs to be accountability to give people the incentive to change their behaviour. That doesn't exist in the health service at the moment."

For families, this is not about the money. Titcombe explained that the current compensation system "retraumatises" parents while discouraging improvements in care. "For families, the last thing on their mind is litigation," he said. "They want the organisation to learn and they want to heal."



THE PATIENT VIEW

Better digital records could avoid mistakes in the NHS, the commission's patient panel concluded. Scrapping junk food advertisements and depoliticising health and social care were also among the topics discussed by the 11 patients and service users (Georgia Lambert writes).

Patient-centred care is a longstanding goal for the NHS, but the consequences of failing to diagnose and treat the whole person are significant and patients such as Vipan Maini have been left in danger by inaccurate data. Maini, 57, a career coach, has had three heart attacks over the past decade. During his third admission to hospital 18 months ago an error in his notes left clinicians thinking he had undergone a quadruple heart bypass.

"Luckily I was still conscious," Maini said. "I didn't have a quadruple bypass. I had nine stents through the various heart attacks that I have had. The dangers of what could have happened due to data inaccuracy became clear to me on that occasion."

Before receiving a diagnosis Maini was told by his GP that his symptoms probably had a psychological cause and that he and his wife needed marital counselling. Gloria Nelson, 58, had to wait three years for her breast cancer to be diagnosed because her symptoms were mistaken for menopause.

The panel welcomed digital patient records but Ismail Kaji, 45, warned that their adoption had to be accessible to those with learning disabilities. Kaji, a parliamentary affairs officer at Mencap, called for easy-to-read documents and learning disability awareness training modules to improve interactions between clinicians and patients.

Donna Cook, 35, from Lanarkshire, had heart failure diagnosed at the age of 26 and praised technology innovation, specifically the My Diabetes My Way app for monitoring health and test results.

The panel emphasised the need for a more holistic approach to diagnostics and care, particularly when a patient has a number of rare or chronic diseases. Elvira Wynn, 63, left her nursing job because of chronic migraine, which remains one of the most underfunded and under-recognised medical diseases worldwide, and vasculitis, a rare autoimmune disease causing inflammation of the blood vessels.

She said: "I was absolutely committed to it [the NHS] as a nurse and getting the patients the best possible care that they could, but where I think it often fails is that it's a one-symptom way of looking at things. When people go to the GP, they have five or ten minutes to discuss one problem. Sadly, this means that rare diseases are missed significantly because they can often be multi-system."

The panel unanimously advocated for patients to see the "right consultant at the right time" to prevent delayed care and misdiagnosis. Tim Atkinson, 57, an author from Lincolnshire, was "batted around" different departments in the hope of receiving an effective treatment plan.

Atkinson, who has chronic pain, emphasised the importance of nuance and providing patients with tools to manage their conditions. He warned, however, against substituting painkillers with unconventional treatments without careful thought. "Ten years ago I was routinely prescribed strong opioids and the dose escalated without any hesitation," he said. "Then the brakes took hold and I found myself unable to get them at all."

Ananga Moonsinghe, 76, had dementia and died last year. He told the commission that his social care was not funded. He said: "I feel like a second-class citizen. People with cancers are treated far better because they say that [Alzheimer's] is an old people's disease."

Nick Richardson suffers from degenerative arthritis and said that this problematic one-size-fits-all approach extended to pain-management services, hindering collaboration between departments. He was medically retired from the Royal Navy in 2012 and enrolled on a specialist pain-management course at the Stanford Hall Military Rehabilitation Estate in Loughborough, Leicestershire. "I received state-of-the-art care where I could see a physiotherapist, a consultant, a sports rehab, an occupational therapist and a social worker," he said. "They treated me in a holistically rounded way but that is not the case with the NHS. They are very siloed."

Maini later emphasised the racial bias in clinical trials and said that medication was often tested only on white people. "If you don't fit the mould it causes chaos within the system," he said, adding that he had observed "critical failures in leadership" in NHS trusts, evidenced in a deep-seated cultural flaw in the NHS that "prevents it from learning from past mistakes".

Norman Phillips, 71, who supports a Hospital at Home team to care for his wife, who has dementia, said the government was hesitant to tackle the flow between emergency and social care because it wasn't "sexy". He added: "Older people in hospitals are a problem and we need to get them out of acute care. It's the worst place for them because they get no stimulation. That's the problem with my wife: if you don't keep talking to her she goes downhill very quickly. You pride yourself that you've done 20,000 operations but what happens if 5,000 of those need never have been done because the person was looked after at home?

The digital health care team in Bracknell uses a virtual ward to identify at-risk patients and take action before they reach crisis point

"We've still got this war between social care and hospital care ... let them throw more money at the NHS but that's not understanding the system. We're losing care workers because they are not being paid enough. We've got away from what it was intended to be and we've settled for an ever-growing National Sickness Service." He believes that not only should social care workers receive pay parity to those in the NHS, but they also need to feel valued.

The panellists agreed that investment in prevention was the key to the health of future generations. Martin Emmerson, 64, from Sussex has type 2 diabetes and feels that if prevention methods such as banning advertisements of junk food to children were used, there was a chance of "stopping the tidal wave".

The patient advisory panel

Gloria Nelson
Ismail Kaji
Norman Phillips
Martin Emmerson
Vipan Maini
Nick Hartshorne-Evans
Elvira Wynn
Nick Richardson
Donna Cook
Tim Atkinson
Ananga Moonesinghe

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Science and technology

A digital health account for all patients could open up the benefits of data, AI and an integrated health system. The development of the Covid-19 vaccine showed what could be achieved when the government, the NHS and academia work together and further research by medical professionals should be encouraged

Clara Canbolat, 2, is in Great Ormond Street Hospital with the rare condition galactosialidosis. She has dialysis at the hospital for up to twelve hours, four days a week, but her parents are hoping that she will be accepted on to a gene therapy trial in the United States costing £2.5 million

At Singapore General Hospital, robots deliver medicines, pick drugs for prescriptions and wash equipment. Patients arriving for a clinic register using an app on their mobile phone, sign themselves in at touchscreen kiosks and receive a printed schedule that gives them the time of their scans, tests and appointments throughout the day. Computer records are all connected and data shared between GPs and hospital staff. Prosthetic limbs and medical devices are created by 3D printers.

It is part of a wider drive in Singapore to transform healthcare through technology. Patients can access their medical records, book appointments, see test results or referral letters and browse useful tips on a digital "Health Hub". The Singaporean government has a partnership with Apple, called Lumi Health, that encourages people through an app on their Apple Watch or iPhone to complete fitness challenges and eat well. If they meet their weekly activity goals they receive financial rewards.

In Estonia there is an online patient portal with an app to access medical records, read test results and book appointments. In Denmark patients have a credit card-sized medical card to access services that they tap on a card reader when they arrive at A&E or use to pick up a prescription at the pharmacy. In the US, the Mayo Clinic in Minnesota has dozens of data analysts working alongside its clinicians and has created more than 180 AI models for improving healthcare. Its virtual wards have expanded to include emergency medicine and neonatal care, with specialists providing real-time expertise to local doctors in rural hospitals across the Midwest.

The commission visited the Souravsky Medical Center in Tel Aviv, Israel, before the Gaza conflict began. A robot was showing patients around the emergency department. People registered digitally, identifying themselves through facial recognition, then measured their own blood pressure, temperature and heart rate in "self-triage booths". In the control room upstairs banks of screens showed bed capacity and operating theatre slots, using AI to predict surges in demand and reallocate staff. Surgeons operated with headsets that allowed them to visualise the inside of the patient's body. Innovation was encouraged.

Around the world technology is turning healthcare on its head in the same way that it has shaken up other industries. Personalised medicines, precision gene therapies, robotic surgery, AI diagnostics and predictive data analytics are no longer the stuff of science fiction and if used across the NHS will dramatically boost productivity, cut costs, reduce burnout among staff and improve outcomes for patients. Since the pandemic there is a clear appetite for reform. More than 33 million patients have signed up for the NHS app. Two million appointments are booked and 600,000 repeat prescriptions ordered on it every week.

New solutions are emerging within the health service. Northumbria Healthcare NHS Foundation Trust successfully introduced drones for transporting chemotherapy, which has a limited shelf life, quickly and efficiently. On the south coast, medication that would normally take four hours to get from the manufacturing unit in Portsmouth to the Isle of Wight, via taxi and hovercraft, arrived in 30 minutes by drone. "We are bringing on-demand delivery to healthcare," Alexander Trewby, chief executive of the drone company Apian, founded by two NHS doctors, said. "We think it's wrong that a patient can get a pizza delivered to their bedside but it takes a couple of days to get their lab test turned around."

The NHS is rapidly adapting but there is a long way to go. About 10 per cent of hospitals are still entirely paper-based and the health service has spent more than £1 billion on storing paper medical records over the past five years. A survey by NHS Providers for the health commission found that 61 per cent of trust leaders were not confident that the potential of digital ways of working was being fully exploited. Although most companies have switched to emails, large parts of the health service still rely on paper letters. A YouGov poll for the commission found that 7 per cent of people said that they or a member of their family had missed an NHS appointment because a letter had not arrived in time.

The systems that do exist are often hopelessly outdated and slow. One study found that doctors were wasting 13.5 million hours a year on inefficient IT. Computers can take half an hour or more to switch on. The health service still has more than 600 fax machines and 79,000 pagers. Sarah Clarke, president of the Royal College of Physicians, said that when she was on call during the junior doctors' strike she discovered that she could not cut and paste data while writing up the discharge summaries and had to retype each document, a ridiculous misuse of a senior consultant's time and more likely to lead to mistakes. Social care is even further behind.

The NHS has spectacularly underinvested in technology over many years, repeatedly raiding the capital budgets that fund IT projects to chuck money at the latest winter crisis. Tim Ferris, professor of medicine at Harvard Medical School who was NHS England's national director of transformation until last September, said the health service lagged far behind other organisations in its spending on IT. "There is a very large international bank that spends 12 per cent of its budget on its tech and data," he said. "An organisation undergoing a major tech transformation typically spends in the 8 to 10 per cent range. Several large healthcare organisations in the United States are spending 4 to 5 per cent. NHS trusts have told me that they spend in the 1.5 per cent range."

Joe Harrison, chief executive of Milton Keynes University Hospital who is also NHS England's digital lead, said that every £1 spent on technology generated between £3.50 and £4 in savings. At his trust doctors use voice-recognition technology to transcribe their notes automatically during ward rounds, saving time and reducing paperwork. There is a Harry Potter-style "marauder's map" to track staff and equipment. The hospital is also handing out 2,000 Apple watches to diabetes patients that they will be able to keep if they exercise a certain amount every

day. The programme will pay for itself if a single amputation is avoided.

Some hospitals and GP surgeries are using data and technology to streamline their activity and improve efficiency but the health service as a whole is woefully fragmented. The commission heard that there were "between forty and sixty" different types of electronic patient records within the NHS. Matt Hancock recalled joining a hospital night shift about a month after being appointed as health secretary. "I went to the nurse who was standing directing operations around the emergency department. He had two screens, and he said, 'It's a total nightmare. This screen is for majors and this screen is for the hospital as a whole and if somebody goes from majors into the hospital, then I need to physically type all of the information that we've got about them so far.'"

The federated data platform, which will start being used across the health service in the spring, is a step in the right direction. If successful it will bring together different databases within the hospital system and allow health professionals to access more information about their patients. Privacy campaigners have raised concerns that the American data analytics firm Palantir, which has worked with intelligence agencies and military organisations, is involved in the contract but this is not the main issue. Palantir will not be able to access, use or share data for their own purposes. The real problem is that the platform does not include GP or social care data and so services will still not be properly integrated.

There are vested interests in the health service that are reluctant to reform. The British Medical Association (BMA) spent years threatening legal action against plans to give patients automatic access to their own medical records. That change was implemented last October but the BMA is still refusing to endorse data-sharing with the UK Biobank research programme, even though patients have given consent for their records to be handed over. Some of the specialist bodies are holding out against attempts to use AI to speed up test results. Technology is a threat to the medical establishment because it will alter the power balance between doctor and patient.

The commission believes that the NHS and social care system must fully harness the transformative power of technology and data to empower patients, liberate doctors from bureaucracy, introduce more choice and drive efficiencies. A digital health account should be created for all patients, as exists in Estonia, Denmark, Spain, Singapore and Israel. The "patient passport" would be accessed through the NHS app and could be used to book appointments, order repeat prescriptions, view test results, read referral letters and, in time, arrange social care. GPs, hospitals, paramedics, pharmacists and social care providers should all have access to the data when necessary to provide seamless care for patients.

There must be a single system, available across the whole country, that everyone can use and understand. This is the only way to ensure fair access for patients and secure the full benefits for the NHS. The medical records held by primary and secondary care providers must be integrated and as the technology develops social care should be included. The data should be owned by patients, with different bits of the NHS and social care system able to access it when necessary. People should be able to see who has been looking at their information. Tech providers wanting to work in the NHS must be required to guarantee interoperability with the unified patient record.

The patient passport will allow treatment to become much more personalised, predictive and preventative. People will be able to receive automatic reminders about vaccines or screening programmes and be sent information that is relevant to their own health condition. Everything from fitness advice to details of medication could be included. Patients should also be able to use the app to sign up for medical research, in order to get access to the latest diagnostics and treatments. Over time the health record could be connected to wearable technology such as a Fitbit or Apple Watch enabling people to receive individual health advice in real time based on their own heart rate, blood pressure or sleep patterns. Genetic information could be added if patients agreed. Instead of being given an NHS red book, babies would receive a unique digital code.

Vinod Diwakar, medical director for transformation in NHS England, confirmed that the idea was deliverable if resources were available. "We know it's technologically possible because other countries in the world have done it," he said. "I think we do have to recognise that whilst we've made a lot of progress we've still got an awful lot more to do." The NHS needs a long-term digital strategy, backed up by a guarantee that the capital funding to implement it will not be siphoned off. To support the project the NHS must ensure that all staff have the basic IT skills they need and recruit data scientists and AI specialists.

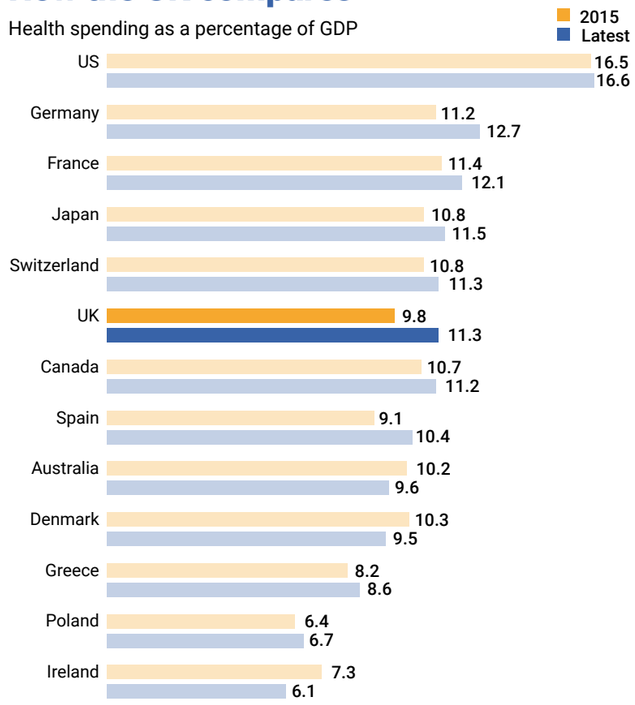
There must also be a grown-up debate about data privacy. If the tax office and banks can keep sensitive financial information secure then there is no reason why the NHS cannot protect health data. A YouGov poll for the health commission found that more than 80 per cent of respondents backed the introduction of a digital health account and the proposal was also widely supported in the commission's patient panel and focus groups. In addition 68 per cent of the public would be happy for their medical records to be shared between clinicians and 56 per cent said it was more important to them to be able to easily book appointments, order prescriptions and view their medical records than to protect the security of their records. Any privacy concerns were outweighed by the prospect of convenience and efficiency. Many participants felt frustrated that they had to repeat their story a number of times.

Sir Keir Starmer, the Labour leader, described meeting the parents of a boy with a life-threatening heart condition who had expressed their frustration at having to repeat the same details to different parts of the NHS. "Common sense has got to come first," he told the commission. "Talk to any parent or patient

> "Without better use of technology the NHS as we know it will not be able to function

How the UK compares

Health spending as a percentage of GDP



SELECTED COUNTRIES. SOURCE: OECD

about whether they want to keep on relaying the same information over and over and over and you will get a resounding 'no'. Ask them whether they think that one hospital should share their records with another hospital when they're about to treat them and they would give a resounding 'yes'. Privacy, of course, is important and it has to be protected but it has to be proportionate."

Of course there are reasons to be cautious. The health service has a long history of failed IT projects that makes ministers and civil servants nervous. Last year Babylon Health, the tech start-up championed by Hancock as health secretary, went bust having received millions of pounds from the NHS. The story of the failed blood-testing firm Theranos, whose founder Elizabeth Holmes was convicted of fraud, is a warning that the new frontier of medicine is still a Wild West. Ethical questions are raised by the role of genetics and AI. It is crucial, for example, that the databases used to train the machines are representative of the population so that, for example, the technology is equally effective with all skin colours.

The commission proposes the creation of a British Data Authority to reassure patients that privacy will be protected and deal with ethical concerns while allowing the advantages of data-sharing to be made available to ensure the best possible care. This is similar to the Danish Data Authority, which has successfully guided the country through the digitisation programme and ensured that the correct balance is struck between openness and security. Face-to-face or telephone consultations should always be available for patients who are not comfortable with technology but the evidence presented to the commission suggests that most people would welcome a more streamlined and proactive system.

The patient passport would be a game-changer for the NHS that could unlock other technological solutions. Homerton University Hospital in east London has introduced an e-triage system in A&E that uses a digital questionnaire accessed through a wall of iPads to manage demand. Next it is going to add ground-breaking technology that will use the iPad camera to measure blood pressure, heart rate, respiratory and oxygen levels remotely in seconds by analysing subtle changes to blood flow under the skin. The doctors who have seen it in action say it works in a similar way to facial recognition technology. They hope it will further reduce waiting times and flag up potential sepsis cases, which are notoriously hard to spot in a busy emergency department. Once the patient passport is in place people will be able to identify themselves instantly and pull up their medical record on arrival at the hospital or GP surgery by touching their phone or medical card on a reader.

The digital health account would also allow the NHS to make better use of its data for medical research. Sir Paul Nurse, the Nobel prize-winning geneticist and director of the Francis Crick Institute, said there was a "gigantic opportunity" that is talked about but not delivered. "We have a national healthcare delivery system, which should also be a national health research system and I do not think it is operating effectively in that way," he told the commission. "If we can position it as a system where you are helping the nation and helping your fellow citizens to be involved in this, it's like the clapping for the NHS, they would participate and yet we don't encourage that. The NHS controlling the data, accumulating the data and using it for the benefit of the people is a one-line blindingly obvious thing to do."

More than a million people have joined Our Future Health, a research programme funded by government and industry that carries out health checks to accumulate data. More than half of the first 100,000 patients who went through the system discovered that they had cholesterols that should have been treated, highlighting the benefit of the project. The UK Biobank, which recently released the DNA sequences of 500,000 people along with their de-identified medical records, highlights the huge value of NHS data for scientific research. It is already being used by 30,000 scientists from 90 countries looking for clues about how to prevent and treat disease and paying for access to the genetic treasure trove. Sir Patrick Vallance, the former chief government scientific adviser, said: "I am strongly of the belief that healthcare data could be hugely beneficial for the way we run the health service and hugely beneficial for the way we think about understanding diseases and creating new treatments."

The NHS must be ready to capitalise on the developments in medical research that are emerging as scientists harness the power

of genomics and AI. Algorithms will be able to transform the prediction and prevention of disease by generating a risk score for each patient using a mixture of genetic and environmental factors. Sir Peter Donnelly, professor of statistical science at Oxford University and chief executive of Genomics, said that people at high risk because of their genetics were 30 times more likely to get diabetes, 20 times more likely to get heart disease, 15 times more likely to get breast cancer and 40 times more likely to develop prostate cancer. "These people are at high risk because of their genetics, but they're currently completely invisible to the NHS," he said. "There'll be a world in which, instead of this very clunky one-size-fits-all system, we can target all the money that's currently spent on screening and prevention programmes much more effectively."

The potential of AI diagnostics is enormous both to accelerate treatment for patients and to relieve workforce pressures in the NHS. At Huddersfield Royal Infirmary, AI has slashed the time it takes to read chest x-rays from seven days to seven seconds, reducing the workload of radiologists by a third and allowing the hospital to identify patients with suspected lung cancer more quickly. The clinicians were initially nervous and double-checked all the scans that the machine said were "normal" before giving patients the all-clear but Adrian Hood, a consultant radiologist, told the commission: "It was always right."

In Birmingham, the NHS has introduced a dermatology tool that works a bit like the Plant Identifier app, using artificial intelligence to analyse a photo of a mole and assess whether it could be cancerous. In Leeds researchers are investigating whether AI-enabled mammograms should be introduced for breast cancer screening. In Cambridge artificial intelligence is reducing the amount of time cancer patients wait for radiotherapy by allowing specialists to plan the treatment two and half times faster than if they were working alone. Meanwhile an AI embryo selection tool used by some fertility clinics has improved the chances of a healthy pregnancy by as much as 30 per cent.

The Brainomix AI-enabled CT scanners that are operating in 24 hospitals across England have tripled the number of stroke patients who recover with no or only slight disability by virtually halving the time it takes to get them from the emergency department to a specialist stroke unit. "We are at a tipping point for AI in healthcare," said Lionel Tarrasenko, president of Reuben College, Oxford, and a leading expert in machine learning. "We really have got the evidence that machine learning does as well as human experts."

A wider medical revolution is under way. The commission visited one of the NHS trial sites for the Galleri blood test, which is designed to detect more than fifty types of cancer before symptoms appear. If successful, this could be used by a million patients within months. So-called "liquid biopsies", which detect tiny fragments of tumour DNA in the bloodstream, also allow doctors to sequence the precise genetic code of the cancer meaning that they can target it with the most effective treatment. Professor Sanjay Poppat, a medical oncologist at the Royal Marsden Hospital and the Institute of Cancer Research, London, said the innovation was "totally transforming" the treatment of lung cancer. "[Before the test] I would have patients walking into my clinic who would be breathless, coughing, on oxygen," he said. "The only thing we could give to those patients would be chemo and that would often be fatal because it would just be too strong for them. Now we can take a sample of the patient's tumour, put it through the gene sequencer, analyse it, find the genetic alteration then take a tablet from the shelf and within three days the breathing is normalised. Instead of living days, weeks or months, patients are living years."

As well as seizing the opportunities offered by science, the health service must do more to head off threats. This includes reducing the inappropriate use of antibiotics and investing in the development of new drugs. In 2019 drug-resistant bacterial infections directly caused 1.27 million deaths and contributed to 4.95 million deaths around the world. If drug-resistant infections continue to rise at their current rate it is estimated that 10 million people will die globally because of AMR by 2050. There should be a "test first" rule for antibiotics where possible to reduce the number of prescriptions. This needs to go hand in hand with educating doctors and patients about the dangers of antibiotic resistance. Lord O'Neill, author of an independent review on antimicrobial resistance, cited a study that showed that by using "affordable state-of-the-art diagnostics you could almost definitely reduce unnecessary prescription by 40 per cent".

The NHS should also start to prepare for the impact of climate change, which is likely to accelerate the spread of infectious diseases and make future pandemics more likely. Sir Andy Haines, professor of environmental change and public health at the London School of Hygiene and Tropical Medicines, told the commission that there could also be a rise in tick-borne diseases and zoonotic diseases, where a pathogen jumps species from animal to human.

The rapid pace of biomedical research, combined with genomics and AI is revolutionising the way disease can be screened for, diagnosed and treated. Robert Lechler, former president of the Academy of Medical Sciences, described new fields of discovery that mean that "we should in the next decade be aiming to cure diseases rather than simply palliate and help people to live with long-term conditions. That's not something that medicine has been able to contemplate in its history before. In order to translate those fantastically exciting discoveries into patient benefit we need to have a health service that is research-receptive and research-engaged." Last year Britain became the first country to authorise a medical treatment that uses a revolutionary gene-editing tool known as CRISPR to reverse the symptoms of sickle-cell disease, possibly permanently. Another study is sequencing the genomes of 100,000 babies to assess the feasibility of screening newborns for rare genetic conditions. In time the heel prick already given to all children at birth could be turned into a more comprehensive test used to find those at risk so that the defective gene can be altered or removed.

There has also been a wave of new therapies targeting the immune system. Peter Johnson, NHS England's national director for cancer, said: "In the last decade there has been an explosion of knowledge about what works and what doesn't work in terms of getting the immune system locked on to tumours." He predicted that within five years patients would be given vaccines instead of chemotherapy or radiotherapy to help to clear up small numbers of remaining cancer cells.

The venture capitalist Dame Kate Bingham, former head of the vaccine task force, said the next step could be personalised cancer vaccines to prevent disease. "You go into Boots and you get your bloods done and they say you've got some risk of colorectal cancer or whatever it might be. They vaccinate you against it. You are then protected in a way that is much more similar to infectious disease rather than presenting with stage 4 metastatic cancer, for which there's nothing you can do."

Some of the new treatments will need flexibility from the NHS and different funding models. Car-T therapy for rare cancers is one highly innovative therapy that involves bioengineering the patient's immune cells to kill off tumour cells. The treatment, given to the patient via an infusion after their cells have been modified in a lab, is currently delivered in centres that usually do bone marrow transplants. It is hugely expensive but it provides a one-off treatment that appears to be curative. Julian Cole, medical director of Gilead and a spokesman for the Cell and Gene Collective, said we needed to make sure, "the NHS is ready to implement and has the capacity to do so".

Sir John Bell, regius professor of medicine at Oxford University, believes that scientific discovery is moving faster than at any time in his 40-year career. "The pace of innovation in medicine is greater now than I've ever seen it," he said. He warned, however, that despite some courageous trailblazers the health service was failing to capitalise on the enormous opportunities offered by science and technology.

The life sciences industry is one of Britain's most successful sectors, employing more than 280,000 people and contributing £94 billion to the economy every year. One study found that every £1 invested in medical research delivered a return equivalent to about 25p every year for ever. Yet the number of patients enrolled into commercial clinical trials by the NHS has dropped by 44 per cent in five years at a cost of almost £1 billion to the health service and far more to the wider economy. The UK has fallen from 4th to 10th in the world ranking on commercial clinical trials.

Susan Reinow, managing director of Pfizer UK and president of the Association of the British Pharmaceutical Industry, said the process of getting a clinical trial running in the UK was "incredibly slow" compared with other countries. The vaccine development and distribution during the pandemic showed "how extraordinary it can be when you have industry, government, the NHS and the academic sector all working together."

Paul Naish, head of UK corporate affairs for AstraZeneca, said his company had been concerned about the direction in which Britain was heading for some years. The UK "did some amazing things during the pandemic but an awful lot of them were because we suspended normal ways of working", he said. "In the pandemic times it was: how do we get to where we need to be as fast as possible? Business as usual is taking one step forward at a time, cautiously, cautiously. The crisis is so great we don't have that luxury."

The Conservative peer Lord O'Shaughnessy, who conducted a government review of commercial clinical trials, warned that there had been a "really precipitous decline" in clinical trials since 2017. "Research doesn't have a high enough priority in the NHS," he said.

With the health service under such pressure, research has often been sidelined to deal with more immediate concerns but the evidence suggests that healthcare organisations that embrace research produce better outcomes for patients and higher staff morale. There is also a financial benefit. The O'Shaughnessy review found that the total direct cost of the near halving of commercial research activity over the past five years had been about £360 million with another £570 million in lost earnings. The Sheba Medical Center in Israel has a portfolio of tech start-ups worth $2 billion, with another $2 billion generated through collaboration with the private sector.

The bureaucratic process for clinical trials and medical approvals should be speeded up. A new funding mechanism must also be created for expensive curative therapies, allowing the NHS to spread the cost over years, based on long-term cost-benefit analysis so patients can benefit from the "new age of cures". More must be done to ensure that research thrives. The commission proposes that some staff time should be ring-fenced, including giving 20 per cent of hospital consultants and other senior clinicians 20 per cent protected time for research. The ambition should be that all healthcare organisations including hospitals, GP surgeries and mental health trusts should take part in and promote research. Patients could sign up to be contacted about research through the digital health account.

The health service is at a tipping point, which means that it can no longer afford to ignore the transformative power of science and technology. Tony Young, a surgeon from Essex, founded four start-ups as a junior doctor and says he "had to fight the health service the whole way". Now he is in charge of innovation at NHS England and has recruited 1,100 NHS staff to his clinical entrepreneur programme. Between them they have founded nearly 500 companies and raised more than $1 billion. "At the moment we have 15,000 centenarians in the UK," Young said. "When the NHS turns 150 in 2098, it is predicted that there will be 1.5 million centenarians. How do we deal with that? Technology has to have a key role to play. People say, 'There's a risk of doing something new.' Let's measure that risk, let's mitigate that risk, but let's look at the risk of the status quo because you could come to harm while waiting to be seen."

30%

Improved chance of a healthy pregnancy by using an AI embryo selection tool

CANCER BLOOD TEST TRIAL

The slogan on the side of the trailer standing in a car park in Gillingham, Kent, declares: "This unit could help us detect cancer early." Inside, nurses are taking blood samples from volunteers taking part in a groundbreaking NHS clinical trial that could revolutionise the diagnosis and treatment of cancer.

About 140,000 people are involved in the study of a test that can detect more than fifty types of cancer before symptoms appear. Mobile testing clinics have been touring eight areas of England, collecting samples from participants aged between 50 and 77. The Galleri test, produced by the US healthcare company Grail, identifies tiny traces of DNA shed into the bloodstream by tumours.

Ellie Saadati, one of the nurses at the Gillingham site, said she knew of several participants who had had cancer diagnosed after the blood test. "One lady had a good friend who happened to be on the trial as well, and he had the DNA detected. It was bowel cancer so now he's having treatment for that." The public had been "hugely supportive".

Rita Hasemore, 54, was returning for her second blood test. "If we can catch the cancers early that's the best thing for everyone," she said.

The preliminary results of the trial are expected early this year and if the pilot programme is successful the test could be offered to a million people from the summer. Amanda Pritchard, chief executive of NHS England, said last year that the test had the potential to "transform cancer care for ever".

Peter Johnson, NHS England's national clinical director for cancer, told the Times Health Commission that the test could eventually be offered routinely on the NHS. "If we can prove it works and if it really does mean that we can diagnose cancers earlier and if doing that means that people are less likely to die from their cancers, then we would expect to turn it into a new national screening programme," he said. "What we do know is that we are getting people writing to us saying, 'I've been part of this great big trial and you've found this cancer and I've just had it removed."

Some experts warn that a national screening programme could risk high numbers of "false positives" causing anxiety for patients and increasing pressure on the NHS. Doctors hope, however, that the test could boost cancer survival rates and save money by enabling much earlier diagnosis. "A lot of people don't have any symptoms at all or have only very minimal symptoms before the cancer has already spread to other parts of the body, which makes it much more difficult to cure," Johnson said. "One of the big appeals of this particular blood test is not only that it tells you that there may be a cancer growing somewhere, but the particular patterns of alteration that you can see in the DNA give you a hint about where in the body it may have been taking place."

CHEMO DRONE DELIVERIES

NHS patients in Northumbria were surprised to see colourful drones whizzing overhead last year as part of a groundbreaking trial to speed up the delivery of medicine and equipment that is now being introduced across the country.

The pilot ran between February and May last year along a route from Wansbeck General Hospital at Ashington up to Alnwick Infirmary and on to Berwick Infirmary, improving efficiency and cutting carbon emissions in a large, predominantly rural patch.

There were 240 drone flights over the three months, covering more than 6,600 miles and reducing the delivery time by road by more than 175 hours. The environmental benefits were demonstrated by a reduction of almost 1,480 kg of carbon emissions, the same amount absorbed by 62 trees in a year.

Professional drone operators flew the fully electric aircraft, which take off and land vertically like a helicopter and fly horizontally like a plane by combining fixed wings with rotors. They carry up to 3kg and have a maximum speed of almost 70mph.

There were 15 flights a day, delivering chemotherapy medication to Alnwick and on to Berwick. Return flights delivered blood pathology samples to Wansbeck. Blood packs, prescriptions, medical equipment and mail were also delivered.

Sir Jim Mackey, the former chief executive of Northumbria Healthcare, who commissioned the trial and is now moving to run Newcastle Hospitals, said drone delivery had the potential to transform logistics in the NHS. "It's working really well so it's definitely got a role to play," he told the commission. "If you think of rural Northumberland in the middle of January and there's six foot of snow, and you're an old person living by yourself, it's genuinely game-changing. Every year we have a short period where we're thinking, 'How are we going to look after these people when all the roads are closed?' "

Alexander Trewby, chief executive of the drone company Apian, said the next step was to "light up London" with drones delivering blood tests between Guy's and St Thomas' hospitals. "Eventually we will do this up and down the land and create a network of drone corridors and drone delivery systems so you can have a surgeon in Essex have a device delivered from Nottingham. The benefits of drones aren't just speed, it's also about being more reliable and smarter. You're able to give a couple of minutes' window when the drone is going to arrive whereas who knows when it's arriving by van? If you have a reliable delivery mechanism then you can start to consolidate your stock."

1 2 3 4 5 6 7 8 9 10

Social care

The population is ageing but policy has not kept up. Successive governments have promised and failed to fix social care, which continues to be seen as the poor relation of the health service

Joan Bakewell is a broadcaster, campaigner, author, university president and member of the House of Lords. At the age of 90 she is more active than most people half her age, even turning up to vote in parliament last year with a chemotherapy pump attached to her body. Yet she says that she is still sometimes patronised and ignored. “As you get older you have less and less voice,” she told the commission. “However much you get together and make statements and issue reports you are, nonetheless, judged to be at death’s door. There’s a real problem with people who are ageing and the attitude of society to them.” This is, she thinks, what explains the failure by successive governments to find a solution to the policy conundrum that is social care. “Money will always help but I just think the attitude of society at large is in need of a real kicking. There’s a feeling that older people are over the hill; they’re not of any use. Social care needs people to care more.”

Rishi Sunak is just the latest prime minister to kick the can down the road on social care, having announced soon after arriving in Downing Street that reform would be delayed until October 2025, after the next general election. Boris Johnson promised to “fix” social care, declaring from outside No 10 on his first day as prime minister that he had an “oven ready” plan but he did not deliver. Theresa May abandoned reform after it was dubbed the “dementia tax” during the 2017 election campaign. David Cameron passed legislation but never implemented it. Gordon Brown’s policy was denounced as a “death tax” by the Conservatives and came to nothing. Caroline Abrahams, the Age UK charity director, said the elderly population had been led on a wild goose chase by politicians. “The transformational rhetoric is not being matched remotely by reality,” she said. “We’re still living, 75 years on from the foundation of the NHS, with social care as an afterthought. It’s got to the point now where politicians are frightened to think about it and view it as in the ‘too difficult box’.”

The political failure over more than two decades has left many people approaching old age “as though they’re standing in the middle of the road with a lorry driving towards them and the best they can hope for is that they die before the lorry hits them”, Sir Andrew Dilnot told his fellow commissioners. Dilnot, the author of the landmark government review on the funding of social care, said it was “very distressing” to see social care still at the bottom of the priority list. “We have at the moment in this country people who need care who wish they would die to help their families. We have people who need care whose family members sometimes can’t help thinking, ‘Gosh I wish X would die.’ This is not a civilised way to behave.” He believes there is an “invisibility” to the problems in social care that do not exist in the health service. “We don’t find looking at old age comfortable,” he said. “It’s a bit scary. Incontinence is not something we like thinking about. Old people look a bit wrinkly.”

The crisis in A&E departments over the past year has highlighted the consequences for the NHS. More than 13,000 people who are medically fit to go home are stuck in hospital beds, many of them because there is no social care provision. The Institute for Fiscal studies found that a 31 per cent reduction in spending on older people’s adult social care was associated with an 18 per cent increase in A&E admissions and a 12.5 per cent increase in A&E readmissions within 7 days. Lord Darzi of Denham described seeing this play out on a daily basis in the health service. “I do a ward round every morning and 40 per cent of the patients have social care problems. They are sitting in first class seats, which have intensive care support, operating time attached to them, highly specialised nursing. The way we are running this is just completely illogical.”

And of course the impact is not just on the NHS. “From a humanity perspective, the way we’re treating our elderly is absolutely dismal in certain parts of the country,” he said. “It’s inhumane.”

The moral and demographic case for creating a fairer and more sustainable social care system is overwhelming. By 2050 there will be 2.6 million people over 85 in the UK, meaning that there is an increasingly urgent need to act. Already too many elderly people are being left without adequate support. According to Age UK, 1.6 million older people in England do not receive the support they require for activities essential for living; 2.6 million over-fifties have some kind of unmet need; and 76 people are dying every day while waiting for care. The proportion of over-65s in the most deprived areas lacking care is twice as high as in the least deprived. The true scale of the problem is likely to be even higher. An additional 470,000 people are waiting for an assessment of their needs. Those who do not receive help are more likely to have a fall and end up in hospital, setting in train a cycle of admission, delayed discharge and readmission.

There is a postcode lottery, with patchy and often inadequate publicly funded provision. Access to care has been unfairly rationed and nearly a third of people who request state support do not get it. Self-funders are increasingly cross-subsidising state support because the money paid by local authorities does not cover the costs. The system is complex and confusing, creating huge anxiety for individuals and their families. Some have to sell their homes to pay for care. The uncertainty makes it hard for people to plan and reduces the incentive for providers to invest in improving services. Two thirds of those who have had contact with adult social care services were dissatisfied with them. Last year the Care Quality Commission rated 21 per cent of nursing homes and 18 per cent of residential care homes as either “inadequate” or “requires improvement”.

> “I just think the attitude of society at large is in need of a real kicking

The social care market is in a fragile state. The combination of increases in mortgage rates, energy bills and the minimum wage has left many providers teetering on the brink of collapse. The commission heard of one care home whose energy bill had increased by 600 per cent and others have had large rises in the premiums for the liability insurance they require to operate. Some insurers have withdrawn altogether from the care home market after the pandemic, creating more instability. Last year two thirds of councils reported that domiciliary care providers in their area had “closed, ceased trading or handed back council contracts” affecting more than 8,000 people. The impact is disproportionately felt in disadvantaged areas, where care homes do not have as many self-funders to cross-subsidise council-funded places and care “black spots” have developed.

The workforce crisis in social care is even greater than the one in the NHS. There are 152,000 staff vacancies in England. The vacancy rate dropped last year because there were high numbers of international recruits but it is likely to rise again after the introduction of new controls on visas for overseas care workers. The Care Quality Commission found that more than half of adult social care providers in England were having challenges recruiting new staff and almost a third were finding it difficult to retain those that they did have. The staff turnover rate is 28 per cent and almost a quarter of those working in adult social care are on zero-hours contracts. The average pay last March was £10.11 an hour, down 35p in a year. There is a growing salary gap with equivalent roles in the NHS. When people can earn more at the local supermarket, call centre or hospital, it is not surprising that care homes are struggling to recruit and retain staff for emotionally draining, insecure jobs. Figures from local authorities show that about 170,000 hours a week of home care cannot be delivered because of a shortage of care workers. Between 2010 and 2018 spending on adult social care fell by 12 per cent, after adjusting for a growing and ageing population.

There is now an urgent need to act. Almost one in five of the UK population is over 65. By 2050 it will be one in four. We cannot afford to wait any longer to fix social care. Politicians do not want to find the money to pay for reform but this is a false economy because far greater costs are piling up in the NHS instead. It is in any case cruel and irresponsible to leave so many vulnerable elderly people and their families to fend for themselves rather than sharing the burden across society. As Dilnot put it: “The amounts of money that we’re talking about in terms of the effects on the public finances are really very small. It just seems very sad. Lives supported by care can be really fruitful and good. It’s a mistake to think that this is just God’s waiting room and there’s nothing going on there. It matters because 80 per cent of us are going to need social care.”

The state must underwrite the costs of social care because the private sector will never take on

such an unpredictable risk. One in seven adults aged 65 face lifetime care costs of more than £100,000 but there is no way of knowing where the expense will fall or who will be liable. "We have no idea whether we're going to be walking up Snowdon fully fit at 92 or whether we and our partners are going to need ten years of residential care with terrible dementia or chronic arthritis, which could easily cost more than a million pounds," Dilnot said. "Without risk-pooling people are exposed to unbelievable levels of risk, which are paralysing. We can only do this together. We wouldn't dream of saying, 'Save up enough just in case your house burns down.'" There is also the fundamental unfairness that at the moment if you get cancer all your care is paid for by the NHS but if you have Alzheimer's you are responsible for costs that can total hundreds of thousands of pounds.

The commission recommends the creation of a new National Care System giving everyone the right to appropriate support when they need it. Equal to but different from the NHS, the NCS should be administered locally and delivered by a mixture of the public and private sectors, as now, but with national guidelines, registered providers, minimum standards for users and employment rights for workers. There should be a single booking system, giving people a simple way to access support and more choice and control over the care they receive. Families and individuals would have a list of registered providers they could trust and be able to request an assessment or book care online through the patient passport, with telephone or face-to-face help offered as a back-up for those who need it. A statutory duty should be imposed on local authorities to provide information, advice and assistance.

Independent providers should receive a fair rate and be required to sign up to national standards on care quality, workforce and financial conduct in return for a licence to operate. This would mean greater consistency across the country, reinforced by a national NCS brand that would help to generate pride in the care service. The new system must be backed by a workforce strategy. Social care was a glaring omission in last year's NHS plan and all future strategies should be integrated. Care workers will need to be better paid, over time rising towards parity with NHS staff doing comparable roles. There should also be better career paths, routes to promotion and management.

The NCS would help to arrange support for everyone, regardless of income but, as now, wealthier older people would pay some care costs up to a cap. At the moment people with assets over £23,500 get no state support at all and people with assets of £14,250 start to lose their funding. These levels have been frozen for more than a decade. The cut-off point should be higher and should also, in the future, rise with inflation to ensure that it keeps pace with the real-world cost of living. The commission looked at the alternative option of free personal care as in Scotland but the evidence suggested that this would be prohibitively expensive and would not in any case solve one of the main problems because the system is based on a set weekly payment that does not usually cover the full costs and so some people still face catastrophic bills. According to the Health Foundation, introducing a Scottish model and providing basic protection for all in England would cost £6 billion a year in 2026-27, rising to £7 billion by 2035-36 without giving the necessary reassurance. Introducing an NHS-style model of universal and comprehensive care could cost up to £17 billion a year by 2035-36. We believe that it would be better to introduce a form of social insurance, underwritten by the state.

> "There are millions of family carers but they are being forgotten

The government has in fact already legislated for a cap on social care costs, as recommended by the Dilnot commission, which would mean that nobody would pay more than £86,000 over a lifetime. The changes were due to come in in October 2023 but have been delayed. This reform must now be introduced as a matter of urgency and the cap should apply to all care costs, including means-tested council funding (reversing the government amendment that means that only private contributions should be counted). According to the Health Foundation, the cost would be about £500 million in 2026-27, rising to about £3.5 billion by 2035-36 but this is already factored into the Treasury's plans. "Reform is not unaffordable," the health foundation analysis concluded. "If it chooses to, government can afford to provide a better, fairer and more generous social care system in England ... The cost of the cap equates to around £4.25 per household per week, or about the same as households spend on insuring home and contents." Successive prime ministers have backed such a plan and the recommendations have twice been endorsed by parliament so it is time to get on with it. The cap on care costs should also drive up standards by creating a viable market in provision. People who can afford to do so will be more willing to spend more at the start of their time in care knowing that there is a limit on the total they will have to pay so they will not run out of money even if they end up needing long-term support.

The expectation should be that people will stay at home rather than go into residential care. There will always be times when a care home is the right place for a patient but there ought to be a greater emphasis on prevention to enable more people to live independent lives. Those who need it must have the right to a social care assessment. Over time this should become a routine part of getting older. On a visit to Denmark, the commission heard that all Danes are automatically given an appointment at the age of 75 that allows the municipality to be much more proactive and take action to stop problems developing or elderly people having falls.

In Manchester, Bernie Enright, the director of adult social services, has managed to balance the books, an extraordinary feat, by putting in place an extensive reablement programme that has slashed demand for care. When people come out of hospital they are given a short-term intensive package that might include installing equipment, making home adaptations or physiotherapy. As a result, 61 per cent of users are discharged with no care needs at all and a further 11 per cent have had a reduction in their needs. Enright likes to quote the late archbishop Desmond Tutu: "We've got to stop just pulling people out of the river, and go upstream and find out why they're falling in." She said: "We're getting people out of hospital, we're assessing them in their own home — or as close to home as possible — and supporting them to be independent." There is also a strong collaboration between the NHS and social care in Manchester with jointly funded intermediate care units to reduce bed-blocking. These should be expanded around the country. The NCS should work closely with the NHS to ensure that care packages are in place when people need them. The two systems must be able to communicate with each other digitally, using a single patient identifier linked to the patient passport.

Technology can help to boost efficiency and empower staff but is often lacking in social care. The NCS should primarily be managed digitally, giving an incentive to providers to adapt. Some trailblazers are already seeing the benefits of modernised systems. The digital domiciliary care company Cera, which works with a hundred local authorities across Britain providing in-home support for the elderly, has an algorithm to plan carers' routes and reduce travelling time. This means that staff typically deliver two extra visits a day and receive 30 per cent higher take-home pay, which has transformed recruitment and retention rates simply by better allocating resources. The company also uses artificial intelligence to match hospital patients with home carers, meaning that they can be discharged five times faster than before. Another tool allows it to predict and prevent hospital admissions, tapping into a huge database to identify tiny danger signs. The founder Ben Marathappu, a former A&E doctor, said the technology was able to predict 80 per cent of emergencies a week before they occured and carers had been able to reduce admissions by 70 per cent by taking preventative action. "Our mission is to stop hospitalisations and to keep people at home," he said. He estimated that last year, at the height of the winter crisis, Cera was saving the NHS £1 million a day through reduced hospital admissions and accelerated discharges. If the model were used across the country, that could save up to £5 billion a year. The company is now trialling sophisticated sensors in elderly people's homes that allow continuous monitoring of patients anywhere in the house and can predict if someone is about to have a fall.

Martin Green, the chief executive of Care England, which represents care home providers, said wearable technology could transform the quality of care for the elderly. "I saw a person who was living with advanced dementia and they had been into hospital five times in four months because of urinary tract infections. They were then fitted with a very cheap, small Fitbit, which identified changes in body temperature and activity patterns. For the last 11 months of that person's life, they never went back to hospital, because proactive medicine meant they could be treated in their home." Care homes should, Green suggested, become "the centres of support for people who have long-term conditions" in the community, with drop-in services and flexible respite care to help with changing needs.

It is important to remember that social care is not just about older people. Working age adults account for half the budget and their needs are just as worthy. The commission proposes that, as part of the NCS, those who are born with a disability or develop a care need before the age of 25 should automatically be entitled to free social care. The cost of this would not be enormous because most already receive support but introducing a universal right would simplify the service and reduce anxiety for users. At the moment parents cannot leave assets to a disabled child without them losing their social care entitlements. There should also be more respite provision for unpaid carers and a review of the minimum income guarantee for disabled people to ensure that it is fair and reasonable.

Care must be personalised to the needs of the individual, with an increase in the number of people receiving direct payments. Sir Ed Davey, the Liberal Democrat leader, described worrying about the future for his disabled son, John. As a teenager he also cared for his mother when she was dying of cancer. "There are millions of family carers but they are being forgotten," he said. "Most do it because it's the right thing to do and they want to do it but for many of us our greatest worry is what happens when we are not there to care for loved ones because no one can look after them like we can."

The National Care System will require funding, but there is also a cost attached to not investing in reform, to individuals, the NHS and the wider economy. The UK is facing significant labour market shortages and being an unpaid carer is one reason people stop working before they reach retirement age. The Fabian Society has calculated that providing some paid support would increase the employment rate for this group of unpaid carers by 8.7 per cent.

Analysis for the commission by the Health Foundation think tank found that the total additional funding required by 2032-33 is

Population in England

By age group and percentage of the population

Age	Population	Proportion
0 to 4	3,067,382	5.4%
5 to 9	3,340,505	5.9%
10 to 14	3,496,358	6.1%
15 to 19	3,298,659	5.8%
20 to 24	3,435,925	6%
25 to 29	3,719,711	6.5%
30 to 34	3,991,299	7%
35 to 39	3,859,912	6.8%
40 to 44	3,685,992	6.5%
45 to 49	3,479,246	6.1%
50 to 54	3,866,701	6.8%
55 to 59	3,853,765	6.8%
60 to 64	3,381,076	5.9%
65 to 69	2,825,807	5%
70 to 74	2,657,736	4.7%
75 to 79	2,283,780	4%
80 to 84	1,437,673	2.5%
85 to 89	904,542	1.6%
90 and over	520,329	0.9%

SOURCE: ONS

£8.3 billion a year to simply meet future demand, £11.6 billion to meet future demand and improve access to care. To meet future demand, improve access and pay for more care, for example with higher wages, would cost £18.4 billion.

It is not the role of the commission to make tax policy but we would suggest that about half the money should be raised from older people rather than the working-age population. This is the proportion of the budget that is spent on elderly care. There are now more millionaire pensioners than older people living in poverty. More than a quarter of pensioners live in households with property and pension wealth of more than £1 million. As Lord Willetts, the former Conservative minister and president of the Resolution Foundation, said: "When tax is already rising and the younger generation are not enjoying the increases in living standards that previous generations enjoyed, making it a further tax burden on them is not generationally fair."

The Resolution Foundation has costed some options for measures that would ensure that older people paid a fair share of the costs of social care. For example, scrapping the pension triple lock (which guarantees that the state pension will rise in line with whichever is higher of prices, earnings or 2.5 per cent) to a simple earnings uprating would raise £14 billion a year (in today's terms) by 2041-42. Means-testing the winter fuel payment that is given to 12.5 million pensioners would save

11%

Proportion of prescriptions that are paid for. Free medication cost £17bn in 2020-21

about £1.8 billion. Changing the rules to make all employees and employers pay national insurance, regardless of age (at the moment people do not pay it after they reach state pension age, currently 66) would raise about £1.2 billion. A more radical version would be to switch the incidence of NICs paid to the pensions drawdown phase, which the Resolution Foundation estimates would bring in revenues of more than £4 billion a year once it is fully phased in. In Japan people pay a higher tax rate when they reach 40 to reflect the rising costs of social care. Increasing national insurance for older workers in this country would raise almost £3 billion a year.

The government could also consider making more people pay for prescriptions. At the moment only 11 per cent of prescriptions are paid for because there are so many exemptions. According to the Institute for Fiscal Studies, free prescriptions cost £17 billion a year in 2020-21 and 60 per cent of those were for those aged over 60, at a cost of £10 billion a year. Raising the age at which people became eligible for free prescriptions to the state pension age would be logical and generate significant revenue. Another idea would be a new higher band for council tax. The amount raised would depend on the level at which it was set. There are many options but to govern is to choose and whoever wins the next election cannot continue to ignore social care.

We need to think differently about the ageing process. Older people should not be kept out of sight and out of mind. The Nightingale House care home in Clapham, southwest London, has a nursery on its premises. Children take part in singing, gardening and cooking with residents. Judith Ish Horowitz, who runs the nursery, said the benefits were clear for all ages. "For the older people it gives them a sense of purpose, community and a reason to get up. The children develop a connection with history and they learn about the natural cycle of life in a very unthreatening way." Most care workers are female so nurseries in care homes could also benefit staff.

There should be more initiatives to encourage interaction between the generations. A National Volunteer Service should be created for young people to work in care homes and visit the elderly or long-term disabled. This could be part of a National Care Apprenticeship open to all 18 to 25-year-olds, paying the living wage, or a reduction in university tuition fees, with accredited training as a route into health and care roles. All medical students should be expected to spend some time in a social care setting during their training to help to break down barriers between the two sectors.

Developers must be encouraged to create more sheltered housing and intergenerational homes with a new planning class of "housing with care". Other countries have already embraced such ideas with powerful effect. In the Danish city of Aarhus the House of Generations combines affordable housing with residential care home and nursing home places, student accommodation and a kindergarten.

The commission visited Japan, which, with the highest life expectancy and one of the lowest birth rates, has the greatest proportion of elderly citizens in the world. Almost a third of the population is over 65 and 15 per cent is over 75. An extra 690,000 care workers will be needed by 2040 to cope with the rapidly ageing population. There are robots in care homes and a "Restaurant of Mistaken Orders", which operates pop-up evenings. It is staffed by people with dementia. "They may or may not get your order right," the website says. "However, even if your order is mistaken everything on our menu is delicious and one of a kind." The aim is to spread a feeling of "openness and understanding" of ageing.

Japan is further down the same track along which Britain is trundling with increasing speed but policymakers there are focused on helping people to age well rather than simply limp towards the end of life. Their aim is not just to improve life expectancy but to boost healthy life expectancy and it is working. Tama City, a suburb of Tokyo, was once a gleaming new town, built to cope with an expanding population during Japan's economic boom fifty years ago. In the 1970s its apartment blocks were full of young couples, attracted by the green spaces and modern development only thirty minutes from the centre of the capital. But now those bright young things have grown old, their children have moved out and Tama has become a symbol of Japan's greying society.

In 1989 only 5 per cent of the population in the suburb was over 65; now it is almost a third and in another 20 years it is projected that 40 per cent of the population will be elderly. The number of children has dropped sharply and the city hall occupies a former school. There has been an exodus of businesses as well as wealth, with many shops boarded up around the crumbling estates. By 2025 officials predict that almost one in four elderly residents will be bedridden and one in seven will suffer from dementia. To make matters worse the suburb is deeply unsuitable for frail elderly people. It is built on steep hills and most of its five-floor housing developments have no lifts.

Instead of sinking into decline and despair, however, the local mayor, Hiroyuki Abe, has declared that Tama should become what he calls a "healthy-happy city". A network of pedestrian walkways has been laid to encourage people to walk around the town rather than get into their car. Specialist exercise equipment has been installed in parks and instructors offer fitness classes to prevent "tripping" and "wobbles".

Tama City has more than 1,400 "silver volunteers" who do gardening or cooking for the community in return for a token fee. A hollowed-out shopping street has been turned into a hub for charities offering help with grocery shopping, laundry and using a smartphone. In the local café, the chef is in her seventies. Elderly people, some wearing traditional *yukata* gowns and slippers, gather daily for a lunch of fish, rice, vegetables and miso soup, which is delicious and costs 500 yen (£2.50). There is a "brain health class" designed to ward off dementia, weekly exercise classes for the elderly and an octogenarian football team. The star player Mutsuhito Nomura, 83, is a former member of the Japanese national side. He recently declared: "If possible, of course I want to keep playing until I'm a hundred."

The aim, according to Abe, is to allow more people to live independently at home for as long as possible. The number of those requiring hospital treatment or social care has dropped and there is a gap of only 18 months between healthy and unhealthy life expectancy at 65 in Tama City, compared with more than a decade in Britain. As a result, the social care insurance premiums that the municipality is required to pay have been reduced. "In the end it saves money," Abe said.

Case study Robot carers in Japan

A robot stands at the front of a meeting room where 30 elderly people are gathered at the Shintomi care home in Tokyo. Pepper, a singing and dancing machine with big black eyes, jug ears and a screen on its stomach, is an integral member of the staff. It sings and dances, leading the group in a music and movement session.

Shintomi has more than twenty types of robot, which use artificial intelligence to soothe, entertain, support and stimulate its forty residents. On a table to the side of the hall a small robotic dog wags its tail and turns its head towards an elderly man who speaks to it. When asked to do so Aibo sits and offers a paw, then rears up on its hind legs to be patted.

Across the room, an old lady strokes a furry seal that blinks and nods its head in response to her movements. Paro, the world's most therapeutic robot, has been shown to reduce stress and anxiety among dementia patients.

The residential care home, part of the Silver Wing Social Welfare Corporation, has been pioneering the use of technology for almost a decade. There are exoskeletons that help the elderly to walk, muscle suits that give extra strength to the carers and motion sensors that detect when someone has fallen out of bed. The home has communication robots, empathy robots, toilet support robots, fun robots, caring robots and monitoring robots.

Residents of the House of Generations in Denmark have neighbours of all ages

“IT HELPS YOUNGER ONES TO MATURE AND GIVES BACK A JOY OF LIFE TO OLDER ONES.

Anne Bents, 24, kindergarten teacher at the House of Generations, Aarhus

Mental health

The pandemic has left behind an epidemic of depression, anxiety, self-harm and tics. Young people have been badly hit, which means it is a crisis with long-term consequences

When Anne Longfield became the children's commissioner for England in 2015, young people would often talk to her about their mental health. "They said they knew they couldn't get help and treatment easily because there just wasn't enough help to go around," she told the Times Health Commission. "Some said, 'We know that we've almost got to try and take our own life before we can get help.' And I thought that was pretty shocking at the time. Now, young people are saying not only do they have to try to take their own life, they have to try and take their own life several times and they say there will be an assessment of levels of intent within that."

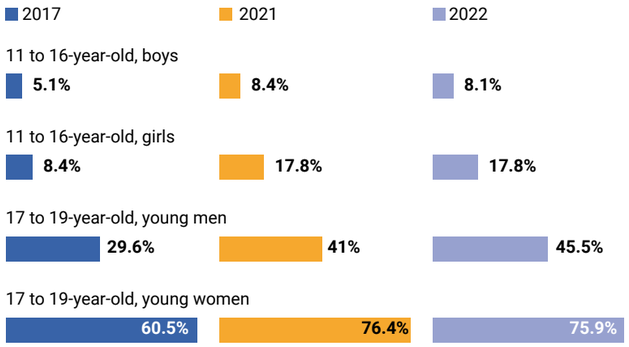
The pandemic has left behind a mental health crisis in Britain, across the whole population but particularly among the young. The number of children and young people with a probable mental health disorder rose from one in nine before the coronavirus crisis to more than one in five last year. Almost a quarter of those aged 17 to 19 had a diagnosed problem. More than a fifth of young women had an eating disorder, a thirteen-fold increase in five years. There have been big rises in anxiety, depression, self-harm and tics. When half of adult mental health problems emerge before the age of 15, and three quarters before the age of 18, this is an immediate crisis with long-term consequences.

NHS data suggests that the cost of living crisis is compounding the sense of unease created by Covid-19. A quarter of children aged 8 to 16 with a probable mental health disorder had a parent who could not afford for their child to take part in activities outside school, compared with a tenth of those in good mental health. Children from the poorest families are four times more likely to have a problem than those from the richest households. They are also often the least able to get support. Climate change, war, terrorism, floods and famine have left many young people with an underlying fear about the world they are growing up in. The buzz of social media is constant and in some cases pernicious.

Tamsin Ford, professor of child and adolescent psychiatry at Cambridge University, said the pressure on the NHS was "absolutely horrendous" for those working with the young. "They are playing catch up, they are seeing more children and young people than they ever used to. The deteriorating mental health is demanding that and so we need to get smarter. We need to be skilling up everybody who works with children to manage the minor issues and to be able to differentiate between them and more serious problems. We need to be teaching people about how to look after themselves. We teach them about physical

Increasing challenge

Percentage of children and young people screened for possible eating problems



SOURCE: NHS DIGITAL - YOUNG PEOPLE MENTAL HEALTH SURVEY

health, we ought to be helping them understand what stresses them out."

There are long waiting lists and ever stricter criteria for NHS help. Analysis by the children's commissioner for England found that half the 1.4 million young people with a probable mental health disorder did not receive any treatment at all from children's mental health services in 2021-22. Many of those who were seen were only given a single appointment. A third of children who were referred for treatment had their case closed before they got any support.

The number of children receiving NHS-funded support has increased to 732,121, which is 42 per cent higher than in 2019. Spending on children's mental health services has increased every year since 2017 but it has failed to keep up with demand. The average waiting time for a child between receiving a referral and starting treatment in 2021-22 was 40 days, up from 32 the previous year. There is, however, huge variation across the country with treatment beginning as quickly as 13 days in NHS Leicester City to as long as 80 days in NHS Sunderland. Freedom of Information requests for the Times Health Commission found that some children were waiting almost four years for an autism assessment but data is patchy and unreliable and many mental health trusts cannot provide accurate information about waiting times.

Claire Murdoch, NHS England's national mental health director, who has been a mental health nurse for 40 years, told an evidence session that only one in four children with a probable disorder were receiving the mental health treatment they needed. "I don't think anyone could defend it," she said. "If I had to choose one priority above all others, as we look forward to the next five years, I think it has to be our children and young people. We've proven that we can make a difference, but it's not enough. We have to close that gap." She insisted, however, that mental health could not just be seen as a challenge for the NHS. "I think something is happening with our young and the pandemic will have exacerbated that. The last thing we want to do as the NHS is to pathologise the ordinary anxiety and distress and milestones of development," she said. There is a need, in her view, to encourage children to think about "sleep hygiene, how much screen time you have, eating healthily, running a mile a day or physical activity. The whole point is to help our young see that some of this is very normal, part of growing up, in a very complex world. I think some of the social media, the idealised body images, the fact that a hugely significant number of ten-year-old plus have got iPhones or equivalent [mean] they are bombarded. So, I think there's a role for others where we would not want to intervene as the NHS, but wider society needs to be more responsible about how we treat our young."

The Children's Society's annual survey of young people shows that children's wellbeing has been falling for more than a decade. Last year almost a third were unhappy with at least one area of their lives. Almost half were worried about rising prices and 40 per cent were worried about the environment. Rachel de Souza, the children's commissioner for England and a former head teacher, said that she had seen an "absolute explosion of mental health issues" around the country since taking up the position in 2021. "It's everything from low-level anxiety, concern and worry to a massive rise in eating disorders since lockdown. There are capacity issues. The government has put more money in but not enough. You can see that clearly." She said there was a link with the worrying collapse in school attendance. "It's heartbreaking. Two years on from the pandemic we are still seeing 1.8 million kids persistently absent. The majority are mental health, anxiety and special educational needs [cases]. So many of the children who are not back are not back because of anxiety issues and they need professional treatment. It's not just going to happen by magic."

Laura Dunt, chief executive of the mental health charity Young Minds, which runs a helpline, said it was increasingly difficult for young people to get the help they require. "It's quite hard to find the words to describe how bad it is. There's a mental health emergency for young people at the moment in terms of the number of young people that we hear from who are struggling after the really challenging time of the last few years. We're hearing from young people waiting up to two years to get support; that's not uncommon. On average we hear it's about twenty weeks, or five months, until the first appointment from point of referral but that's really variable across the country. We hear stories from parents about young people's mental health really getting worse in that waiting time because if you're told you are going to get support, on the one hand that feels like it might be a moment of relief and hope that something is going to get better and then it can just go quiet. You might feel like you've been forgotten about. Young people talk about not feeling heard or listened to or taken seriously. When you're 13 and 14, a two-year waiting list is enormous. You can't imagine what it's going to be like in two years' time because those adolescent years are so changeable and you're a different character from year to year." She said there had been 3,000 urgent referrals to crisis teams for under-18s last April, a record for a single month and three times higher than in May 2019. "So it's both the number of referrals and the intensity of the need has gone up. These young people are really desperate for support: they are calling for help. That's the underlying reason why young people are hurting. We hear, tragically, more and more about young people attempting to take their own life and self-harming in a way that is obviously very dangerous. They are just desperate. Parents are sleeping on the floor of their kids' bedrooms in order to keep them safe. I mean, the unimaginable horror that must be for families."

Although the pandemic affected mental health and resilience, the crisis started before coronavirus forced the country into lockdown and closed schools. Tamsin Ford said there was a "sudden and quite marked uptick in anxiety, depression and self-harm among young women"

1/4

The number of children with a probable mental health disorder who receive the help they need

first detected in about 2014. The pressure of exams is in her view a big factor. "We do have a huge amount of tests and a huge amount of stress in our system and I think girls are socialised to care about that," she said. "People worry about social media and there's no doubt that there is some vile content out there. If you get sucked in and if you're vulnerable it's really not going to be good for you." She added, however, that there were many positive things about being connected online. "I don't think it's just 'social media bad'; it's what you're doing with it. There's lots on the internet that's great. It's not how much you're on there, it's what you're doing and who you're doing it with."

The psychologist Amy Orben, group leader at Cambridge's Cognition and Brain Sciences Unit, explained that the evidence on the impact of social media on the teenage brain was very mixed and inconclusive. "We'll have people who are extremely harmed by it and we'll have people who use it for good," she said. "It's like diet. Food can have both positive and negative influences. For example, eating a bar of chocolate can land a diabetic in hospital but if I've just run a marathon it might be really important for me. Technology is very similar. It's how you use it and why."

Addiction is a growing problem, particularly among the young. Henrietta Bowden-Jones, a psychiatrist and national clinical adviser for gambling harms who runs several addiction clinics, said recent studies had shown that 60,000 children were now addicted to gambling. There should in her view be much stricter controls on advertising around sports matches and on football shirts. "We have ended up with a gamblification of sport. We have taken away the pleasure of sport as an activity not just for our younger generations, but for everybody." And gambling is not the only problem. "Pornography has become one more significant issue. I get told all the time that young people are not understanding how to evolve in terms of their own sexuality and their relationships because all they're doing is watching this porn at school. The gamers are up through the night. They don't eat properly. They say, 'I haven't brushed my teeth for several days; I don't shower regularly because everything that is not gaming is a waste of time.' They gradually withdraw from their everyday reality and they crawl into this dark net. It can impact on anyone but right now we're seeing a mass of people under 25 and they seem to be the most vulnerable. There are young children who leave the home in the middle of night at the age of 11 or 12 because their parents have stopped the internet. They walk for miles to end up on doorsteps of people who they know have internet, or they unscrew windows on the ground floor to escape from their family house in the middle of the night or they blackmail parents to get internet access. The stories are extreme, we have families who've called the police ten or twenty times because of violence driven by gaming disorder."

Children are not the only ones who are struggling. According to the Royal College of Psychiatrists, there has been a 20 per cent increase in mental health need across all ages. In 2022, 5,642 people took their own lives, three quarters of them men. People in the poorest 10 per cent of the population are two and half times more likely to have a mental health problem than those in the top 10 per cent. Rates of depression are twice as high in Knowsley, Merseyside, than they are in Richmond upon Thames, southwest London. At the same time one in seven consultant posts in psychiatry are vacant as senior doctors take early retirement or decide that the stress of the job is too much, meaning that backlogs for treatment are growing and services are under severe pressure.

Last year the Care Quality Commission (CQC) rated 40 per cent of mental health providers as "requires improvement" or "inadequate" for safety. It found that lack of capacity meant that people with mental health problems were being cared for in the wrong environment, such as A&E. At one trust in a single month 42 mental health patients waited for more than 36 hours. Almost one in five mental health nursing posts are vacant, contributing to an over-use of restrictive practices, including restraint, seclusion and segregation, the CQC found.

Lade Smith, president of the Royal College of Psychiatrists, said politicians had repeatedly promised to create "parity of esteem" between physical and mental health but it had not

happened. “It’s a completely false economy,” she said. “Unlike physical health problems that happen when people are in their late fifties, we can effectively treat a really significant proportion of mental health problems in children so they don’t become adults with mental health conditions. Unfortunately we’re not treating them and so they’re not getting better, they’re becoming adults with problems who don’t thrive, don’t achieve their potential. I work in forensic psychiatry and I see people as young adults and so often I think, ‘Oh gosh, this 19-year-old in prison, if only we’d met this person when they were five this could have all been avoided.’ ”

Other public services are dealing with the consequences. When the commission spent a day with the London Ambulance Service many of the emergency cases involved somebody who was mentally ill. The Metropolitan Police has announced that it will no longer attend emergency calls related to mental health incidents. Sir Mark Rowley, the Met commissioner, warned that too many officers were being diverted away from their crime-fighting duties. Mara Violato, a health economist at Oxford University, has calculated the long-term cost to the country of mental health problems in the young. “We found evidence that childhood anxiety problems are associated with worse outcomes in 15 domains of everyday life,” she said. “This is about risk of persistent mental health problems but also worse outcomes in education, employment and so on. We found that the aggregated national lifetime loss of earnings for children with anxiety problems at the age of 14, who then failed to achieve at least five GCSEs in England, is more than £850 million. That is a conservative estimate and this is only for one year, so you can imagine if you do these similar calculations for every year, then the billions increase. If we intervene sooner rather than later we can save a lot of money later on along the line, not only for the children and their families but also for the whole society.” According to the Royal College of Psychiatrists, the full economic impact of mental illness is about £118 billion a year, equivalent to 5 per cent of GDP.

There is a strong link between rising levels of mental illness and the growing number of people of working age who are economically inactive. A survey for the commission by the professional services firm PwC found that mental rather than physical illness appeared to be the main cause of long-term sickness in the workforce. Two thirds of employers reported an increase in the use of counselling services since the pandemic and two in five companies had seen an increase in employees taking long-term sick leave because of mental ill health. More than half the 150 employers polled reported that the mental health of staff had worsened since the pandemic. In addition, 53 per cent said that the cost of living crisis had damaged the wellbeing of their employees. The survey found that mental health support was the most in-demand benefit for employees, with 64 per cent of companies saying that there had been an increase in the number of staff asking for counselling. This compared with a 19 per cent rise for gym membership and a 21 per cent increase for private medical insurance. Lord O’Donnell, the economist and former cabinet secretary, said the consequences were severe. “Half of absenteeism is down to mental health so there are massive impacts for working-age people and then when it comes to children there is a lot of evidence that we need to do more. Let’s try and prevent things rather than cure them.”

The commission believes that children’s mental health has to be given a much higher priority. It cannot be right that young people have to make multiple suicide attempts in order to get support. That is not a cry for help, it is a disaster waiting to happen. The benefits of dealing with problems as they start to emerge and before people reach crisis point or develop a long-term disorder are clear for individuals and the country. National four-week maximum waiting times should be guaranteed for all children and young people who need access to mental health services, with appointments within a week for those at risk of self-harm and suicide. This must not just be a tick box exercise, to meet a target: the crucial thing is that young people start to get professional help. In many cases the initial assessment could be digital, with clinical oversight, to ensure that the treatment itself begins promptly.

There needs to be much better data so that progress can be monitored. Mental health trusts should be required to publish key metrics including waiting lists and waiting times for children’s and adult services and criteria for treatment being refused. This would highlight gaps in provision and drive up standards by exposing the poor performers. The government should undertake a national wellbeing survey in secondary schools, which would focus attention on the importance of mental health and build a better understanding of how to create contented children. It would be based on the BeeWell survey in Greater Manchester, which has produced a wealth of granular data to inform local policymaking and has now expanded to Hampshire and the Isle of Wight.

Mental health hubs should be set up across the country, offering drop-in facilities and early intervention, including peer-to-peer support. Digital services have a role to play to expand the workforce and give greater flexibility. In Wales, the SilverCloud online mental health tool offers free support to anyone over the age of 11, backed up by a team of psychologists. During the pilot, 64 per cent reported a positive outcome after referring themselves.

All children must have mental health support at school with access to specialist NHS teams. Only about a third of pupils are now covered by school mental health teams. The programme will be expanded this year but it will still cover only about half of schools. Claire Murdoch said she wanted to expand the scheme to all pupils and the health service must be resourced to do so. This would cost just under £250 million a year. Such a crucial service should be universal. Children’s wellbeing is every bit as important as their ability to read and write. There is in any case strong evidence of the link between mental health and educational attainment and many are missing out on school because of the alarming absence rates driven by anxiety. Research by the children’s charity Barnardo’s found that mental health school teams were effective at supporting children and young people with mild to moderate mental health problems and improved outcomes for those with access to them. The analysis suggests that every £1 invested generates £1.90 in savings.

More mental health support is important but the real aim should be to stop children needing professional help. There must be a greater emphasis on developing the emotional resilience of young people so that they can cope with the ordinary pressures of life. This means encouraging activities such as sport, drama, debating and volunteering as part of a broader, more-rounded education. Pupils should be taught about the importance of sleep, healthy eating and exercise and learn how to manage their screen time, including social media.

In Finland, schools deliberately set out to inculcate what they call *sisu*, the Finnish word for grit or resilience, in their pupils. Children are sent outside between lessons, whatever the weather, and are expected to walk home on their own from an early age. There are also “media literacy” classes from the age of 7. Angela Duckworth, professor of psychology at the University of Pennsylvania and author of the bestselling book *Grit*, argues that passion and perseverance, the qualities that are in her view the key drivers of success in life, are just as likely to be learnt on the football pitch as in the classroom.

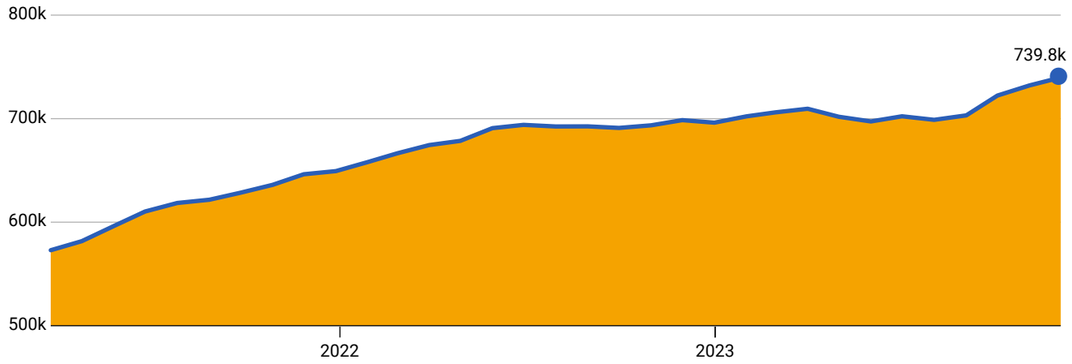
The most forward-thinking parts of the health and care system understand that there is a false dichotomy between mind and body. The mental health service Arian Wellbeing founded by Waheed Arian, puts personal trainers to work alongside psychologists in supporting traumatised populations, such as refugees, asylum seekers and the homeless. The results have shown that it works. Ed Bullmore, professor of psychiatry at Cambridge University, said “we live in a very fractured universe” in healthcare and patients were being let down. “There has been a tacit understanding that mental health symptoms in the context of physical disease can’t be related to the same disease mechanisms that are driving the physical disorder. They must reflect some personal frailty or predisposition on the part of the patient. I think that does a massive injustice to many patients who have lived experience of both physical and mental problems coexisting.”

In Cambridge the new children’s hospital will combine mental and physical health so that young people with eating disorders, for example, can be treated in one place rather than having to be transferred by ambulance to a different location if their condition deteriorates. Isobel Heyman, a consultant at Great Ormond Street Hospital and lead for child mental health at the new Cambridge hospital, said it was increasingly clear that the distinctions put in place by traditional medicine were artificial. “We noticed, particularly straight after the pandemic, increased numbers of children presenting with really florid tics. It’s part of a much more general phenomenon that a child presenting with physical complaints is often a marker of underlying emotional distress. We’ve seen increased rates of children presenting with abdominal pain, with headache, with pain in general, with non-epileptic seizures ... other types of functional symptoms. I think we have a false divide. I would say mental and physical health are two sides of the same coin.” She warned of the “over-medicalisation of ordinary distress, ordinary ebullience and overenthusiasm in young people”.

There needs to be a better understanding of the difference between acceptable levels of stress or sadness and a serious mental health disorder. Sir Simon Wessely, regius professor of psychiatry at King’s College London, warned of a “professionalisation of normal emotions”, particularly among the young. “If you ask

Consistent rise

Number of children and young people accessing mental health services in the last 12 months



SOURCE: NHS DIGITAL

> “We noticed increased numbers of children presenting with really florid tics

students, you find about two thirds will say they have mental health problems but when you go into more detail you find that a lot of them are actually talking about things like loneliness, exam stress, homesickness, which most of us would not consider a mental disorder. It's obviously not going to respond to antidepressants, I doubt it would respond to counselling, it might respond to social interaction. I would stop mental health awareness, because I think it's gone too far. You get unintended consequences, which may be what's happened in the student generation where kids now say, 'I'm feeling a bit bipolar today.' "

For those suffering from serious psychiatric illness significant iniquities remain. The law is in urgent need of reform yet plans have stalled. Wessely's review of the Mental Health Act, which proposed more respect for patients, a reduction in unnecessary detention and action to end discrimination, was backed by all parties at Westminster but legislation has been shelved by the government.

"Of course I'm cross," Wessely told the commission. "But it's nothing to do with disagreement with the contents, which were mainly accepted." There are, he insisted, good reasons to have a Mental Health Act. "Most societies think that when you're very young, when you have dementia and when you have severe mental illness the state has a duty to protect you and occasionally take decisions for you," he said. "But we do need a more balanced, fairer, better one, with more respect for people's human rights even when they're mentally ill. There are times in people's lives where the state has to intervene but those should be short and at the least coercive level as possible, and not discriminatory, and we've fallen behind on that."

His review highlighted the stark racial disparities in the use of the powers. Black people are four times more likely than white people to be detained under the Mental Health Act and eleven times more likely to be given a community treatment order in England. One of those who suffered the consequence was the actor David Harewood, who described the experience of being sectioned during a psychotic episode when he was 23. Seven policemen sat on top of him and he later discovered by reading his medical records that he had been given three times the standard dose of sedatives. "People are quite afraid of large black men, so they tend to overmedicate," he said. Reform of the Mental Health Act is long overdue. The proposals are ready to go and they must be implemented at the earliest opportunity.

Theresa May identified the treatment of people detained under mental health legislation as one of the "burning injustices" she wanted to tackle as prime minister but it has not happened. There are about 115 people with severe autism and learning disabilities in long-term segregation, in effect solitary confinement, in psychiatric hospitals or specialist units. Many are living in appalling conditions, separated from their families and with no proper treatment plan or understanding of when they will be released. "They are warehoused," Baroness Hollins, the crossbench peer who conducted a government review of segregation last year, said. "What we found was that there were no minimum standards as to what accommodation should be provided. Some people were being detained in a room without any natural light, with just a mattress on the floor, with no toilet facilities. It's totally shocking. Some are expected to use the floor as a toilet, and they are then given a mop and brush and clean up their own mess." Many facilities do not have CCTV cameras so abuse of patients by staff also happens. "We heard allegations of emotional, sexual and physical abuse," Hollins said.

The commission was told about one man with autism who went into hospital for a routine medication review and ended up being detained for four years. Hollins described a Kafka-esque nightmare for many patients and their families. "If you already feel unsafe in the community and then you go into a hospital where you know nobody, where there are other very distressed people, where there are a lot of agency staff, or perhaps unskilled staff, where there is sensory overload, noise, lack of familiarity and rules that you don't understand, you're going to get even more disturbed. Then people get put in seclusion and that makes them even more distressed. So then that's a justification for keeping them in seclusion, so that then becomes long-term segregation. And then the staff say, well this person has attacked every staff member who's gone into their room, and so clearly they're not safe to come out."

One patient had been in three different hospitals over five months "but she still did not have a treatment plan", Hollins said. "This was a private hospital without in-house specialist staff, relying on a visiting psychologist and visiting therapists perhaps once a fortnight. This is costing a huge amount, sometimes £350,000 a year or more for each person. My panel saw this poor practice as an abuse of human rights."

The way in which people are being treated is completely unacceptable. There may be some limited circumstances in which segregation is justified for the safety of patients or those around them but the accountability of providers has to be improved. Long-term solitary confinement should end and patients with severe autism and learning disabilities must be offered better support at an earlier stage. More than 10,000 autistic adults in England are not receiving the social care they need, leaving them vulnerable and at risk of being detained, according to the Autism Alliance. Its analysis found that 44 per cent of autistic adults have to wait more than two years for social care provision and 77 per cent reach crisis point before care is provided.

"We lock people up because we haven't got round to sorting out the support they need in the community," Hollins said. "Taxpayers' money is being spent on doing the wrong thing and we're doing harm to people when they are in a vulnerable situation." The true measure of any society can be found in how it treats its most vulnerable and when it comes to mental health Britain is failing.

Case Study The Mosaic Clubhouse mental health hub in Brixton

When David, a man in his fifties, ended up in hospital after suffering a bereavement in May 2009, he felt as if his freedom had been taken away. A turning point came when he discovered a purpose in the Mosaic Clubhouse in Brixton (Georgia Lambert writes).

Some call it a haven; others their workplace. The non-clinical mental health charity in south London transcends conventional labels as a place of safety for its users aged 16 and over, who seek crisis support, access to education, rehabilitation, volunteering and employment.

The centre receives 70 per cent of its funding from Lambeth council and NHS Lambeth. It is one of more than 300 Clubhouses globally based on the idea that, when people volunteer with peers in a safe and supportive space, mental health and wellbeing improve.

"It's based on work-ordered days to encourage people to think about getting back to work," Chris Thomas, chief executive of Mosaic, says. "Our members are people right across the spectrum, from people who are in and out of hospital, people with severe mental health conditions and people who are out of employment, perhaps because of bouts of anxiety and depression."

Inside there are no staff wearing lanyards or uniforms just individuals tending to their tasks. Members take charge of various roles, from manning the reception to housekeeping, serving home-cooked meals in the café, and administration work. Its services are deliberately understaffed to ensure that the newcomers can always be accepted.

Mosaic offers a range of support, including youth engagement socials and practical housing and welfare support. It has a drop-in information hub run by Raymond Stone, left, a staff member originally from Glasgow. "We function as an advice and signposting service, so we cover a host of essentially any practical issue, which would be a burden to someone in mental health recovery," he says. "That could be anything from benefits advice, helping with applications for that, helping people who've been experiencing homelessness or any other housing issue."

Cutting homelessness by solving the housing crisis and investing in preventative services such as Mosaic will reduce mental ill health, Thomas says. "The first Clubhouse was started in New York in 1948 and there are years of research and evidence showing that it does keep people healthy, it does keep people out of hospital and it can save health systems a lot of money."

Case Study Alder Hey Children's Hospital in Liverpool

Sunflower House, the inpatient mental health facility at Alder Hey Children's Hospital in Liverpool, has an "immersive room". Young patients can lie on bean bags and float with the stars, swim through virtual oceans or walk down their local high street with images projected on the walls and ceiling around them.

This 12-bedroom unit is one of only six specialist facilities in England for children aged 5 to 13. It has a therapy garden with a ping-pong table, a calming sensory room, a classroom and a safe kitchen for cookery lessons. Children, who sometimes stay for months, can decorate their bedrooms and choose the colour of the lighting.

Sunflower House deals with some of the youngest and most challenging mental health patients in the country. Andrea O'Donnell, the clinical lead, says children are exhibiting increasingly extreme symptoms even at a very early age. "We've seen, especially through Covid, an influx of eating disorders. We've seen an increase in self-harm as a coping mechanism."

Alder Hey is leading the way for children's mental health provision. A 24-hour crisis helpline, staffed by specialists, gives young people, their parents and doctors immediate access to support and advice. The service is available for anybody who is under 18 with a Liverpool or Sefton GP. The crisis is self-defined by the caller rather than the service so there is no minimum requirement.

Last year 9,022 people called the line, a 13 per cent increase on the previous year. About 12 per cent were from the young person themselves, 36 per from professionals and 51 per cent from parents. The majority of the calls — 70 per cent — were from or about girls.

All calls are answered by a qualified specialist and a risk assessment is made. A plan is then immediately developed with the caller to keep the young person safe.

The crisis line has seven qualified staff working 8am to 8pm, supported by a senior psychiatrist or psychologist. Overnight there are three staff with a psychiatrist on call. The cost is about £1.4 million a year, which includes appointments with the young people.

“WITHOUT URGENT ACTION MOTHERS AND THEIR BABIES ARE NOT GOING TO RECEIVE THE SAFE MATERNITY CARE THEY DESERVE.

Donna Ockenden, midwife

Health inequalities

The healthy life expectancy gap between the poorest and richest in Britain is profound and growing. A more equal country would have economic as well as social benefits but the whole system needs to work toegther more effectively

People living in Blackpool have the same healthy life expectancy as those in Angola. Glaswegians can expect to live in good health for the same number of years as people in Eritrea. For Hull, the comparison is with Gambia, for Belfast it is Burkina Faso and for Blaenau Gwent it is Pakistan. These figures, presented to the Times Health Commission by the International Longevity Centre (ILC), were striking enough but even more shocking were the stark differences within the UK. There is an 18-year gap in average healthy life expectancy between the healthiest and most unhealthy areas around Britain. Men in Blackpool can expect to live in good health for an astonishing 21 years less than those living in Rutland. They are typically well for 53.5 years compared with the 74.7 years enjoyed by those a three-hour drive away. Women in Stoke-on-Trent live 16 years less in good health than those in Wokingham. Hull is 14 years behind Windsor and Sunderland is 12 years behind Surrey.

The health inequalities around Britain are not only profound and widespread but they are growing. While healthy life expectancy for men in Rutland has improved by nine years over the past decade, it has dropped by almost nine years in northeast Lincolnshire over the same period, according to the ILC. In 2011-13 the gap between average healthy life expectancy in Wokingham and Blackpool was 13.7 years but the latest data showed it had increased to 17.2 years. Overall, people in the healthiest areas have got healthier in the past ten years but healthy life expectancy has fallen in the least healthy areas.

Absolute life expectancy, as opposed to healthy life expectancy, is falling. Men living in the poorest areas can expect to die 9.4 years sooner than those living in the richest areas and the difference for women is 7.7 years. Compared with other similar nations internationally, between 2011 and 2017 the slowdown in life expectancy in the UK was marked and the UK as a whole has experienced lower rates of improvement annually than all the countries, except the USA and Iceland. Overall, inequalities in avoidable deaths increased markedly between 2010 and 2017 in the most deprived areas in England, by 8 per cent among females and 17 per cent among males.

Arguably, though, healthy life expectancy is a more important and useful measure. People in the poorest areas are dying earlier but they are also living a greater share of their lives in ill health, often unable to work. The Health Foundation found that the poorest women were unhealthy for more than a third of their lives, compared with 18 per cent for the richest. Among men, the figures were 30 and 15 per cent. Those in the most deprived fifth of the population on average develop multiple long-term conditions ten years earlier than those in the least deprived fifth. Children born into the poorest fifth of families in the UK are nearly 13 times more likely to experience poor health and educational outcomes by the age of 17 than the richest fifth. Almost a quarter of five-year-olds have dental decay and it affects 2.5 times as many children in the most deprived fifth as in the least deprived fifth.

Sir Michael Marmot, director of the UCL Institute of Health Equity, said it was "heart-rending" that health inequalities had got worse since he published his landmark report on the subject in 2010. "The greater the deprivation, the shorter the life expectancy and that gradient is steeper for healthy life expectancy than it is for life expectancy," he told the commission. "If you go to the Royal Borough of Kensington & Chelsea and look at the life expectancy in the area next to Grenfell Tower, it's a 16-year gap for men. We were rightly terribly upset when 72 people died in the conflagration in Grenfell but the slow burn of inequalities somehow passes people by. Why aren't we similarly upset at that loss every day?"

Those in the poorest parts of England are now more than four times as likely to die early from a health condition that could have been prevented or treated, such as diet-related heart disease or cancer caused by smoking. There is a terrible human cost to these avoidable deaths, of course, but the country is also paying a huge economic price for allowing some parts of the population to fall so far behind. An analysis for the Times Health Commission by the economics and finance consultancy Oxera found that the cost of people in deprived areas dying early from health conditions that could have been prevented or treated has risen to almost £8 billion a year, an increase of 20 per cent since the pandemic.

The study showed that the economic impact of avoidable deaths in the poorest parts of England rose from £6.3 billion in 2019 to £7.7 billion in 2021. These figures do not take account of deaths directly related to Covid. They also exclude the cost to the NHS and the economic damage of people being off sick for a long time. The Oxera report warned of a "permanent scarring effect on the economy" if the trend was not reversed. It said that on the present trajectory there would be a "substantial loss" of productive capacity to the economy of £60 billion to £80 billion over the next decade, equivalent to the cost of 250 to 350 new hospitals. Poor health is one of the main drivers of the country's low productivity. The Northern Health Science Alliance found that long-term sickness was the key explanation for lower productivity in the north of England and concluded that improving health in the region would generate £13.2 billion for the UK economy.

Michael Gove, the communities secretary, denied that the growing health gap "made a mockery" of the government's mission of levelling up the country but he insisted: "It makes the case for levelling up all the more profound and necessary." He warned against putting all the blame on individuals. Some Conservative MPs have suggested that people need to learn how to cook and budget properly rather than use food banks, but Gove said the causes of ill health were "not so much lifestyle choices as limited opportunities and narrowed horizons".

> "The greater the deprivation, the shorter the life expectancy

He told the commission: "Poor diet isn't simply a matter of poor self-control; it's a matter of the environment in which people live. Of course it is possible to have a healthy diet on a budget but the constraints that people who are poorer face mean that it's more difficult." There are also, he said, "deaths of despair" related to smoking, drinking or substance misuse. "People who are facing very difficult and constrained circumstances, for a variety of reasons, will find that what appear to be either ways of managing stress or in the worst circumstances ways of escaping from what they see as a life of despair can take them into habits and patterns of behaviour that are profoundly deleterious to their health."

Gove said that Bevan had been responsible for housing as well as health when he founded the NHS. "One of the things that undoubtedly affects the quality of people's lives and their life expectancy is the quality of the homes in which they live. If you have strong family relationships, if you're embedded within a community, if you have a sense of purpose — that can be either through faith, your job or the sense of being of worth to others — then that gives you the motivation or reinforces the sense of 'worthwhileness' in your life that can enable you better to cope with the inevitable buffeting. People who are living with anxiety, depression and insecurity are more likely to exhibit the types of behaviour that lead to poorer physical health as well."

The NHS may be responsible for delivering care to the sick but less than 20 per cent of our health is determined by medical interventions; the vast majority is driven by wider social factors including diet, smoking, housing, alcohol, air quality, education, poverty and working conditions. This is what explains the stark health inequalities and when the other social determinants are going in the wrong direction then healthy life expectancy will too.

People in the most deprived areas of England are three times more likely to smoke than those living in the richest areas. Smoking is the leading cause of health inequalities and accounts for half the difference in life expectancy between the most and least affluent communities. There is also a strong link between obesity and deprivation. In the poorest areas in England, 72 per cent of the population is overweight or obese, compared with 58 per cent in the wealthiest. People in poorer areas are twice as likely to be taken into hospital with obesity as those in the richest areas, and weight issues are hampering efforts to boost the labour market. Rates of obesity-related hospital

episodes and bariatric surgery are about two and a half times and four times higher respectively in the most deprived areas compared with the least deprived. Cardiovascular disease is among the largest contributors to health inequalities, accounting for one fifth of the life expectancy gap, according to the King's Fund.

At the same time as obesity rates have soared, "Victorian" diseases such as scurvy and rickets that are associated with poor diet have risen. Almost 11,000 people in England were hospitalised with malnutrition in 2022, according to data obtained by the commission under Freedom of Information laws. The number of cases of malnutrition have more than doubled in a decade and have quadrupled since 2007-08. The figures also showed that 171 people were treated for scurvy and 482 patients were admitted with rickets, 405 of them children. Scurvy is caused by severe vitamin C deficiency; rickets is caused by prolonged vitamin D deficiency. "If this is indicative of the health of our most vulnerable then it is shocking," Dame Clare Gerada, former president of the Royal College of GPs, said. "The poorest people in this country are poorer than any other counterparts in Europe and it's poor diet. The most common reason a child under five has a general anaesthetic now is for dental care, so that's a sign of malnutrition. This isn't about the health system, it's about the social determinants of ill health."

The environment in which people live is hugely important and there are vast discrepancies. Almost half the fast-food outlets in England are in the most deprived parts of the country. The most affluent 10 per cent of the country is home to only 3 per cent of fast-food restaurants, chip shops and burger bars, and the poorest decile has 17 per cent, according to data from Public Health England. Knowsley, the second most deprived borough in England, has the country's most severe childhood obesity problem. Of the children who completed primary school in the borough last year 47 per cent were overweight, including 31 per cent who were obese. According to a report by a Liverpool University researcher in 2021, Knowsley has 98 takeaways and two greengrocers. More than a million people in the UK live in "food deserts" with limited access to fresh, affordable food.

Air quality is another issue. Ella Kissi-Debrah, a nine-year-old from London who died in 2013 after suffering a fatal asthma attack, was the first person to have air pollution listed as a cause of death on her death certificate. Public Health England estimates that poor air quality will cost the NHS more than £5 billion a year by 2035. Up to 36,000 people die prematurely a year because of dirty air. Then there is housing: about a fifth of children are growing up in damp homes, with sometimes devastating consequences. In 2020 Awaab Ishak, a two-year-old from Rochdale, died as a result of overexposure to untreated mould in a social housing flat. Poor-quality housing costs the NHS £1.4 billion a year, according to an analysis by the Building Research Establishment consultancy, which suggested that every £1 spent on warming up the homes of vulnerable households would yield £4 in health benefits.

Marmot blamed cuts to local government budgets for the rising inequalities. "In the least-deprived quintile, the spending per person went down by 17 per cent and the greater the deprivation, the greater the reduction in spending," he said. "In the most deprived, it went down by 32 per cent from 2010 to 2019. In Liverpool it went down by 42 per cent. The more deprived, the less money there was to spend. If you think that adult social care, child protection, green space, leisure centres, housing, all of those things, are important, as I do, it's hardly surprising that health might have stopped improving." The pandemic and the cost of living had made the situation worse. "It's not the case that people are lazy, ignorant, feckless or can't be bothered to cook," Marmot said. "People who understand nothing say, 'How could they have food insecurity? Their children are obese. They must have enough food to eat.' They don't recognise the difference between quality and quantity and how cheap it is, relatively speaking, to eat calorie-rich food compared with nutritious food. If people followed the healthy eating guidance those in the bottom 20 per cent of household income would need to spend 50 per cent of their income on food." Desperation leads people to live unhealthy lives, he said. "If you say to an 18-year-old, 'You really should stop smoking because you might get lung cancer and die when you're 55.' They will say, 'Do me a favour. Give me a break. I don't know whether I'm going to survive till I'm 25, let alone 55. I can't think about the long-term future.' "

The wider context matters. "Rich people drink more than poor people, against all the prejudices people might think, but if you look at alcohol-associated hospital admissions, it goes the other way," Marmot said. "The greater the deprivation, the higher the rate of alcohol-associated hospital admission and alcohol-associated mortality, like cirrhosis. If your half a bottle of Bordeaux goes along with better food, healthier lifestyle and so on, as distinct from being malnourished, we've got potential explanations for the so-called 'alcohol paradox'." He said that health inequalities would never be narrowed without wider support for the poorest in society. "What do you want a good society to do at the minimum? You want children to be fed; to be living in secure, warm, housing; to be clothed; to have light so they can read to do their homework; to have toothpaste so they can clean their teeth."

Economic divides are not the only problem. The paralympian Baroness Grey-Thompson warned her fellow commissioners that disabled people were often forgotten or discriminated against in the health and care system. "At the start of the pandemic, compulsory DNR [do not resuscitate orders] were put on tens of thousands of people who had no underlying health conditions, basically saying if you get Covid you were told you wouldn't get treated." Disabled people were left "feeling like they have no value", she said. "That's a worry. Someone like Stephen Hawking [the physicist who had motor neurone disease and died in 2018], with his impairment, he would have been put on a 'do not resuscitate list'." When Grey-Thompson, who was born with spina bifida, was pregnant in 2001 she went to see her doctor. "The first thing I was offered was a termination because people like me should not be allowed to have children," she said. She changed hospitals and gave birth to her daughter, Carys, but said that for disabled people "the relationship with the NHS can be quite mixed."

There are also appalling inequalities in maternity care, with black women four times more likely to die in childbirth than white mothers. The racial disparities were laid bare during the pandemic. Manish Pareek, professor of infectious diseases at Leicester University, wrote the first paper highlighting the disproportionate impact of Covid on people from ethnic minorities. He said that the social determinants of health were a crucial factor. "You can't die of Covid if you don't get infected. Increased risks of infection are driven by things like multi-occupancy households, multigenerational households, people working as key workers or not able to lock down," he said. "Then once you've been infected we know that certain ethnic minority groups have a higher proportion or prevalence of certain underlying conditions: diabetes, cardiovascular disease. So you're then at slightly higher risk of then going down to a more severe form of Covid. I don't think this is a genetic thing at all. People from certain groups, both ethnic minority and from lower social economic classes, have different life experiences both in terms of housing, economics and also their experiences of accessing healthcare."

The social policy expert Baroness Casey of Blackstock, who has worked for Labour and Conservative prime ministers, said the pandemic had "ripped the country apart" in terms of the divide between the haves and the have nots. "We've known for years about health inequalities and I don't think people care about it, or not the right people care about it," she said. "It's not like it's an unsolvable problem that nobody can do anything about. When people are in government, they have a responsibility to step up for the entire nation, not just the people who put them in parliament. The government has to be responsible for the unification of all its citizens, so that the divides in our society are smaller, the rancour and discontent that people rightly feel is not present. We have too big a number of people who are leading very difficult lives without the basics being met."

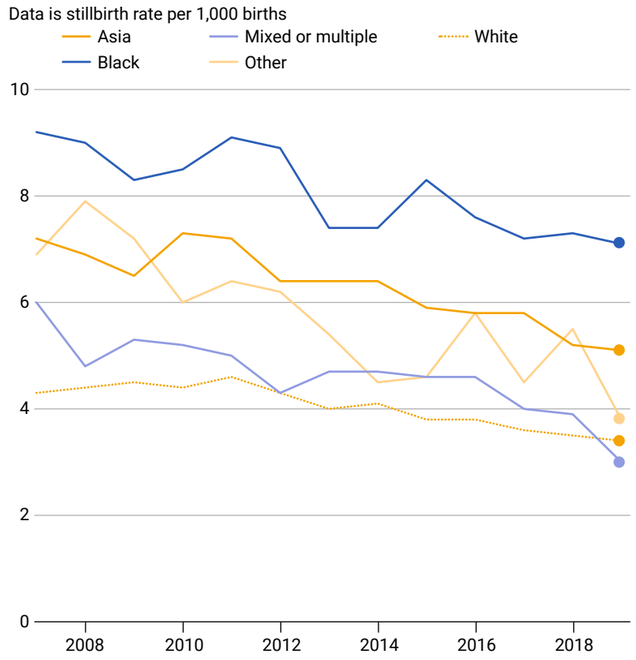
There is now a moral, social and economic imperative to tackle the growing health inequalities around the country. Progress should be monitored by the Healthy Lives Committee with clear annual targets for narrowing the gap between rich and poor. The approach required will be different in each area and local communities must be empowered to enact the changes that they think will be most effective. The commission recommends that more money and power over health policy should be devolved to mayors and regions to stimulate innovation and incentivise local leaders to take stronger action and also more clearly link health budgets with healthy life expectancy. This would fit with the existing direction of travel and build on the work of Integrated Care Partnerships, which oversee local health strategy and are often chaired by local government leaders.

The evidence suggests that the 2014 devolution deal that granted Greater Manchester increased control over a range of public services, including health and social care, has had a positive impact on life expectancy. A study in The Lancet found that eight of the ten devolved local authorities had had higher increases in life expectancy than a control group and these were larger in the areas that had had higher income deprivation and lower life expectancy before devolution. "Improvements were likely to be due to a coordinated devolution across sectors, affecting wider determinants of health and the organisation of care services," the paper concluded.

Greater integration meant that Manchester could introduce multiple measures across different parts of the public sector, including targeting help at people asking GPs for a sick note, spending money on vouchers to encourage people to quit smoking, fitness initiatives and a dedicated clinic for the homeless. Andy Burnham, the Greater Manchester mayor and a former Labour health secretary, said the key thing was understanding that it is not only the NHS that is responsible for people's health. "It's everything outside: people's homes, people's jobs and communities. You need a whole -system approach." Mark Fisher, the chief executive

Rates compared

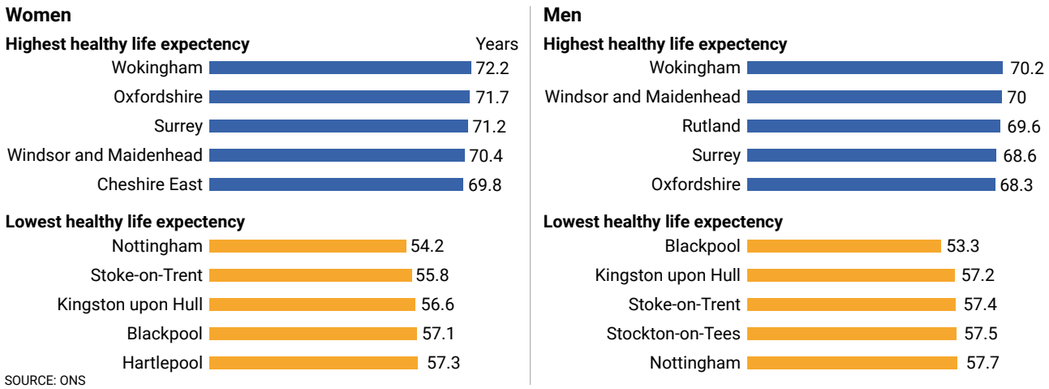
Stillbirth rate by ethnicity of the baby in England and Wales



SOURCE: ONS

Regional differences

Highest and lowest healthy life expectancy at birth for men and women by areas in England



SOURCE: ONS

of NHS Greater Manchester Integrated Care, said genuine collaboration and a shift towards prevention was the only way to stop the health service being overwhelmed. "My own view is, we're never going to get off the hamster wheel and end this extra demand unless we activate place, community, neighbourhoods, people and local government to do what they can do to reduce flow into the system in the first place."

In Barnsley the Health on the High Street project has put a diagnostic and imaging centre in the middle of the town's regenerated market square complex. It has boosted breast screening rates by 25 per cent and reduced no-shows by a similar amount while also adding a footfall of about 60,000 people every year to the town centre. Oliver Coppard, South Yorkshire's new mayor, has declared his ambition to make his area "the healthiest region in the country". He has also taken on responsibility for local health strategy by becoming chairman of the regional Integrated Care Partnership.

"There is nothing inevitable or insurmountable about the position we are in here in South Yorkshire," he said. "We have a 20-year healthy life expectancy gap. On our current trajectory a baby born in South Yorkshire today will likely live a life five years shorter than a baby born in a wealthy part of London. We have to do things differently. Our health challenges are also planning challenges, transport, educational and environmental challenges and, perhaps most of all, economic challenges." He plans to lend bikes to people in the poorest areas and ban advertising of junk food on trams but he says he does not have the budgets or power to make all the changes he wants. "Giving mayors like me greater powers offers us the chance for more accountability but most importantly we know our communities best so we know where the money should be spent."

There is one other practical change that would make a difference nationally: sick pay should be reformed to ensure that people do not go to work when they are acutely ill and likely to be infectious. This would minimise transmission of disease, reduce periods of prolonged absence, improve mental health and create healthier workplaces. At the moment sick pay is only available from the fourth day that a worker is ill and if they earn less than £123 per week with an employer they are not eligible for it. Nearly two million low-income workers with more than one job receive no sick pay, despite working in crucial industries such as cleaning, care work and food services. This incentivises people to go to work when they are sick because they cannot afford to take the time off. We propose that the earnings threshold should be abolished and the waiting period removed.

A cost-benefit analysis by WPI Economics for the Centre for Progressive Change estimated that this would give a £4.1 billion financial boost to business, government and the wider economy. Amanda Walters, director of the Safe Sick Pay campaign, argued that the current system was not working for companies or individuals. "Low sick pay causes presenteeism amongst workers, which at best means returning to work whilst unproductive and at worst can mean future health complications or the spread of infectious diseases."

John Godfrey, director of levelling up at Legal and General Group, said businesses had significant influence over public health and also backed a change in sick pay. "Creating a healthy workforce is vital if we are to unlock the full potential of the UK economy."

In general, healthcare must be brought closer to people, particularly in the most deprived areas, which often have both poor health and low levels of engagement with the NHS. There should be more community link workers in GP practices to help patients to cope with social issues affecting their health and wellbeing such as social isolation, money worries, unemployment, benefits or bereavement. Family hubs are another good way to provide support for parents and their children and point the way to other services. Public information campaigns on vaccinations are essential to keep levels high enough for herd immunity and more effort needs to be put into tailoring messages to communities that are traditionally sceptical about jabs.

There are some bright spots that show the way forward. Nearly 1.2 million people have now been invited for NHS lung cancer screening in mobile testing units parked in supermarket car parks and outside community centres. Since its creation in April 2019 the programme has discovered 2,705 lung cancers and about three quarters of them were at an early stage so they could be treated, compared with about a quarter without the proactive approach. The proportion of those from the poorest areas who have been given a diagnosis at stage one or two rose from 30 per cent in 2019 to 34 per cent in 2022. People who have lung cancer diagnosed at the earliest stage are nearly twenty times more likely to survive for five years than those whose cancer is caught late. Peter Johnson, NHS England's national director for cancer, said: "By taking the diagnostics to people, we've been able to get uptake rates which are much higher and what's most encouraging about it is that usually the most well-off people are more likely to get their cancers diagnosed at an earlier stage than the least well-off. The difference is about eight or nine percentage points between the top and the bottom of the scale. But because we've targeted the lung health checks programme specifically at those parts of the country where we have the highest rates of lung cancer and the worst rates of late diagnosis, we've actually inverted that relationship and we're diagnosing lung cancer earlier in the most deprived communities because that's where we started our work. What that demonstrates to me is that if you put the investment in, you put the organisation in and you get people lined up to really get behind an idea, you can actually move the dial. We are not helpless in the face of these difficulties; there are things that we can actually do." The "Man Van", developed by the Royal Marsden NHS Foundation Trust and the Institute of Cancer Research is a similar pilot outreach programme for men who are at increased risk of prostate cancer.

1.2m

Number of people invited for NHS lung cancer screening in mobile testing units

These initiatives rely on information about gender, ethnicity and lifestyle to help to identify those most at risk of cancer, but data can also highlight other social problems if information is shared between different public services. In Bradford, literacy rates have been significantly improved by cross-checking NHS and school records. They showed that a third of pupils who had poor eyesight diagnosed were not going to the optician to get spectacles, which meant that they struggled with learning to read and write. Under the "glasses for classes" programme, children have a vision test in the reception class and those who need spectacles are automatically given two free pairs: one to keep in school and one to take home. In 2017, when the scheme was introduced, pupils in Bradford were 6.2 percentage points behind the national average in reading at the end of primary school and within two years that had halved to 3.1 per cent. The "glasses in classes" initiative emerged from the Born in Bradford study, which is tracking the health and wellbeing of more than 13,500 children born at Bradford Royal Infirmary between March 2007 and 2010 through childhood and into adult life. Mark Mons-Williams, professor of cognitive psychology at Leeds University, who is running the project, said the programme had revealed the fact that "a lot of our children were experiencing health barriers to their educational progress" and poor educational outcomes were also having an impact on people's health. "Two years of education outperformed the very best drugs that we had for cardiovascular disease," he said.

He and his team are now applying the same principles to autism. By analysing data about children with autism diagnosed at the age of 11 by the NHS, they found that many of the traits were already apparent in the information that had been collected by schools for educational purposes at the end of reception year. "The teacher has observed this child over a year in a classroom — how the child interacts with other children, how good they are at speaking — it turns out that information is an incredibly rich insight into that child's developmental status. What we could show is that they're unaware of it but they're picking up all the children who really should be within the health system being assessed for autism."

Mons-Williams and his team started looking at new data, using the same methodology to spot the children who were likely to develop a problem. With 1,700 children on the NHS autism waiting list in Bradford, they decided to bypass the normal process, which could take years, and started visiting schools to carry out immediate assessments of those they had identified as being at risk. The results were extraordinary. "It takes us two weeks to assess one child in the hospital, it took us one day to assess a child in schools," Mons-Williams said. "Suddenly, every family turned up for an assessment, the children were in their normal environment, the schools could be part of our process. Then if you did diagnose autism you could immediately put a care plan in place so the next day the school knew what accommodations needed to be made and how they could properly support the child, and the family could be part of that conversation. It was the simplest thing in the whole world but it was unbelievably effective. We've already shown that when you identify those children and put that support in place those children do so much better. The evidence is overwhelming."

It is another example of the power of data to transform public services for the benefit of users and staff. There must be greater coordination between government agencies to identify problems early and stop the most vulnerable falling through the gaps. The patient passport that will connect up the health and social care system should also be linked with education data through the unique code given to children at birth. At the moment children are given an NHS number when they are born and are allocated a separate number when they get to school but greater co-ordination has been shown to have a tangible impact on outcomes at little extra cost. The whole system needs to work together to create a healthier, more equal Britain.

MAN VAN CANCER DETECTION

Prostate cancer is the most common cancer in men in the UK, with more than 50,000 cases every year. In 20 per cent of cases in England men seek help too late for their cancer to be cured (Claire Bithell writes).

The Man Van was developed to help more men to get an earlier diagnosis. The mobile clinic's first visit was to a construction site in Croydon to offer workers health checks. Men of working age who find it harder to access healthcare are targeted for checks by the team. They also prioritise black men, who have roughly double the risk of developing prostate cancer and an increased risk of death once diagnosed.

When the commission speaks to Nick James, professor of prostate and bladder cancer, who leads the project, the van is parked up outside Brent Town Hall. Brent is a very diverse area with higher levels of premature mortality, poverty and high rates of late presentation of disease. "It is a different way of taking healthcare to more deprived areas where we know they have worse outcomes," he says. "We've profiled our own area to work out which areas have the highest rates and biggest presentation."

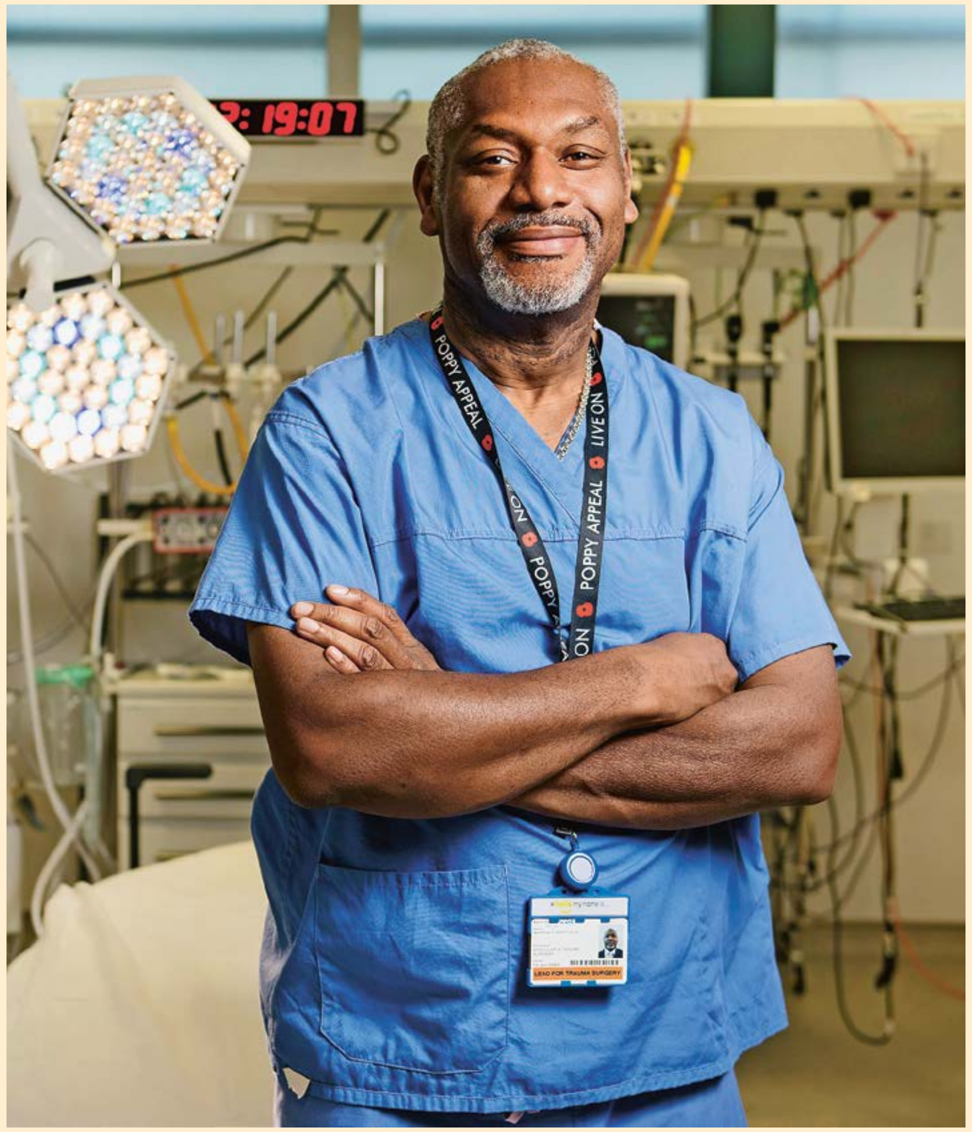
Men in the most deprived areas have a 14 per cent higher chance of dying of prostate cancer and a 29 per cent higher chance of their cancer only being identified when it has already spread. "We are targeting men in various ways: we're sending texts through their GP ... a whole series of videos, which are being distributing through community groups." The team also raises awareness of their work by speaking to men's groups, churches, mosques, trade unions and a local radio station.

The Man Van offers men a private and informal space to talk about their health, get support from clinicians and receive simple but potentially lifesaving tests. As well as prostate cancer, it offers tests to spot diabetes and risk factors for other diseases. Men can also opt to take part in research projects to improve understanding of diseases.

James recognises the value of taking healthcare into communities. "If you're working, live in some high-rise flat and you've got some low-paid job, zero-hours contract, all these things, it's hard to go and see a GP. They don't offer check-ups anyway and you may not speak English that well. There's everything stacked against you."

Between January and September last year it screened 2,321 men and found 46 clinically significant prostate cancer cases. Analysis of 615 men screened during the project pilot showed that 7.3 per cent of black men had prostate cancer, compared with only 1.4 per cent of white men.

SURGEONS AND KNIFE CRIME



Martin Griffiths, a surgeon at the Royal London Hospital's major trauma centre in Whitechapel became so worried about the number of children coming into the emergency department with stab and gun wounds that he decided he had to do something to break the vicious cycle of crime.

He set up the UK's first hospital ward-based violence reduction service, working with the St Giles Trust charity to help to turn around the lives of young patients who had been stabbed or shot. There is also a team of police officers based at the hospital.

Since the programme was created in 2015, readmission rates have been shrunk from about 35 per cent to under 3 per cent. "The headline figure is great but actually it's about these kids getting education and training, being able to maintain a lifestyle that makes them less likely to be involved in violence," Griffiths says. "Young people can meet individuals who have backgrounds like themselves but have gone on to have successful careers."

Griffiths, left, says that the NHS can no longer act in isolation from the rest of society. "If someone is stabbed you have to ask yourself why. If you've got a patient who is coming back to you and knows your name from last time, or somebody's mum says, 'Good to see you again, how are things?' You think to yourself why has it happened? You see that certain populations are predominantly affected. It made me wonder why knife crime is distributed so unequally in society, why it's so many poor kids, so many kids of colour."

He says a "mirror world" exists in parts of the country, with different groups living parallel lives. "The gazelles and the zebras don't congregate. If you're living one life you're in whole different society."

After a sharp reduction in knife and gun crime during the pandemic, cases have now risen to pre-Covid level. "We will probably admit two stabbings a day and a couple of shootings a week will come through our door," Griffiths says. "It's all day, every day rain or shine, younger kids between about 3 and 6pm; older kids in the evening. What's changed is the age. Our victims are getting younger. The youngest child I've operated on who had been shot was five. I've operated on children as young as eight and nine who were actively engaged in street life. We are seeing a normalisation of violence. It's now unusual to have a patient who has been stabbed who is surprised."

There are now violence reduction units in 13 hospital emergency departments across London. Griffiths, who is NHS England's national clinical director for violent reduction, says trauma specialists were increasingly interested in dealing with the causes of crime. "You become much more interested in prevention because that makes society safer," he says. "Most kids get stabbed over nonsense. These are not hardcore gang leaders, they are not deeply involved in organised crime."

1 2 3 4 5 6 7 8 9 10

Obesity and public health

Unhealthy lifestyles are costing lives, costing the NHS billions and costing companies a fortune in lost productivity. Better diet, an end to smoking and more exercise can all be encouraged if we lose our aversion to the "nanny state"

The problem, according to the restaurateur and food campaigner Henry Dimbleby, is that health policy is being distorted by the myth of the "nanny state" created by a political class "who had nannies and had ambivalent feelings about those nannies". Jacob Rees-Mogg may be the only MP who has taken his nanny on the campaign trail but he is not the only politician who is terrified of appearing to tell the British people how to live their lives. The health service is left having to "clear up the dirt", Dimbleby told his fellow commissioners. "The crisis in social care and the crisis in the NHS are predominantly being brought about because the underlying health of our population is so poor. We need to encourage people to live more healthily before they get into the health service and put off for as long as possible the time at which they engage with the health service with chronic illnesses. We need to be spending more on prevention to reduce the cost of treatment, but politically that shift is difficult not only because of the money but because of attitudes to the nanny state."

Almost one in three British adults is now obese. Two thirds are overweight or obese, up from half a generation ago, and in some age groups the rates are even higher. Three quarters of people aged 45 to 74 are obese or overweight, according to the latest Health Survey for England. The Institute for Government think tank concluded last year that obesity was "a global problem but particularly chronic in the UK".

Over the past 30 years the proportion of people who are obese (with a body mass index of 30 or above) has doubled in this country. The average man weighs 6kg more and the average woman is 5kg heavier than in 1993. By the time they start school 10 per cent of children are already obese and an additional 12 per cent are overweight. Children living in the most deprived parts of England are more than twice as likely to be obese as those living in the wealthiest areas. Almost a third of the poorest primary school leavers have obesity, compared with 13.5 per cent in the least deprived areas.

As a result, Britain has some of the highest rates of preventable disease in the world, including heart disease, diabetes, cancers and dementia. Cancer Research UK predicts that 42 million adults in the UK will be overweight or obese by 2040 and at higher risk of 13 types of cancer. Cases of type 2 diabetes in children and young adults have risen faster in Britain than anywhere else in the world. The number of younger people with the condition, which is linked to obesity, has almost quadrupled since 1990.

There is growing evidence that obesity is undermining our wealth as well as our health. An analysis by Frontier Economics, commissioned by the Tony Blair Institute, found that Britain's weight problem was costing £98 billion a year, equivalent to almost 4 per cent of GDP. About a third of the cost falls on the state and wider society through higher NHS treatment costs and lower productivity. An estimated 350,000 people aged 50 to 64 are out of work because of their weight. The analysis suggests that the impact will increase by another £10 billion annually by 2040 if nothing is done to reverse the trend.

Obesity is already costing the health service £19 billion a year, according to the Frontier Economics research. NHS figures show that hospital admissions linked to obesity have doubled in six years to more than 3,000 people a day. There are three times as many admissions linked to obesity as there are admissions linked to smoking, with a record 1.2 million people being taken into hospital where obesity was a factor in 2022-23, up from 617,000 in 2016-17. More than twenty children are admitted to hospital because of obesity every day.

Tony Ellis, a consultant gastroenterologist and liver specialist, said many of his patients had conditions brought on by lifestyle. "Obesity is where smoking was in the 1970s," he told the commission. "If you're overweight, your risks are vastly increased for diabetes, heart disease, stroke, weight-related cancers and the destruction of weight-bearing joints. If you look at everyone with advanced osteoarthritis who has a hip replacement or a knee replacement the majority of those would be overweight." There are implications for hospital budgets, he warned. "If you admit a very obese patient, you might have a two-bedded bay that can only manage one bed. At the extreme, some patients are so heavy that you need overhead pulley systems and traction rails to nurse them. Bariatric ambulances are now needed in such cases for patient transfers." According to Freedom of Information requests by the health commission, annual spending on bariatric equipment by the NHS in England has doubled in three years, from £5 million in 2018-19 to £10 million in 2021-22. Many hospitals have to buy reinforced beds, crutches with higher weight limits and super-size wheelchairs. There are more than 1,150 mortuary fridges for obese patients.

Dimbleby said that without a "fundamental change" in political attitudes the health service would soon become unaffordable. "Unless we start thinking much more about creating a healthier population, the cost of the NHS will grow and grow as we pay to treat people and that will suck money out of every other part of government. We have to help people get healthier so they don't create these problems in the NHS."

Susan Jebb, professor of diet and population health at Oxford University, pointed out that diet, a lack of physical activity, smoking and alcohol accounted for about 80 per cent of non-communicable diseases. "It's a huge proportion and yet we are simply not mobilising our health and care systems in a way that bears any resemblance to that evidence," she said. "We are so caught up in dealing with the problem in front of our nose — ambulances, waiting times — that we can never get to the root causes. We're so busy mopping up the overflow from the butt that's overflowing we never get round to turning off the tap." She said it took an "extraordinary effort" in the current climate to avoid being overfed. "It's not about the nanny state. Actually, what's happening is advertising is undermining people's free will. Advertising means that the businesses with the most money have the biggest influence

on people's behaviour. That's not fair. At the moment we allow advertising for commercial gain with no health controls on it whatsoever and we've ended up with a complete market failure because what you get advertised is chocolate and not cauliflower."

The chef and Great British Bake Off judge Prue Leith agreed that the government should be much more willing to intervene to help people to make the healthy choice. "I think that sometimes the state has to be a nanny," she said. "We don't mind the fact that the nanny state insists we go to school to learn maths, so the nanny state, who has to pay enormous sums of money to rectify the problems of obesity, has every right to want the nation to learn to like good food."

Every government since 1992 has identified obesity as a big problem. There have been 14 obesity strategies and 689 schemes. David Cameron and George Osborne announced a sugar tax in 2016 but the levy does not apply to milkshakes. Boris Johnson promised a crackdown on obesity in 2020 after coming out of hospital where he was treated for Covid. He pledged to ban junk food advertising on television before the 9pm watershed and end "buy one, get one free" promotions on unhealthy products. His strategy paper called obesity "one of the biggest health crises the country faces". Yet many of the key policies have been delayed or dropped. Ministers argued that it was impossible to introduce a ban on "buy one, get one free" promotions during a cost of living emergency even though a government-commissioned report found that three-for-two offers saved people only 27p a week, a minuscule amount compared with the rise in mortgage rates or energy bills.

The government approach is driven by the idea that people should take responsibility for the choices that they make but in Britain it is increasingly difficult to be healthy. The supermarket shelves are heaving with sugar-laden cereals and highly processed food that is cheaper than fresh fruit and vegetables. We are trapped in a junk food cycle. Ultra-processed foods — high in salt, refined carbohydrates, sugar and fats — are on average a third of the cost per calorie of healthier foods and now make up 57 per cent of the average UK diet. The fruit and veg market is worth only £2.2 billion a year, compared with the £3.9 billion that is spent on confectionery. There are 20 kinds of KitKat and even a KitKat breakfast cereal but in some parts of the country it is almost impossible to buy a carrot. It is hard for individual willpower to hold out against the powerful and all-pervasive influence of the "obesogenic" environment. With ready meals and take aways easily available, some people have forgotten how to cook. Many children never learn. In 1980, 57 per cent of the average household budget was spent on fresh ingredients to cook at home. That has fallen to 35 per cent.

The chef Jamie Oliver, who has been campaigning for healthier school meals for almost twenty years, said that in old cook books "there was no difference between nourishment and the pharmacy. Everything was in one book. You turn a page from a syllabub and there'd be an ointment for a rash." Obesity and diet-related disease are, he told the commission "a normal response to an abnormal environment" and progress on tackling that had been "unforgivably slow." Far from promoting real choice, "the free market is currently the Wild West," he said. "I had all that nanny state business thrown at me every single day often by very well-off males, but kids really benefit from a good nanny. It's the nanny state that controls the quality of the rivets in the plane that holds you up 36,000 feet in the air. It's the nanny state that makes sure the tyres are built with some integrity on your car. For the love of God, why would you not treat food the same? Sugar, salt, fat are all incredible but like many things in life if they're misused — which they are undoubtedly are — then you get the problem that Britain has. The cake aisle never lies to you, it's the most honest thing in the supermarket. You go down the breakfast cereal aisle and it's just a pack of lies: it's cake without any milk in it."

Anna Taylor, chief executive of the Food Foundation, said Britain's obesity problem had to be seen in the context of the wider culture. "We're one of the highest consumers globally of ultra-processed foods as a percentage of our calories," she said. "I think we're reaching a crisis point in terms of the knock-on effects that this is having on children as they develop. There is a 7cm difference in height between our five-year-olds and Dutch five-year-olds. It's environmental factors rather than genetic factors." There are height differences between the children from the least and most deprived areas, of about 1.3cm for boys, but even wealthier children in this country are on average smaller than their international peers. "We've got a diet crisis which is on a scale parallel to some of the poorest countries in the world that have got very high levels of undernutrition in children and very high levels of childhood stunting," Taylor said.

The commission heard from many witnesses that more action was needed to stop people being bombarded with harmful and unhealthy products. The chef Thomasina Miers argued that ultra-processed food should be treated like tobacco. "It's an addictive substance. We know it's bad for us so you have to intervene, like we did with smoking, because we know that it's killing people. You obviously have to be very careful because people will not want to be told that they can't have a pack of Pringles at a football match if they want one. But you can start properly labelling these foods as potentially really bad for your health."

The television presenter Dr Chris Van Tulleken, author of the best-selling book Ultra-Processed People, said more controls were needed to give people a real choice. "We want good food to be affordable and available. We don't want to ban anything but at the moment the market is controlled by a very small cabal of transnational food corporations and people don't have choice or opportunity. People have the right to be free from misinformation and the right to good food. If you live with a low income in this country you cannot afford to buy real bread."

Politicians who are now out of government were almost universally in favour of doing more to tackle the crisis. The Conservative peer Lord Bethell, who was a health minister during the pandemic, saw its grim impact during daily zoom meetings with NHS leaders at the height of the Covid crisis. "What you realised was that many of the people who were going into the intensive care units were people who were already carrying many morbidities and the most common was obesity," he said. "It made you realise, 'My goodness. The problem here is not lack of ICU beds.' That's like arguing about whether you've got the right fire extinguisher when the house is burning down." He said a complacency had developed because of the safety net of the NHS. "The free-at-the-point-of-delivery commitment is an amazing thing, and I am extremely proud of it, and we should never get rid of it but the implication of it is that when you fall ill, we will pick you up and put you back on your feet. Implied in that is frankly that you don't have to look after yourself."

7cm

Difference in height between Dutch and British five-year-olds

The government decision to abandon anti-obesity measures was "going to cost the country very, very heavily", he argued. "We need to change the environment in which our children are brought up ... We needed to lean into business and ask them, in the politest and firmest way, to be partners in the health of the country rather than to feel like they have free rein and a fiduciary duty to maximise their profits with enormous externalities and social costs. If you do that, I think the British public will breathe a huge sigh of relief and there will be a massive economic benefit. The maths of it is really straightforward. A small improvement in the health of the nation will yield a huge financial dividend."

George Osborne, who introduced the sugar tax, said he wished he had gone further. "I would extend it to other drinks. If I'd remained chancellor I would have extended it to milkshakes and fruit juices. I think you could also extend it to sugary products in general like biscuits," he told the commission. "Conservatives often make an argument that lower taxes incentivise things: enterprise or hard work or whatever. Surely if you believe that then you must believe higher taxes disincentive things which you want to prevent."

Lord Lansley, a former Conservative health secretary, said the Covid crisis showed that it was possible to act. "Obesity will kill more people even than the pandemic did and look what behaviour change was required there. The behavioural scientists wouldn't have believed that people would adapt their behaviour to the extent that they did. So people will adapt their behaviour, but they need to believe that it matters sufficiently and the dangers are sufficiently great."

Wes Streeting, the shadow health secretary, promised that a Labour government would not be afraid to use the "heavy hand of state regulation" to promote healthy choices if industry did not "pull their finger out". He singled out Nestlé's KitKat cereal as "just crackers" and "not serious" and said the soft drinks industry levy was a "successful intervention and a model to follow". Starmer has embraced the idea of the nanny state, with plans for supervised toothbrushing and more controls on the promotion of unhealthy food to children. "If a parent acted in the way the government acted they'd be charged with neglect," he told the commission.

New anti-obesity drugs offer hope to the most extreme cases but they cannot be the answer for all. They are expensive, have side-effects and must be taken for a limited period so they will be a solution only if combined with cultural change. Sadaf Farooqi, professor of metabolism and medicine at Cambridge University, said medication such as semaglutide (sold as Wegovy) was effective but should only be for those with a genuine medical need. "We shouldn't be giving them to people who just want to fit into a dress for their wedding. What we've created is a slightly Wild West scenario where people can go online and get things, and therefore that's disrupted the healthcare environment, so the people who actually are in clinics and needing medical help, now can't get the drugs." She explained that genes had a significant role in people's weight but that environment also plays a part.

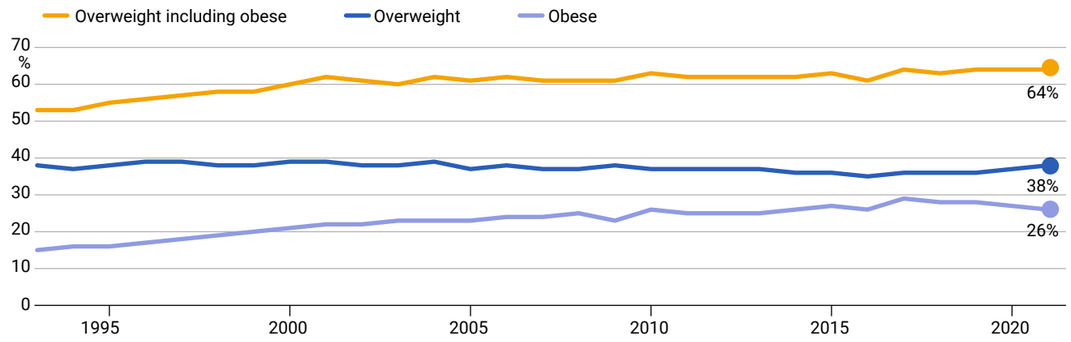
The fitness guru Joe Wicks argued that anti-obesity drugs were a "temporary fix" that would not improve mental or physical health for the long term. "Even if it does help you lose weight, it's not going to help you with your emotions, your mental health, it's not going to help with your energy and your sleep," he said. "There are no shortcuts. There's no drug in the world that's going to really replace exercise." He drew a connection between the reduction in school sport and the youth mental health crisis, explaining that exercise had been a form of therapy for him as a child. "It's a powerful tool," he said.

It is not only food that is the problem in unhealthy Britain. The commission heard that more than a quarter of adults and a third of children were not meeting the chief medical officer's guidelines to do 150 minutes of moderate to intense physical activity per week. "In the last decade 42,000 hours of PE have been lost within schools," Huw Edwards, chief executive of UK Active, said. Physical inactivity is associated with one in six deaths in the UK and is estimated to cost £7.4 billion annually. "We're a nation who like watching sport but doing it is all a bit of a challenge," the paralympian Baroness Grey-Thompson said. "For me, prevention is a big part of refocusing our energy. You can restructure [the NHS] all you want but it's not the problem. We

> "We're so busy mopping up the overflow that we never get round to turning off the tap

Obesity rate rising

The proportion of adults in England who are overweight including obese has risen by 11 per cent since 1993



SOURCE: NHS DIGITAL

Data for England only. Latest figures for 2021

need to educate our doctors differently on what they do because it's too easy to prescribe meds."

Although smoking rates have fallen, there are still an estimated 1.8 million households in England with children where someone smokes. Smoking costs the state £17 billion, significantly more than it raises in taxes. The UK also has some of the highest rates of binge drinking in the OECD, with 26 per cent of women and 45 per cent of men engaging in heavy episodic drinking.

Some companies are keen on legislation to enforce a healthier culture. They argue that there needs to be a level playing field so that individual retailers who do make the right decision are not penalised for it. James Mayer, president of Danone UK, said last year "government intervention is required" and added that ministers should "consider taxing products high in fat, sugar or salt". Lord Rose, the Asda chairman and former boss of Marks & Spencer, told his fellow commissioners that having spent 40 years in the food industry he felt that something needed to change. "I think we are encouraging people to have the wrong behavioural styles, but it's not all fixable by food retailers; it needs to be a joined-up process." Employers should, he said, have a "legal obligation" to do something about their employees' health. "It was known as enlightened self-interest. We kept our employees healthy because if our employees were healthy, our business was healthy," he said.

Neville Koopowitz, chief executive of the health insurer Vitality UK, argued that businesses should be required to report on the health of their employees as part of corporate social responsibility. There was, he said, a "paradox of wellness versus sickness" in this country that meant that the incentives needed to be rebalanced for companies and individuals. "When you're ill, you can get treatment straight away and you see the results fairly quickly. You go for an operation, you get cured and you don't see the cost because somebody else is paying. Wellness is exactly the opposite. It takes time to eat well and to see the benefits of weight loss or getting physically active. It's more expensive, because you've got to sign up to go to a gym or a personal trainer or eat healthy foods so you've got this healthcare dilemma."

Vitality has developed a health and fitness programme using behavioural science and data analytics. People who enrol, as individuals or through their company, are given an Apple watch that they can partly pay for by reaching certain fitness goals each month. They also earn points that give them access to rewards including coffee or cinema tickets. On average, those engaged with the programme for a year increased their exercise by 22 per cent, reduced consumption of fatty foods by 27 per cent and increased the amount of fruit and vegetables they ate by 11 per cent. Vitality members who recorded physical activity at least once a week had a 15 per cent lower risk of hospitalisation and those exercising five times a week had a 29 per cent lower risk. Highly active members had a 41 per cent lower mortality risk.

Analysis by the company suggests that incentivising healthy habits and reducing 10 per cent of the preventable disease burden could save the NHS at least £1.2 billion a year. Office employees who meet health service guidelines to do 150 minutes of exercise a week lose 28 per cent fewer productive days and those who eat five portions of fruit and veg a day lose 12 per cent fewer productive days.

In Japan the commission witnessed the mandatory annual health check in progress at the Dai-ichi Life insurance company in Tokyo. Doctors and nurses in white coats were measuring blood pressure and heart rates as well as taking blood samples to test. Behind a screen at the end of the room employees were weighed and had their waists measured, a legal requirement under the 2008 "Metabo" Law. If people do not meet standard guidelines for waist size, they are expected to attend counselling or receive motivational support. Businesses can be fined if they do not achieve sufficient participation rates.

The impact on corporate culture is huge. Dai-ichi, which has 50,000 employees, has targets for reducing obesity among its staff as well as measures for financial success. Along with IT specialists and accountants, the company employs 15 full-time doctors, an in-house pharmacist and a health consultant to advise on diet and exercise. An incentive scheme offers rewards such as Amazon gift cards for employees who take at least 8,000 steps a day, measured by a corporate app. Sickness rates are incredibly low: 1.3 days on average per employee every year, compared with 5.7 in the UK. "We believe that health is the foundation of everything," Mieko Ishii, the leader of the company's health promotion section, said. "When the health of the employees will lead to the improved productivity of the company."

> We are fat and ill because we live in a world full of food that makes us fat and ill

For most nations there is a correlation between wealth and weight: the richer a country becomes the higher its obesity rates. Japan has bucked the trend and has obesity levels equivalent to some of the poorest countries in the world, including Ethiopia and Bangladesh. This is partly because the traditional Japanese diet, which includes a lot of fresh fish, tofu and vegetables, is healthier than much western food. But such food choices are not an inbuilt national trait. For decades, successive Japanese governments have deliberately set out to promote healthy eating and keep obesity in check.

In 1954 the School Lunch Act was introduced guaranteeing a healthy meal for all pupils every day and in 2005 a *shokuiku* law made food education a compulsory part of the school curriculum. At the Kohoku primary school in Tokyo the commission watched children serve each other spiced baked fish, vegetables sprinkled with dried bonito and rice for lunch. There were no dinner ladies doling out baked beans and turkey twizzlers; instead the pupils stirred soy sauce into the dishes and ladled out bowls of miso soup. Before they started eating with chop sticks at their desks, the children heard about the nutritional value of the food. Lunchtime is "part of the education", Yasuhiro Matsuda, the deputy head, explained. "We want children to have an understanding of the importance of good nutrition and how to eat well and we have found that healthy school meals lead to better concentration and greater mental stability too."

Japan is not the only place that has shown that it is possible to shape its eating habits and tackle obesity. Amsterdam managed to achieve a 12 per cent drop in childhood obesity over three years after setting up the Health Weight Approach initiative in 2012. Fruit juice was banned from schools, fast food outlets were limited, advertising restricted and subsidised activities offered to low-income families. As Dimbleby said: "Good food cultures don't just happen, they are made by us." Willpower is not enough when the environment is conspiring against individuals. "We are fat and ill because we live in a world full of food that makes us fat and ill. The mantra of 'choice' beloved of free marketeers is simply deluded."

The commission believes that transformative change is now essential to tackle obesity. There needs to be a concerted effort by government, business, civil society and individuals to break the junk food cycle. Our supermarkets, high streets and school canteens are flooded with unhealthy options and millions of pounds are spent on marketing them. The incentives in the system need to be rebalanced to make it harder to profit from foods that are harmful and easier for people to access nutritious food.

We propose that the soft drinks industry levy (the "sugar tax") should be expanded to other sugary drinks and products and also to highly salted foods. The evidence for an expansion from sugar to salt is persuasive. Britons eat 40 per cent more salt than the recommended 6g per day and a high intake of salt is associated with a 23 per cent increase in the risk of stroke and a 14 per cent increase in the risk of cardiovascular disease. When salt consumption in northern Japan fell by 4g a day, stroke deaths fell by 80 per cent.

The purpose of the policy would be to encourage manufacturers to change their recipes so the extra tax would be imposed on the sugar and salt bought in bulk for food processing, rather than on the milkshakes, doughnuts, biscuits or crisps sold in shops. When the soft drinks levy was introduced in 2018 the companies rapidly reformulated their products and reduced the sugar content by 29 per cent across the market, rather than increasing their prices. Consumers hardly noticed and sales remained stable. The new tax would aim to have the same effect while raising an estimated £2.9 billion to £3.4 billion.

This money should be used to expand free school meals to all children whose families are on universal credit, starting with the most deprived postcodes. At the moment only those with a household income of up to £7,400 are eligible and a growing number are going hungry. The total cost would be £1 billion. The change could be introduced in stages and a cost/benefit analysis by PwC found that every £1 invested is estimated to generate £1.38 in long-term benefits. There should be more investment in school kitchens and chefs, with food and nutrition promoted in the classroom, as in Japan. All children should learn to cook basic recipes by the age of 11. Cookery and nutrition lessons should be inspected with the same rigour as maths or English and the government should pay for the ingredients. Ofsted should monitor whether schools are meeting food standards. Those serving unhealthy lunches should not be able to get an "outstanding" grade.

There must be a legal requirement on all public sector bodies — hospitals, prisons, care homes and army barracks as well as schools — to serve healthy food to promote the long-term health of the nation. Taxpayers should not be funding unhealthy meals and procurement rules should be rewritten to ensure that they do not.

Tougher action is also required on the promotion and marketing of unhealthy food. The pre-watershed television advertising ban that was delayed must be introduced as soon as possible and should also apply to digital platforms targeting young audiences including social media and YouTube. Sports sponsorship that promotes unhealthy food, alcohol or gambling should be banned. There should be stricter controls on ultra-processed products that are high in sugar or salt but confuse shoppers with claims about

being “organic” or “natural”. Supermarkets could be encouraged to experiment with “buy one, get one free” offers on healthy rather than unhealthy products. The government should look at outlawing packaging for unhealthy food that aims to appeal to children. In Chile, labelling laws have banned the cartoon character Tony the Tiger from Zucaritas, the equivalent of Frosties. Instead the sugary cereal must carry a health warning. More than 68 per cent of people have changed their eating habits and 20 per cent of the industry has modified its products. Businesses must be encouraged to do more to promote the health of their employees and “H” for health should be added to the environmental social and corporate governance (ESG) requirements for companies.

Planning laws should be reformed to empower local authorities to reduce the prevalence of unhealthy food outlets such as chicken shops and other takeaways, particularly around schools, and to minimise adverts for unhealthy products. Councils could also be incentivised to look at differential tax rates for fruit and vegetable shops, or to require a certain ratio of fresh food to fast food retailers in an area to deal with food deserts. Empty shops on neglected high streets should be offered to community groups to run exercise classes or social canteens, offering nutritious and affordable meals. At the same time the NHS should expand prescription of vouchers for fruit and vegetables for poor families, as has been piloted by two GP surgeries in London.

As a nation we need to increase our activity levels to boost fitness and reduce frailty in old age. Schools should be open to the community as much as possible over the holidays to improve access to low-cost exercise facilities for families. Private schools should be expected to participate, offering up their playing fields, swimming pools and gyms in return for tax breaks.

Smoking should be phased out. Vapes are useful as a smoking cessation tool but they must not be marketed to children with appealing colours and flavours. Minimum unit pricing for alcohol should also be introduced in England. Since it was introduced in Scotland five years ago, deaths caused by alcohol have dropped by more than 13 per cent and hospital admissions by 4 per cent. There was no evidence of substantial negative impacts on the alcohol industry.

The commission found strong support for more state intervention to promote healthier lifestyles. Almost three times as many people thought that the government should be doing more to encourage people to eat healthily as believed that the government was doing too much. Our YouGov poll showed that 74 per cent of people supported banning foods high in salt, sugar or fat from using packaging that aims to appeal to children, compared with 18 per cent who are against. More than twice as many voters backed the pre-watershed ban on television junk food advertising as opposed it (59 per cent compared with 28 per cent). There were clear majorities in favour of extending the “sugar tax” to other unhealthy foods. The YouGov poll found that 53 per cent backed expanding the levy to foods that are high in salt, 54 per cent believed that it should be applied to foods that are high in fat and 49 per cent said it should cover milk shakes.

There is too often a sense of fatalism in Britain about our health but other countries have managed to transform their outcomes by concerted and sustained effort. In the 1970s men in North Karelia, a remote province of Finland, had the highest mortality rate from heart failure ever recorded anywhere in the world. The levels were 30 per cent higher than in Mediterranean countries. In fact so many men were dropping dead in their 40s and 50s that the area became known as the unhealthiest region on earth. In 1972 a 27-year-old doctor called Pekka Puska was hired to lead a public health project.

Over the next three decades he created a programme that reduced heart disease by 80 per cent among the men of North Karelia. He realised that the problem was their diet and he set out to change it. After the Second World war, veterans had been given plots of land to tend and, without the skills for arable farming, most had decided to rear pigs and cows. This had led to a dramatic increase in the amount of red meat, butter and animal fat that the local population ate. A typical North Karelian stew had three ingredients: water, fatty pork and salt. Vegetables were avoided because they were seen as valuable animal feed. Puska’s attitude was to “do everything, everywhere all at once”. He wrote a recipe book that added vegetables to traditional dishes; he held more than 300 local “parties of long life,” where healthy food was served to villagers; he cleared the snow from footpaths and built bicycle lanes; he set up co-operatives to pick and freeze berries in summer for use in winter. On their own the measures seemed trivial but together they brought about a huge cultural shift. “You have to have your boots deep in the mud,” Puska told the health commission. “Strategies on paper do not do the work; you need to read people in their everyday surroundings.”

Within five years deaths from heart disease had started to fall. Puska was asked to introduce his project across Finland. He created an X Factor-style television show on which contestants competed to see who was the healthiest. It was watched by a third of the population. By 2009 the mortality rate from heart disease had fallen by 85 per cent in North Karelia and by 80 per cent across Finland. Average life expectancy rose by seven years for men and six years for women. “The target was the whole community, not just people at high risk,” he said. “The healthy lifestyle needs to be made easy.” That is not the nanny state, it is helping people to help themselves.

The Times Health Commission began by analysing the scale of the problem in the NHS and social care system. It concludes by identifying the breadth of the solution that is required to create a healthier and wealthier Britain. The healthy lifestyle needs to be made the easy choice. People must be empowered to take charge of their own health, clinicians liberated from bureaucracy, staff supported, patients heard. Innovation must be embraced. Technology can shape the future. And with collaboration between individuals, businesses, government, health professionals and community groups it is possible to turn things around. Everything, everywhere, all at once.

Case Study Chefs in schools

There are no pizzas or turkey twizzlers on the menu for lunch at Gayhurst School, a state primary in Hackney, east London. Instead, children eat Persian beef biryani, carrot and coriander fritters or black beans with brown rice. Pudding is lime cheesecake and amaretti crumble.

It is a regular Thursday but pupils sit down to a feast. The daily-changing menu at the school is created by the chef Sergio Vitale, who works with a kitchen team of five producing around 650 meals a day for children and staff.

Louise Nichols, the executive head, says the focus is on “making fresh unprocessed easy meals rather than ‘healthy’, which is the kiss of death to any school dinner hall.”

Creativity in the kitchen is encouraged. “The chefs develop their own styles and also respond to what the children like whilst still pushing them to eat things they don’t eat usually,” she says.

The pupils all eat lunch together, there are no packed lunches and staff take up of school food is about 85 per cent so pupils sometimes eat with the teachers. Food education is seen as an essential part of the curriculum. All children have lessons at the nearby Hackney School of Food, where they harvest home-grown food from the garden and are taught how to prepare it by professional chefs.

Gayhurst was the first to trial a new model of school lunches, which is now being promoted more widely by the charity Chefs in Schools. Nicole Pisani, former head chef at Yotam Ottolenghi’s restaurant Nopi, ran the school kitchen to restaurant standard, serving grilled radicchio instead of baked beans, quinoa not chips and octopus rather than chicken nuggets. The children loved it and parents queued up to attend fundraising dinners.

In 2018 Pisani and the restaurateur Henry Dimbleby, a Times health commissioner, set up Chefs in Schools to promote the approach more widely. The charity now works in 190 schools with more than 50,000 children across the country from Yorkshire to Devon.

At The Grove School in Totnes, Devon, (above) fish fingers have been replaced by fresh fish from Brixham, prepped and breaded in the school, and tinned sweetcorn with celeriac remoulade.

The chef Marco Pilloni previously worked in Michelin-starred restaurants but he prefers his new customers. “Feeding all these kids has a different meaning to feeding paying customers. An early education in a better diet is vital and if I get to inspire these children for the rest of their lives I can’t ask for any more.”

APPENDIX
List of recommendations

Chapter 1 - The scale of the problem

Establish a Healthy Lives Committee empowered by a legally binding commitment to increase healthy life expectancy by five years in a decade and reduce health inequalities to encourage a long-term approach with cross-party agreement.

Chapter 2 – Hospitals and waiting lists

Tackle waiting lists by introducing a national programme of weekend high-intensity theatre (HIT) lists once a month in 50 hospitals to get through a week of planned operations in a day with two operating theatres working in parallel. Introduce seven-day-a-week surgical hubs across the country to boost productivity.
Invest in community diagnostic centres, this will require about £1.6 billion, partly for new facilities and partly for upgrading small sites to larger ones. Involving the private sector would minimise capital expenditure and accelerate the programme. It must also take full advantage of AI diagnostic tools as they become available.
Create a user-friendly version of the Model Hospital website, which ranks all hospitals in the country on hundreds of key metrics covering everything from surgical outcomes to the cost of hospital food, for use by the public to drive up standards and give patients the tools to make an informed choice about their care.
Over time the NHS should aim to separate "hot" and "cold" (acute and planned) care altogether as much as possible, creating specialist emergency centres and distinct elective hubs.
More patients should be cared for at home with virtual wards, in which staff monitor their vital statistics remotely. Outpatient appointments must also be streamlined.

Chapter 3 – GPs and primary care

Reform the GP contract to focus on wider health outcomes rather than box-ticking, ensure that patients get prompt appointments and restore continuity of care.
Encourage more super-practices operating at scale and create a network of new community health centres with outpatient clinics, diagnostic services, pharmacists, mental health professionals, community nurses and physicians' assistants working alongside family doctors. Operating within the community, these health centres could include diagnostic centres, outpatient clinics, family hubs, dentists, obesity support or frailty clinics as well as other services such as employment and housing advice, depending on local need.
Pharmacists should be incentivised to do more prescribing, consultations and community care.
The role of the GP as the "gatekeeper" to healthcare must evolve, with patients able to self-refer to a specialist for certain conditions such as dermatology and musculoskeletal problems.
The barriers between primary and secondary care should be broken down. That could involve GPs being employed by hospitals or consultants doing outpatient appointments in the community.

Chapter 4 – Workforce and culture

Write off student loans for doctors, nurses and midwives who stay in the NHS to improve retention and recruitment. Debt would be reduced by 30 per cent for those who stay three years, 70 per cent for seven years and 100 per cent for ten years. Student doctors should be eligible for full maintenance loans throughout their training.
The health service across the board needs to become a much better employer in ways that go beyond pay settlements. This includes providing affordable and healthy staff canteens, night transport or parking, a comfortable staff room, private spaces for clinicians to decompress and somewhere to get a hot drink. There should be more on-site childcare and flexible work contracts to allow those with caring responsibilities to remain in the workforce.
There must be a zero-tolerance approach to bullying, harassment, assault and racism, with prompt inquiries and action against those found guilty, however senior.
Professional development and training must be offered at all levels to give staff a greater sense of career progression.
The NHS workforce strategy must be updated and independently verified every two years, with the process overseen by the Healthy Lives Committee. It should include social care and software engineers as well as doctors and nurses.
The increasingly important role of non-medics in community care and chronic disease management must also be recognised.
There needs to be better training and career development for managers, the NHS Leadership Academy should be boosted and the Care Quality Commission's "well-led" category for inspections broadened to include a detailed review of management practices.
Medical training must be reformed to include more accelerated degrees and a greater emphasis on team-work and empathy. The private sector should be expected to support and fund medical training, including offering work placements to junior doctors and student nurses. The requirement for junior doctors to rotate all over the country must end to make it easier to balance work and family.

Chapter 5 – Patient safety

Introduce a no-blame compensation scheme for medical errors with settlements determined according to need rather than through a lengthy court battle to ensure that families get the support they need more quickly and encourage the NHS to learn from mistakes.
The promised introduction of "Martha's rule", named after Martha Mills, which would make it easier for families to insist on a second opinion, must come into force.
There should be a review of the regulatory landscape with the aim of creating a simpler, more easily understood system to bring clarity for patients and the health service.
The health ombudsman, who at present can only respond to complaints, should have the power to initiate investigations and ensure that the outcome of inquiries by other bodies are implemented in a timely fashion.

Chapter 6 – Science and technology

Create a digital health account for all patients to unlock the benefits of technology, data and AI in the health and care system.
The "patient passport", accessed through the NHS app, would be used to book appointments, order prescriptions, view medical records, test results or referral letters, sign up for research with an opt-out system and connect hospitals, GP surgeries, pharmacists and social care. Tech providers wanting to work in the NHS must be required to guarantee interoperability with the unified patient record.
Incentivise NHS staff to take part in research and put the case for research to their patients by giving 20 per cent of hospital consultants and other senior clinicians 20 per cent protected time for research. Thought should be given to how other NHS staff could be given protected time for research.
The NHS must ensure that all staff have the basic IT skills they need to operate in the digital world and recruit data scientists and AI specialists to work alongside clinicians.
A new British Data Authority to be created to reassure patients that privacy will be protected and deal with ethical concerns while allowing the advantages of data-sharing to be made available to ensure the best possible care. It would also be responsible for ensuring that a digital divide does not develop and ensure that everyone could access care.
Introduce a "test first" rule for antibiotics where possible to reduce the number of prescriptions. This needs to go hand in hand with educating doctors and patients about the dangers of antibiotic resistance.
The bureaucratic process for clinical trials and medical approvals should be speeded up.
A new funding mechanism should be created for expensive curative therapies, allowing the NHS to spread the cost over a number of years if NICE approves the drug, based on long-term cost-benefit analysis so patients can benefit from the "new age of cures".

Chapter 7 – Social care

A new National Care System should be created giving everyone the right to appropriate support in a timely fashion. Equal but different from the NHS, it should be administered locally and delivered by a mixture of the public and private sectors but with national guidelines, registered providers, minimum standards for users and employment rights for workers.
A statutory duty should be imposed on local authorities to provide information, advice and assistance about social care.
Independent social care providers should receive a fair pay rate and be required to sign up to national standards on care quality, workforce and financial conduct in return for a licence to operate.
Social care should be included in the NHS workforce plan and all future strategies should be integrated. Care workers need to be better paid, over time rising towards parity with NHS staff doing comparable roles. There should also be better career paths, routes to promotion and management.
The pay caps for how much people can have in assets before they pay towards their social care should be higher and, in the future, rise with inflation to ensure that it keeps pace with the cost of living.
The delayed government legislated cap on social care costs must now be introduced as a matter of urgency and the cap should apply to all care costs, including means-tested council funding (reversing the government amendment that means that only private contributions should be counted).
Those who need it must have the right to a social care assessment. Over time this should become a routine part of getting older Reablement programmes, with a strong link between health and social care, should be expanded around the country to reduce healthcare demand.
Those born with a disability or who develop a care need before the age of 25 should automatically be entitled to free social care.
There should also be more respite provision for unpaid carers and a review of the minimum income guarantee for disabled people to ensure it is fair and reasonable.
A National Volunteer Service should be created for young people to work in care homes and visit the elderly or long-term disabled. All medical students should be expected to spend some time in a social care setting during their training to help to break down barriers between the two sectors.
Developers must be encouraged to create more sheltered housing and intergenerational homes with a new planning class of "housing with care".

Chapter 8 – Mental health

Guarantee that all children and young people requiring mental health support can get access to treatment within four weeks for non-urgent referrals; within seven days when there is a risk of harm; and rapid follow up appointments for those who need help. Publish data on the waiting times for all mental health services.
All children must have mental health support at school with access to specialist NHS teams.
The government should undertake a national wellbeing survey in secondary schools that would focus attention on the importance of mental health and build a better understanding of how to create contented children.
Mental health hubs across the country should offer drop-in facilities and early intervention, including peer-to-peer support.
Reform of the Mental Health Act is long overdue. The proposals are ready to go and they must be implemented at the earliest opportunity.

Chapter 9 – Health inequalities

Progress in narrowing health inequalities should be monitored by the new Healthy Lives Committee with clear annual targets for narrowing the gap between rich and poor.
More money and power over health policy should be devolved to mayors and regions to stimulate innovation and incentivise local leaders to take stronger action and also more clearly link health budgets with healthy life expectancy.
Sick pay should be reformed to ensure that people do not go to work when they are acutely ill and likely to be infectious. We propose that the earnings threshold should be abolished and the waiting period before sick pay is accessed be removed.
There should be more community link workers in GP practices to help patients to cope with social issues affecting their health and wellbeing such as social isolation, money worries, unemployment, benefits or bereavement.
There must be greater coordination between government agencies to identify problems early and stop the most vulnerable falling through the gaps. The patient passport that will connect the health and social care systems should also be linked with education data through the unique code given to children at birth.

Chapter 10 – Public health and obesity

Tackle obesity by expanding the sugar tax, taxing salt, implementing a pre-watershed ban on junk food advertising and reducing cartoons on packaging to minimise children's exposure to unhealthy food. There should be stricter controls on ultra-processed products, which are high in sugar or salt, but confuse shoppers with claims about being "organic" or "natural".
Expand free school meals to all children whose families are on universal credit, rolling out from the most deprived postcodes.
More investment in school kitchens and chefs, with food and nutrition promoted in the classroom. All children must learn to cook basic recipes by the age of 11. Cookery and nutrition lessons should be inspected with the same rigour as maths or English and the government should pay for the ingredients. Ofsted should also monitor whether schools are meeting school food standards and those serving unhealthy lunches should not be able to get an "outstanding" grade.
There must be a legal requirement on all public sector bodies — hospitals, prisons, care homes and army barracks as well as schools — to serve healthy food to promote the long-term health of the nation.
Tougher action is also required on the promotion and marketing of unhealthy food. The pre-watershed television advertising ban, which was delayed, must be introduced as soon as possible and should also apply to digital platforms targeting young audiences including social media and YouTube. Sports sponsorship that promotes unhealthy food, alcohol or gambling should be banned.
Businesses must be encouraged to do more to promote the health of their employees, with "H" for Health added to the Environmental Social and Corporate Governance (ESG) requirements for companies.
Planning laws should be reformed to empower local authorities to reduce the prevalence of unhealthy food outlets, incentivise healthy food shops and minimise adverts for unhealthy products. Empty shops on neglected high streets should be offered to community groups to run exercise classes or social canteens, offering tasty, nutritious meals at affordable prices.
Schools should be open to the community as much as possible over the holidays to improve access to low-cost exercise facilities for families. Private schools should be expected to participate in the scheme, offering up their playing fields, swimming pools and gyms in return for tax breaks.
Smoking should be phased out and vapes must not be marketed to children with appealing colours and flavours.
Minimum unit pricing for alcohol should be introduced in England.

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IT IS ONLY BY CREATING A HEALTHIER BRITAIN THAT WE WILL UNLOCK THE COUNTRY'S POTENTIAL.

Rachel Sylvester,
chairwoman of the Times
Health Commission

Illness is neither an indulgence for which people have to pay; nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community

ANEURIN BEVAN, ARCHITECT OF THE NHS

THE TIMES